

1.1 CONFERENCE COMMITTEE REPORT ON H. F. No. 1362

1.2 A bill for an act

1.3 relating to state government; establishing the health and human services budget;
1.4 making changes to licensing; Minnesota family investment program, children,
1.5 and adult supports; child support; the Department of Health; health care
1.6 programs; making technical changes; chemical and mental health; continuing
1.7 care programs; establishing the State-County Results, Accountability, and
1.8 Service Delivery Redesign; public health; health-related fees; making forecast
1.9 adjustments; creating work groups and pilot projects; requiring reports;
1.10 decreasing provider reimbursements; increasing fees; appropriating money to
1.11 various state agencies for health and human services provisions; amending
1.12 Minnesota Statutes 2008, sections 62J.495; 62J.496; 62J.497, subdivisions
1.13 1, 2, by adding subdivisions; 62J.692, subdivision 7; 103I.208, subdivision 2;
1.14 125A.744, subdivision 3; 144.0724, subdivisions 2, 4, 8, by adding subdivisions;
1.15 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision 1a; 144.125,
1.16 subdivision 1; 144.226, subdivision 4; 144.72, subdivisions 1, 3; 144.9501,
1.17 subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions 1g, 4;
1.18 144.9508, subdivisions 2, 3, 4; 144.9512, subdivision 2; 144.966, by adding
1.19 a subdivision; 144.97, subdivisions 2, 4, 6, by adding subdivisions; 144.98,
1.20 subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision 1; 144A.073, by
1.21 adding a subdivision; 144A.44, subdivision 2; 144A.46, subdivision 1; 148.108;
1.22 148.6445, by adding a subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180,
1.23 subdivisions 1, 2, 3, 5; 153A.17; 156.015; 157.15, by adding a subdivision;
1.24 157.16; 157.22; 176.011, subdivision 9; 245.462, subdivision 18; 245.470,
1.25 subdivision 1; 245.4871, subdivision 27; 245.488, subdivision 1; 245.4885,
1.26 subdivision 1; 245A.03, by adding a subdivision; 245A.10, subdivisions 2, 3,
1.27 4, 5, by adding subdivisions; 245A.11, subdivision 2a, by adding a subdivision;
1.28 245A.16, subdivisions 1, 3; 245C.03, subdivision 2; 245C.04, subdivisions 1,
1.29 3; 245C.05, subdivision 4; 245C.08, subdivision 2; 245C.10, subdivision 3,
1.30 by adding subdivisions; 245C.17, by adding a subdivision; 245C.20; 245C.21,
1.31 subdivision 1a; 245C.23, subdivision 2; 246.50, subdivision 5, by adding
1.32 subdivisions; 246.51, by adding subdivisions; 246.511; 246.52; 246B.01, by
1.33 adding subdivisions; 252.46, by adding a subdivision; 252.50, subdivision
1.34 1; 254A.02, by adding a subdivision; 254A.16, by adding a subdivision;
1.35 254B.03, subdivisions 1, 3, by adding a subdivision; 254B.05, subdivision
1.36 1; 254B.09, subdivision 2; 256.01, subdivision 2b, by adding subdivisions;
1.37 256.045, subdivision 3; 256.476, subdivisions 5, 11; 256.962, subdivisions
1.38 2, 6; 256.963, by adding a subdivision; 256.969, subdivision 3a; 256.975,
1.39 subdivision 7; 256.983, subdivision 1; 256B.04, subdivision 16; 256B.055,
1.40 subdivisions 7, 12; 256B.056, subdivisions 3, 3b, 3c, by adding a subdivision;
1.41 256B.057, subdivisions 3, 9, by adding a subdivision; 256B.0575; 256B.0595,
1.42 subdivisions 1, 2; 256B.06, subdivisions 4, 5; 256B.0621, subdivision 2;

2.1 256B.0622, subdivision 2; 256B.0623, subdivision 5; 256B.0624, subdivisions
2.2 5, 8; 256B.0625, subdivisions 3c, 7, 8, 8a, 9, 13e, 17, 19a, 19c, 26, 41, 42, 47;
2.3 256B.0631, subdivision 1; 256B.0641, subdivision 3; 256B.0651; 256B.0652;
2.4 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657, subdivisions
2.5 2, 6, 8, by adding a subdivision; 256B.08, by adding a subdivision; 256B.0911,
2.6 subdivisions 1, 1a, 3, 3a, 4a, 5, 6, 7, by adding subdivisions; 256B.0913,
2.7 subdivision 4; 256B.0915, subdivisions 3e, 3h, 5, by adding a subdivision;
2.8 256B.0916, subdivision 2; 256B.0917, by adding a subdivision; 256B.092,
2.9 subdivision 8a, by adding subdivisions; 256B.0943, subdivision 1; 256B.0944,
2.10 by adding a subdivision; 256B.0945, subdivision 4; 256B.0947, subdivision
2.11 1; 256B.15, subdivisions 1, 1a, 1h, 2, by adding subdivisions; 256B.37,
2.12 subdivisions 1, 5; 256B.434, by adding a subdivision; 256B.437, subdivision 6;
2.13 256B.441, subdivisions 48, 55, by adding subdivisions; 256B.49, subdivisions
2.14 12, 13, 14, 17, by adding subdivisions; 256B.501, subdivision 4a; 256B.5011,
2.15 subdivision 2; 256B.5012, by adding a subdivision; 256B.5013, subdivision
2.16 1; 256B.69, subdivisions 5a, 5c, 5f; 256B.76, subdivisions 1, 4, by adding
2.17 a subdivision; 256B.761; 256D.024, by adding a subdivision; 256D.03,
2.18 subdivision 4; 256D.051, subdivision 2a; 256D.0515; 256D.06, subdivision
2.19 2; 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.49, subdivision 3;
2.20 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivisions 1a, 7c;
2.21 256J.08, subdivision 73a; 256J.20, subdivision 3; 256J.24, subdivisions 5a,
2.22 10; 256J.26, by adding a subdivision; 256J.37, subdivision 3a, by adding a
2.23 subdivision; 256J.38, subdivision 1; 256J.45, subdivision 3; 256J.49, subdivision
2.24 13; 256J.575, subdivisions 3, 6, 7; 256J.621; 256J.626, subdivision 6; 256J.751,
2.25 by adding a subdivision; 256J.95, subdivision 12; 256L.04, subdivision 10a,
2.26 by adding a subdivision; 256L.05, subdivision 1, by adding subdivisions;
2.27 256L.11, subdivisions 1, 7; 256L.12, subdivision 9; 256L.17, subdivision 3;
2.28 259.67, by adding a subdivision; 270A.09, by adding a subdivision; 295.52,
2.29 by adding a subdivision; 327.14, by adding a subdivision; 327.15; 327.16;
2.30 327.20, subdivision 1, by adding a subdivision; 393.07, subdivision 10; 501B.89,
2.31 by adding a subdivision; 518A.53, subdivisions 1, 4, 10; 519.05; 604A.33,
2.32 subdivision 1; 609.232, subdivision 11; 626.556, subdivision 3c; 626.5572,
2.33 subdivisions 6, 13, 21; Laws 2003, First Special Session chapter 14, article
2.34 13C, section 2, subdivision 1, as amended; Laws 2007, chapter 147, article
2.35 19, section 3, subdivision 4, as amended; proposing coding for new law in
2.36 Minnesota Statutes, chapters 62A; 62Q; 156; 246B; 254B; 256; 256B; proposing
2.37 coding for new law as Minnesota Statutes, chapter 402A; repealing Minnesota
2.38 Statutes 2008, sections 62U.08; 103I.112; 144.9501, subdivision 17b; 148D.180,
2.39 subdivision 8; 246.51, subdivision 1; 246.53, subdivision 3; 256.962, subdivision
2.40 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10,
2.41 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092, subdivision 5a; 256B.19,
2.42 subdivision 1d; 256B.431, subdivision 23; 256D.46; 256I.06, subdivision 9;
2.43 256J.626, subdivision 7; 327.14, subdivisions 5, 6; Laws 1988, chapter 689,
2.44 section 251; Minnesota Rules, parts 4626.2015, subpart 9; 9100.0400, subparts
2.45 1, 3; 9100.0500; 9100.0600; 9500.1243, subpart 3; 9500.1261, subparts 3, 4, 5,
2.46 6; 9555.6125, subpart 4, item B.

2.47
2.48 The Honorable Margaret Anderson Kelliher
2.49 Speaker of the House of Representatives

2.50 The Honorable James P. Metzen
2.51 President of the Senate

2.52 We, the undersigned conferees for H. F. No. 1362 report that we have agreed upon
2.53 the items in dispute and recommend as follows:

3.1 That the Senate recede from its amendment and that H. F. No. 1362 be further
3.2 amended as follows:

3.3 Delete everything after the enacting clause and insert:

3.4 **"ARTICLE 1**
3.5 **LICENSING**

3.6 Section 1. Minnesota Statutes 2008, section 245A.10, subdivision 2, is amended to
3.7 read:

3.8 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
3.9 purposes of family and group family child care licensing under this chapter, a county
3.10 agency may charge a fee to an applicant or license holder to recover the actual cost of
3.11 background studies, but in any case not to exceed \$100 annually. A county agency may
3.12 also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year
3.13 license or \$100 for a two-year license.

3.14 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
3.15 applicant for authorization to recover the actual cost of background studies completed
3.16 under section 119B.125, but in any case not to exceed \$100 annually.

3.17 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

3.18 (1) in cases of financial hardship;

3.19 (2) if the county has a shortage of providers in the county's area;

3.20 (3) for new providers; or

3.21 (4) for providers who have attained at least 16 hours of training before seeking
3.22 initial licensure.

3.23 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
3.24 an installment basis for up to one year. If the provider is receiving child care assistance
3.25 payments from the state, the provider may have the fees under paragraph (a) or (b)
3.26 deducted from the child care assistance payments for up to one year and the state shall
3.27 reimburse the county for the county fees collected in this manner.

3.28 (e) For purposes of adult foster care and child foster care licensing under this
3.29 chapter, a county agency may charge a fee to a corporate applicant or corporate license
3.30 holder to recover ~~the actual cost of background studies. A county agency may also charge~~
3.31 ~~a fee to a corporate applicant or corporate license holder to recover~~ the actual cost of
3.32 licensing inspections, not to exceed \$500 annually.

3.33 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
3.34 following circumstances:

3.35 (1) in cases of financial hardship;

- 4.1 (2) if the county has a shortage of providers in the county's area; or
- 4.2 (3) for new providers.

4.3 Sec. 2. Minnesota Statutes 2008, section 245A.10, subdivision 3, is amended to read:

4.4 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
4.5 under subdivision 1, an applicant for an initial license or certification issued by the
4.6 commissioner shall submit a \$500 application fee with each new application required
4.7 under this subdivision. The application fee shall not be prorated, is nonrefundable, and
4.8 is in lieu of the annual license or certification fee that expires on December 31. The
4.9 commissioner shall not process an application until the application fee is paid.

4.10 (b) Except as provided in clauses (1) to (3), an applicant shall apply for a license
4.11 to provide services at a specific location.

4.12 (1) For a license to provide ~~waivered~~ residential-based habilitation services to
4.13 persons with developmental disabilities ~~or related conditions~~ under chapter 245B, an
4.14 applicant shall submit an application for each county in which the ~~waivered~~ services will
4.15 be provided. Upon licensure, the license holder may provide services to persons in that
4.16 county plus no more than three persons at any one time in each of up to ten additional
4.17 counties. A license holder in one county may not provide services under the home and
4.18 community-based waiver for persons with developmental disabilities to more than three
4.19 people in a second county without holding a separate license for that second county.
4.20 Applicants or licensees providing services under this clause to not more than three persons
4.21 remain subject to the inspection fees established in section 245A.10, subdivision 2, for
4.22 each location. The license issued by the commissioner must state the name of each
4.23 additional county where services are being provided to persons with developmental
4.24 disabilities. A license holder must notify the commissioner before making any changes
4.25 that would alter the license information listed under section 245A.04, subdivision 7,
4.26 paragraph (a), including any additional counties where persons with developmental
4.27 disabilities are being served.

4.28 (2) For a license to provide supported employment, crisis respite, or
4.29 semi-independent living services to persons with developmental disabilities ~~or related~~
4.30 ~~conditions~~ under chapter 245B, an applicant shall submit a single application to provide
4.31 services statewide.

4.32 (3) For a license to provide independent living assistance for youth under section
4.33 245A.22, an applicant shall submit a single application to provide services statewide.

4.34 Sec. 3. Minnesota Statutes 2008, section 245A.11, subdivision 2a, is amended to read:

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

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

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

5.12 (c) The commissioner may grant variances to paragraph (a) to allow the use of a fifth
5.13 bed for emergency crisis services for a person with serious and persistent mental illness
5.14 or a developmental disability, regardless of age, if the variance complies with section
5.15 245A.04, subdivision 9, and approval of the variance is recommended by the county in
5.16 which the licensed foster care provider is located.

5.17 (d) ~~Notwithstanding paragraph (a),~~ If the 2009 legislature adopts a rate reduction
5.18 that impacts providers of adult foster care services, the commissioner may issue an adult
5.19 foster care license with a capacity of five adults if the fifth bed does not increase the
5.20 overall statewide capacity of licensed adult foster care beds in homes that are not the
5.21 primary residence of the license holder, over the licensed capacity in such homes on July
5.22 1, 2009, as identified in a plan submitted to the commissioner by the county, when the
5.23 capacity is recommended by the county licensing agency of the county in which the
5.24 facility is located and if the recommendation verifies that:

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

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

5.28 (i) individualized plan of care;

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

5.30 (iii) individual resident placement agreement under Minnesota Rules, part
5.31 9555.5105, subpart 19, if required;

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

5.36 (4) the facility was licensed for adult foster care before March 1, ~~2003~~ 2009.

6.1 (e) The commissioner shall not issue a new adult foster care license under paragraph
6.2 (d) after June 30, ~~2005~~ 2011. The commissioner shall allow a facility with an adult foster
6.3 care license issued under paragraph (d) before June 30, ~~2005~~ 2011, to continue with a
6.4 capacity of five adults if the license holder continues to comply with the requirements in
6.5 paragraph (d).

6.6 **EFFECTIVE DATE.** This section is effective July 1, 2009.

6.7 Sec. 4. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
6.8 to read:

6.9 **Subd. 7a. Alternate overnight supervision technology; adult foster care license.**

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

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

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

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

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

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

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

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

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

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

7.8 (i) a description of the triggering incident;

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

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

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

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

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

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

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

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

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

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

7.33 (i) the license holder has a written description of the interactive technological
7.34 applications that will assist the licenser holder in communicating with and assessing the
7.35 needs related to care, health, and safety of the foster care recipients. This interactive
7.36 technology must permit the license holder to remotely assess the well being of the foster

8.1 care recipient without requiring the initiation of the foster care recipient. Requiring the
8.2 foster care recipient to initiate a telephone call does not meet this requirement;

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

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

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

8.13 (f) All placement agreements, individual service agreements, and plans applicable
8.14 to the foster care recipient must clearly state that the adult foster care license category is
8.15 a program without the presence of a caregiver in the residence during normal sleeping
8.16 hours; the protocols in place for responding to situations that present a serious risk to
8.17 health, safety, or rights of foster care recipients under paragraph (e), clause (1) or (2); and a
8.18 signed informed consent from each foster care recipient or the person's legal representative
8.19 documenting the person's or legal representative's agreement with placement in the
8.20 program. If electronic monitoring technology is used in the home, the informed consent
8.21 form must also explain the following:

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

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

8.26 (3) how the license holder is trained on the use of the technology;

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

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

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

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

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

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

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

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

9.16 Sec. 5. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
9.17 to read:

9.18 Subd. 8b. **Adult foster care data privacy and security.** (a) An adult foster
9.19 care license holder who creates, collects, records, maintains, stores, or discloses any
9.20 individually identifiable recipient data, whether in an electronic or any other format,
9.21 must comply with the privacy and security provisions of applicable privacy laws and
9.22 regulations, including:

9.23 (1) the federal Health Insurance Portability and Accountability Act of 1996
9.24 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
9.25 title 45, part 160, and subparts A and E of part 164; and

9.26 (2) the Minnesota Government Data Practices Act as codified in chapter 13.

9.27 (b) For purposes of licensure, the license holder shall be monitored for compliance
9.28 with the following data privacy and security provisions:

9.29 (1) the license holder must control access to data on foster care recipients according
9.30 to the definitions of public and private data on individuals under section 13.02;
9.31 classification of the data on individuals as private under section 13.46, subdivision 2;
9.32 and control over the collection, storage, use, access, protection, and contracting related
9.33 to data according to section 13.05, in which the license holder is assigned the duties
9.34 of a government entity;

10.1 (2) the license holder must provide each foster care recipient with a notice that
10.2 meets the requirements under section 13.04, in which the license holder is assigned the
10.3 duties of the government entity, and that meets the requirements of Code of Federal
10.4 Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of
10.5 the data, and to whom and why it may be disclosed pursuant to law. The notice must
10.6 inform the recipient that the license holder uses electronic monitoring and, if applicable,
10.7 that recording technology is used;

10.8 (3) the license holder must not install monitoring cameras in bathrooms;

10.9 (4) electronic monitoring cameras must not be concealed from the foster care
10.10 recipients; and

10.11 (5) electronic video and audio recordings of foster care recipients shall not be stored
10.12 by the license holder for more than five days.

10.13 (c) The commissioner shall develop, and make available to license holders and
10.14 county licensing workers, a checklist of the data privacy provisions to be monitored
10.15 for purposes of licensure.

10.16 Sec. 6. Minnesota Statutes 2008, section 245A.16, subdivision 1, is amended to read:

10.17 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
10.18 private agencies that have been designated or licensed by the commissioner to perform
10.19 licensing functions and activities under section 245A.04 and background studies for
10.20 ~~adult foster care, family adult day services, and family child care~~, under chapter 245C; to
10.21 recommend denial of applicants under section 245A.05; to issue correction orders, to issue
10.22 variances, and recommend a conditional license under section 245A.06, or to recommend
10.23 suspending or revoking a license or issuing a fine under section 245A.07, shall comply
10.24 with rules and directives of the commissioner governing those functions and with this
10.25 section. The following variances are excluded from the delegation of variance authority
10.26 and may be issued only by the commissioner:

10.27 (1) dual licensure of family child care and child foster care, dual licensure of child
10.28 and adult foster care, and adult foster care and family child care;

10.29 (2) adult foster care maximum capacity;

10.30 (3) adult foster care minimum age requirement;

10.31 (4) child foster care maximum age requirement;

10.32 (5) variances regarding disqualified individuals except that county agencies may
10.33 issue variances under section 245C.30 regarding disqualified individuals when the county
10.34 is responsible for conducting a consolidated reconsideration according to sections 245C.25

11.1 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
11.2 and a disqualification based on serious or recurring maltreatment; and

11.3 (6) the required presence of a caregiver in the adult foster care residence during
11.4 normal sleeping hours.

11.5 (b) County agencies must report information about disqualification reconsiderations
11.6 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
11.7 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
11.8 prescribed by the commissioner.

11.9 (c) For family day care programs, the commissioner may authorize licensing reviews
11.10 every two years after a licensee has had at least one annual review.

11.11 (d) For family adult day services programs, the commissioner may authorize
11.12 licensing reviews every two years after a licensee has had at least one annual review.

11.13 (e) A license issued under this section may be issued for up to two years.

11.14 Sec. 7. Minnesota Statutes 2008, section 245A.16, subdivision 3, is amended to read:

11.15 Subd. 3. **Recommendations to commissioner.** The county or private agency
11.16 shall not make recommendations to the commissioner regarding licensure without first
11.17 conducting an inspection, and for ~~adult foster care, family adult day services, and family~~
11.18 ~~child care~~, a background study of the applicant under chapter 245C. The county or private
11.19 agency must forward its recommendation to the commissioner regarding the appropriate
11.20 licensing action within 20 working days of receipt of a completed application.

11.21 Sec. 8. Minnesota Statutes 2008, section 245C.04, subdivision 1, is amended to read:

11.22 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a
11.23 background study of an individual required to be studied under section 245C.03,
11.24 subdivision 1, at least upon application for initial license for all license types.

11.25 (b) The commissioner shall conduct a background study of an individual required to
11.26 be studied under section 245C.03, subdivision 1, at reapplication for a license for ~~adult~~
11.27 ~~foster care, family adult day services, and family child care.~~

11.28 (c) The commissioner is not required to conduct a study of an individual at the time
11.29 of reapplication for a license if the individual's background study was completed by the
11.30 commissioner of human services for an adult foster care license holder that is also:

11.31 (1) registered under chapter 144D; or

11.32 (2) licensed to provide home and community-based services to people with
11.33 disabilities at the foster care location and the license holder does not reside in the foster
11.34 care residence; and

12.1 (3) the following conditions are met:

12.2 (i) a study of the individual was conducted either at the time of initial licensure or
12.3 when the individual became affiliated with the license holder;

12.4 (ii) the individual has been continuously affiliated with the license holder since
12.5 the last study was conducted; and

12.6 (iii) the last study of the individual was conducted on or after October 1, 1995.

12.7 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall
12.8 conduct a study of an individual required to be studied under section 245C.03, at the
12.9 time of reapplication for a child foster care license. The county or private agency shall
12.10 collect and forward to the commissioner the information required under section 245C.05,
12.11 subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background
12.12 study conducted by the commissioner of human services under this paragraph must
12.13 include a review of the information required under section 245C.08, subdivisions 1,
12.14 paragraph (a), clauses (1) to (5), 3, and 4.

12.15 (e) The commissioner of human services shall conduct a background study of an
12.16 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
12.17 to (6), who is newly affiliated with a child foster care license holder. The county or
12.18 private agency shall collect and forward to the commissioner the information required
12.19 under section 245C.05, subdivisions 1 and 5. The background study conducted by the
12.20 commissioner of human services under this paragraph must include a review of the
12.21 information required under section 245C.08, subdivisions 1, 3, and 4.

12.22 (f) From January 1, 2010, to December 31, 2012, unless otherwise specified in
12.23 paragraph (c), the commissioner shall conduct a study of an individual required to be
12.24 studied under section 245C.03 at the time of reapplication for an adult foster care or family
12.25 adult day services license: (1) the county shall collect and forward to the commissioner
12.26 the information required under section 245C.05, subdivision 1, paragraphs (a) and (b),
12.27 and subdivision 5, paragraphs (a) and (b), for background studies conducted by the
12.28 commissioner for adult foster care and family adult day services when the license holder
12.29 resides in the adult foster care or family adult day services residence; (2) the license
12.30 holder shall collect and forward to the commissioner the information required under
12.31 section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b),
12.32 for background studies conducted by the commissioner for adult foster care when the
12.33 license holder does not reside in the adult foster care residence; and (3) the background
12.34 study conducted by the commissioner under this paragraph must include a review of the
12.35 information required under section 245C.08, subdivision 1, paragraph (a), clauses (1)
12.36 to (5), and subdivisions 3 and 4.

13.1 (g) The commissioner shall conduct a background study of an individual specified
13.2 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
13.3 affiliated with an adult foster care or family adult day services license holder: (1) the
13.4 county shall collect and forward to the commissioner the information required under
13.5 section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a)
13.6 and (b), for background studies conducted by the commissioner for adult foster care
13.7 and family adult day services when the license holder resides in the adult foster care or
13.8 family adult day services residence; (2) the license holder shall collect and forward to the
13.9 commissioner the information required under section 245C.05, subdivisions 1, paragraphs
13.10 (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the
13.11 commissioner for adult foster care when the license holder does not reside in the adult
13.12 foster care residence; and (3) the background study conducted by the commissioner under
13.13 this paragraph must include a review of the information required under section 245C.08,
13.14 subdivision 1, paragraph (a), and subdivisions 3 and 4.

13.15 (h) Applicants for licensure, license holders, and other entities as provided in this
13.16 chapter must submit completed background study forms to the commissioner before
13.17 individuals specified in section 245C.03, subdivision 1, begin positions allowing direct
13.18 contact in any licensed program.

13.19 ~~(g)~~ (i) For purposes of this section, a physician licensed under chapter 147 is
13.20 considered to be continuously affiliated upon the license holder's receipt from the
13.21 commissioner of health or human services of the physician's background study results.

13.22 Sec. 9. Minnesota Statutes 2008, section 245C.05, is amended by adding a subdivision
13.23 to read:

13.24 Subd. 2b. **County agency to collect and forward information to the**
13.25 **commissioner.** For background studies related to adult foster care and family adult
13.26 day services when the license holder resides in the adult foster care or family adult
13.27 day services residence, the county agency must collect the information required under
13.28 subdivision 1 and forward it to the commissioner.

13.29 Sec. 10. Minnesota Statutes 2008, section 245C.05, subdivision 4, is amended to read:

13.30 Subd. 4. **Electronic transmission.** For background studies conducted by the
13.31 Department of Human Services, the commissioner shall implement a system for the
13.32 electronic transmission of:

- 13.33 (1) background study information to the commissioner;
13.34 (2) background study results to the license holder; ~~and~~

14.1 (3) background study results to county and private agencies for background studies
14.2 conducted by the commissioner for child foster care; and

14.3 (4) background study results to county agencies for background studies conducted
14.4 by the commissioner for adult foster care and family adult day services.

14.5 Sec. 11. Minnesota Statutes 2008, section 245C.08, subdivision 2, is amended to read:

14.6 Subd. 2. **Background studies conducted by a county agency.** (a) For a background
14.7 study conducted by a county agency for ~~adult foster care, family adult day services, and~~
14.8 family child care services, the commissioner shall review:

14.9 (1) information from the county agency's record of substantiated maltreatment
14.10 of adults and the maltreatment of minors;

14.11 (2) information from juvenile courts as required in subdivision 4 for individuals
14.12 listed in section 245C.03, subdivision 1, clauses (2), (5), and (6); and

14.13 (3) information from the Bureau of Criminal Apprehension.

14.14 (b) If the individual has resided in the county for less than five years, the study shall
14.15 include the records specified under paragraph (a) for the previous county or counties of
14.16 residence for the past five years.

14.17 (c) Notwithstanding expungement by a court, the county agency may consider
14.18 information obtained under paragraph (a), clause (3), unless the commissioner received
14.19 notice of the petition for expungement and the court order for expungement is directed
14.20 specifically to the commissioner.

14.21 Sec. 12. Minnesota Statutes 2008, section 245C.10, is amended by adding a
14.22 subdivision to read:

14.23 Subd. 5. **Adult foster care services.** The commissioner shall recover the cost of
14.24 background studies required under section 245C.03, subdivision 1, for the purposes of
14.25 adult foster care and family adult day services licensing, through a fee of no more than
14.26 \$20 per study charged to the license holder. The fees collected under this subdivision are
14.27 appropriated to the commissioner for the purpose of conducting background studies.

14.28 Sec. 13. Minnesota Statutes 2008, section 245C.10, is amended by adding a
14.29 subdivision to read:

14.30 Subd. 8. **Private agencies.** The commissioner shall recover the cost of conducting
14.31 background studies under section 245C.33 for studies initiated by private agencies for the
14.32 purpose of adoption through a fee of no more than \$70 per study charged to the private

15.1 agency. The fees collected under this subdivision are appropriated to the commissioner for
15.2 the purpose of conducting background studies.

15.3 Sec. 14. Minnesota Statutes 2008, section 245C.17, is amended by adding a
15.4 subdivision to read:

15.5 Subd. 6. **Notice to county agency.** For studies on individuals related to a license
15.6 to provide adult foster care and family adult day services, the commissioner shall also
15.7 provide a notice of the background study results to the county agency that initiated the
15.8 background study.

15.9 Sec. 15. Minnesota Statutes 2008, section 245C.20, is amended to read:

15.10 **245C.20 LICENSE HOLDER RECORD KEEPING.**

15.11 A licensed program shall document the date the program initiates a background
15.12 study under this chapter in the program's personnel files. When a background study is
15.13 completed under this chapter, a licensed program shall maintain a notice that the study
15.14 was undertaken and completed in the program's personnel files. Except when background
15.15 studies are initiated through the commissioner's online system, if a licensed program
15.16 has not received a response from the commissioner under section 245C.17 within 45
15.17 days of initiation of the background study request, the licensed program must contact the
15.18 commissioner human services licensing division to inquire about the status of the study. If
15.19 a license holder initiates a background study under the commissioner's online system, but
15.20 the background study subject's name does not appear in the list of active or recent studies
15.21 initiated by that license holder, the license holder must either contact the human services
15.22 licensing division or resubmit the background study information online for that individual.

15.23 Sec. 16. Minnesota Statutes 2008, section 245C.21, subdivision 1a, is amended to read:

15.24 Subd. 1a. **Submission of reconsideration request to county or private agency.** (a)
15.25 For disqualifications related to studies conducted by county agencies for family child care,
15.26 and for disqualifications related to studies conducted by the commissioner for child foster
15.27 care, adult foster care, and family adult day services, the individual shall submit the request
15.28 for reconsideration to the county or private agency that initiated the background study.

15.29 (b) For disqualifications related to studies conducted by the commissioner for child
15.30 foster care, the individual shall submit the request for reconsideration to the private agency
15.31 that initiated the background study.

16.1 (c) A reconsideration request shall be submitted within 30 days of the individual's
16.2 receipt of the disqualification notice or the time frames specified in subdivision 2,
16.3 whichever time frame is shorter.

16.4 ~~(c)~~ (d) The county or private agency shall forward the individual's request for
16.5 reconsideration and provide the commissioner with a recommendation whether to set aside
16.6 the individual's disqualification.

16.7 Sec. 17. Minnesota Statutes 2008, section 245C.23, subdivision 2, is amended to read:

16.8 Subd. 2. **Commissioner's notice of disqualification that is not set aside.** (a) The
16.9 commissioner shall notify the license holder of the disqualification and order the license
16.10 holder to immediately remove the individual from any position allowing direct contact
16.11 with persons receiving services from the license holder if:

16.12 (1) the individual studied does not submit a timely request for reconsideration
16.13 under section 245C.21;

16.14 (2) the individual submits a timely request for reconsideration, but the commissioner
16.15 does not set aside the disqualification for that license holder under section 245C.22;

16.16 (3) an individual who has a right to request a hearing under sections 245C.27 and
16.17 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
16.18 not request a hearing within the specified time; or

16.19 (4) an individual submitted a timely request for a hearing under sections 245C.27
16.20 and 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
16.21 disqualification under section 245A.08, subdivision 5, or 256.045.

16.22 (b) If the commissioner does not set aside the disqualification under section 245C.22,
16.23 and the license holder was previously ordered under section 245C.17 to immediately
16.24 remove the disqualified individual from direct contact with persons receiving services or
16.25 to ensure that the individual is under continuous, direct supervision when providing direct
16.26 contact services, the order remains in effect pending the outcome of a hearing under
16.27 sections 245C.27 and 256.045, or 245C.28 and chapter 14.

16.28 (c) For background studies related to child foster care, the commissioner shall
16.29 also notify the county or private agency that initiated the study of the results of the
16.30 reconsideration.

16.31 (d) For background studies related to adult foster care and family adult day services,
16.32 the commissioner shall also notify the county that initiated the study of the results of
16.33 the reconsideration.

17.1 Sec. 18. Minnesota Statutes 2008, section 256B.092, is amended by adding a
17.2 subdivision to read:

17.3 Subd. 5b. **Revised per diem based on legislated rate reduction.** Notwithstanding
17.4 section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction
17.5 that impacts payment to providers of adult foster care services, the commissioner may
17.6 issue adult foster care licenses that permit a capacity of five adults. The application for a
17.7 five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to
17.8 admission of the fifth recipient of adult foster care services, the county must negotiate a
17.9 revised per diem rate for room and board and waiver services that reflects the legislated
17.10 rate reduction and results in an overall average per diem reduction for all foster care
17.11 recipients in that home. The revised per diem must allow the provider to maintain, as
17.12 much as possible, the level of services or enhanced services provided in the residence,
17.13 while mitigating the losses of the legislated rate reduction.

17.14 **EFFECTIVE DATE.** This section is effective July 1, 2009.

17.15 Sec. 19. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

17.16 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
17.17 that the average per capita expenditures estimated in any fiscal year for home and
17.18 community-based waiver recipients does not exceed the average per capita expenditures
17.19 that would have been made to provide institutional services for recipients in the absence
17.20 of the waiver.

17.21 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
17.22 need-based methods for allocating to local agencies the home and community-based
17.23 waived service resources available to support recipients with disabilities in need of
17.24 the level of care provided in a nursing facility or a hospital. The commissioner shall
17.25 allocate resources to single counties and county partnerships in a manner that reflects
17.26 consideration of:

- 17.27 (1) an incentive-based payment process for achieving outcomes;
17.28 (2) the need for a state-level risk pool;
17.29 (3) the need for retention of management responsibility at the state agency level; and
17.30 (4) a phase-in strategy as appropriate.

17.31 (c) Until the allocation methods described in paragraph (b) are implemented, the
17.32 annual allowable reimbursement level of home and community-based waiver services
17.33 shall be the greater of:

18.1 (1) the statewide average payment amount which the recipient is assigned under the
18.2 waiver reimbursement system in place on June 30, 2001, modified by the percentage of
18.3 any provider rate increase appropriated for home and community-based services; or

18.4 (2) an amount approved by the commissioner based on the recipient's extraordinary
18.5 needs that cannot be met within the current allowable reimbursement level. The
18.6 increased reimbursement level must be necessary to allow the recipient to be discharged
18.7 from an institution or to prevent imminent placement in an institution. The additional
18.8 reimbursement may be used to secure environmental modifications; assistive technology
18.9 and equipment; and increased costs for supervision, training, and support services
18.10 necessary to address the recipient's extraordinary needs. The commissioner may approve
18.11 an increased reimbursement level for up to one year of the recipient's relocation from an
18.12 institution or up to six months of a determination that a current waiver recipient is at
18.13 imminent risk of being placed in an institution.

18.14 (d) Beginning July 1, 2001, medically necessary private duty nursing services will be
18.15 authorized under this section as complex and regular care according to sections 256B.0651
18.16 and 256B.0653 to 256B.0656. The rate established by the commissioner for registered
18.17 nurse or licensed practical nurse services under any home and community-based waiver as
18.18 of January 1, 2001, shall not be reduced.

18.19 (e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
18.20 legislature adopts a rate reduction that impacts payment to providers of adult foster care
18.21 services, the commissioner may issue adult foster care licenses that permit a capacity of
18.22 five adults. The application for a five-bed license must meet the requirements of section
18.23 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care
18.24 services, the county must negotiate a revised per diem rate for room and board and waiver
18.25 services that reflects the legislated rate reduction and results in an overall average per
18.26 diem reduction for all foster care recipients in that home. The revised per diem must allow
18.27 the provider to maintain, as much as possible, the level of services or enhanced services
18.28 provided in the residence, while mitigating the losses of the legislated rate reduction.

18.29 **EFFECTIVE DATE.** This section is effective July 1, 2009.

18.30 Sec. 20. **WAIVER.**

18.31 By December 1, 2009, the commissioner shall request all federal approvals and
18.32 waiver amendments to the disability home and community-based waivers to allow properly
18.33 licensed adult foster care homes to provide residential services for up to five individuals.

18.34 **EFFECTIVE DATE.** This section is effective July 1, 2009.

19.1 Sec. 21. **REPEALER.**

19.2 (a) Minnesota Statutes 2008, section 245C.11, subdivisions 1 and 2, are repealed.

19.3 (b) Minnesota Statutes 2008, section 256B.092, subdivision 5a, is repealed effective
19.4 July 1, 2009.

19.5 (c) Minnesota Rules, part 9555.6125, subpart 4, item B, is repealed.

19.6 **ARTICLE 2**

19.7 **MFIP/CHILD CARE/ADULT SUPPORTS/FRAUD PREVENTION**

19.8 Section 1. Minnesota Statutes 2008, section 119B.09, subdivision 7, is amended to read:

19.9 Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child
19.10 care assistance under this chapter is the later of the date the application was signed; the
19.11 beginning date of employment, education, or training; the date the infant is born for
19.12 applicants to the at-home infant care program; or the date a determination has been made
19.13 that the applicant is a participant in employment and training services under Minnesota
19.14 Rules, part 3400.0080, or chapter 256J.

19.15 (b) Payment ceases for a family under the at-home infant child care program when a
19.16 family has used a total of 12 months of assistance as specified under section 119B.035.
19.17 Payment of child care assistance for employed persons on MFIP is effective the date of
19.18 employment or the date of MFIP eligibility, whichever is later. Payment of child care
19.19 assistance for MFIP or DWP participants in employment and training services is effective
19.20 the date of commencement of the services or the date of MFIP or DWP eligibility,
19.21 whichever is later. Payment of child care assistance for transition year child care must be
19.22 made retroactive to the date of eligibility for transition year child care.

19.23 (c) Notwithstanding paragraph (b), payment of child care assistance for participants
19.24 eligible under section 119B.05 may only be made retroactive for a maximum of six
19.25 months from the date of application for child care assistance.

19.26 **EFFECTIVE DATE.** This section is effective October 1, 2009.

19.27 Sec. 2. Minnesota Statutes 2008, section 119B.13, subdivision 6, is amended to read:

19.28 Subd. 6. **Provider payments.** (a) Counties or the state shall make vendor payments
19.29 to the child care provider or pay the parent directly for eligible child care expenses.

19.30 (b) If payments for child care assistance are made to providers, the provider shall
19.31 bill the county for services provided within ten days of the end of the service period. If
19.32 bills are submitted within ten days of the end of the service period, a county or the state
19.33 shall issue payment to the provider of child care under the child care fund within 30 days

20.1 of receiving a bill from the provider. Counties or the state may establish policies that
20.2 make payments on a more frequent basis.

20.3 (c) ~~All bills~~ If a provider has received an authorization of care and been issued a
20.4 billing form for an eligible family, the bill must be submitted within 60 days of the last
20.5 date of service on the bill. A county may pay a bill submitted more than 60 days after
20.6 the last date of service if the provider shows good cause why the bill was not submitted
20.7 within 60 days. Good cause must be defined in the county's child care fund plan under
20.8 section 119B.08, subdivision 3, and the definition of good cause must include county
20.9 error. A county may not pay any bill submitted more than a year after the last date of
20.10 service on the bill.

20.11 (d) If a provider provided care for a time period without receiving an authorization
20.12 of care and a billing form for an eligible family, payment of child care assistance may only
20.13 be made retroactively for a maximum of six months from the date the provider is issued
20.14 an authorization of care and billing form.

20.15 (e) A county may stop payment issued to a provider or may refuse to pay a bill
20.16 submitted by a provider if:

20.17 (1) the provider admits to intentionally giving the county materially false information
20.18 on the provider's billing forms; or

20.19 (2) a county finds by a preponderance of the evidence that the provider intentionally
20.20 gave the county materially false information on the provider's billing forms.

20.21 ~~(e)~~ (f) A county's payment policies must be included in the county's child care plan
20.22 under section 119B.08, subdivision 3. If payments are made by the state, in addition to
20.23 being in compliance with this subdivision, the payments must be made in compliance
20.24 with section 16A.124.

20.25 **EFFECTIVE DATE.** This section is effective October 1, 2009.

20.26 Sec. 3. Minnesota Statutes 2008, section 119B.21, subdivision 5, is amended to read:

20.27 Subd. 5. **Child care services grants.** (a) A child care resource and referral program
20.28 designated under section 119B.19, subdivision 1a, may award child care services grants
20.29 for:

20.30 (1) creating new licensed child care facilities and expanding existing facilities,
20.31 including, but not limited to, supplies, equipment, facility renovation, and remodeling;

20.32 (2) improving licensed child care facility programs;

20.33 (3) staff training and development services including, but not limited to, in-service
20.34 training, curriculum development, accreditation, certification, consulting, resource

21.1 centers, program and resource materials, supporting effective teacher-child interactions,
21.2 child-focused teaching, and content-driven classroom instruction;

21.3 (4) interim financing;

21.4 (5) capacity building through the purchase of appropriate technology to create,
21.5 enhance, and maintain business management systems;

21.6 (6) emergency assistance for child care programs;

21.7 (7) new programs or projects for the creation, expansion, or improvement of
21.8 programs that serve ethnic immigrant and refugee communities; and

21.9 (8) targeted recruitment initiatives to expand and build the capacity of the child
21.10 care system and to improve the quality of care provided by legal nonlicensed child care
21.11 providers.

21.12 (b) A child care resource and referral program designated under section 119B.19,
21.13 subdivision 1a, may award child care services grants to:

21.14 (1) licensed providers;

21.15 (2) providers in the process of being licensed;

21.16 (3) corporations or public agencies that develop or provide child care services;

21.17 (4) school-age care programs;

21.18 (5) legal nonlicensed or family, friend, and neighbor care providers; or

21.19 (6) any combination of clauses (1) to (5).

21.20 (c) A recipient of a child care services grant for facility improvements, interim
21.21 financing, or staff training and development must provide a 25 percent local match.

21.22 (d) Beginning July 1, 2009, grants under this subdivision shall be increasingly
21.23 awarded for activities that improve provider quality, including activities under paragraph
21.24 (a), clauses (1) to (3) and (7).

21.25 Sec. 4. Minnesota Statutes 2008, section 119B.21, subdivision 10, is amended to read:

21.26 Subd. 10. **Family child care technical assistance grants.** (a) A child care resource
21.27 and referral organization designated under section 119B.19, subdivision 1a, may award
21.28 technical assistance grants of up to \$1,000. These grants may be used for:

21.29 (1) facility improvements, including, but not limited to, improvements to meet
21.30 licensing requirements;

21.31 (2) improvements to expand a child care facility or program;

21.32 (3) toys, materials, and equipment to improve the learning environment;

21.33 (4) technology and software to create, enhance, and maintain business management
21.34 systems;

21.35 (5) start-up costs;

- 22.1 (6) staff training and development; and
22.2 (7) other uses approved by the commissioner.
22.3 (b) A child care resource and referral program may award family child care technical
22.4 assistance grants to:
22.5 (1) licensed family child care providers;
22.6 (2) child care providers in the process of becoming licensed; or
22.7 (3) legal nonlicensed or family, friend, and neighbor care providers.
22.8 (c) A local match is not required for a family child care technical assistance grant.
22.9 (d) Beginning July 1, 2009, grants under this subdivision shall be increasingly
22.10 awarded for activities that improve provider quality, including activities under paragraph
22.11 (a), clauses (1), (3), and (6).

22.12 Sec. 5. Minnesota Statutes 2008, section 119B.231, subdivision 2, is amended to read:

22.13 Subd. 2. **Provider eligibility.** (a) To be considered for an SRSA, a provider shall
22.14 apply to the commissioner or have been chosen as an SRSA provider prior to June 30,
22.15 2009, and have complied with all requirements of the SRSA agreement. Priority for funds
22.16 is given to providers who had agreements prior to June 30, 2009. If sufficient funds are
22.17 available, the commissioner shall make applications available to additional providers. To
22.18 be eligible to apply for an SRSA, a provider shall:

- 22.19 (1) be eligible for child care assistance payments under chapter 119B;
22.20 (2) have at least 25 percent of the children enrolled with the provider subsidized
22.21 through the child care assistance program;
22.22 (3) provide full-time, full-year child care services; and
22.23 (4) ~~serve at least one child who is subsidized through the child care assistance~~
22.24 ~~program and who is expected to enter kindergarten within the following 30 months~~ have
22.25 obtained a level 3 or 4 star rating under the voluntary Parent Aware quality rating system.

22.26 (b) The commissioner may waive the 25 percent requirement in paragraph (a),
22.27 clause (2), if necessary to achieve geographic distribution of SRSA providers and diversity
22.28 of types of care provided by SRSA providers.

22.29 (c) An eligible provider who would like to enter into an SRSA with the commissioner
22.30 shall submit an SRSA application. To determine whether to enter into an SRSA with a
22.31 provider, the commissioner shall evaluate the following factors:

- 22.32 (1) ~~the qualifications of the provider and the provider's staff~~ provider's Parent
22.33 Aware rating score;
22.34 ~~(2) the provider's staff-child ratios;~~
22.35 ~~(3) the provider's curriculum;~~

- 23.1 ~~(4) the provider's current or planned parent education activities;~~
- 23.2 ~~(5) (2) the provider's current or planned social service and employment linkages;~~
- 23.3 ~~(6) the provider's child development assessment plan;~~
- 23.4 ~~(7) (3) the geographic distribution needed for SRSA providers;~~
- 23.5 ~~(8) (4) the inclusion of a variety of child care delivery models; and~~
- 23.6 ~~(9) (5) other related factors determined by the commissioner.~~

23.7 Sec. 6. Minnesota Statutes 2008, section 119B.231, subdivision 3, is amended to read:

23.8 Subd. 3. **Family and child eligibility.** (a) A family eligible to choose an SRSA
23.9 provider for their children shall:

23.10 (1) be eligible to receive child care assistance under any provision in chapter 119B
23.11 except section 119B.035;

23.12 (2) be in an authorized activity for an average of at least 35 hours per week when
23.13 initial eligibility is determined; and

23.14 (3) include a child who has not yet entered kindergarten.

23.15 (b) A family who is determined to be eligible to choose an SRSA provider remains
23.16 eligible to be paid at a higher rate through the SRSA provider when the following
23.17 conditions exist:

23.18 (1) the child attends child care with the SRSA provider a minimum of 25 hours per
23.19 week, on average;

23.20 (2) the family has a child who has not yet entered kindergarten; and

23.21 (3) the family maintains eligibility under chapter 119B except section 119B.035.

23.22 (c) ~~For the 12 months~~ After initial eligibility has been determined, a decrease in the
23.23 family's authorized activities to an average of less than 35 hours per week does not result
23.24 in ineligibility for the SRSA rate. A family must continue to maintain eligibility under this
23.25 chapter and be in an authorized activity.

23.26 (d) A family that moves between counties but continues to use the same SRSA
23.27 provider shall continue to receive SRSA funding for the increased payments.

23.28 Sec. 7. Minnesota Statutes 2008, section 119B.231, subdivision 4, is amended to read:

23.29 Subd. 4. **Requirements of providers.** An SRSA must include assessment,
23.30 evaluation, and reporting requirements that promote the goals of improved school
23.31 readiness and movement toward appropriate child development milestones. A provider
23.32 who enters into an SRSA shall comply with all SRSA requirements, including the
23.33 assessment, evaluation, and reporting requirements in the SRSA. Providers who have been
23.34 selected previously for SRSAs must begin the process to obtain a rating using Parent

24.1 Aware according to timelines established by the commissioner. If the initial Parent Aware
24.2 rating is less than three stars, the provider must submit a plan to improve the rating. If
24.3 a 3 or 4 star rating is not obtained within established timelines, the commissioner may
24.4 consider continuation of the agreement, depending upon the progress made and other
24.5 factors. Providers who apply and are selected for a new SRSA agreement on or after July
24.6 1, 2009, must have a level 3 or 4 star rating under the voluntary Parent Aware quality
24.7 rating system at the time the SRSA agreement is signed.

24.8 Sec. 8. Minnesota Statutes 2008, section 145A.17, is amended by adding a subdivision
24.9 to read:

24.10 Subd. 4a. **Home visitors as MFIP employment and training service providers.**
24.11 The county social service agency and the local public health department may mutually
24.12 agree to utilize home visitors under this section as MFIP employment and training service
24.13 providers under section 256J.49, subdivision 4, for MFIP participants who are: (1) ill or
24.14 incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section
24.15 256J.54. The county social service agency and the local public health department may
24.16 also mutually agree to utilize home visitors to provide outreach to MFIP families who are
24.17 being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

24.18 Sec. 9. Minnesota Statutes 2008, section 256.045, subdivision 3, is amended to read:

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

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

24.26 (2) any patient or relative aggrieved by an order of the commissioner under section
24.27 252.27;

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

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

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

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

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

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

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

25.10 (10) except as provided under chapter 245C, an individual disqualified under sections
25.11 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance
25.12 of the evidence that the individual has committed an act or acts that meet the definition
25.13 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make
25.14 reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
25.15 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
25.16 this clause in which the basis for a disqualification is serious or recurring maltreatment,
25.17 which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated
25.18 into a single fair hearing. In such cases, the scope of review by the human services referee
25.19 shall include both the maltreatment determination and the disqualification. The failure to
25.20 exercise the right to an administrative reconsideration shall not be a bar to a hearing under
25.21 this section if federal law provides an individual the right to a hearing to dispute a finding
25.22 of maltreatment. Individuals and organizations specified in this section may contest the
25.23 specified action, decision, or final disposition before the state agency by submitting a
25.24 written request for a hearing to the state agency within 30 days after receiving written
25.25 notice of the action, decision, or final disposition, or within 90 days of such written notice
25.26 if the applicant, recipient, patient, or relative shows good cause why the request was not
25.27 submitted within the 30-day time limit; or

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

25.33 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
25.34 (10), is the only administrative appeal to the final agency determination specifically,
25.35 including a challenge to the accuracy and completeness of data under section 13.04.
25.36 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment

26.1 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
26.2 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
26.3 contested case proceeding under the provisions of chapter 14. Hearings requested under
26.4 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
26.5 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
26.6 only available when there is no juvenile court or adult criminal action pending. If such
26.7 action is filed in either court while an administrative review is pending, the administrative
26.8 review must be suspended until the judicial actions are completed. If the juvenile court
26.9 action or criminal charge is dismissed or the criminal action overturned, the matter may be
26.10 considered in an administrative hearing.

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

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

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

26.23 (f) An applicant or recipient is not entitled to receive social services beyond the
26.24 services prescribed under chapter 256M or other social services the person is eligible
26.25 for under state law.

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

26.29 Sec. 10. Minnesota Statutes 2008, section 256.983, subdivision 1, is amended to read:

26.30 Subdivision 1. **Programs established.** Within the limits of available appropriations,
26.31 the commissioner of human services shall require the maintenance of budget neutral
26.32 fraud prevention investigation programs in the counties participating in the fraud
26.33 prevention investigation project established under this section. If funds are sufficient,
26.34 the commissioner may also extend fraud prevention investigation programs to other
26.35 counties provided the expansion is budget neutral to the state. Under any expansion, the

27.1 commissioner has the final authority in decisions regarding the creation and realignment
 27.2 of individual county or regional operations.

27.3 Sec. 11. Minnesota Statutes 2008, section 256I.03, subdivision 7, is amended to read:

27.4 Subd. 7. **Countable income.** "Countable income" means all income received by an
 27.5 applicant or recipient less any applicable exclusions or disregards. For a recipient of any
 27.6 cash benefit from the SSI program, countable income means the SSI benefit limit in effect
 27.7 at the time the person is in a GRH ~~setting less \$20~~, less the medical assistance personal
 27.8 needs allowance. If the SSI limit has been reduced for a person due to events occurring
 27.9 prior to the persons entering the GRH setting, countable income means actual income less
 27.10 any applicable exclusions and disregards.

27.11 **EFFECTIVE DATE.** This section is effective April 1, 2010.

27.12 Sec. 12. Minnesota Statutes 2008, section 256I.05, subdivision 7c, is amended to read:

27.13 Subd. 7c. **Demonstration project.** The commissioner is authorized to pursue the
 27.14 expansion of a demonstration project under federal food stamp regulation for the purpose
 27.15 of gaining additional federal reimbursement of food and nutritional costs currently paid by
 27.16 the state group residential housing program. The commissioner shall seek approval no
 27.17 later than ~~January 1, 2004~~ October 1, 2009. Any reimbursement received is nondedicated
 27.18 revenue to the general fund.

27.19 Sec. 13. Minnesota Statutes 2008, section 256J.24, subdivision 5, is amended to read:

27.20 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based
 27.21 on the number of persons in the assistance unit eligible for both food and cash assistance
 27.22 unless the restrictions in subdivision 6 on the birth of a child apply. The following table
 27.23 represents the transitional standards effective ~~October 1, 2007~~ April 1, 2009.

27.24	Number of Eligible People	Transitional Standard	Cash Portion	Food Portion
27.25	1	\$391 <u>\$428:</u>	\$250	\$141 <u>\$178</u>
27.26	2	\$698 <u>\$764:</u>	\$437	\$261 <u>\$327</u>
27.27	3	\$910 <u>\$1,005:</u>	\$532	\$378 <u>\$473</u>
27.28	4	\$1,091 <u>\$1,217:</u>	\$621	\$470 <u>\$596</u>
27.29	5	\$1,245 <u>\$1,393:</u>	\$697	\$548 <u>\$696</u>
27.30	6	\$1,425 <u>\$1,602:</u>	\$773	\$652 <u>\$829</u>

28.1	7	\$1,553 <u>\$1,748</u> :	\$850	\$703 <u>\$898</u>
28.2	8	\$1,713 <u>\$1,934</u> :	\$916	\$797 <u>\$1,018</u>
28.3	9	\$1,871 <u>\$2,119</u> :	\$980	\$891 <u>\$1,139</u>
28.4	10	\$2,024 <u>\$2,298</u> :	\$1,035	\$989 <u>\$1,263</u>
28.5	over 10	add \$151 <u>\$178</u> :	\$53	\$98 <u>\$125</u>

28.6 per additional member.

28.7 The commissioner shall annually publish in the State Register the transitional
 28.8 standard for an assistance unit sizes 1 to 10 including a breakdown of the cash and food
 28.9 portions.

28.10 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2009.

28.11 Sec. 14. Minnesota Statutes 2008, section 256J.425, subdivision 2, is amended to read:

28.12 Subd. 2. **Ill or incapacitated.** (a) An assistance unit subject to the time limit in
 28.13 section 256J.42, subdivision 1, is eligible to receive months of assistance under a hardship
 28.14 extension if the participant who reached the time limit belongs to any of the following
 28.15 groups:

28.16 (1) participants who are suffering from an illness, injury, or incapacity which
 28.17 has been certified by a qualified professional when the illness, injury, or incapacity is
 28.18 expected to continue for more than 30 days and ~~prevents the person from obtaining or~~
 28.19 ~~retaining employment~~ severely limits the person's ability to obtain or maintain suitable
 28.20 employment. These participants must follow the treatment recommendations of the
 28.21 qualified professional certifying the illness, injury, or incapacity;

28.22 (2) participants whose presence in the home is required as a caregiver because of
 28.23 the illness, injury, or incapacity of another member in the assistance unit, a relative in the
 28.24 household, or a foster child in the household when the illness or incapacity and the need
 28.25 for a person to provide assistance in the home has been certified by a qualified professional
 28.26 and is expected to continue for more than 30 days; or

28.27 (3) caregivers with a child or an adult in the household who meets the disability or
 28.28 medical criteria for home care services under section 256B.0651, subdivision 1, paragraph
 28.29 (c), or a home and community-based waiver services program under chapter 256B, or
 28.30 meets the criteria for severe emotional disturbance under section 245.4871, subdivision
 28.31 6, or for serious and persistent mental illness under section 245.462, subdivision 20,
 28.32 paragraph (c). Caregivers in this category are presumed to be prevented from obtaining
 28.33 or retaining employment.

29.1 (b) An assistance unit receiving assistance under a hardship extension under this
29.2 subdivision may continue to receive assistance as long as the participant meets the criteria
29.3 in paragraph (a), clause (1), (2), or (3).

29.4 Sec. 15. Minnesota Statutes 2008, section 256J.425, subdivision 3, is amended to read:

29.5 Subd. 3. **Hard-to-employ participants.** (a) An assistance unit subject to the time
29.6 limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under
29.7 a hardship extension if the participant who reached the time limit belongs to any of the
29.8 following groups:

29.9 (1) a person who is diagnosed by a licensed physician, psychological practitioner,
29.10 or other qualified professional, as developmentally disabled or mentally ill, and ~~that~~
29.11 ~~condition prevents the person from obtaining or retaining unsubsidized employment~~ the
29.12 condition severely limits the person's ability to obtain or maintain suitable employment;

29.13 (2) a person who:

29.14 (i) has been assessed by a vocational specialist or the county agency to be
29.15 unemployable for purposes of this subdivision; or

29.16 (ii) has an IQ below 80 who has been assessed by a vocational specialist or a county
29.17 agency to be employable, but ~~not at a level that makes the participant eligible for an~~
29.18 ~~extension under subdivision 4~~ the condition severely limits the person's ability to obtain or
29.19 maintain suitable employment. The determination of IQ level must be made by a qualified
29.20 professional. In the case of a non-English-speaking person: (A) the determination must
29.21 be made by a qualified professional with experience conducting culturally appropriate
29.22 assessments, whenever possible; (B) the county may accept reports that identify an
29.23 IQ range as opposed to a specific score; (C) these reports must include a statement of
29.24 confidence in the results;

29.25 (3) a person who is determined by a qualified professional to be learning disabled,
29.26 and the ~~disability~~ condition severely limits the person's ability to obtain, ~~perform,~~ or
29.27 maintain suitable employment. For purposes of the initial approval of a learning disability
29.28 extension, the determination must have been made or confirmed within the previous 12
29.29 months. In the case of a non-English-speaking person: (i) the determination must be made
29.30 by a qualified professional with experience conducting culturally appropriate assessments,
29.31 whenever possible; and (ii) these reports must include a statement of confidence in the
29.32 results. If a rehabilitation plan for a participant extended as learning disabled is developed
29.33 or approved by the county agency, the plan must be incorporated into the employment
29.34 plan. However, a rehabilitation plan does not replace the requirement to develop and
29.35 comply with an employment plan under section 256J.521; or

30.1 (4) a person who has been granted a family violence waiver, and who is complying
30.2 with an employment plan under section 256J.521, subdivision 3.

30.3 (b) For purposes of this section, "severely limits the person's ability to obtain or
30.4 maintain suitable employment" means that a qualified professional has determined that the
30.5 person's condition prevents the person from working 20 or more hours per week.

30.6 Sec. 16. Minnesota Statutes 2008, section 256J.49, subdivision 1, is amended to read:

30.7 Subdivision 1. **Scope.** The terms used in sections ~~256J.50~~ 256J.425 to 256J.72 have
30.8 the meanings given them in this section.

30.9 Sec. 17. Minnesota Statutes 2008, section 256J.49, subdivision 4, is amended to read:

30.10 Subd. 4. **Employment and training service provider.** "Employment and training
30.11 service provider" means:

30.12 (1) a public, private, or nonprofit agency with which a county has contracted to
30.13 provide employment and training services and which is included in the county's service
30.14 agreement submitted under section 256J.626, subdivision 4; ~~or~~

30.15 (2) a county agency, if the county has opted to provide employment and training
30.16 services and the county has indicated that fact in the service agreement submitted under
30.17 section 256J.626, subdivision 4; or

30.18 (3) a local public health department under section 145A.17, subdivision 3a, that a
30.19 county has designated to provide employment and training services and is included in the
30.20 county's service agreement submitted under section 256J.626, subdivision 4.

30.21 Notwithstanding section 116L.871, an employment and training services provider
30.22 meeting this definition may deliver employment and training services under this chapter.

30.23 Sec. 18. Minnesota Statutes 2008, section 256J.521, subdivision 2, is amended to read:

30.24 Subd. 2. **Employment plan; contents.** (a) Based on the assessment under
30.25 subdivision 1, the job counselor and the participant must develop an employment plan
30.26 that includes participation in activities and hours that meet the requirements of section
30.27 256J.55, subdivision 1. The purpose of the employment plan is to identify for each
30.28 participant the most direct path to unsubsidized employment and any subsequent steps that
30.29 support long-term economic stability. The employment plan should be developed using
30.30 the highest level of activity appropriate for the participant. Activities must be chosen from
30.31 clauses (1) to (6), which are listed in order of preference. Notwithstanding this order of
30.32 preference for activities, priority must be given for activities related to a family violence
30.33 waiver when developing the employment plan. The employment plan must also list the

31.1 specific steps the participant will take to obtain employment, including steps necessary
31.2 for the participant to progress from one level of activity to another, and a timetable for
31.3 completion of each step. Levels of activity include:

- 31.4 (1) unsubsidized employment;
- 31.5 (2) job search;
- 31.6 (3) subsidized employment or unpaid work experience;
- 31.7 (4) unsubsidized employment and job readiness education or job skills training;
- 31.8 (5) unsubsidized employment or unpaid work experience and activities related to
31.9 a family violence waiver or preemployment needs; and
- 31.10 (6) activities related to a family violence waiver or preemployment needs.

31.11 (b) Participants who are determined to possess sufficient skills such that the
31.12 participant is likely to succeed in obtaining unsubsidized employment must job search at
31.13 least 30 hours per week for up to six weeks and accept any offer of suitable employment.
31.14 The remaining hours necessary to meet the requirements of section 256J.55, subdivision
31.15 1, may be met through participation in other work activities under section 256J.49,
31.16 subdivision 13. The participant's employment plan must specify, at a minimum: (1)
31.17 whether the job search is supervised or unsupervised; (2) support services that will
31.18 be provided; and (3) how frequently the participant must report to the job counselor.
31.19 Participants who are unable to find suitable employment after six weeks must meet
31.20 with the job counselor to determine whether other activities in paragraph (a) should be
31.21 incorporated into the employment plan. Job search activities which are continued after six
31.22 weeks must be structured and supervised.

31.23 ~~(c) Beginning July 1, 2004, activities and hourly requirements in the employment~~
31.24 ~~plan may be adjusted as necessary to accommodate the personal and family circumstances~~
31.25 ~~of participants identified under section 256J.561, subdivision 2, paragraph (d). Participants~~
31.26 ~~who no longer meet the provisions of section 256J.561, subdivision 2, paragraph (d),~~
31.27 ~~must meet with the job counselor within ten days of the determination to revise the~~
31.28 ~~employment plan.~~

31.29 ~~(d)~~ Participants who are determined to have barriers to obtaining or retaining
31.30 employment that will not be overcome during six weeks of job search under paragraph (b)
31.31 must work with the job counselor to develop an employment plan that addresses those
31.32 barriers by incorporating appropriate activities from paragraph (a), clauses (1) to (6).
31.33 The employment plan must include enough hours to meet the participation requirements
31.34 in section 256J.55, subdivision 1, unless a compelling reason to require fewer hours
31.35 is noted in the participant's file.

32.1 ~~(e)~~ (d) The job counselor and the participant must sign the employment plan to
32.2 indicate agreement on the contents.

32.3 ~~(f)~~ (e) Except as provided under paragraph ~~(g)~~ (f), failure to develop or comply with
32.4 activities in the plan, or voluntarily quitting suitable employment without good cause, will
32.5 result in the imposition of a sanction under section 256J.46.

32.6 ~~(g)~~ (f) When a participant fails to meet the agreed upon hours of participation in paid
32.7 employment because the participant is not eligible for holiday pay and the participant's
32.8 place of employment is closed for a holiday, the job counselor shall not impose a sanction
32.9 or increase the hours of participation in any other activity, including paid employment, to
32.10 offset the hours that were missed due to the holiday.

32.11 ~~(h)~~ (g) Employment plans must be reviewed at least every three months to determine
32.12 whether activities and hourly requirements should be revised. The job counselor is
32.13 encouraged to allow participants who are participating in at least 20 hours of work
32.14 activities to also participate in education and training activities in order to meet the federal
32.15 hourly participation rates.

32.16 Sec. 19. Minnesota Statutes 2008, section 256J.545, is amended to read:

32.17 **256J.545 FAMILY VIOLENCE WAIVER CRITERIA.**

32.18 (a) In order to qualify for a family violence waiver, an individual must provide
32.19 documentation of past or current family violence which may prevent the individual from
32.20 participating in certain employment activities.

32.21 (b) The following items may be considered acceptable documentation or verification
32.22 of family violence:

32.23 (1) police, government agency, or court records;

32.24 (2) a statement from a battered women's shelter staff with knowledge of the
32.25 circumstances ~~or credible evidence that supports the sworn statement;~~

32.26 (3) a statement from a sexual assault or domestic violence advocate with knowledge
32.27 of the circumstances ~~or credible evidence that supports the sworn statement;~~ or

32.28 (4) a statement from professionals from whom the applicant or recipient has sought
32.29 assistance for the abuse.

32.30 (c) A claim of family violence may also be documented by a sworn statement from
32.31 the applicant or participant and a sworn statement from any other person with knowledge
32.32 of the circumstances or credible evidence that supports the client's statement.

32.33 Sec. 20. Minnesota Statutes 2008, section 256J.561, subdivision 2, is amended to read:

33.1 Subd. 2. **Participation requirements.** (a) All MFIP caregivers, except caregivers
33.2 who meet the criteria in subdivision 3, must ~~participate in employment services~~ develop an
33.3 individualized employment plan that identifies the activities the participant is required to
33.4 participate in and the required hours of participation. ~~Except as specified in paragraphs (b)~~
33.5 ~~to (d), the employment plan must meet the requirements of section 256J.521, subdivision~~
33.6 ~~2, contain allowable work activities, as defined in section 256J.49, subdivision 13, and,~~
33.7 ~~include at a minimum, the number of participation hours required under section 256J.55,~~
33.8 ~~subdivision 1.~~

33.9 ~~(b) Minor caregivers and caregivers who are less than age 20 who have not~~
33.10 ~~completed high school or obtained a GED are required to comply with section 256J.54.~~

33.11 ~~(c) A participant who has a family violence waiver shall develop and comply with~~
33.12 ~~an employment plan under section 256J.521, subdivision 3.~~

33.13 ~~(d) As specified in section 256J.521, subdivision 2, paragraph (c), a participant who~~
33.14 ~~meets any one of the following criteria may work with the job counselor to develop an~~
33.15 ~~employment plan that contains less than the number of participation hours under section~~
33.16 ~~256J.55, subdivision 1. Employment plans for participants covered under this paragraph~~
33.17 ~~must be tailored to recognize the special circumstances of caregivers and families~~
33.18 ~~including limitations due to illness or disability and caregiving needs:~~

33.19 ~~(1) a participant who is age 60 or older;~~

33.20 ~~(2) a participant who has been diagnosed by a qualified professional as suffering~~
33.21 ~~from an illness or incapacity that is expected to last for 30 days or more, including a~~
33.22 ~~pregnant participant who is determined to be unable to obtain or retain employment due~~
33.23 ~~to the pregnancy; or~~

33.24 ~~(3) a participant who is determined by a qualified professional as being needed in~~
33.25 ~~the home to care for an ill or incapacitated family member, including caregivers with a~~
33.26 ~~child or an adult in the household who meets the disability or medical criteria for home~~
33.27 ~~care services under section 256B.0651, subdivision 1, paragraph (c), or a home and~~
33.28 ~~community-based waiver services program under chapter 256B, or meets the criteria for~~
33.29 ~~severe emotional disturbance under section 245.4871, subdivision 6, or for serious and~~
33.30 ~~persistent mental illness under section 245.462, subdivision 20, paragraph (c).~~

33.31 ~~(e) For participants covered under paragraphs (c) and (d), the county shall review~~
33.32 ~~the participant's employment services status every three months to determine whether~~
33.33 ~~conditions have changed. When it is determined that the participant's status is no longer~~
33.34 ~~covered under paragraph (c) or (d), the county shall notify the participant that a new or~~
33.35 ~~revised employment plan is needed. The participant and job counselor shall meet within~~
33.36 ~~ten days of the determination to revise the employment plan.~~

34.1 (b) Participants who meet the eligibility requirements in section 256J.575,
34.2 subdivision 3, must develop a family stabilization services plan that meets the
34.3 requirements in section 256J.575, subdivision 5.

34.4 (c) Minor caregivers and caregivers who are less than age 20 who have not
34.5 completed high school or obtained a GED must develop an education plan that meets the
34.6 requirements in section 256J.54.

34.7 (d) Participants with a family violence waiver must develop an employment plan
34.8 that meets the requirements in section 256J.521, which cover the provisions in section
34.9 256J.575, subdivision 5.

34.10 (e) All other participants must develop an employment plan that meets the
34.11 requirements of section 256J.521, subdivision 2, and contains allowable work activities,
34.12 as defined in section 256J.49, subdivision 13. The employment plan must include, at a
34.13 minimum, the number of participation hours required under section 256J.55, subdivision 1.

34.14 Sec. 21. Minnesota Statutes 2008, section 256J.561, subdivision 3, is amended to read:

34.15 Subd. 3. **Child under 12 ~~weeks~~ months of age.** (a) A participant who has a
34.16 natural born child who is less than 12 ~~weeks~~ months of age who meets the criteria in this
34.17 subdivision is not required to participate in employment services until the child reaches
34.18 12 ~~weeks~~ months of age. To be eligible for this provision, the assistance unit must not
34.19 have already used this provision or the previously allowed child under age one exemption.
34.20 However, an assistance unit that has an approved child under age one exemption at the
34.21 time this provision becomes effective may continue to use that exemption until the child
34.22 reaches one year of age.

34.23 (b) The provision in paragraph (a) ends the first full month after the child reaches
34.24 12 ~~weeks~~ months of age. This provision is available only once in a caregiver's lifetime.
34.25 In a two-parent household, only one parent shall be allowed to use this provision. The
34.26 participant and job counselor must meet within ten days after the child reaches 12 ~~weeks~~
34.27 months of age to revise the participant's employment plan.

34.28 **EFFECTIVE DATE.** This section is effective March 1, 2010.

34.29 Sec. 22. Minnesota Statutes 2008, section 256J.57, subdivision 1, is amended to read:

34.30 Subdivision 1. **Good cause for failure to comply.** The county agency shall not
34.31 impose the sanction under section 256J.46 if it determines that the participant has good
34.32 cause for failing to comply with the requirements of sections 256J.515 to 256J.57. Good
34.33 cause exists when:

34.34 (1) appropriate child care is not available;

- 35.1 (2) the job does not meet the definition of suitable employment;
- 35.2 (3) the participant is ill or injured;
- 35.3 (4) a member of the assistance unit, a relative in the household, or a foster child in
35.4 the household is ill and needs care by the participant that prevents the participant from
35.5 complying with the employment plan;
- 35.6 (5) the participant is unable to secure necessary transportation;
- 35.7 (6) the participant is in an emergency situation that prevents compliance with the
35.8 employment plan;
- 35.9 (7) the schedule of compliance with the employment plan conflicts with judicial
35.10 proceedings;
- 35.11 (8) a mandatory MFIP meeting is scheduled during a time that conflicts with a
35.12 judicial proceeding or a meeting related to a juvenile court matter, or a participant's work
35.13 schedule;
- 35.14 (9) the participant is already participating in acceptable work activities;
- 35.15 (10) the employment plan requires an educational program for a caregiver under age
35.16 20, but the educational program is not available;
- 35.17 (11) activities identified in the employment plan are not available;
- 35.18 (12) the participant is willing to accept suitable employment, but suitable
35.19 employment is not available; ~~or~~
- 35.20 (13) the participant documents other verifiable impediments to compliance with the
35.21 employment plan beyond the participant's control; or
- 35.22 (14) the documentation needed to determine if a participant is eligible for family
35.23 stabilization services is not available, but there is information that the participant may
35.24 qualify and the participant is cooperating with the county or employment service provider's
35.25 efforts to obtain the documentation necessary to determine eligibility.

35.26 The job counselor shall work with the participant to reschedule mandatory meetings
35.27 for individuals who fall under clauses (1), (3), (4), (5), (6), (7), and (8).

35.28 Sec. 23. Minnesota Statutes 2008, section 256J.575, subdivision 3, is amended to read:

35.29 Subd. 3. **Eligibility.** (a) The following MFIP ~~or diversionary work program (DWP)~~
35.30 participants are eligible for the services under this section:

- 35.31 (1) a participant who meets the requirements for or has been granted a hardship
35.32 extension under section 256J.425, subdivision 2 or 3, except that it is not necessary for
35.33 the participant to have reached or be approaching 60 months of eligibility for this section
35.34 to apply;

36.1 (2) a participant who is applying for Supplemental Security Income or Social
36.2 Security disability insurance; ~~and~~

36.3 (3) a participant who is a noncitizen who has been in the United States for 12 or
36.4 fewer months; and

36.5 (4) a participant who is age 60 or older.

36.6 (b) Families must meet all other eligibility requirements for MFIP established in
36.7 this chapter. Families are eligible for financial assistance to the same extent as if they
36.8 were participating in MFIP.

36.9 (c) A participant under paragraph (a), clause (3), must be provided with English as a
36.10 second language opportunities and skills training for up to 12 months. After 12 months,
36.11 the case manager and participant must determine whether the participant should continue
36.12 with English as a second language classes or skills training, or both, and continue to
36.13 receive family stabilization services.

36.14 (d) If a county agency or employment services provider has information that
36.15 an MFIP participant may meet the eligibility criteria set forth in this subdivision, the
36.16 county agency or employment services provider must assist the participant in obtaining
36.17 the documentation necessary to determine eligibility. Until necessary documentation is
36.18 obtained, the participant must be treated as an eligible participant under subdivisions 5 to 7.

36.19 **EFFECTIVE DATE.** This section is effective July 1, 2009, except the amendment
36.20 to paragraph (a) striking "or diversionary work program (DWP)" is effective March 1,
36.21 2010.

36.22 Sec. 24. Minnesota Statutes 2008, section 256J.575, subdivision 4, is amended to read:

36.23 Subd. 4. **Universal participation.** All caregivers must participate in family
36.24 stabilization services as defined in subdivision 2, except for caregivers exempt under
36.25 section 256J.561, subdivision 3.

36.26 **EFFECTIVE DATE.** This section is effective March 1, 2010.

36.27 Sec. 25. Minnesota Statutes 2008, section 256J.575, subdivision 6, is amended to read:

36.28 Subd. 6. **Cooperation with services requirements.** (a) ~~To be eligible,~~ A participant
36.29 who is eligible for family stabilization services under this section shall comply with
36.30 paragraphs (b) to (d).

36.31 (b) Participants shall engage in family stabilization plan services for the appropriate
36.32 number of hours per week that the activities are scheduled and available, unless good
36.33 cause exists for not doing so, as defined in section 256J.57, subdivision 1. The appropriate
36.34 number of hours must be based on the participant's plan.

37.1 (c) The case manager shall review the participant's progress toward the goals in the
37.2 family stabilization plan every six months to determine whether conditions have changed,
37.3 including whether revisions to the plan are needed.

37.4 (d) A participant's requirement to comply with any or all family stabilization plan
37.5 requirements under this subdivision is excused when the case management services,
37.6 training and educational services, or family support services identified in the participant's
37.7 family stabilization plan are unavailable for reasons beyond the control of the participant,
37.8 including when money appropriated is not sufficient to provide the services.

37.9 Sec. 26. Minnesota Statutes 2008, section 256J.575, subdivision 7, is amended to read:

37.10 Subd. 7. **Sanctions.** (a) The county agency or employment services provider must
37.11 follow the requirements of this subdivision at the time the county agency or employment
37.12 services provider has information that an MFIP recipient may meet the eligibility criteria
37.13 in subdivision 3.

37.14 (b) The financial assistance grant of a participating family is reduced according to
37.15 section 256J.46, if a participating adult fails without good cause to comply or continue
37.16 to comply with the family stabilization plan requirements in this subdivision, unless
37.17 compliance has been excused under subdivision 6, paragraph (d).

37.18 ~~(b)~~ (c) Given the purpose of the family stabilization services in this section and the
37.19 nature of the underlying family circumstances that act as barriers to both employment and
37.20 full compliance with program requirements, there must be a review by the county agency
37.21 prior to imposing a sanction to determine whether the plan was appropriated to the needs
37.22 of the participant and family, ~~and~~ There must be a current assessment by a behavioral
37.23 health or medical professional confirming that the participant in all ways had the ability to
37.24 comply with the plan, as confirmed by a behavioral health or medical professional.

37.25 ~~(c)~~ (d) Prior to the imposition of a sanction, the county agency or employment
37.26 services provider shall review the participant's case to determine if the family stabilization
37.27 plan is still appropriate and meet with the participant face-to-face. ~~The participant may~~
37.28 ~~bring an advocate~~ The county agency or employment services provider must inform the
37.29 participant of the right to bring an advocate to the face-to-face meeting.

37.30 During the face-to-face meeting, the county agency shall:

37.31 (1) determine whether the continued noncompliance can be explained and mitigated
37.32 by providing a needed family stabilization service, as defined in subdivision 2, paragraph
37.33 (d);

37.34 (2) determine whether the participant qualifies for a good cause exception under
37.35 section 256J.57, or if the sanction is for noncooperation with child support requirements,

38.1 determine if the participant qualifies for a good cause exemption under section 256.741,
38.2 subdivision 10;

38.3 (3) determine whether activities in the family stabilization plan are appropriate
38.4 based on the family's circumstances;

38.5 (4) explain the consequences of continuing noncompliance;

38.6 (5) identify other resources that may be available to the participant to meet the
38.7 needs of the family; and

38.8 (6) inform the participant of the right to appeal under section 256J.40.

38.9 If the lack of an identified activity or service can explain the noncompliance, the
38.10 county shall work with the participant to provide the identified activity.

38.11 (d) If the participant fails to come to the face-to-face meeting, the case manager or a
38.12 designee shall attempt at least one home visit. If a face-to-face meeting is not conducted,
38.13 the county agency shall send the participant a written notice that includes the information
38.14 under paragraph (c).

38.15 (e) After the requirements of paragraphs (c) and (d) are met and prior to imposition
38.16 of a sanction, the county agency shall provide a notice of intent to sanction under section
38.17 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section
38.18 256J.31.

38.19 (f) Section 256J.57 applies to this section except to the extent that it is modified
38.20 by this subdivision.

38.21 Sec. 27. Minnesota Statutes 2008, section 256J.621, is amended to read:

38.22 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

38.23 (a) Effective October 1, 2009, upon exiting the diversionary work program (DWP)
38.24 or upon terminating the Minnesota family investment program with earnings, a participant
38.25 who is employed may be eligible for work participation cash benefits of ~~\$75~~ \$50 per
38.26 month to assist in meeting the family's basic needs as the participant continues to move
38.27 toward self-sufficiency.

38.28 (b) To be eligible for work participation cash benefits, the participant shall not
38.29 receive MFIP or diversionary work program assistance during the month and the
38.30 participant or participants must meet the following work requirements:

38.31 (1) if the participant is a single caregiver and has a child under six years of age, the
38.32 participant must be employed at least 87 hours per month;

38.33 (2) if the participant is a single caregiver and does not have a child under six years of
38.34 age, the participant must be employed at least 130 hours per month; or

39.1 (3) if the household is a two-parent family, at least one of the parents must be
39.2 employed an average of at least 130 hours per month.

39.3 Whenever a participant exits the diversionary work program or is terminated from
39.4 MFIP and meets the other criteria in this section, work participation cash benefits are
39.5 available for up to 24 consecutive months.

39.6 (c) Expenditures on the program are maintenance of effort state funds under
39.7 a separate state program for participants under paragraph (b), clauses (1) and (2).
39.8 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
39.9 funds. Months in which a participant receives work participation cash benefits under this
39.10 section do not count toward the participant's MFIP 60-month time limit.

39.11 Sec. 28. Minnesota Statutes 2008, section 256J.626, subdivision 7, is amended to read:

39.12 Subd. 7. **Performance base funds.** (a) For the purpose of this section, the following
39.13 terms have the meanings given.

39.14 (1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota
39.15 TANF and separate state program caseload has fallen relative to federal fiscal year 2005
39.16 based on caseload data from October 1 to September 30.

39.17 (2) "TANF participation rate target" means a 50 percent participation rate reduced by
39.18 the CRC for the previous year.

39.19 (b) For calendar year ~~2009~~ 2010 and yearly thereafter, each county and tribe will be
39.20 allocated 95 percent of their initial calendar year allocation. Counties and tribes will be
39.21 allocated additional funds based on performance as follows:

39.22 (1) a county or tribe that achieves ~~a 50 percent~~ the TANF participation rate target
39.23 or a five percentage point improvement over the previous year's TANF participation rate
39.24 under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive
39.25 months for the most recent year for which the measurements are available, will receive an
39.26 additional allocation equal to 2.5 percent of its initial allocation; ~~and~~

39.27 (2) a county or tribe that performs within or above its range of expected performance
39.28 on the annualized three-year self-support index under section 256J.751, subdivision 2,
39.29 clause (6), will receive an additional allocation equal to 2.5 percent of its initial allocation;
39.30 and

39.31 (3) a county or tribe that does not achieve ~~a 50 percent~~ the TANF participation rate
39.32 target or a five percentage point improvement over the previous year's TANF participation
39.33 rate under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive
39.34 months for the most recent year for which the measurements are available, will not

40.1 receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear
40.2 improvement plan with the commissioner; or

40.3 (4) a county or tribe that does not perform within or above its range of expected
40.4 performance on the annualized three-year self-support index under section 256J.751,
40.5 subdivision 2, clause (6), will not receive an additional allocation equal to 2.5 percent
40.6 of its initial allocation until after negotiating a multiyear improvement plan with the
40.7 commissioner.

40.8 ~~(b)~~ (c) For calendar year 2009 and yearly thereafter, performance-based funds for
40.9 a federally approved tribal TANF program in which the state and tribe have in place
40.10 a contract under section 256.01, addressing consolidated funding, will be allocated as
40.11 follows:

40.12 (1) a tribe that achieves the participation rate approved in its federal TANF plan
40.13 using the average of 12 consecutive months for the most recent year for which the
40.14 measurements are available, will receive an additional allocation equal to 2.5 percent of
40.15 its initial allocation; and

40.16 (2) a tribe that performs within or above its range of expected performance on the
40.17 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
40.18 will receive an additional allocation equal to 2.5 percent of its initial allocation; or

40.19 (3) a tribe that does not achieve the participation rate approved in its federal TANF
40.20 plan using the average of 12 consecutive months for the most recent year for which the
40.21 measurements are available, will not receive an additional allocation equal to 2.5 percent
40.22 of its initial allocation until after negotiating a multiyear improvement plan with the
40.23 commissioner; or

40.24 (4) a tribe that does not perform within or above its range of expected performance
40.25 on the annualized three-year self-support index under section 256J.751, subdivision
40.26 2, clause (6), will not receive an additional allocation equal to 2.5 percent until after
40.27 negotiating a multiyear improvement plan with the commissioner.

40.28 ~~(c)~~ (d) Funds remaining unallocated after the performance-based allocations
40.29 in paragraph ~~(a)~~ (b) are available to the commissioner for innovation projects under
40.30 subdivision 5.

40.31 ~~(d)~~ (1) If available funds are insufficient to meet county and tribal allocations under
40.32 paragraph ~~(a)~~ (b), the commissioner may make available for allocation funds that are
40.33 unobligated and available from the innovation projects through the end of the current
40.34 biennium.

40.35 (2) If after the application of clause (1) funds remain insufficient to meet county
40.36 and tribal allocations under paragraph ~~(a)~~ (b), the commissioner must proportionally

41.1 reduce the allocation of each county and tribe with respect to their maximum allocation
41.2 available under paragraph ~~(a)~~ (b).

41.3 Sec. 29. Minnesota Statutes 2008, section 256J.95, subdivision 3, is amended to read:

41.4 Subd. 3. **Eligibility for diversionary work program.** (a) Except for the categories
41.5 of family units listed below, all family units who apply for cash benefits and who
41.6 meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must
41.7 participate in the diversionary work program. Family units that are not eligible for the
41.8 diversionary work program include:

41.9 (1) child only cases;

41.10 (2) a single-parent family unit that includes a child under 12 ~~weeks~~ months of age.

41.11 A parent is eligible for this exception once in a parent's lifetime and is not eligible if
41.12 the parent has already used the previously allowed child under age one exemption from
41.13 MFIP employment services;

41.14 (3) a minor parent without a high school diploma or its equivalent;

41.15 (4) an 18- or 19-year-old caregiver without a high school diploma or its equivalent
41.16 who chooses to have an employment plan with an education option;

41.17 (5) a caregiver age 60 or over;

41.18 (6) family units with a caregiver who received DWP benefits in the 12 months prior
41.19 to the month the family applied for DWP, except as provided in paragraph (c);

41.20 (7) family units with a caregiver who received MFIP within the 12 months prior to
41.21 the month the family unit applied for DWP;

41.22 (8) a family unit with a caregiver who received 60 or more months of TANF
41.23 assistance;

41.24 (9) a family unit with a caregiver who is disqualified from DWP or MFIP due to
41.25 fraud; and

41.26 (10) refugees and asylees as defined in Code of Federal Regulations, title 45, part
41.27 400, subpart d, section 400.43, who arrived in the United States in the 12 months prior to
41.28 the date of application for family cash assistance.

41.29 (b) A two-parent family must participate in DWP unless both caregivers meet the
41.30 criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit
41.31 includes a parent who meets the criteria in paragraph (a), clause (6), (7), (8), (9), or (10).

41.32 (c) Once DWP eligibility is determined, the four months run consecutively. If a
41.33 participant leaves the program for any reason and reapplies during the four-month period,
41.34 the county must redetermine eligibility for DWP.

41.35 **EFFECTIVE DATE.** This section is effective March 1, 2010.

42.1 Sec. 30. Minnesota Statutes 2008, section 256J.95, subdivision 11, is amended to read:

42.2 Subd. 11. **Universal participation required.** (a) All DWP caregivers, except
42.3 caregivers who meet the criteria in paragraph (d), are required to participate in DWP
42.4 employment services. Except as specified in paragraphs (b) and (c), employment plans
42.5 under DWP must, at a minimum, meet the requirements in section 256J.55, subdivision 1.

42.6 (b) A caregiver who is a member of a two-parent family that is required to participate
42.7 in DWP who would otherwise be ineligible for DWP under subdivision 3 may be allowed
42.8 to develop an employment plan under section 256J.521, subdivision 2, ~~paragraph (c)~~, that
42.9 may contain alternate activities and reduced hours.

42.10 (c) A participant who is a victim of family violence shall be allowed to develop an
42.11 employment plan under section 256J.521, subdivision 3. A claim of family violence must
42.12 be documented by the applicant or participant by providing a sworn statement which is
42.13 supported by collateral documentation in section 256J.545, paragraph (b).

42.14 (d) One parent in a two-parent family unit that has a natural born child under 12
42.15 ~~weeks~~ months of age is not required to have an employment plan until the child reaches 12
42.16 ~~weeks~~ months of age unless the family unit has already used the exclusion under section
42.17 256J.561, subdivision 3, or the previously allowed child under age one exemption under
42.18 section 256J.56, paragraph (a), clause (5).

42.19 (e) The provision in paragraph (d) ends the first full month after the child reaches 12
42.20 ~~weeks~~ months of age. This provision is allowable only once in a caregiver's lifetime. In a
42.21 two-parent household, only one parent shall be allowed to use this category.

42.22 (f) The participant and job counselor must meet within ten working days after the
42.23 child reaches 12 ~~weeks~~ months of age to revise the participant's employment plan. The
42.24 employment plan for a family unit that has a child under 12 ~~weeks~~ months of age that has
42.25 already used the exclusion in section 256J.561 or the previously allowed child under
42.26 age one exemption under section 256J.56, paragraph (a), clause (5), must be tailored to
42.27 recognize the caregiving needs of the parent.

42.28 **EFFECTIVE DATE.** This section is effective March 1, 2010.

42.29 Sec. 31. Minnesota Statutes 2008, section 256J.95, subdivision 12, is amended to read:

42.30 Subd. 12. **Conversion or referral to MFIP.** (a) If at any time during the DWP
42.31 application process or during the four-month DWP eligibility period, it is determined that
42.32 a participant is unlikely to benefit from the diversionary work program, the county shall
42.33 convert or refer the participant to MFIP as specified in paragraph (d). Participants who are
42.34 determined to be unlikely to benefit from the diversionary work program must develop
42.35 and sign an employment plan. ~~Participants who meet any one of the criteria in paragraph~~

43.1 ~~(b) shall be considered to be unlikely to benefit from DWP, provided the necessary~~
43.2 ~~documentation is available to support the determination.~~

43.3 (b) A participant who ~~meets the eligibility requirements under section 256J.575,~~
43.4 subdivision 3, must be considered to be unlikely to benefit from DWP, provided the
43.5 necessary documentation is available to support the determination.

43.6 ~~(1) has been determined by a qualified professional as being unable to obtain or retain~~
43.7 ~~employment due to an illness, injury, or incapacity that is expected to last at least 60 days;~~

43.8 ~~(2) is required in the home as a caregiver because of the illness, injury, or incapacity,~~
43.9 ~~of a family member, or a relative in the household, or a foster child, and the illness, injury,~~
43.10 ~~or incapacity and the need for a person to provide assistance in the home has been certified~~
43.11 ~~by a qualified professional and is expected to continue more than 60 days;~~

43.12 ~~(3) is determined by a qualified professional as being needed in the home to care for~~
43.13 ~~a child or adult meeting the special medical criteria in section 256J.561, subdivision 2,~~
43.14 ~~paragraph (d), clause (3);~~

43.15 ~~(4) is pregnant and is determined by a qualified professional as being unable to~~
43.16 ~~obtain or retain employment due to the pregnancy; or~~

43.17 ~~(5) has applied for SSI or SSDI.~~

43.18 (c) In a two-parent family unit, ~~both parents must be~~ if one parent is determined
43.19 to be unlikely to benefit from the diversionary work program ~~before,~~ the family unit
43.20 ~~can~~ must be converted or referred to MFIP.

43.21 (d) A participant who is determined to be unlikely to benefit from the diversionary
43.22 work program shall be converted to MFIP and, if the determination was made within 30
43.23 days of the initial application for benefits, no additional application form is required.

43.24 A participant who is determined to be unlikely to benefit from the diversionary work
43.25 program shall be referred to MFIP and, if the determination is made more than 30
43.26 days after the initial application, the participant must submit a program change request
43.27 form. The county agency shall process the program change request form by the first of
43.28 the following month to ensure that no gap in benefits is due to delayed action by the
43.29 county agency. In processing the program change request form, the county must follow
43.30 section 256J.32, subdivision 1, except that the county agency shall not require additional
43.31 verification of the information in the case file from the DWP application unless the
43.32 information in the case file is inaccurate, questionable, or no longer current.

43.33 (e) The county shall not request a combined application form for a participant who
43.34 has exhausted the four months of the diversionary work program, has continued need for
43.35 cash and food assistance, and has completed, signed, and submitted a program change
43.36 request form within 30 days of the fourth month of the diversionary work program. The

44.1 county must process the program change request according to section 256J.32, subdivision
44.2 1, except that the county agency shall not require additional verification of information
44.3 in the case file unless the information is inaccurate, questionable, or no longer current.
44.4 When a participant does not request MFIP within 30 days of the diversionary work
44.5 program benefits being exhausted, a new combined application form must be completed
44.6 for any subsequent request for MFIP.

44.7 **EFFECTIVE DATE.** This section is effective March 1, 2010.

44.8 Sec. 32. Minnesota Statutes 2008, section 256J.95, subdivision 13, is amended to read:

44.9 Subd. 13. **Immediate referral to employment services.** Within one working day of
44.10 determination that the applicant is eligible for the diversionary work program, but before
44.11 benefits are issued to or on behalf of the family unit, the county shall refer all caregivers to
44.12 employment services. The referral to the DWP employment services must be in writing
44.13 and must contain the following information:

44.14 (1) notification that, as part of the application process, applicants are required to
44.15 develop an employment plan or the DWP application will be denied;

44.16 (2) the employment services provider name and phone number;

44.17 ~~(3) the date, time, and location of the scheduled employment services interview;~~

44.18 ~~(4)~~ the immediate availability of supportive services, including, but not limited to,
44.19 child care, transportation, and other work-related aid; and

44.20 ~~(5)~~ (4) the rights, responsibilities, and obligations of participants in the program,
44.21 including, but not limited to, the grounds for good cause, the consequences of refusing or
44.22 failing to participate fully with program requirements, and the appeal process.

44.23 Sec. 33. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision
44.24 to read:

44.25 Subd. 3b. **Extension; adoption finalized after age 16.** A child who has attained the
44.26 age of 16 prior to finalization of their adoption is eligible for extension of the adoption
44.27 assistance agreement to the date the child attains age 21 if the child is:

44.28 (1) completing a secondary education program or a program leading to an equivalent
44.29 credential;

44.30 (2) enrolled in an institution which provides postsecondary or vocational education;

44.31 (3) participating in a program or activity designed to promote or remove barriers to
44.32 employment;

44.33 (4) employed for at least 80 hours per month; or

45.1 (5) incapable of doing any of the activities described in clauses (1) to (4) due to a
45.2 medical condition which incapability is supported by regularly updated information in
45.3 the case plan of the child.

45.4 **EFFECTIVE DATE.** This section is effective October 1, 2010.

45.5 Sec. 34. Minnesota Statutes 2008, section 270A.09, is amended by adding a
45.6 subdivision to read:

45.7 **Subd. 1b. Department of Human Services claims.** Notwithstanding subdivision 1,
45.8 any debtor contesting a setoff claim by the Department of Human Services or a county
45.9 agency whose claim relates to a debt resulting from receipt of public assistance, medical
45.10 care, or the federal Food Stamp Act shall have a hearing conducted in the same manner as
45.11 an appeal under sections 256.045 and 256.0451.

45.12 Sec. 35. **AMERICAN INDIAN CHILD WELFARE PROJECTS.**

45.13 Notwithstanding Minnesota Statutes, section 16A.28, the commissioner of human
45.14 services shall extend payment of state fiscal year 2009 funds in state fiscal year 2010
45.15 to tribes participating in the American Indian child welfare projects under Minnesota
45.16 Statutes, section 256.01, subdivision 14b. Future extensions of payment for a tribe
45.17 participating in the Indian child welfare projects under Minnesota Statutes, section 256.01,
45.18 subdivision 14b, must be granted according to the commissioner's authority under
45.19 Minnesota Statutes, section 16A.28.

45.20 Sec. 36. **REPEALER.**

45.21 Minnesota Statutes 2008, section 256I.06, subdivision 9, is repealed.

45.22 **ARTICLE 3**

45.23 **STATE-OPERATED SERVICES/MINNESOTA SEX OFFENDER PROGRAM**

45.24 Section 1. Minnesota Statutes 2008, section 246.50, subdivision 5, is amended to read:

45.25 Subd. 5. **Cost of care.** "Cost of care" means the commissioner's charge for services
45.26 provided to any person admitted to a state facility.

45.27 For purposes of this subdivision, "charge for services" means the ~~cost of services,~~
45.28 ~~treatment, maintenance, bonds issued for capital improvements, depreciation of buildings~~
45.29 ~~and equipment, and indirect costs related to the operation of state facilities. The~~
45.30 ~~commissioner may determine the charge for services on an anticipated average per diem~~
45.31 ~~basis as an all-inclusive charge per facility, per disability group, or per treatment program.~~
45.32 ~~The commissioner may determine a charge per service, using a method that includes direct~~

46.1 ~~and indirect costs~~ usual and customary fee charged for services provided to clients. The
46.2 usual and customary fee shall be established in a manner required to appropriately bill
46.3 services to all payers and shall include the costs related to the operations of any program
46.4 offered by the state.

46.5 Sec. 2. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
46.6 to read:

46.7 Subd. 10. **State-operated community-based program.** "State-operated
46.8 community-based program" means any program operated in the community including
46.9 community behavioral health hospitals, crisis centers, residential facilities, outpatient
46.10 services, and other community-based services developed and operated by the state and
46.11 under the commissioner's control.

46.12 Sec. 3. Minnesota Statutes 2008, section 246.50, is amended by adding a subdivision
46.13 to read:

46.14 Subd. 11. **Health plan company.** "Health plan company" has the meaning given it
46.15 in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in
46.16 section 256B.69, subdivision 2, paragraph (b), a county or group of counties participating
46.17 in county-based purchasing according to section 256B.692, and a children's mental health
46.18 collaborative under contract to provide medical assistance for individuals enrolled in
46.19 the prepaid medical assistance and MinnesotaCare programs under sections 245.493 to
46.20 245.495.

46.21 Sec. 4. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
46.22 to read:

46.23 Subd. 1a. **Clients in state-operated community-based programs; determination.**
46.24 The commissioner shall determine available health plan coverage from a health plan
46.25 company for services provided to clients admitted to a state-operated community-based
46.26 program. If the health plan coverage requires a co-pay or deductible, or if there is no
46.27 available health plan coverage, the commissioner shall determine or redetermine, what
46.28 part of the noncovered cost of care, if any, the client is able to pay. If the client is unable to
46.29 pay the uncovered cost of care, the commissioner shall determine the client's relatives'
46.30 ability to pay. The client and relatives shall provide to the commissioner documents and
46.31 proof necessary to determine the client and relatives' ability to pay. Failure to provide the
46.32 commissioner with sufficient information to determine ability to pay may make the client
46.33 or relatives liable for the full cost of care until the time when sufficient information is

47.1 provided. If it is determined that the responsible party does not have the ability to pay,
47.2 the commissioner shall waive payment of the portion that exceeds ability to pay under
47.3 the determination.

47.4 Sec. 5. Minnesota Statutes 2008, section 246.51, is amended by adding a subdivision
47.5 to read:

47.6 **Subd. 1b. Clients served by regional treatment centers or nursing homes;**
47.7 **determination.** The commissioner shall determine or redetermine, if necessary, what part
47.8 of the cost of care, if any, a client served in regional treatment centers or nursing homes
47.9 operated by state-operated services, is able to pay. If the client is unable to pay the full cost
47.10 of care, the commissioner shall determine if the client's relatives have the ability to pay.
47.11 The client and relatives shall provide to the commissioner documents and proof necessary
47.12 to determine the client and relatives' ability to pay. Failure to provide the commissioner
47.13 with sufficient information to determine ability to pay may make the client or relatives
47.14 liable for the full cost of care until the time when sufficient information is provided. No
47.15 parent shall be liable for the cost of care given a client at a regional treatment center after
47.16 the client has reached the age of 18 years.

47.17 Sec. 6. Minnesota Statutes 2008, section 246.511, is amended to read:

47.18 **246.511 RELATIVE RESPONSIBILITY.**

47.19 Except for chemical dependency services paid for with funds provided under chapter
47.20 254B, a client's relatives shall not, pursuant to the commissioner's authority under section
47.21 246.51, be ordered to pay more than ~~ten percent of the cost of~~ the following: (1) for
47.22 services provided in a community-based service, the noncovered cost of care as determined
47.23 under the ability to pay determination; and (2) for services provided at a regional treatment
47.24 center operated by state-operated services, 20 percent of the cost of care, unless they
47.25 reside outside the state. Parents of children in state facilities shall have their responsibility
47.26 to pay determined according to section 252.27, subdivision 2, or in rules adopted under
47.27 chapter 254B if the cost of care is paid under chapter 254B. The commissioner may
47.28 accept voluntary payments in excess of ~~ten~~ 20 percent. The commissioner may require
47.29 full payment of the full per capita cost of care in state facilities for clients whose parent,
47.30 parents, spouse, guardian, or conservator do not reside in Minnesota.

47.31 Sec. 7. Minnesota Statutes 2008, section 246.52, is amended to read:

47.32 **246.52 PAYMENT FOR CARE; ORDER; ACTION.**

48.1 The commissioner shall issue an order to the client or the guardian of the estate, if
48.2 there be one, and relatives determined able to pay requiring them to pay ~~monthly~~ to the
48.3 state of Minnesota the amounts so determined the total of which shall not exceed the full
48.4 cost of care. Such order shall specifically state the commissioner's determination and shall
48.5 be conclusive unless appealed from as herein provided. When a client or relative fails to
48.6 pay the amount due hereunder the attorney general, upon request of the commissioner,
48.7 may institute, or direct the appropriate county attorney to institute, civil action to recover
48.8 such amount.

48.9 Sec. 8. Minnesota Statutes 2008, section 246.54, subdivision 2, is amended to read:

48.10 Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the
48.11 Minnesota Security Hospital, ~~the Minnesota sex offender program,~~ or the Minnesota
48.12 extended treatment options program. For services at these facilities, a county's payment
48.13 shall be made from the county's own sources of revenue and payments shall be paid as
48.14 follows: payments to the state from the county shall equal ten percent of the cost of care,
48.15 as determined by the commissioner, for each day, or the portion thereof, that the client
48.16 spends at the facility. If payments received by the state under sections 246.50 to 246.53
48.17 exceed 90 percent of the cost of care, the county shall be responsible for paying the state
48.18 only the remaining amount. The county shall not be entitled to reimbursement from the
48.19 client, the client's estate, or from the client's relatives, except as provided in section 246.53.

48.20 (b) Regardless of the facility to which the client is committed, subdivision 1 does
48.21 not apply to the following individuals:

48.22 (1) clients who are committed as mentally ill and dangerous under section 253B.02,
48.23 subdivision 17;

48.24 (2) clients who are committed as sexual psychopathic personalities under section
48.25 253B.02, subdivision 18b; and

48.26 (3) clients who are committed as sexually dangerous persons under section 253B.02,
48.27 subdivision 18c.

48.28 For each of the individuals in clauses (1) to (3), the payment by the county to the state
48.29 shall equal ten percent of the cost of care for each day as determined by the commissioner.

48.30 Sec. 9. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
48.31 to read:

48.32 Subd. 1a. **Client.** "Client" means a person who is admitted to the Minnesota sex
48.33 offender program or subject to a court hold order under section 253B.185 for the purpose

49.1 of assessment, diagnosis, care, treatment, supervision, or other services provided by the
49.2 Minnesota sex offender program.

49.3 Sec. 10. Minnesota Statutes 2008, section 246B.01, is amended by adding a
49.4 subdivision to read:

49.5 Subd. 1b. **Client's county.** "Client's county" means the county of the client's
49.6 legal settlement for poor relief purposes at the time of commitment. If the client has no
49.7 legal settlement for poor relief in this state, it means the county of commitment, except
49.8 that when a client with no legal settlement for poor relief is committed while serving a
49.9 sentence at a penal institution, it means the county from which the client was sentenced.

49.10 Sec. 11. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
49.11 to read:

49.12 Subd. 2a. **Cost of care.** "Cost of care" means the commissioner's charge for housing
49.13 and treatment services provided to any person admitted to the Minnesota sex offender
49.14 program.

49.15 For purposes of this subdivision, "charge for housing and treatment services" means
49.16 the cost of services, treatment, maintenance, bonds issued for capital improvements,
49.17 depreciation of buildings and equipment, and indirect costs related to the operation of
49.18 state facilities. The commissioner may determine the charge for services on an anticipated
49.19 average per diem basis as an all-inclusive charge per facility.

49.20 Sec. 12. Minnesota Statutes 2008, section 246B.01, is amended by adding a
49.21 subdivision to read:

49.22 Subd. 2b. **Local social services agency.** "Local social services agency" means the
49.23 local social services agency of the client's county as defined in subdivision 1b and of the
49.24 county of commitment, and any other local social services agency possessing information
49.25 regarding, or requested by the commissioner to investigate, the financial circumstances
49.26 of a client.

49.27 Sec. 13. **[246B.07] PAYMENT FOR CARE AND TREATMENT:**
49.28 **DETERMINATION.**

49.29 Subdivision 1. **Procedures.** The commissioner shall determine or redetermine, if
49.30 necessary, what amount of the cost of care, if any, the client is able to pay. The client shall
49.31 provide to the commissioner documents and proof necessary to determine the ability to
49.32 pay. Failure to provide the commissioner with sufficient information to determine ability

50.1 to pay may make the client liable for the full cost of care until the time when sufficient
50.2 information is provided.

50.3 Subd. 2. **Rules.** The commissioner shall use the standards in section 246.51,
50.4 subdivision 2, to determine the client's liability for the care provided by the Minnesota sex
50.5 offender program.

50.6 Subd. 3. **Applicability.** The commissioner may recover, under sections 246B.07 to
50.7 246B.10, the cost of any care provided by the Minnesota sex offender program.

50.8 **Sec. 14. [246B.08] PAYMENT FOR CARE; ORDER; ACTION.**

50.9 The commissioner shall issue an order to the client or the guardian of the estate, if
50.10 there is one, requiring the client or guardian to pay to the state the amounts determined, the
50.11 total of which must not exceed the full cost of care. The order must specifically state the
50.12 commissioner's determination and must be conclusive, unless appealed. If a client fails to
50.13 pay the amount due, the attorney general, upon request of the commissioner, may institute,
50.14 or direct the appropriate county attorney to institute a civil action to recover the amount.

50.15 **Sec. 15. [246B.09] CLAIM AGAINST ESTATE OF DECEASED CLIENT.**

50.16 Subdivision 1. **Client's estate.** Upon the death of a client, or a former client, the
50.17 total cost of care provided to the client, less the amount actually paid toward the cost of
50.18 care by the client, must be filed by the commissioner as a claim against the estate of the
50.19 client with the court having jurisdiction to probate the estate, and all proceeds collected
50.20 by the state in the case must be divided between the state and county in proportion to
50.21 the cost of care each has borne.

50.22 Subd. 2. **Preferred status.** An estate claim in subdivision 1 must be considered an
50.23 expense of the last illness for purposes of section 524.3-805.

50.24 If the commissioner determines that the property or estate of a client is not more
50.25 than needed to care for and maintain the spouse and minor or dependent children of a
50.26 deceased client, the commissioner has the power to compromise the claim of the state in a
50.27 manner deemed just and proper.

50.28 Subd. 3. **Exception from statute of limitations.** Any statute of limitations that
50.29 limits the commissioner in recovering the cost of care obligation incurred by a client or
50.30 former client must not apply to any claim against an estate made under this section to
50.31 recover cost of care.

50.32 **Sec. 16. [246B.10] LIABILITY OF COUNTY; REIMBURSEMENT.**

51.1 The client's county shall pay to the state a portion of the cost of care provided in
51.2 the Minnesota sex offender program to a client who has legally settled in that county. A
51.3 county's payment must be made from the county's own sources of revenue and payments
51.4 must equal ten percent of the cost of care, as determined by the commissioner, for each
51.5 day or portion of a day, that the client spends at the facility. If payments received by the
51.6 state under this chapter exceed 90 percent of the cost of care, the county is responsible
51.7 for paying the state the remaining amount. The county is not entitled to reimbursement
51.8 from the client, the client's estate, or from the client's relatives, except as provided in
51.9 section 246B.07.

51.10 Sec. 17. Minnesota Statutes 2008, section 252.025, subdivision 7, is amended to read:

51.11 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
51.12 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have
51.13 developmental disabilities and exhibit severe behaviors which present a risk to public
51.14 safety. This program is statewide and must provide specialized residential services in
51.15 Cambridge and an array of ~~community support~~ community-based services statewide with
51.16 sufficient levels of care and a sufficient number of specialists to ensure that individuals
51.17 referred to the program receive the appropriate care. The individuals working in the
51.18 community-based services under this section are state employees supervised by the
51.19 commissioner of human services. No layoffs shall occur as a result of restructuring
51.20 under this section.

51.21 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
51.22 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
51.23 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

51.24 In consultation with community partners, the commissioner of human services
51.25 shall develop an array of community-based services to transform the current services
51.26 now provided to patients at the Anoka-Metro Regional Treatment Center. The
51.27 community-based services may be provided in facilities with 16 or fewer beds, and must
51.28 provide the appropriate level of care for the patients being admitted to the facilities. The
51.29 planning for this transition must be completed by October 1, 2009, with an initial report
51.30 to the committee chairs of health and human services by November 30, 2009, and a
51.31 semiannual report on progress until the transition is completed. The commissioner of
51.32 human services shall solicit interest from stakeholders and potential community partners.
51.33 The individuals working in the community-based services facilities under this section are

52.1 state employees supervised by the commissioner of human services. No layoffs shall
52.2 occur as a result of restructuring under this section.

52.3 Sec. 19. **REPEALER.**

52.4 Minnesota Statutes 2008, sections 246.51, subdivision 1; and 246.53, subdivision
52.5 3, are repealed.

52.6 **ARTICLE 4**
52.7 **DEPARTMENT OF HEALTH**

52.8 Section 1. Minnesota Statutes 2008, section 62J.495, is amended to read:

52.9 **62J.495 HEALTH INFORMATION TECHNOLOGY AND**
52.10 **INFRASTRUCTURE.**

52.11 Subdivision 1. **Implementation.** By January 1, 2015, all hospitals and health care
52.12 providers must have in place an interoperable electronic health records system within their
52.13 hospital system or clinical practice setting. The commissioner of health, in consultation
52.14 with the e-Health Information Technology and Infrastructure Advisory Committee,
52.15 shall develop a statewide plan to meet this goal, including uniform standards to be used
52.16 for the interoperable system for sharing and synchronizing patient data across systems.
52.17 The standards must be compatible with federal efforts. The uniform standards must be
52.18 developed by January 1, 2009, ~~with a status report on the development of these standards~~
52.19 ~~submitted to the legislature by January 15, 2008~~ and updated on an ongoing basis. The
52.20 commissioner shall include an update on standards development as part of an annual
52.21 report to the legislature.

52.22 Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an
52.23 electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH
52.24 Act to meet the standards and implementation specifications adopted under section 3004
52.25 as applicable.

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

52.27 (c) "Pharmaceutical electronic data intermediary" means any entity that provides
52.28 the infrastructure to connect computer systems or other electronic devices utilized
52.29 by prescribing practitioners with those used by pharmacies, health plans, third party
52.30 administrators, and pharmacy benefit manager in order to facilitate the secure transmission
52.31 of electronic prescriptions, refill authorization requests, communications, and other
52.32 prescription-related information between such entities.

52.33 (d) "HITECH Act" means the Health Information Technology for Economic and
52.34 Clinical Health Act in division A, title XIII and division B, title IV of the American

53.1 Recovery and Reinvestment Act of 2009, including federal regulations adopted under
53.2 that act.

53.3 (e) "Interoperable electronic health record" means an electronic health record that
53.4 securely exchanges health information with another electronic health record system that
53.5 meets national requirements for certification under the HITECH Act.

53.6 (f) "Qualified electronic health record" means an electronic record of health-related
53.7 information on an individual that includes patient demographic and clinical health
53.8 information and has the capacity to:

53.9 (1) provide clinical decision support;

53.10 (2) support physician order entry;

53.11 (3) capture and query information relevant to health care quality; and

53.12 (4) exchange electronic health information with, and integrate such information
53.13 from, other sources.

53.14 Subd. 2. ~~E-Health Information Technology and Infrastructure Advisory~~
53.15 ~~Committee.~~ (a) The commissioner shall establish ~~a~~ an e-Health Information Technology
53.16 ~~and Infrastructure~~ Advisory Committee governed by section 15.059 to advise the
53.17 commissioner on the following matters:

53.18 (1) assessment of the adoption and effective use of health information technology by
53.19 the state, licensed health care providers and facilities, and local public health agencies;

53.20 (2) recommendations for implementing a statewide interoperable health information
53.21 infrastructure, to include estimates of necessary resources, and for determining standards
53.22 for ~~administrative~~ clinical data exchange, clinical support programs, patient privacy
53.23 requirements, and maintenance of the security and confidentiality of individual patient
53.24 data;

53.25 (3) recommendations for encouraging use of innovative health care applications
53.26 using information technology and systems to improve patient care and reduce the cost
53.27 of care, including applications relating to disease management and personal health
53.28 management that enable remote monitoring of patients' conditions, especially those with
53.29 chronic conditions; and

53.30 (4) other related issues as requested by the commissioner.

53.31 (b) The members of the ~~e-Health Information Technology and Infrastructure~~
53.32 Advisory Committee shall include the commissioners, or commissioners' designees, of
53.33 health, human services, administration, and commerce and additional members to be
53.34 appointed by the commissioner to include persons representing Minnesota's local public
53.35 health agencies, licensed hospitals and other licensed facilities and providers, private
53.36 purchasers, the medical and nursing professions, health insurers and health plans, the

54.1 state quality improvement organization, academic and research institutions, consumer
54.2 advisory organizations with an interest and expertise in health information technology, and
54.3 other stakeholders as identified by the ~~Health Information Technology and Infrastructure~~
54.4 ~~Advisory Committee~~ commissioner to fulfill the requirements of section 3013, paragraph
54.5 (g) of the HITECH Act.

54.6 (c) The commissioner shall prepare and issue an annual report not later than January
54.7 30 of each year outlining progress to date in implementing a statewide health information
54.8 infrastructure and recommending ~~future projects~~ action on policy and necessary resources
54.9 to continue the promotion of adoption and effective use of health information technology.

54.10 (d) Notwithstanding section 15.059, this subdivision expires June 30, 2015.

54.11 Subd. 3. **Interoperable electronic health record requirements.** ~~(a)~~ To meet the
54.12 requirements of subdivision 1, hospitals and health care providers must meet the following
54.13 criteria when implementing an interoperable electronic health records system within their
54.14 hospital system or clinical practice setting.

54.15 (a) The electronic health record must be a qualified electronic health record.

54.16 (b) The electronic health record must be certified by the ~~Certification Commission~~
54.17 ~~for Healthcare Information Technology, or its successor~~ Office of the National Coordinator
54.18 pursuant to the HITECH Act. This criterion only applies to hospitals and health care
54.19 providers ~~whose practice setting is a practice setting covered by the Certification~~
54.20 ~~Commission for Healthcare Information Technology certifications~~ only if a certified
54.21 electronic health record product for the provider's particular practice setting is available.

54.22 This criterion shall be considered met if a hospital or health care provider is using an
54.23 electronic health records system that has been certified within the last three years, even if a
54.24 more current version of the system has been certified within the three-year period.

54.25 (c) The electronic health record must meet the standards established according to
54.26 section 3004 of the HITECH Act as applicable.

54.27 (d) The electronic health record must have the ability to generate information on
54.28 clinical quality measures and other measures reported under sections 4101, 4102, and
54.29 4201 of the HITECH Act.

54.30 ~~(e)~~ (e) A health care provider who is a prescriber or dispenser of ~~controlled~~
54.31 ~~substances~~ legend drugs must have an electronic health record system that meets the
54.32 requirements of section 62J.497.

54.33 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner,
54.34 in consultation with the e-Health Advisory Committee, shall update the statewide
54.35 implementation plan required under subdivision 2 and released June 2008, to be consistent
54.36 with the updated Federal HIT Strategic Plan released by the Office of the National

55.1 Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan
55.2 shall meet the requirements for a plan required under section 3013 of the HITECH Act.

55.3 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall
55.4 work to ensure coordination between state, regional, and national efforts to support and
55.5 accelerate efforts to effectively use health information technology to improve the quality
55.6 and coordination of health care and continuity of patient care among health care providers,
55.7 to reduce medical errors, to improve population health, to reduce health disparities, and
55.8 to reduce chronic disease. The commissioner's coordination efforts shall include but not
55.9 be limited to:

55.10 (1) assisting in the development and support of health information technology
55.11 regional extension centers established under section 3012(c) of the HITECH Act to
55.12 provide technical assistance and disseminate best practices; and

55.13 (2) providing supplemental information to the best practices gathered by regional
55.14 centers to ensure that the information is relayed in a meaningful way to the Minnesota
55.15 health care community.

55.16 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
55.17 monitor national activity related to health information technology and shall coordinate
55.18 statewide input on policy development. The commissioner shall coordinate statewide
55.19 responses to proposed federal health information technology regulations in order to ensure
55.20 that the needs of the Minnesota health care community are adequately and efficiently
55.21 addressed in the proposed regulations. The commissioner's responses may include, but
55.22 are not limited to:

55.23 (1) reviewing and evaluating any standard, implementation specification, or
55.24 certification criteria proposed by the national HIT standards committee;

55.25 (2) reviewing and evaluating policy proposed by the national HIT policy
55.26 committee relating to the implementation of a nationwide health information technology
55.27 infrastructure;

55.28 (3) monitoring and responding to activity related to the development of quality
55.29 measures and other measures as required by section 4101 of the HITECH Act. Any
55.30 response related to quality measures shall consider and address the quality efforts required
55.31 under chapter 62U; and

55.32 (4) monitoring and responding to national activity related to privacy, security, and
55.33 data stewardship of electronic health information and individually identifiable health
55.34 information.

55.35 (d) To the extent that the state is either required or allowed to apply, or designate an
55.36 entity to apply for or carry out activities and programs under section 3013 of the HITECH

56.1 Act, the commissioner of health, in consultation with the e-Health Advisory Committee
56.2 and the commissioner of human services, shall be the lead applicant or sole designating
56.3 authority. The commissioner shall make such designations consistent with the goals and
56.4 objectives of sections 62J.495 to 62J.497, and sections 62J.50 to 62J.61.

56.5 (e) The commissioner of human services shall apply for funding necessary to
56.6 administer the incentive payments to providers authorized under title IV of the American
56.7 Recovery and Reinvestment Act.

56.8 (f) The commissioner shall include in the report to the legislature information on the
56.9 activities of this subdivision and provide recommendations on any relevant policy changes
56.10 that should be considered in Minnesota.

56.11 Subd. 5. **Collection of data for assessment and eligibility determination.** (a)
56.12 The commissioner of health, in consultation with the commissioner of human services,
56.13 may require providers, dispensers, group purchasers, and pharmaceutical electronic data
56.14 intermediaries to submit data in a form and manner specified by the commissioner to
56.15 assess the status of adoption, effective use, and interoperability of electronic health
56.16 records for the purpose of:

56.17 (1) demonstrating Minnesota's progress on goals established by the Office of the
56.18 National Coordinator to accelerate the adoption and effective use of health information
56.19 technology established under the HITECH Act;

56.20 (2) assisting the Center for Medicare and Medicaid Services and Department of
56.21 Human Services in determining eligibility of health care professionals and hospitals
56.22 to receive federal incentives for the adoption and effective use of health information
56.23 technology under the HITECH Act or other federal incentive programs;

56.24 (3) assisting the Office of the National Coordinator in completing required
56.25 assessments of the impact of the implementation and effective use of health information
56.26 technology in achieving goals identified in the national strategic plan, and completing
56.27 studies required by the HITECH Act;

56.28 (4) providing the data necessary to assist the Office of the National Coordinator in
56.29 conducting evaluations of regional extension centers as required by the HITECH Act; and

56.30 (5) other purposes as necessary to support the implementation of the HITECH Act.

56.31 (b) The commissioner shall coordinate with the commissioner of human services
56.32 and other state agencies in the collection of data required under this section to:

56.33 (1) avoid duplicative reporting requirements;

56.34 (2) maximize efficiencies in the development of reports on state activities as
56.35 required by HITECH; and

57.1 (3) determine health professional and hospital eligibility for incentives available
57.2 under the HITECH Act.

57.3 (c) The commissioner must not collect data or publish analyses that identify, or could
57.4 potentially identify, individual patients. The commissioner must not collect individual
57.5 data in identified or de-identified form.

57.6 Sec. 2. Minnesota Statutes 2008, section 62J.496, is amended to read:

57.7 **62J.496 ELECTRONIC HEALTH RECORD SYSTEM REVOLVING**
57.8 **ACCOUNT AND LOAN PROGRAM.**

57.9 Subdivision 1. **Account establishment.** (a) An account is established to: provide
57.10 loans to eligible borrowers to assist in financing the installation or support of an
57.11 interoperable health record system. The system must provide for the interoperable
57.12 exchange of health care information between the applicant and, at a minimum, a hospital
57.13 system, pharmacy, and a health care clinic or other physician group.

57.14 (1) finance the purchase of certified electronic health records or qualified electronic
57.15 health records as defined in section 62J.495, subdivision 1a;

57.16 (2) enhance the utilization of electronic health record technology, which may include
57.17 costs associated with upgrading the technology to meet the criteria necessary to be a
57.18 certified electronic health record or a qualified electronic health record;

57.19 (3) train personnel in the use of electronic health record technology; and

57.20 (4) improve the secure electronic exchange of health information.

57.21 (b) Amounts deposited in the account, including any grant funds obtained through
57.22 federal or other sources, loan repayments, and interest earned on the amounts shall be
57.23 used only for awarding loans or loan guarantees, as a source of reserve and security for
57.24 leveraged loans, or for the administration of the account.

57.25 (c) The commissioner may accept contributions to the account from private sector
57.26 entities subject to the following provisions:

57.27 (1) the contributing entity may not specify the recipient or recipients of any loan
57.28 issued under this subdivision;

57.29 (2) the commissioner shall make public the identity of any private contributor to the
57.30 loan fund, as well as the amount of the contribution provided; and

57.31 (3) the commissioner may issue letters of commendation or make other awards that
57.32 have no financial value to any such entity.

57.33 A contributing entity may not specify that the recipient or recipients of any loan use
57.34 specific products or services, nor may the contributing entity imply that a contribution is
57.35 an endorsement of any specific product or service.

58.1 (d) The commissioner may use the loan funds to reimburse private sector entities
58.2 for any contribution made to the loan fund. Reimbursement to private entities may not
58.3 exceed the principle amount contributed to the loan fund.

58.4 (e) The commissioner may use funds deposited in the account to guarantee, or
58.5 purchase insurance for, a local obligation if the guarantee or purchase would improve
58.6 credit market access or reduce the interest rate applicable to the obligation involved.

58.7 (f) The commissioner may use funds deposited in the account as a source of revenue
58.8 or security for the payment of principal and interest on revenue or bonds issued by the
58.9 state if the proceeds of the sale of the bonds will be deposited into the loan fund.

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

58.11 (1) federally qualified health centers;

58.12 ~~(1)~~ (2) community clinics, as defined under section 145.9268;

58.13 ~~(2)~~ (3) nonprofit or local unit of government hospitals eligible for rural hospital
58.14 capital improvement grants, as defined in section 144.148 licensed under sections 144.50
58.15 to 144.56;

58.16 ~~(3)~~ physician clinics located in a community with a population of less than 50,000
58.17 according to United States Census Bureau statistics and outside the seven-county
58.18 metropolitan area;

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

58.21 ~~(4)~~ (5) nursing facilities licensed under sections 144A.01 to 144A.27; and

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

58.23 ~~(5)~~ (7) other providers of health or health care services approved by the
58.24 commissioner for which interoperable electronic health record capability would improve
58.25 quality of care, patient safety, or community health.

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

58.28 (1) critical access hospitals;

58.29 (2) federally qualified health centers;

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

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

58.33 ~~(b) To be eligible for a loan under this section, the~~ (c) An eligible applicant must
58.34 submit a loan application to the commissioner of health on forms prescribed by the
58.35 commissioner. The application must include, at a minimum:

- 59.1 (1) the amount of the loan requested and a description of the purpose or project
59.2 for which the loan proceeds will be used;
- 59.3 (2) a quote from a vendor;
- 59.4 (3) a description of the health care entities and other groups participating in the
59.5 project;
- 59.6 (4) evidence of financial stability and a demonstrated ability to repay the loan; and
- 59.7 (5) a description of how the system to be financed ~~interconnects~~ interoperates or
59.8 plans in the future to ~~interconnect~~ interoperate with other health care entities and provider
59.9 groups located in the same geographical area;
- 59.10 (6) a plan on how the certified electronic health record technology will be maintained
59.11 and supported over time; and
- 59.12 (7) any other requirements for applications included or developed pursuant to
59.13 section 3014 of the HITECH Act.

59.14 Subd. 3. **Loans.** (a) The commissioner of health may make a no interest loan or
59.15 low interest loan to a provider or provider group who is eligible under subdivision 2
59.16 ~~on a first-come, first-served basis provided that the applicant is able to comply with this~~
59.17 ~~section~~ consistent with the priorities established in subdivision 2. The total accumulative
59.18 loan principal must not exceed ~~\$1,500,000~~ \$3,000,000 per loan. The interest rate for each
59.19 loan, if imposed, shall not exceed the current market interest rate. The commissioner of
59.20 health has discretion over the size, interest rate, and number of loans made. Nothing in
59.21 this section shall require the commissioner to make a loan to an eligible borrower under
59.22 subdivision 2.

59.23 (b) The commissioner of health may prescribe forms and establish an application
59.24 process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable
59.25 application fee to cover the cost of administering the loan program. Any application
59.26 fees imposed and collected under the electronic health records system revolving account
59.27 and loan program in this section are appropriated to the commissioner of health for the
59.28 duration of the loan program. The commissioner may apply for and use all federal funds
59.29 available through the HITECH Act to administer the loan program.

59.30 (c) For loans approved prior to July 1, 2009, the borrower must begin repaying the
59.31 principal no later than two years from the date of the loan. Loans must be amortized no
59.32 later than six years from the date of the loan.

59.33 (d) For loans granted on January 1, 2010, or thereafter, the borrower must begin
59.34 repaying the principle no later than one year from the date of the loan. Loans must be
59.35 amortized no later than six years after the date of the loan.

60.1 ~~(d) Repayments~~ (e) All repayments and interest paid on each loan must be credited
60.2 to the account.

60.3 (f) The loan agreement shall include the assurances that borrower meets requirements
60.4 included or developed pursuant to section 3014 of the HITECH Act. The requirements
60.5 shall include, but are not limited to:

60.6 (1) submitting reports on quality measures in compliance with regulations adopted
60.7 by the federal government;

60.8 (2) demonstrating that any certified electronic health record technology purchased,
60.9 improved, or otherwise financially supported by this loan program is used to exchange
60.10 health information in a manner that, in accordance with law and standards applicable to
60.11 the exchange of information, improves the quality of health care;

60.12 (3) including a plan on how the borrower intends to maintain and support the
60.13 certified electronic health record technology over time and the resources expected to be
60.14 used to maintain and support the technology purchased with the loan; and

60.15 (4) complying with other requirements the secretary may require to use loans funds
60.16 under the HITECH Act.

60.17 Subd. 4. **Data classification.** Data collected by the commissioner of health on the
60.18 application to determine eligibility under subdivision 2 and to monitor borrowers' default
60.19 risk or collect payments owed under subdivision 3 are (1) private data on individuals as
60.20 defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section
60.21 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted
60.22 are public data.

60.23 Sec. 3. Minnesota Statutes 2008, section 62J.497, subdivision 1, is amended to read:

60.24 Subdivision 1. **Definitions.** For the purposes of this section, the following terms
60.25 have the meanings given.

60.26 (a) "Backward compatible" means that the newer version of a data transmission
60.27 standard would retain, at a minimum, the full functionality of the versions previously
60.28 adopted, and would permit the successful completion of the applicable transactions with
60.29 entities that continue to use the older versions.

60.30 ~~(a)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01,
60.31 subdivision 30. Dispensing does not include the direct administering of a controlled
60.32 substance to a patient by a licensed health care professional.

60.33 ~~(b)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled
60.34 substance, pursuant to a valid prescription.

61.1 ~~(e)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
61.2 title 45, part 160.103.

61.3 ~~(d)~~ (e) "E-prescribing" means the transmission using electronic media of prescription
61.4 or prescription-related information between a prescriber, dispenser, pharmacy benefit
61.5 manager, or group purchaser, either directly or through an intermediary, including
61.6 an e-prescribing network. E-prescribing includes, but is not limited to, two-way
61.7 transmissions between the point of care and the dispenser and two-way transmissions
61.8 related to eligibility, formulary, and medication history information.

61.9 ~~(e)~~ (f) "Electronic prescription drug program" means a program that provides for
61.10 e-prescribing.

61.11 ~~(f)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

61.12 ~~(g)~~ (h) "HL7 messages" means a standard approved by the standards development
61.13 organization known as Health Level Seven.

61.14 ~~(h)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under
61.15 Code of Federal Regulations, title 45, part 162.406.

61.16 ~~(i)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

61.17 ~~(j)~~ (k) "NCPDP Formulary and Benefits Standard" means the National Council for
61.18 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
61.19 Version 1, Release 0, October 2005.

61.20 ~~(k)~~ (l) "NCPDP SCRIPT Standard" means the National Council for Prescription
61.21 Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation
61.22 Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard
61.23 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
61.24 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and
61.25 regulations adopted under it. The standards shall be implemented according to the Centers
61.26 for Medicare and Medicaid Services schedule for compliance. Subsequently released
61.27 versions of the NCPDP SCRIPT Standard may be used, provided that the new version
61.28 of the standard is backward compatible to the current version adopted by the Centers for
61.29 Medicare and Medicaid Services.

61.30 ~~(l)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

61.31 ~~(m)~~ (n) "Prescriber" means a licensed health care professional who is authorized to
61.32 ~~prescribe a controlled substance under section 152.12, subdivision 1.~~ practitioner, other
61.33 than a veterinarian, as defined in section 151.01, subdivision 23.

61.34 ~~(n)~~ (o) "Prescription-related information" means information regarding eligibility for
61.35 drug benefits, medication history, or related health or drug information.

62.1 ~~(o)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03,
62.2 subdivision 8.

62.3 Sec. 4. Minnesota Statutes 2008, section 62J.497, subdivision 2, is amended to read:

62.4 Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011,
62.5 all providers, group purchasers, prescribers, and dispensers must establish ~~and~~₂ maintain₂
62.6 and use an electronic prescription drug program that complies. This program must comply
62.7 with the applicable standards in this section for transmitting, directly or through an
62.8 intermediary, prescriptions and prescription-related information using electronic media.

62.9 ~~(b) Nothing in this section requires providers, group purchasers, prescribers, or~~
62.10 ~~dispensers to conduct the transactions described in this section.~~ If transactions described in
62.11 this section are conducted, they must be done electronically using the standards described
62.12 in this section. Nothing in this section requires providers, group purchasers, prescribers,
62.13 or dispensers to electronically conduct transactions that are expressly prohibited by other
62.14 sections or federal law.

62.15 (c) Providers, group purchasers, prescribers, and dispensers must use either HL7
62.16 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related
62.17 information internally when the sender and the recipient are part of the same legal entity. If
62.18 an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard
62.19 or other applicable standards required by this section. Any pharmacy within an entity
62.20 must be able to receive electronic prescription transmittals from outside the entity using
62.21 the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health
62.22 Insurance Portability and Accountability Act (HIPAA) requirement that may require the
62.23 use of a HIPAA transaction standard within an organization.

62.24 ~~(d) Entities transmitting prescriptions or prescription-related information where the~~
62.25 ~~prescriber is required by law to issue a prescription for a patient to a nonprescribing~~
62.26 ~~provider that in turn forwards the prescription to a dispenser are exempt from the~~
62.27 ~~requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or~~
62.28 ~~prescription-related information.~~

62.29 Sec. 5. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
62.30 to read:

62.31 Subd. 4. **Development and use of uniform formulary exception form.** (a) The
62.32 commissioner of health, in consultation with the Minnesota Administrative Uniformity
62.33 Committee, shall develop by July 1, 2009, or six weeks after enactment of this subdivision,
62.34 whichever is later, a uniform formulary exception form that allows health care providers

63.1 to request exceptions from group purchaser formularies using a uniform form. Upon
63.2 development of the form, all health care providers must submit requests for formulary
63.3 exceptions using the uniform form, and all group purchasers must accept this form from
63.4 health care providers.

63.5 (b) No later than January 1, 2011, the uniform formulary exception form must be
63.6 accessible and submitted by health care providers, and accepted and processed by group
63.7 purchasers, through secure electronic transmissions. Facsimile shall not be considered
63.8 secure electronic transmissions.

63.9 Sec. 6. Minnesota Statutes 2008, section 62J.497, is amended by adding a subdivision
63.10 to read:

63.11 Subd. 5. **Electronic drug prior authorization standardization and transmission.**

63.12 (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory
63.13 Committee and the Minnesota Administrative Uniformity Committee, shall, by February
63.14 15, 2010, identify an outline on how best to standardize drug prior authorization request
63.15 transactions between providers and group purchasers with the goal of maximizing
63.16 administrative simplification and efficiency in preparation for electronic transmissions.

63.17 (b) No later than January 1, 2011, drug prior authorization requests must be
63.18 accessible and submitted by health care providers, and accepted and processed by group
63.19 purchasers, electronically through secure electronic transmissions. Facsimile shall not be
63.20 considered electronic transmission.

63.21 Sec. 7. **[62Q.676] MEDICATION THERAPY MANAGEMENT.**

63.22 A pharmacy benefit manager that provides prescription drug services must make
63.23 available medication therapy management services for enrollees taking four or more
63.24 prescriptions to treat or prevent two or more chronic medical conditions. For purposes
63.25 of this section, "medication therapy management" means the provision of the following
63.26 pharmaceutical care services by, or under the supervision of, a licensed pharmacist to
63.27 optimize the therapeutic outcomes of the patient's medications:

63.28 (1) performing a comprehensive medication review to identify, resolve, and prevent
63.29 medication-related problems, including adverse drug events;

63.30 (2) communicating essential information to the patient's other primary care
63.31 providers; and

63.32 (3) providing verbal education and training designed to enhance patient
63.33 understanding and appropriate use of the patient's medications.

64.1 Nothing in this section shall be construed to expand or modify the scope of practice
64.2 of the pharmacist as defined in section 151.01, subdivision 27.

64.3 Sec. 8. Minnesota Statutes 2008, section 144.122, is amended to read:

64.4 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

64.5 (a) The state commissioner of health, by rule, may prescribe procedures and fees
64.6 for filing with the commissioner as prescribed by statute and for the issuance of original
64.7 and renewal permits, licenses, registrations, and certifications issued under authority of
64.8 the commissioner. The expiration dates of the various licenses, permits, registrations,
64.9 and certifications as prescribed by the rules shall be plainly marked thereon. Fees may
64.10 include application and examination fees and a penalty fee for renewal applications
64.11 submitted after the expiration date of the previously issued permit, license, registration,
64.12 and certification. The commissioner may also prescribe, by rule, reduced fees for permits,
64.13 licenses, registrations, and certifications when the application therefor is submitted
64.14 during the last three months of the permit, license, registration, or certification period.
64.15 Fees proposed to be prescribed in the rules shall be first approved by the Department of
64.16 Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
64.17 in an amount so that the total fees collected by the commissioner will, where practical,
64.18 approximate the cost to the commissioner in administering the program. All fees collected
64.19 shall be deposited in the state treasury and credited to the state government special revenue
64.20 fund unless otherwise specifically appropriated by law for specific purposes.

64.21 (b) The commissioner may charge a fee for voluntary certification of medical
64.22 laboratories and environmental laboratories, and for environmental and medical laboratory
64.23 services provided by the department, without complying with paragraph (a) or chapter 14.
64.24 Fees charged for environment and medical laboratory services provided by the department
64.25 must be approximately equal to the costs of providing the services.

64.26 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
64.27 conducted at clinics held by the services for children with disabilities program. All
64.28 receipts generated by the program are annually appropriated to the commissioner for use
64.29 in the maternal and child health program.

64.30 (d) The commissioner shall set license fees for hospitals and nursing homes that are
64.31 not boarding care homes at the following levels:

- 65.1 Joint Commission on Accreditation of ~~\$7,555~~ \$7,655 plus ~~\$13~~ \$16 per bed
- 65.2 Healthcare Organizations (JCAHO) and
- 65.3 American Osteopathic Association (AOA)
- 65.4 hospitals
- 65.5 Non-JCAHO and non-AOA hospitals ~~\$5,180~~ \$5,280 plus ~~\$247~~ \$250 per bed
- 65.6 Nursing home \$183 plus \$91 per bed

65.7 The commissioner shall set license fees for outpatient surgical centers, boarding care
 65.8 homes, and supervised living facilities at the following levels:

- 65.9 Outpatient surgical centers ~~\$3,349~~ \$3,712
- 65.10 Boarding care homes \$183 plus \$91 per bed
- 65.11 Supervised living facilities \$183 plus \$91 per bed.

65.12 (e) Unless prohibited by federal law, the commissioner of health shall charge
 65.13 applicants the following fees to cover the cost of any initial certification surveys required
 65.14 to determine a provider's eligibility to participate in the Medicare or Medicaid program:

65.15	Prospective payment surveys for hospitals	\$ 900
65.16	Swing bed surveys for nursing homes	\$ 1,200
65.17	Psychiatric hospitals	\$ 1,400
65.18	Rural health facilities	\$ 1,100
65.19	Portable x-ray providers	\$ 500
65.20	Home health agencies	\$ 1,800
65.21	Outpatient therapy agencies	\$ 800
65.22	End stage renal dialysis providers	\$ 2,100
65.23	Independent therapists	\$ 800
65.24	Comprehensive rehabilitation outpatient facilities	\$ 1,200
65.25	Hospice providers	\$ 1,700
65.26	Ambulatory surgical providers	\$ 1,800
65.27	Hospitals	\$ 4,200
65.28	Other provider categories or additional	Actual surveyor costs: average surveyor cost x number of hours for the survey process.
65.29	resurveys required to complete initial	
65.30	certification	

66.1 These fees shall be submitted at the time of the application for federal certification
66.2 and shall not be refunded. All fees collected after the date that the imposition of fees is not
66.3 prohibited by federal law shall be deposited in the state treasury and credited to the state
66.4 government special revenue fund.

66.5 Sec. 9. Minnesota Statutes 2008, section 144.226, subdivision 4, is amended to read:

66.6 Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under
66.7 subdivision 1, there is a nonrefundable surcharge of \$2 for each certified and noncertified
66.8 birth, stillbirth, or death record, and for a certification that the record cannot be found.
66.9 The local or state registrar shall forward this amount to the commissioner of finance to
66.10 be deposited into the state government special revenue fund. This surcharge shall not be
66.11 charged under those circumstances in which no fee for a birth, stillbirth, or death record is
66.12 permitted under subdivision 1, paragraph (a).

66.13 (b) Effective August 1, 2005, ~~to June 30, 2009~~, the surcharge in paragraph (a) ~~shall~~
66.14 ~~be~~ is \$4.

66.15 Sec. 10. Minnesota Statutes 2008, section 148.6445, is amended by adding a
66.16 subdivision to read:

66.17 Subd. 2a. **Duplicate license fee.** The fee for a duplicate license is \$25.

66.18 **ARTICLE 5**
66.19 **HEALTH CARE**

66.20 Section 1. Minnesota Statutes 2008, section 60A.092, subdivision 2, is amended to
66.21 read:

66.22 Subd. 2. **Licensed assuming insurer.** Reinsurance is ceded to an assuming insurer
66.23 if the assuming insurer is licensed to transact insurance or reinsurance in this state. For
66.24 purposes of reinsuring any health risk, an insurer is defined under section 62A.63.

66.25 Sec. 2. Minnesota Statutes 2008, section 62D.03, subdivision 4, is amended to read:

66.26 Subd. 4. **Application requirements.** Each application for a certificate of authority
66.27 shall be verified by an officer or authorized representative of the applicant, and shall be
66.28 in a form prescribed by the commissioner of health. Each application shall include the
66.29 following:

66.30 (a) a copy of the basic organizational document, if any, of the applicant and of
66.31 each major participating entity; such as the articles of incorporation, or other applicable
66.32 documents, and all amendments thereto;

67.1 (b) a copy of the bylaws, rules and regulations, or similar document, if any, and all
67.2 amendments thereto which regulate the conduct of the affairs of the applicant and of
67.3 each major participating entity;

67.4 (c) a list of the names, addresses, and official positions of the following:

67.5 (1) all members of the board of directors, or governing body of the local government
67.6 unit, and the principal officers and shareholders of the applicant organization; and

67.7 (2) all members of the board of directors, or governing body of the local government
67.8 unit, and the principal officers of the major participating entity and each shareholder
67.9 beneficially owning more than ten percent of any voting stock of the major participating
67.10 entity;

67.11 The commissioner may by rule identify persons included in the term "principal
67.12 officers";

67.13 (d) a full disclosure of the extent and nature of any contract or financial arrangements
67.14 between the following:

67.15 (1) the health maintenance organization and the persons listed in clause (c)(1);

67.16 (2) the health maintenance organization and the persons listed in clause (c)(2);

67.17 (3) each major participating entity and the persons listed in clause (c)(1) concerning
67.18 any financial relationship with the health maintenance organization; and

67.19 (4) each major participating entity and the persons listed in clause (c)(2) concerning
67.20 any financial relationship with the health maintenance organization;

67.21 (e) the name and address of each participating entity and the agreed upon duration of
67.22 each contract or agreement;

67.23 (f) a copy of the form of each contract binding the participating entities and the
67.24 health maintenance organization. Contractual provisions shall be consistent with the
67.25 purposes of sections 62D.01 to 62D.30, in regard to the services to be performed under the
67.26 contract, the manner in which payment for services is determined, the nature and extent
67.27 of responsibilities to be retained by the health maintenance organization, the nature and
67.28 extent of risk sharing permissible, and contractual termination provisions;

67.29 (g) a copy of each contract binding major participating entities and the health
67.30 maintenance organization. Contract information filed with the commissioner shall be
67.31 confidential and subject to the provisions of section 13.37, subdivision 1, clause (b), upon
67.32 the request of the health maintenance organization.

67.33 Upon initial filing of each contract, the health maintenance organization shall file
67.34 a separate document detailing the projected annual expenses to the major participating
67.35 entity in performing the contract and the projected annual revenues received by the entity
67.36 from the health maintenance organization for such performance. The commissioner

68.1 shall disapprove any contract with a major participating entity if the contract will result
68.2 in an unreasonable expense under section 62D.19. The commissioner shall approve or
68.3 disapprove a contract within 30 days of filing.

68.4 Within 120 days of the anniversary of the implementation of each contract, the
68.5 health maintenance organization shall file a document detailing the actual expenses
68.6 incurred and reported by the major participating entity in performing the contract in the
68.7 preceding year and the actual revenues received from the health maintenance organization
68.8 by the entity in payment for the performance;

68.9 (h) a statement generally describing the health maintenance organization, its health
68.10 maintenance contracts and separate health service contracts, facilities, and personnel,
68.11 including a statement describing the manner in which the applicant proposes to provide
68.12 enrollees with comprehensive health maintenance services and separate health services;

68.13 (i) a copy of the form of each evidence of coverage to be issued to the enrollees;

68.14 (j) a copy of the form of each individual or group health maintenance contract
68.15 and each separate health service contract which is to be issued to enrollees or their
68.16 representatives;

68.17 (k) financial statements showing the applicant's assets, liabilities, and sources of
68.18 financial support. If the applicant's financial affairs are audited by independent certified
68.19 public accountants, a copy of the applicant's most recent certified financial statement
68.20 may be deemed to satisfy this requirement;

68.21 (l) a description of the proposed method of marketing the plan, a schedule of
68.22 proposed charges, and a financial plan which includes a three-year projection of the
68.23 expenses and income and other sources of future capital;

68.24 (m) a statement reasonably describing the geographic area or areas to be served and
68.25 the type or types of enrollees to be served;

68.26 (n) a description of the complaint procedures to be utilized as required under section
68.27 62D.11;

68.28 (o) a description of the procedures and programs to be implemented to meet the
68.29 requirements of section 62D.04, subdivision 1, clauses (b) and (c) and to monitor the
68.30 quality of health care provided to enrollees;

68.31 (p) a description of the mechanism by which enrollees will be afforded an
68.32 opportunity to participate in matters of policy and operation under section 62D.06;

68.33 (q) a copy of any agreement between the health maintenance organization and
68.34 an insurer ~~or~~, including any nonprofit health service corporation or another health
68.35 maintenance organization, regarding reinsurance, stop-loss coverage, insolvency

69.1 coverage, or any other type of coverage for potential costs of health services, as authorized
69.2 in sections 62D.04, subdivision 1, clause (f), 62D.05, subdivision 3, and 62D.13;

69.3 (r) a copy of the conflict of interest policy which applies to all members of the board
69.4 of directors and the principal officers of the health maintenance organization, as described
69.5 in section 62D.04, subdivision 1, paragraph (g). All currently licensed health maintenance
69.6 organizations shall also file a conflict of interest policy with the commissioner within 60
69.7 days after August 1, 1990, or at a later date if approved by the commissioner;

69.8 (s) a copy of the statement that describes the health maintenance organization's prior
69.9 authorization administrative procedures; and

69.10 (t) other information as the commissioner of health may reasonably require to be
69.11 provided.

69.12 Sec. 3. Minnesota Statutes 2008, section 62D.05, subdivision 3, is amended to read:

69.13 Subd. 3. **Contracts; health services.** A health maintenance organization may
69.14 contract with providers of health care services to render the services the health maintenance
69.15 organization has promised to provide under the terms of its health maintenance contracts,
69.16 may, subject to section 62D.12, subdivision 11, enter into separate prepaid dental contracts,
69.17 or other separate health service contracts, may, subject to the limitations of section
69.18 62D.04, subdivision 1, clause (f), contract with insurance companies ~~and, including~~
69.19 nonprofit health service plan corporations or other health maintenance organizations,
69.20 for insurance, indemnity or reimbursement of its cost of providing health care services
69.21 for enrollees or against the risks incurred by the health maintenance organization, may
69.22 contract with insurance companies and nonprofit health service plan corporations for
69.23 insolvency insurance coverage, and may contract with insurance companies and nonprofit
69.24 health service plan corporations to insure or cover the enrollees' costs and expenses in the
69.25 health maintenance organization, including the customary prepayment amount and any
69.26 co-payment obligations, and may contract to provide reinsurance or insolvency insurance
69.27 coverage to health insurers or nonprofit health service plan corporations.

69.28 Sec. 4. Minnesota Statutes 2008, section 62J.692, subdivision 7, is amended to read:

69.29 Subd. 7. **Transfers from the commissioner of human services.** ~~(a) The amount~~
69.30 ~~transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall~~
69.31 ~~be distributed by the commissioner annually to clinical medical education programs that~~
69.32 ~~meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph~~
69.33 ~~(a) Of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a),~~
69.34 ~~clauses (1) to (4), \$21,714,000 shall be distributed as follows:~~

70.1 (1) \$2,157,000 shall be distributed by the commissioner to the University of
70.2 Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40;

70.3 (2) \$1,035,360 shall be distributed by the commissioner to the Hennepin County
70.4 Medical Center for clinical medical education;

70.5 (3) \$17,400,000 shall be distributed by the commissioner to the University of
70.6 Minnesota Board of Regents for purposes of medial education;

70.7 (4) \$1,121,640 shall be distributed by the commissioner to clinical medical education
70.8 denial innovation grants in accordance with subdivision 7a; and

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

70.13 ~~(b) Fifty percent of the amount transferred according to section 256B.69, subdivision~~
70.14 ~~5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of~~
70.15 ~~Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40. Of~~
70.16 ~~the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph~~
70.17 ~~(a), clause (2), 24 percent of the amount shall be distributed by the commissioner to~~
70.18 ~~the Hennepin County Medical Center for clinical medical education. The remaining 26~~
70.19 ~~percent of the amount transferred shall be distributed by the commissioner in accordance~~
70.20 ~~with subdivision 7a. If the federal approval is not obtained for the matching funds under~~
70.21 ~~section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount~~
70.22 ~~transferred under this paragraph shall be distributed by the commissioner to the University~~
70.23 ~~of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40.~~

70.24 ~~(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph~~
70.25 ~~(a), clauses (3) and (4), shall be distributed by the commissioner upon receipt to the~~
70.26 ~~University of Minnesota Board of Regents for the purposes of clinical graduate medical~~
70.27 ~~education.~~

70.28 Sec. 5. Minnesota Statutes 2008, section 256.01, subdivision 2b, is amended to read:

70.29 Subd. 2b. **Performance payments.** ~~(a)~~ The commissioner shall develop and
70.30 implement a pay-for-performance system to provide performance payments to eligible
70.31 medical groups and clinics that demonstrate optimum care in serving individuals
70.32 with chronic diseases who are enrolled in health care programs administered by the
70.33 commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any
70.34 federal matching money that is made available through the medical assistance program
70.35 for managed care oversight contracted through vendors, including consumer surveys,

71.1 studies, and external quality reviews as required by the federal Balanced Budget Act of
71.2 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external
71.3 quality review. Any federal money received for managed care oversight is appropriated
71.4 to the commissioner for this purpose. The commissioner may expend the federal money
71.5 received in either year of the biennium.

71.6 ~~(b) Effective July 1, 2008, or upon federal approval, whichever is later, the~~
71.7 ~~commissioner shall develop and implement a patient incentive health program to provide~~
71.8 ~~incentives and rewards to patients who are enrolled in health care programs administered~~
71.9 ~~by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and~~
71.10 ~~have met personal health goals established with the patients' primary care providers to~~
71.11 ~~manage a chronic disease or condition, including but not limited to diabetes, high blood~~
71.12 ~~pressure, and coronary artery disease.~~

71.13 Sec. 6. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
71.14 to read:

71.15 Subd. 18a. **Public Assistance Reporting Information System.** (a) Effective
71.16 October 1, 2009, the commissioner shall comply with the federal requirements in Public
71.17 Law 110-379 in implementing the Public Assistance Reporting Information System
71.18 (PARIS) to determine eligibility for all individuals applying for:

71.19 (1) health care benefits under chapters 256B, 256D, and 256L; and
71.20 (2) public benefits under chapters 119B, 256D, 256I, and the supplemental nutrition
71.21 assistance program.

71.22 (b) The commissioner shall determine eligibility under paragraph (a) by performing
71.23 data matches, including matching with medical assistance, cash, child care, and
71.24 supplemental assistance programs operated by other states.

71.25 **EFFECTIVE DATE.** This section is effective October 1, 2009.

71.26 Sec. 7. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
71.27 to read:

71.28 Subd. 18b. **Protections for American Indians.** Effective February 18, 2009, the
71.29 commissioner shall comply with the federal requirements in the American Recovery and
71.30 Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding American Indians.

71.31 Sec. 8. Minnesota Statutes 2008, section 256.962, subdivision 2, is amended to read:

72.1 Subd. 2. **Outreach grants.** (a) The commissioner shall award grants to public and
72.2 private organizations, regional collaboratives, and regional health care outreach centers
72.3 for outreach activities, including, but not limited to:

72.4 (1) providing information, applications, and assistance in obtaining coverage
72.5 through Minnesota public health care programs;

72.6 (2) collaborating with public and private entities such as hospitals, providers, health
72.7 plans, legal aid offices, pharmacies, insurance agencies, and faith-based organizations to
72.8 develop outreach activities and partnerships to ensure the distribution of information
72.9 and applications and provide assistance in obtaining coverage through Minnesota health
72.10 care programs; ~~and~~

72.11 (3) providing or collaborating with public and private entities to provide multilingual
72.12 and culturally specific information and assistance to applicants in areas of high
72.13 uninsurance in the state or populations with high rates of uninsurance; and

72.14 (4) targeting geographic areas with high rates of (i) eligible but unenrolled children,
72.15 including children who reside in rural areas, or (ii) racial and ethnic minorities and health
72.16 disparity populations.

72.17 (b) The commissioner shall ensure that all outreach materials are available in
72.18 languages other than English.

72.19 (c) The commissioner shall establish an outreach trainer program to provide
72.20 training to designated individuals from the community and public and private entities on
72.21 application assistance in order for these individuals to provide training to others in the
72.22 community on an as-needed basis.

72.23 Sec. 9. Minnesota Statutes 2008, section 256.962, subdivision 6, is amended to read:

72.24 Subd. 6. **School districts and charter schools.** (a) At the beginning of each school
72.25 year, a school district or charter school shall provide information to each student on the
72.26 availability of health care coverage through the Minnesota health care programs and how
72.27 to obtain an application for the Minnesota health care programs.

72.28 ~~(b) For each child who is determined to be eligible for the free and reduced-price~~
72.29 ~~school lunch program, the district shall provide the child's family with information on how~~
72.30 ~~to obtain an application for the Minnesota health care programs and application assistance.~~

72.31 ~~(c)~~ (e) A school district or charter school shall also ensure that applications and
72.32 information on application assistance are available at early childhood education sites and
72.33 public schools located within the district's jurisdiction.

72.34 ~~(d)~~ (c) Each district shall designate an enrollment specialist to provide application
72.35 assistance and follow-up services with families who have indicated an interest in receiving

73.1 information or an application for the Minnesota health care program. A district is eligible
73.2 for the application assistance bonus described in subdivision 5.

73.3 ~~(c) Each~~ (d) If a school district or charter school maintains a district Web site, the
73.4 school district or charter school shall provide on their its Web site a link to information on
73.5 how to obtain an application and application assistance.

73.6 Sec. 10. **[256.964] DENTAL CARE PILOT PROJECTS.**

73.7 The commissioner shall authorize pilot projects to reduce the total cost to the state
73.8 for dental services provided to enrollees of the state public health care programs by
73.9 reducing hospital emergency room costs for preventable or nonemergency dental services.
73.10 As part of the project, a community dental clinic or dental provider, in collaboration with a
73.11 hospital emergency room, shall provide urgent care dental services as an alternative to the
73.12 hospital emergency room for nonemergency dental care. The project participants shall
73.13 establish a process to divert a patient presenting at the emergency room for nonemergency
73.14 dental care to the dental community clinic or to an appropriate dental provider. The
73.15 commissioner may establish special payment rates for urgent care services provided and
73.16 may change or waive existing payment policies in order to adequately reimburse providers
73.17 for providing cost-effective alternative services in an outpatient or urgent care setting.
73.18 The commissioner may establish a project in conjunction with the initiative authorized
73.19 under section 256.963.

73.20 Sec. 11. Minnesota Statutes 2008, section 256.969, subdivision 2b, is amended to read:

73.21 Subd. 2b. **Operating payment rates.** In determining operating payment rates for
73.22 admissions occurring on or after the rate year beginning January 1, 1991, and every two
73.23 years after, or more frequently as determined by the commissioner, the commissioner
73.24 shall obtain operating data from an updated base year and establish operating payment
73.25 rates per admission for each hospital based on the cost-finding methods and allowable
73.26 costs of the Medicare program in effect during the base year. Rates under the general
73.27 assistance medical care, medical assistance, and MinnesotaCare programs shall not be
73.28 rebased to more current data on January 1, 1997, January 1, 2005, ~~and~~ for the first 24
73.29 months of the rebased period beginning January 1, 2009, and for the first three months of
73.30 the rebased period beginning January 1, 2011. From April 1, 2011, to March 31, 2012,
73.31 rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change.
73.32 Effective April 1, 2012, rates shall be rebased at full value. The base year operating
73.33 payment rate per admission is standardized by the case mix index and adjusted by the
73.34 hospital cost index, relative values, and disproportionate population adjustment. The

74.1 cost and charge data used to establish operating rates shall only reflect inpatient services
74.2 covered by medical assistance and shall not include property cost information and costs
74.3 recognized in outlier payments.

74.4 Sec. 12. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

74.5 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
74.6 assistance program must not be submitted until the recipient is discharged. However,
74.7 the commissioner shall establish monthly interim payments for inpatient hospitals that
74.8 have individual patient lengths of stay over 30 days regardless of diagnostic category.
74.9 Except as provided in section 256.9693, medical assistance reimbursement for treatment
74.10 of mental illness shall be reimbursed based on diagnostic classifications. Individual
74.11 hospital payments established under this section and sections 256.9685, 256.9686, and
74.12 256.9695, in addition to third party and recipient liability, for discharges occurring during
74.13 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
74.14 inpatient services paid for the same period of time to the hospital. This payment limitation
74.15 shall be calculated separately for medical assistance and general assistance medical
74.16 care services. The limitation on general assistance medical care shall be effective for
74.17 admissions occurring on or after July 1, 1991. Services that have rates established under
74.18 subdivision 11 or 12, must be limited separately from other services. After consulting with
74.19 the affected hospitals, the commissioner may consider related hospitals one entity and
74.20 may merge the payment rates while maintaining separate provider numbers. The operating
74.21 and property base rates per admission or per day shall be derived from the best Medicare
74.22 and claims data available when rates are established. The commissioner shall determine
74.23 the best Medicare and claims data, taking into consideration variables of recency of the
74.24 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
74.25 The commissioner shall notify hospitals of payment rates by December 1 of the year
74.26 preceding the rate year. The rate setting data must reflect the admissions data used to
74.27 establish relative values. Base year changes from 1981 to the base year established for the
74.28 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
74.29 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
74.30 1. The commissioner may adjust base year cost, relative value, and case mix index data
74.31 to exclude the costs of services that have been discontinued by the October 1 of the year
74.32 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
74.33 that encompass portions of two or more rate years shall have payments established based
74.34 on payment rates in effect at the time of admission unless the date of admission preceded
74.35 the rate year in effect by six months or more. In this case, operating payment rates for

75.1 services rendered during the rate year in effect and established based on the date of
75.2 admission shall be adjusted to the rate year in effect by the hospital cost index.

75.3 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
75.4 payment, before third-party liability and spenddown, made to hospitals for inpatient
75.5 services is reduced by .5 percent from the current statutory rates.

75.6 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
75.7 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services
75.8 before third-party liability and spenddown, is reduced five percent from the current
75.9 statutory rates. Mental health services within diagnosis related groups 424 to 432, and
75.10 facilities defined under subdivision 16 are excluded from this paragraph.

75.11 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
75.12 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
75.13 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
75.14 from the current statutory rates. Mental health services within diagnosis related groups
75.15 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
75.16 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
75.17 assistance does not include general assistance medical care. Payments made to managed
75.18 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
75.19 this reduction.

75.20 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
75.21 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
75.22 to hospitals for inpatient services before third-party liability and spenddown, is reduced
75.23 3.46 percent from the current statutory rates. Mental health services with diagnosis related
75.24 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
75.25 paragraph. Payments made to managed care plans shall be reduced for services provided
75.26 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

75.27 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
75.28 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
75.29 to hospitals for inpatient services before third-party liability and spenddown, is reduced
75.30 1.9 percent from the current statutory rates. Mental health services with diagnosis related
75.31 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
75.32 paragraph. Payments made to managed care plans shall be reduced for services provided
75.33 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

75.34 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
75.35 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
75.36 inpatient services before third-party liability and spenddown, is reduced 1.79 percent

76.1 from the current statutory rates. Mental health services with diagnosis related groups
76.2 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
76.3 Payments made to managed care plans shall be reduced for services provided on or after
76.4 July 1, 2010, to reflect this reduction.

76.5 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
76.6 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
76.7 hospitals for inpatient services before third-party liability and spenddown, is reduced
76.8 one percent from the current statutory rates. Facilities defined under subdivision 16 are
76.9 excluded from this paragraph. Payments made to managed care plans shall be reduced for
76.10 services provided on or after October 1, 2009, to reflect this reduction.

76.11 Sec. 13. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
76.12 to read:

76.13 Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain**
76.14 **treatments.** (a) The commissioner must not make medical assistance payments to a
76.15 hospital for any costs of care that result from a condition listed in paragraph (c), if the
76.16 condition was hospital acquired.

76.17 (b) For purposes of this subdivision, a condition is hospital acquired if it is not
76.18 identified by the hospital as present on admission. For purposes of this subdivision,
76.19 medical assistance includes general assistance medical care and MinnesotaCare.

76.20 (c) The prohibition in paragraph (a) applies to payment for each hospital-acquired
76.21 condition listed in this paragraph that is represented by an ICD-9-CM diagnosis code and
76.22 is designated as a complicating condition or a major complicating condition:

76.23 (1) foreign object retained after surgery (ICD-9-CM codes 998.4 or 998.7);

76.24 (2) air embolism (ICD-9-CM code 999.1);

76.25 (3) blood incompatibility (ICD-9-CM code 999.6);

76.26 (4) pressure ulcers stage III or IV (ICD-9-CM codes 707.23 or 707.24);

76.27 (5) falls and trauma, including fracture, dislocation, intracranial injury, crushing
76.28 injury, burn, and electric shock (ICD-9-CM codes with these ranges on the complicating
76.29 condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929;
76.30 940-949; and 991-994);

76.31 (6) catheter-associated urinary tract infection (ICD-9-CM code 996.64);

76.32 (7) vascular catheter-associated infection (ICD-9-CM code 999.31);

76.33 (8) manifestations of poor glycemic control (ICD-9-CM codes 249.10; 249.11;
76.34 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and
76.35 251.0);

77.1 (9) surgical site infection (ICD-9-CM codes 996.67 or 998.59) following certain
77.2 orthopedic procedures (procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07;
77.3 81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and
77.4 81.85);

77.5 (10) surgical site infection (ICD-9-CM code 998.59) following bariatric surgery
77.6 (procedure codes 44.38; 44.39; or 44.95) for a principal diagnosis of morbid obesity
77.7 (ICD-9-CM code 278.01);

77.8 (11) surgical site infection, mediastinitis (ICD-9-CM code 519.2) following coronary
77.9 artery bypass graft (procedure codes 36.10 to 36.19); and

77.10 (12) deep vein thrombosis (ICD-9-CM codes 453.40 to 453.42) or pulmonary
77.11 embolism (ICD-9-CM codes 415.11 or 415.91) following total knee replacement
77.12 (procedure code 81.54) or hip replacement (procedure codes 00.85 to 00.87 or 81.51
77.13 to 81.52).

77.14 (d) The prohibition in paragraph (a) applies to any additional payments that result
77.15 from a hospital-acquired condition listed in paragraph (c), including, but not limited to,
77.16 additional treatment or procedures, readmission to the facility after discharge, increased
77.17 length of stay, change to a higher diagnostic category, or transfer to another hospital. In
77.18 the event of a transfer to another hospital, the hospital where the condition listed under
77.19 paragraph (c) was acquired is responsible for any costs incurred at the hospital to which
77.20 the patient is transferred.

77.21 (e) A hospital shall not bill a recipient of services for any payment disallowed under
77.22 this subdivision.

77.23 Sec. 14. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
77.24 to read:

77.25 Subd. 28. **Temporary rate increase for qualifying hospitals.** For the period
77.26 from April 1, 2009, to September 30, 2010, for each hospital with a medical assistance
77.27 utilization rate equal to or greater than 25 percent during the base year, the commissioner
77.28 shall provide an equal percentage rate increase for each medical assistance admission. The
77.29 commissioner shall estimate the percentage rate increase using as the state share of the
77.30 increase the amount available under section 256B.199, paragraph (d). The commissioner
77.31 shall settle up payments to qualifying hospitals based on actual payments under that
77.32 section and actual hospital admissions.

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

78.1 Sec. 15. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
78.2 to read:

78.3 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
78.4 **and intervention program.** For services provided on or after July 1, 2010, in addition to
78.5 any other payment under this section, the commissioner shall reimburse hospitals for the
78.6 increase in the fee for the early hearing detection and intervention program described in
78.7 section 144.125, subdivision 1, paid by the hospital for public program recipients.

78.8 Sec. 16. **[256B.032] ELIGIBLE VENDORS OF MEDICAL CARE.**

78.9 (a) Effective January 1, 2011, the commissioner shall establish performance
78.10 thresholds for health care providers included in the provider peer grouping system
78.11 developed by the commissioner of health under section 62U.04. The thresholds shall be
78.12 set at the 10th percentile of the combined cost and quality measure used for provider peer
78.13 grouping, and separate thresholds shall be set for hospital and physician services.

78.14 (b) Beginning January 1, 2012, any health care provider with a combined cost and
78.15 quality score below the threshold set in paragraph (a) shall be prohibited from enrolling
78.16 as a vendor of medical care in the medical assistance, general assistance medical care,
78.17 or MinnesotaCare programs, and shall not be eligible for direct payments under those
78.18 programs or for payments made by managed care plans under their contracts with the
78.19 commissioner under section 256B.69 or 256L.12. A health care provider that is prohibited
78.20 from enrolling as a vendor or receiving payments under this paragraph may reenroll
78.21 effective January 1 of any subsequent year if the provider's most recent combined cost and
78.22 quality score exceeds the threshold established in paragraph (a).

78.23 (c) Notwithstanding paragraph (b), a provider may continue to participate as a vendor
78.24 or as part of a managed care plan provider network if the commissioner determines that a
78.25 contract with the provider is necessary to ensure adequate access to health care services.

78.26 (d) By January 15, 2013, the commissioner shall report to the legislature on the
78.27 impact of this section. The commissioner's report shall include information on:

78.28 (1) the providers falling below the thresholds as of January 1, 2012;

78.29 (2) the volume of services and cost of care provided to enrollees in the medical
78.30 assistance, general assistance medical care, or MinnesotaCare programs in the 12 months
78.31 prior to January 1, 2012, by providers falling below the thresholds;

78.32 (3) providers who fell below the thresholds but continued to be eligible vendors
78.33 under paragraph (c);

78.34 (4) the estimated cost savings achieved by not contracting with providers who do
78.35 not meet the performance thresholds; and

79.1 (5) recommendations for increasing the threshold levels of performance over time.

79.2 Sec. 17. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to
79.3 read:

79.4 Subd. 3c. **Asset limitations for families and children.** A household of two or more
79.5 persons must not own more than \$20,000 in total net assets, and a household of one
79.6 person must not own more than \$10,000 in total net assets. In addition to these maximum
79.7 amounts, an eligible individual or family may accrue interest on these amounts, but they
79.8 must be reduced to the maximum at the time of an eligibility redetermination. The value of
79.9 assets that are not considered in determining eligibility for medical assistance for families
79.10 and children is the value of those assets excluded under the AFDC state plan as of July 16,
79.11 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
79.12 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

79.14 (2) capital and operating assets of a trade or business up to \$200,000 are not
79.15 considered, except that a bank account that contains personal income or assets, or is used to
79.16 pay personal expenses, is not considered a capital or operating asset of a trade or business;

79.17 (3) one motor vehicle is excluded for each person of legal driving age who is
79.18 employed or seeking employment;

79.19 (4) one burial plot and all other burial expenses equal to the supplemental security
79.20 income program asset limit are not considered for each individual;

79.21 (5) court-ordered settlements up to \$10,000 are not considered;

79.22 (6) individual retirement accounts and funds are not considered; and

79.23 (7) assets owned by children are not considered.

79.24 The assets specified in clause (2) must be disclosed to the local agency at the time of
79.25 application and at the time of an eligibility redetermination, and must be verified upon
79.26 request of the local agency.

79.27 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
79.28 approval, whichever is later.

79.29 Sec. 18. Minnesota Statutes 2008, section 256B.056, subdivision 3d, is amended to
79.30 read:

79.31 Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions
79.32 3 to 3c may be reduced to allowable limits as follows:

79.33 (a) Assets may be reduced in any of the three calendar months before the month
79.34 of application in which the applicant seeks coverage by:

80.1 ~~(1) designating burial funds up to \$1,500 for each applicant, spouse, and MA-eligible~~
80.2 ~~dependent child; and~~

80.3 ~~(2) paying health service bills~~ for health services that are incurred in the retroactive
80.4 period for which the applicant seeks eligibility, starting with the oldest bill. After assets
80.5 are reduced to allowable limits, eligibility begins with the next dollar of MA-covered
80.6 health services incurred in the retroactive period. Applicants reducing assets under this
80.7 subdivision who also have excess income shall first spend excess assets to pay health
80.8 service bills and may meet the income spenddown on remaining bills.

80.9 (b) Assets may be reduced beginning the month of application by:

80.10 ~~(1) paying bills for health services that are incurred during the period specified in~~
80.11 Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical
80.12 assistance; and. After assets are reduced to allowable limits, eligibility begins with the
80.13 next dollar of medical assistance covered health services incurred in the period. Applicants
80.14 reducing assets under this subdivision who also have excess income shall first spend excess
80.15 assets to pay health service bills and may meet the income spenddown on remaining bills.

80.16 ~~(2) using any means other than a transfer of assets for less than fair market value as~~
80.17 ~~defined in section 256B.0595, subdivision 1, paragraph (b).~~

80.18 **EFFECTIVE DATE.** This section is effective January 1, 2011.

80.19 Sec. 19. Minnesota Statutes 2008, section 256B.057, is amended by adding a
80.20 subdivision to read:

80.21 Subd. 11. **Treatment for colorectal cancer.** (a) Medical assistance shall be paid for
80.22 an individual who:

80.23 (1) has been screened for colorectal cancer by the colorectal cancer prevention
80.24 demonstration project;

80.25 (2) according to the individual's treating health professional, needs treatment for
80.26 colorectal cancer;

80.27 (3) meets income eligibility guidelines for the colorectal cancer prevention
80.28 demonstration project;

80.29 (4) is under the age of 65; and

80.30 (5) is not otherwise eligible for medical assistance or covered under creditable
80.31 coverage as defined under United States Code, title 42, section 300gg(a).

80.32 (b) Medical assistance provided under this subdivision shall be limited to services
80.33 provided during the period that the individual receives treatment for colorectal cancer.

81.1 (c) An individual meeting the criteria in paragraph (a) is eligible for medical
81.2 assistance without meeting the eligibility criteria relating to income and assets in section
81.3 256B.056, subdivisions 1a to 5b.

81.4 (d) This subdivision expires December 31, 2010.

81.5 Sec. 20. Minnesota Statutes 2008, section 256B.0575, is amended to read:

81.6 **256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED**
81.7 **PERSONS.**

81.8 Subdivision 1. **Income deductions.** When an institutionalized person is determined
81.9 eligible for medical assistance, the income that exceeds the deductions in paragraphs (a)
81.10 and (b) must be applied to the cost of institutional care.

81.11 (a) The following amounts must be deducted from the institutionalized person's
81.12 income in the following order:

81.13 (1) the personal needs allowance under section 256B.35 or, for a veteran who
81.14 does not have a spouse or child, or a surviving spouse of a veteran having no child, the
81.15 amount of an improved pension received from the veteran's administration not exceeding
81.16 \$90 per month;

81.17 (2) the personal allowance for disabled individuals under section 256B.36;

81.18 (3) if the institutionalized person has a legally appointed guardian or conservator,
81.19 five percent of the recipient's gross monthly income up to \$100 as reimbursement for
81.20 guardianship or conservatorship services;

81.21 (4) a monthly income allowance determined under section 256B.058, subdivision
81.22 2, but only to the extent income of the institutionalized spouse is made available to the
81.23 community spouse;

81.24 (5) a monthly allowance for children under age 18 which, together with the net
81.25 income of the children, would provide income equal to the medical assistance standard
81.26 for families and children according to section 256B.056, subdivision 4, for a family size
81.27 that includes only the minor children. This deduction applies only if the children do not
81.28 live with the community spouse and only to the extent that the deduction is not included
81.29 in the personal needs allowance under section 256B.35, subdivision 1, as child support
81.30 garnished under a court order;

81.31 (6) a monthly family allowance for other family members, equal to one-third of the
81.32 difference between 122 percent of the federal poverty guidelines and the monthly income
81.33 for that family member;

82.1 (7) reparations payments made by the Federal Republic of Germany and reparations
82.2 payments made by the Netherlands for victims of Nazi persecution between 1940 and
82.3 1945;

82.4 (8) all other exclusions from income for institutionalized persons as mandated by
82.5 federal law; and

82.6 (9) amounts for reasonable expenses, as specified in subdivision 2, incurred for
82.7 necessary medical or remedial care for the institutionalized person that are recognized
82.8 under state law, not medical assistance covered expenses, and ~~that are~~ not subject to
82.9 payment by a third party.

82.10 ~~Reasonable expenses are limited to expenses that have not been previously used as a~~
82.11 ~~deduction from income and are incurred during the enrollee's current period of eligibility,~~
82.12 ~~including retroactive months associated with the current period of eligibility, for medical~~
82.13 ~~assistance payment of long-term care services.~~

82.14 For purposes of clause (6), "other family member" means a person who resides
82.15 with the community spouse and who is a minor or dependent child, dependent parent, or
82.16 dependent sibling of either spouse. "Dependent" means a person who could be claimed as
82.17 a dependent for federal income tax purposes under the Internal Revenue Code.

82.18 (b) Income shall be allocated to an institutionalized person for a period of up to three
82.19 calendar months, in an amount equal to the medical assistance standard for a family
82.20 size of one if:

82.21 (1) a physician certifies that the person is expected to reside in the long-term care
82.22 facility for three calendar months or less;

82.23 (2) if the person has expenses of maintaining a residence in the community; and

82.24 (3) if one of the following circumstances apply:

82.25 (i) the person was not living together with a spouse or a family member as defined in
82.26 paragraph (a) when the person entered a long-term care facility; or

82.27 (ii) the person and the person's spouse become institutionalized on the same date, in
82.28 which case the allocation shall be applied to the income of one of the spouses.

82.29 For purposes of this paragraph, a person is determined to be residing in a licensed nursing
82.30 home, regional treatment center, or medical institution if the person is expected to remain
82.31 for a period of one full calendar month or more.

82.32 Subd. 2. Reasonable expenses. For the purposes of subdivision 1, paragraph (a),
82.33 clause (9), reasonable expenses are limited to expenses that have not been previously used
82.34 as a deduction from income and were not:

82.35 (1) for long-term care expenses incurred during a period of ineligibility as defined in
82.36 section 256B.0595, subdivision 2;

83.1 (2) incurred more than three months before the month of application associated with
83.2 the current period of eligibility;

83.3 (3) for expenses incurred by a recipient that are duplicative of services that are
83.4 covered under chapter 256B; or

83.5 (4) nursing facility expenses incurred without a timely assessment as required under
83.6 section 256B.0911.

83.7 Sec. 21. Minnesota Statutes 2008, section 256B.0595, subdivision 1, is amended to
83.8 read:

83.9 Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before
83.10 August 10, 1993, if an institutionalized person or the institutionalized person's spouse has
83.11 given away, sold, or disposed of, for less than fair market value, any asset or interest
83.12 therein, except assets other than the homestead that are excluded under the supplemental
83.13 security program, within 30 months before or any time after the date of institutionalization
83.14 if the person has been determined eligible for medical assistance, or within 30 months
83.15 before or any time after the date of the first approved application for medical assistance
83.16 if the person has not yet been determined eligible for medical assistance, the person is
83.17 ineligible for long-term care services for the period of time determined under subdivision
83.18 2.

83.19 (b) Effective for transfers made after August 10, 1993, an institutionalized person, an
83.20 institutionalized person's spouse, or any person, court, or administrative body with legal
83.21 authority to act in place of, on behalf of, at the direction of, or upon the request of the
83.22 institutionalized person or institutionalized person's spouse, may not give away, sell, or
83.23 dispose of, for less than fair market value, any asset or interest therein, except assets other
83.24 than the homestead that are excluded under the Supplemental Security Income program,
83.25 for the purpose of establishing or maintaining medical assistance eligibility. This applies
83.26 to all transfers, including those made by a community spouse after the month in which
83.27 the institutionalized spouse is determined eligible for medical assistance. For purposes of
83.28 determining eligibility for long-term care services, any transfer of such assets within 36
83.29 months before or any time after an institutionalized person requests medical assistance
83.30 payment of long-term care services, or 36 months before or any time after a medical
83.31 assistance recipient becomes an institutionalized person, for less than fair market value
83.32 may be considered. Any such transfer is presumed to have been made for the purpose
83.33 of establishing or maintaining medical assistance eligibility and the institutionalized
83.34 person is ineligible for long-term care services for the period of time determined under
83.35 subdivision 2, unless the institutionalized person furnishes convincing evidence to

84.1 establish that the transaction was exclusively for another purpose, or unless the transfer is
84.2 permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a
84.3 trust that are considered transfers of assets under federal law, or in the case of any other
84.4 disposal of assets made on or after February 8, 2006, any transfers made within 60 months
84.5 before or any time after an institutionalized person requests medical assistance payment of
84.6 long-term care services and within 60 months before or any time after a medical assistance
84.7 recipient becomes an institutionalized person, may be considered.

84.8 (c) This section applies to transfers, for less than fair market value, of income
84.9 or assets, including assets that are considered income in the month received, such as
84.10 inheritances, court settlements, and retroactive benefit payments or income to which the
84.11 institutionalized person or the institutionalized person's spouse is entitled but does not
84.12 receive due to action by the institutionalized person, the institutionalized person's spouse,
84.13 or any person, court, or administrative body with legal authority to act in place of, on
84.14 behalf of, at the direction of, or upon the request of the institutionalized person or the
84.15 institutionalized person's spouse.

84.16 (d) This section applies to payments for care or personal services provided by a
84.17 relative, unless the compensation was stipulated in a notarized, written agreement which
84.18 was in existence when the service was performed, the care or services directly benefited
84.19 the person, and the payments made represented reasonable compensation for the care
84.20 or services provided. A notarized written agreement is not required if payment for the
84.21 services was made within 60 days after the service was provided.

84.22 (e) This section applies to the portion of any asset or interest that an institutionalized
84.23 person, an institutionalized person's spouse, or any person, court, or administrative body
84.24 with legal authority to act in place of, on behalf of, at the direction of, or upon the request
84.25 of the institutionalized person or the institutionalized person's spouse, transfers to any
84.26 annuity that exceeds the value of the benefit likely to be returned to the institutionalized
84.27 person or institutionalized person's spouse while alive, based on estimated life expectancy
84.28 as determined according to the current actuarial tables published by the Office of the
84.29 Chief Actuary of the Social Security Administration. The commissioner may adopt rules
84.30 reducing life expectancies based on the need for long-term care. This section applies to an
84.31 annuity purchased on or after March 1, 2002, that:

84.32 (1) is not purchased from an insurance company or financial institution that is
84.33 subject to licensing or regulation by the Minnesota Department of Commerce or a similar
84.34 regulatory agency of another state;

84.35 (2) does not pay out principal and interest in equal monthly installments; or

84.36 (3) does not begin payment at the earliest possible date after annuitization.

85.1 (f) Effective for transactions, including the purchase of an annuity, occurring on or
85.2 after February 8, 2006, by or on behalf of an institutionalized person who has applied for
85.3 or is receiving long-term care services or the institutionalized person's spouse shall be
85.4 treated as the disposal of an asset for less than fair market value unless the department is
85.5 named a preferred remainder beneficiary as described in section 256B.056, subdivision
85.6 11. Any subsequent change to the designation of the department as a preferred remainder
85.7 beneficiary shall result in the annuity being treated as a disposal of assets for less than
85.8 fair market value. The amount of such transfer shall be the maximum amount the
85.9 institutionalized person or the institutionalized person's spouse could receive from the
85.10 annuity or similar financial instrument. Any change in the amount of the income or
85.11 principal being withdrawn from the annuity or other similar financial instrument at the
85.12 time of the most recent disclosure shall be deemed to be a transfer of assets for less than
85.13 fair market value unless the institutionalized person or the institutionalized person's spouse
85.14 demonstrates that the transaction was for fair market value. In the event a distribution
85.15 of income or principal has been improperly distributed or disbursed from an annuity or
85.16 other retirement planning instrument of an institutionalized person or the institutionalized
85.17 person's spouse, a cause of action exists against the individual receiving the improper
85.18 distribution for the cost of medical assistance services provided or the amount of the
85.19 improper distribution, whichever is less.

85.20 (g) Effective for transactions, including the purchase of an annuity, occurring on
85.21 or after February 8, 2006, by or on behalf of an institutionalized person applying for or
85.22 receiving long-term care services shall be treated as a disposal of assets for less than fair
85.23 market value unless it is:

85.24 (i) an annuity described in subsection (b) or (q) of section 408 of the Internal
85.25 Revenue Code of 1986; or

85.26 (ii) purchased with proceeds from:

85.27 (A) an account or trust described in subsection (a), (c), or (p) of section 408 of the
85.28 Internal Revenue Code;

85.29 (B) a simplified employee pension within the meaning of section 408(k) of the
85.30 Internal Revenue Code; or

85.31 (C) a Roth IRA described in section 408A of the Internal Revenue Code; or

85.32 (iii) an annuity that is irrevocable and nonassignable; is actuarially sound as
85.33 determined in accordance with actuarial publications of the Office of the Chief Actuary of
85.34 the Social Security Administration; and provides for payments in equal amounts during
85.35 the term of the annuity, with no deferral and no balloon payments made.

86.1 (h) For purposes of this section, long-term care services include services in a nursing
86.2 facility, services that are eligible for payment according to section 256B.0625, subdivision
86.3 2, because they are provided in a swing bed, intermediate care facility for persons with
86.4 developmental disabilities, and home and community-based services provided pursuant
86.5 to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and
86.6 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient
86.7 in a nursing facility or in a swing bed, or intermediate care facility for persons with
86.8 developmental disabilities or who is receiving home and community-based services under
86.9 sections 256B.0915, 256B.092, and 256B.49.

86.10 (i) This section applies to funds used to purchase a promissory note, loan, or
86.11 mortgage unless the note, loan, or mortgage:

86.12 (1) has a repayment term that is actuarially sound;

86.13 (2) provides for payments to be made in equal amounts during the term of the loan,
86.14 with no deferral and no balloon payments made; and

86.15 (3) prohibits the cancellation of the balance upon the death of the lender.

86.16 In the case of a promissory note, loan, or mortgage that does not meet an exception
86.17 in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding
86.18 balance due as of the date of the institutionalized person's request for medical assistance
86.19 payment of long-term care services.

86.20 (j) This section applies to the purchase of a life estate interest in another person's
86.21 home unless the purchaser resides in the home for a period of at least one year after the
86.22 date of purchase.

86.23 (k) This section applies to transfers into a pooled trust that qualifies under United
86.24 States Code, title 42, section 1396p(d)(4)(C), by:

86.25 (1) a person age 65 or older or the person's spouse; or

86.26 (2) any person, court, or administrative body with legal authority to act in place
86.27 of, on behalf of, at the direction of, or upon the request of a person age 65 or older or
86.28 the person's spouse.

86.29 Sec. 22. Minnesota Statutes 2008, section 256B.0595, subdivision 2, is amended to
86.30 read:

86.31 Subd. 2. **Period of ineligibility for long-term care services.** (a) For any
86.32 uncompensated transfer occurring on or before August 10, 1993, the number of months
86.33 of ineligibility for long-term care services shall be the lesser of 30 months, or the
86.34 uncompensated transfer amount divided by the average medical assistance rate for nursing
86.35 facility services in the state in effect on the date of application. The amount used to

87.1 calculate the average medical assistance payment rate shall be adjusted each July 1 to
87.2 reflect payment rates for the previous calendar year. The period of ineligibility begins
87.3 with the month in which the assets were transferred. If the transfer was not reported to
87.4 the local agency at the time of application, and the applicant received long-term care
87.5 services during what would have been the period of ineligibility if the transfer had been
87.6 reported, a cause of action exists against the transferee for the cost of long-term care
87.7 services provided during the period of ineligibility, or for the uncompensated amount of
87.8 the transfer, whichever is less. The uncompensated transfer amount is the fair market
87.9 value of the asset at the time it was given away, sold, or disposed of, less the amount of
87.10 compensation received.

87.11 (b) For uncompensated transfers made after August 10, 1993, the number of months
87.12 of ineligibility for long-term care services shall be the total uncompensated value of the
87.13 resources transferred divided by the average medical assistance rate for nursing facility
87.14 services in the state in effect on the date of application. The amount used to calculate
87.15 the average medical assistance payment rate shall be adjusted each July 1 to reflect
87.16 payment rates for the previous calendar year. The period of ineligibility begins with the
87.17 first day of the month after the month in which the assets were transferred except that
87.18 if one or more uncompensated transfers are made during a period of ineligibility, the
87.19 total assets transferred during the ineligibility period shall be combined and a penalty
87.20 period calculated to begin on the first day of the month after the month in which the first
87.21 uncompensated transfer was made. If the transfer was reported to the local agency after
87.22 the date that advance notice of a period of ineligibility that affects the next month could
87.23 be provided to the recipient and the recipient received medical assistance services or the
87.24 transfer was not reported to the local agency, and the applicant or recipient received
87.25 medical assistance services during what would have been the period of ineligibility if
87.26 the transfer had been reported, a cause of action exists against the transferee for that
87.27 portion of long-term care services provided during the period of ineligibility, or for the
87.28 uncompensated amount of the transfer, whichever is less. The uncompensated transfer
87.29 amount is the fair market value of the asset at the time it was given away, sold, or disposed
87.30 of, less the amount of compensation received. Effective for transfers made on or after
87.31 March 1, 1996, involving persons who apply for medical assistance on or after April 13,
87.32 1996, no cause of action exists for a transfer unless:

87.33 (1) the transferee knew or should have known that the transfer was being made by a
87.34 person who was a resident of a long-term care facility or was receiving that level of care in
87.35 the community at the time of the transfer;

88.1 (2) the transferee knew or should have known that the transfer was being made to
88.2 assist the person to qualify for or retain medical assistance eligibility; or

88.3 (3) the transferee actively solicited the transfer with intent to assist the person to
88.4 qualify for or retain eligibility for medical assistance.

88.5 (c) For uncompensated transfers made on or after February 8, 2006, the period
88.6 of ineligibility:

88.7 (1) for uncompensated transfers by or on behalf of individuals receiving medical
88.8 assistance payment of long-term care services, begins the first day of the month following
88.9 advance notice of the ~~penalty~~ period of ineligibility, but no later than the first day of the
88.10 month that follows three full calendar months from the date of the report or discovery
88.11 of the transfer; or

88.12 (2) for uncompensated transfers by individuals requesting medical assistance
88.13 payment of long-term care services, begins the date on which the individual is eligible
88.14 for medical assistance under the Medicaid state plan and would otherwise be receiving
88.15 long-term care services based on an approved application for such care but for the
88.16 ~~application of the penalty~~ period of ineligibility resulting from the uncompensated
88.17 transfer; and

88.18 (3) cannot begin during any other period of ineligibility.

88.19 (d) If a calculation of a ~~penalty~~ period of ineligibility results in a partial month,
88.20 payments for long-term care services shall be reduced in an amount equal to the fraction.

88.21 (e) In the case of multiple fractional transfers of assets in more than one month for
88.22 less than fair market value on or after February 8, 2006, the period of ineligibility is
88.23 calculated by treating the total, cumulative, uncompensated value of all assets transferred
88.24 during all months on or after February 8, 2006, as one transfer.

88.25 (f) A period of ineligibility established under paragraph (c) may be eliminated if
88.26 all of the assets transferred for less than fair market value used to calculate the period of
88.27 ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned
88.28 within 12 months after the date the period of ineligibility began. A period of ineligibility
88.29 must not be adjusted if less than the full amount of the transferred assets or the full cash
88.30 value of the transferred assets are returned.

88.31 **EFFECTIVE DATE.** This section is effective for periods of ineligibility established
88.32 on or after January 1, 2011.

88.33 Sec. 23. Minnesota Statutes 2008, section 256B.06, subdivision 4, is amended to read:

88.34 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
88.35 to citizens of the United States, qualified noncitizens as defined in this subdivision, and

89.1 other persons residing lawfully in the United States. Citizens or nationals of the United
89.2 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
89.3 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
89.4 Public Law 109-171.

89.5 (b) "Qualified noncitizen" means a person who meets one of the following
89.6 immigration criteria:

89.7 (1) admitted for lawful permanent residence according to United States Code, title 8;

89.8 (2) admitted to the United States as a refugee according to United States Code,
89.9 title 8, section 1157;

89.10 (3) granted asylum according to United States Code, title 8, section 1158;

89.11 (4) granted withholding of deportation according to United States Code, title 8,
89.12 section 1253(h);

89.13 (5) paroled for a period of at least one year according to United States Code, title 8,
89.14 section 1182(d)(5);

89.15 (6) granted conditional entrant status according to United States Code, title 8,
89.16 section 1153(a)(7);

89.17 (7) determined to be a battered noncitizen by the United States Attorney General
89.18 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
89.19 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

89.20 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
89.21 States Attorney General according to the Illegal Immigration Reform and Immigrant
89.22 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
89.23 Public Law 104-200; or

89.24 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
89.25 Law 96-422, the Refugee Education Assistance Act of 1980.

89.26 (c) All qualified noncitizens who were residing in the United States before August
89.27 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
89.28 medical assistance with federal financial participation.

89.29 (d) All qualified noncitizens who entered the United States on or after August 22,
89.30 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
89.31 medical assistance with federal financial participation through November 30, 1996.

89.32 Beginning December 1, 1996, qualified noncitizens who entered the United States
89.33 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
89.34 chapter are eligible for medical assistance with federal participation for five years if they
89.35 meet one of the following criteria:

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

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

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

90.6 (iv) veterans of the United States armed forces with an honorable discharge for
90.7 a reason other than noncitizen status, their spouses and unmarried minor dependent
90.8 children; or

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

90.11 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
90.12 criteria in items (i) to (v) are eligible for medical assistance without federal financial
90.13 participation as described in paragraph (j).

90.14 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
90.15 women who are qualified noncitizens, as described in paragraph (b), are eligible for
90.16 medical assistance with federal financial participation as provided by the federal Children's
90.17 Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

90.18 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
90.19 are lawfully present in the United States, as defined in Code of Federal Regulations, title
90.20 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
90.21 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
90.22 with the United States Citizenship and Immigration Services to pursue any applicable
90.23 immigration status, including citizenship, that would qualify them for medical assistance
90.24 with federal financial participation.

90.25 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
90.26 for medical assistance with federal financial participation through December 31, 1996.

90.27 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
90.28 medical assistance without federal financial participation as described in paragraph (j).

90.29 (3) Beginning December 1, 1996, persons residing in the United States prior to
90.30 August 22, 1996, who were not receiving medical assistance and persons who arrived on
90.31 or after August 22, 1996, are eligible for medical assistance without federal financial
90.32 participation as described in paragraph (j).

90.33 (f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
90.34 are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this
90.35 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
90.36 Code, title 8, section 1101(a)(15).

91.1 (g) Payment shall also be made for care and services that are furnished to noncitizens,
91.2 regardless of immigration status, who otherwise meet the eligibility requirements of
91.3 this chapter, if such care and services are necessary for the treatment of an emergency
91.4 medical condition, except for organ transplants and related care and services and routine
91.5 prenatal care.

91.6 (h) For purposes of this subdivision, the term "emergency medical condition" means
91.7 a medical condition that meets the requirements of United States Code, title 42, section
91.8 1396b(v).

91.9 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
91.10 nonimmigrants, or eligible for medical assistance as described in paragraph (j), lawfully
91.11 present as designated in paragraph (e) and who are not covered by a group health plan
91.12 or health insurance coverage according to Code of Federal Regulations, title 42, section
91.13 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible
91.14 for medical assistance through the period of pregnancy, including labor and delivery,
91.15 and 60 days postpartum, to the extent federal funds are available under title XXI of the
91.16 Social Security Act, and the state children's health insurance program, followed by 60
91.17 days postpartum without federal financial participation.

91.18 (j) Qualified noncitizens as described in paragraph (d), and all other noncitizens
91.19 lawfully residing in the United States as described in paragraph (e), who are ineligible
91.20 for medical assistance with federal financial participation and who otherwise meet the
91.21 eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
91.22 assistance without federal financial participation. Qualified noncitizens as described
91.23 in paragraph (d) are only eligible for medical assistance without federal financial
91.24 participation for five years from their date of entry into the United States.

91.25 (k) Beginning October 1, 2003, persons who are receiving care and rehabilitation
91.26 services from a nonprofit center established to serve victims of torture and are otherwise
91.27 ineligible for medical assistance under this chapter are eligible for medical assistance
91.28 without federal financial participation. These individuals are eligible only for the period
91.29 during which they are receiving services from the center. Individuals eligible under this
91.30 paragraph shall not be required to participate in prepaid medical assistance.

91.31 **EFFECTIVE DATE.** This section is effective July 1, 2009.

91.32 Sec. 24. Minnesota Statutes 2008, section 256B.06, subdivision 5, is amended to read:

91.33 Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility
91.34 for any federal or state funded medical assistance under this section, the income
91.35 and resources of all noncitizens shall be deemed to include their sponsors' income

92.1 and resources as required under the Personal Responsibility and Work Opportunity
92.2 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
92.3 subsequently set out in federal rules. This section is effective May 1, 1997. Beginning
92.4 July 1, 2010, sponsor deeming does not apply to pregnant women and children who are
92.5 qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

92.6 **EFFECTIVE DATE.** This section is effective July 1, 2010.

92.7 Sec. 25. Minnesota Statutes 2008, section 256B.0625, subdivision 3, is amended to
92.8 read:

92.9 Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.
92.10 (b) Rates paid for anesthesiology services provided by physicians shall be according
92.11 to the formula utilized in the Medicare program and shall use a conversion factor "at
92.12 percentile of calendar year set by legislature;" except that rates paid to physicians for the
92.13 medical direction of a certified registered nurse anesthetist shall be the same as the rate
92.14 paid to the certified registered nurse anesthetist under medical direction.

92.15 Sec. 26. Minnesota Statutes 2008, section 256B.0625, subdivision 3c, is amended to
92.16 read:

92.17 Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after
92.18 receiving recommendations from professional physician associations, professional
92.19 associations representing licensed nonphysician health care professionals, and consumer
92.20 groups, shall establish a 13-member Health Services Policy Committee, which consists of
92.21 12 voting members and one nonvoting member. The Health Services Policy Committee
92.22 shall advise the commissioner regarding health services pertaining to the administration
92.23 of health care benefits covered under the medical assistance, general assistance medical
92.24 care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at
92.25 least quarterly. The Health Services Policy Committee shall annually elect a physician
92.26 chair from among its members, who shall work directly with the commissioner's medical
92.27 director, to establish the agenda for each meeting. The Health Services Policy Committee
92.28 shall also recommend criteria for verifying centers of excellence for specific aspects of
92.29 medical care where a specific set of combined services, a volume of patients necessary to
92.30 maintain a high level of competency, or a specific level of technical capacity is associated
92.31 with improved health outcomes.

92.32 (b) The commissioner shall establish a dental subcommittee to operate under the
92.33 Health Services Policy Committee. The dental subcommittee consists of general dentists,
92.34 dental specialists, safety net providers, dental hygienists, health plan company and

93.1 county and public health representatives, health researchers, consumers, and a designee
93.2 of the commissioner of health. The dental subcommittee shall advise the commissioner
93.3 regarding:

93.4 (1) the critical access dental program under section 256B.76, subdivision 4, including
93.5 but not limited to criteria for designating and terminating critical access dental providers;

93.6 (2) any changes to the critical access dental provider program necessary to comply
93.7 with program expenditure limits;

93.8 (3) dental coverage policy based on evidence, quality, continuity of care, and best
93.9 practices;

93.10 (4) the development of dental delivery models; and

93.11 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).

93.12 (c) The Health Services Policy Committee shall study approaches to making
93.13 provider reimbursement under the medical assistance, MinnesotaCare, and general
93.14 assistance medical care programs contingent on patient participation in a patient-centered
93.15 decision-making process, and shall evaluate the impact of these approaches on health
93.16 care quality, patient satisfaction, and health care costs. The committee shall present
93.17 findings and recommendations to the commissioner and the legislative committees with
93.18 jurisdiction over health care by January 15, 2010.

93.19 (d) The Health Services Policy Committee shall monitor and track the practice
93.20 patterns of physicians providing services to medical assistance, MinnesotaCare, and
93.21 general assistance medical care enrollees under fee-for-service, managed care, and
93.22 county-based purchasing. The committee shall focus on services or specialties for which
93.23 there is a high variation in utilization across physicians, or which are associated with
93.24 high medical costs. The commissioner, based upon the findings of the committee, shall
93.25 regularly notify physicians whose practice patterns indicate higher than average utilization
93.26 or costs. Managed care and county-based purchasing plans shall provide the committee
93.27 with utilization and cost data necessary to implement this paragraph.

93.28 (e) The Health Services Policy Committee shall review caesarean section rates
93.29 for the fee-for-service medical assistance population. The committee may develop best
93.30 practices policies related to the minimization of caesarean sections, including but not
93.31 limited to standards and guidelines for health care providers and health care facilities.

93.32 Sec. 27. Minnesota Statutes 2008, section 256B.0625, subdivision 9, is amended to
93.33 read:

94.1 Subd. 9. **Dental services.** (a) Medical assistance covers dental services. ~~Dental~~
94.2 services include, with prior authorization, fixed bridges that are cost-effective for persons
94.3 who cannot use removable dentures because of their medical condition.

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

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

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

94.8 (3) limited exams;

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

94.10 (5) periapical x-rays;

94.11 (6) panoramic x-rays, limited to one every five years, and only if provided in
94.12 conjunction with a posterior extraction or scheduled outpatient facility procedure, or as
94.13 medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology
94.14 and trauma. Panoramic x-rays may be taken once every two years for patients who cannot
94.15 cooperate for intraoral film due to a developmental disability or medical condition that
94.16 does not allow for intraoral film placement;

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

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

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

94.20 (10) anterior fillings;

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

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

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

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

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

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

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

94.32 (2) general anesthesia; and

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

94.34 (d) Medical assistance covers dental services for children that are medically
94.35 necessary. The following guidelines apply:

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

- 95.1 (2) application of sealants once every five years per permanent molar; and
95.2 (3) application of fluoride varnish once every six months.

95.3 **EFFECTIVE DATE.** This section is effective January 1, 2010.

95.4 Sec. 28. Minnesota Statutes 2008, section 256B.0625, subdivision 11, is amended to
95.5 read:

95.6 Subd. 11. **Nurse anesthetist services.** Medical assistance covers nurse anesthetist
95.7 services. Rates paid for anesthesiology services provided by a certified registered nurse
95.8 ~~anesthetists~~ anesthetist under the direction of a physician shall be according to the formula
95.9 utilized in the Medicare program and shall use the conversion factor that is used by
95.10 the Medicare program. Rates paid for anesthesiology services provided by a certified
95.11 registered nurse anesthetist who is not directed by a physician shall be the same rate as
95.12 paid under subdivision 3, paragraph (b).

95.13 Sec. 29. Minnesota Statutes 2008, section 256B.0625, subdivision 13, is amended to
95.14 read:

95.15 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
95.16 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
95.17 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
95.18 program as a dispensing physician, or by a physician, physician assistant, or a nurse
95.19 practitioner employed by or under contract with a community health board as defined in
95.20 section 145A.02, subdivision 5, for the purposes of communicable disease control.

95.21 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
95.22 unless authorized by the commissioner.

95.23 (c) Medical assistance covers the following over-the-counter drugs when prescribed
95.24 by a licensed practitioner or by a licensed pharmacist who meets standards established by
95.25 the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen,
95.26 family planning products, aspirin, insulin, products for the treatment of lice, vitamins for
95.27 adults with documented vitamin deficiencies, vitamins for children under the age of seven
95.28 and pregnant or nursing women, and any other over-the-counter drug identified by the
95.29 commissioner, in consultation with the formulary committee, as necessary, appropriate,
95.30 and cost-effective for the treatment of certain specified chronic diseases, conditions,
95.31 or disorders, and this determination shall not be subject to the requirements of chapter
95.32 14. A pharmacist may prescribe over-the-counter medications as provided under this
95.33 paragraph for purposes of receiving reimbursement under Medicaid. When prescribing
95.34 over-the-counter drugs under this paragraph, licensed pharmacists must consult with the

96.1 recipient to determine necessity, provide drug counseling, review drug therapy for potential
96.2 adverse interactions, and make referrals as needed to other health care professionals.

96.3 (d) Effective January 1, 2006, medical assistance shall not cover drugs that
96.4 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
96.5 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
96.6 for individuals eligible for drug coverage as defined in the Medicare Prescription
96.7 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
96.8 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
96.9 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this
96.10 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
96.11 title 42, section 1396r-8(d)(2)(E), shall not be covered.

96.12 Sec. 30. Minnesota Statutes 2008, section 256B.0625, subdivision 13e, is amended to
96.13 read:

96.14 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
96.15 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
96.16 the maximum allowable cost set by the federal government or by the commissioner plus
96.17 the fixed dispensing fee; or the usual and customary price charged to the public. The
96.18 amount of payment basis must be reduced to reflect all discount amounts applied to the
96.19 charge by any provider/insurer agreement or contract for submitted charges to medical
96.20 assistance programs. The net submitted charge may not be greater than the patient liability
96.21 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee
96.22 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per
96.23 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral
96.24 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral
96.25 nutritional products dispensed in quantities greater than one liter. Actual acquisition
96.26 cost includes quantity and other special discounts except time and cash discounts.
96.27 Effective July 1, ~~2008~~ 2009, the actual acquisition cost of a drug shall be estimated by the
96.28 commissioner, at average wholesale price minus ~~14~~ 15 percent. The actual acquisition
96.29 cost of antihemophilic factor drugs shall be estimated at the average wholesale price
96.30 minus 30 percent. The maximum allowable cost of a multisource drug may be set by the
96.31 commissioner and it shall be comparable to, but no higher than, the maximum amount
96.32 paid by other third-party payors in this state who have maximum allowable cost programs.
96.33 Establishment of the amount of payment for drugs shall not be subject to the requirements
96.34 of the Administrative Procedure Act.

97.1 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
97.2 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
97.3 facilities when a unit dose blister card system, approved by the department, is used. Under
97.4 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
97.5 The National Drug Code (NDC) from the drug container used to fill the blister card must
97.6 be identified on the claim to the department. The unit dose blister card containing the
97.7 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
97.8 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
97.9 will be required to credit the department for the actual acquisition cost of all unused
97.10 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
97.11 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
97.12 dispensed in a quantity that is less than a 30-day supply.

97.13 (c) Whenever a generically equivalent product is available, payment shall be on the
97.14 basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost
97.15 established by the commissioner.

97.16 (d) The basis for determining the amount of payment for drugs administered in an
97.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
97.18 provider or the amount established for Medicare by the United States Department of
97.19 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
97.20 Security Act.

97.21 (e) The commissioner may negotiate lower reimbursement rates for specialty
97.22 pharmacy products than the rates specified in paragraph (a). The commissioner may
97.23 require individuals enrolled in the health care programs administered by the department
97.24 to obtain specialty pharmacy products from providers with whom the commissioner has
97.25 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
97.26 used by a small number of recipients or recipients with complex and chronic diseases
97.27 that require expensive and challenging drug regimens. Examples of these conditions
97.28 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
97.29 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
97.30 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
97.31 biotechnology drugs, high-cost therapies, and therapies that require complex care. The
97.32 commissioner shall consult with the formulary committee to develop a list of specialty
97.33 pharmacy products subject to this paragraph. In consulting with the formulary committee
97.34 in developing this list, the commissioner shall take into consideration the population
97.35 served by specialty pharmacy products, the current delivery system and standard of care in

98.1 the state, and access to care issues. The commissioner shall have the discretion to adjust
98.2 the reimbursement rate to prevent access to care issues.

98.3 Sec. 31. Minnesota Statutes 2008, section 256B.0625, subdivision 13h, is amended to
98.4 read:

98.5 Subd. 13h. **Medication therapy management services.** (a) Medical assistance
98.6 and general assistance medical care cover medication therapy management services for
98.7 a recipient taking four or more prescriptions to treat or prevent two or more chronic
98.8 medical conditions, or a recipient with a drug therapy problem that is identified or prior
98.9 authorized by the commissioner that has resulted or is likely to result in significant
98.10 nondrug program costs. The commissioner may cover medical therapy management
98.11 services under MinnesotaCare if the commissioner determines this is cost-effective. For
98.12 purposes of this subdivision, "medication therapy management" means the provision
98.13 of the following pharmaceutical care services by a licensed pharmacist to optimize the
98.14 therapeutic outcomes of the patient's medications:

98.15 (1) performing or obtaining necessary assessments of the patient's health status;

98.16 (2) formulating a medication treatment plan;

98.17 (3) monitoring and evaluating the patient's response to therapy, including safety
98.18 and effectiveness;

98.19 (4) performing a comprehensive medication review to identify, resolve, and prevent
98.20 medication-related problems, including adverse drug events;

98.21 (5) documenting the care delivered and communicating essential information to
98.22 the patient's other primary care providers;

98.23 (6) providing verbal education and training designed to enhance patient
98.24 understanding and appropriate use of the patient's medications;

98.25 (7) providing information, support services, and resources designed to enhance
98.26 patient adherence with the patient's therapeutic regimens; and

98.27 (8) coordinating and integrating medication therapy management services within the
98.28 broader health care management services being provided to the patient.

98.29 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
98.30 the pharmacist as defined in section 151.01, subdivision 27.

98.31 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
98.32 must meet the following requirements:

98.33 (1) have a valid license issued under chapter 151;

98.34 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
98.35 completed a structured and comprehensive education program approved by the Board of

99.1 Pharmacy and the American Council of Pharmaceutical Education for the provision and
99.2 documentation of pharmaceutical care management services that has both clinical and
99.3 didactic elements;

99.4 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
99.5 have developed a structured patient care process that is offered in a private or semiprivate
99.6 patient care area that is separate from the commercial business that also occurs in the
99.7 setting, or in home settings, excluding long-term care and group homes, if the service is
99.8 ordered by the provider-directed care coordination team; and

99.9 (4) make use of an electronic patient record system that meets state standards.

99.10 (c) For purposes of reimbursement for medication therapy management services,
99.11 the commissioner may enroll individual pharmacists as medical assistance and general
99.12 assistance medical care providers. The commissioner may also establish contact
99.13 requirements between the pharmacist and recipient, including limiting the number of
99.14 reimbursable consultations per recipient.

99.15 ~~(d) The commissioner, after receiving recommendations from professional medical~~
99.16 ~~associations, professional pharmacy associations, and consumer groups, shall convene~~
99.17 ~~an 11-member Medication Therapy Management Advisory Committee to advise~~
99.18 ~~the commissioner on the implementation and administration of medication therapy~~
99.19 ~~management services. The committee shall be comprised of: two licensed physicians;~~
99.20 ~~two licensed pharmacists; two consumer representatives; two health plan company~~
99.21 ~~representatives; and three members with expertise in the area of medication therapy~~
99.22 ~~management, who may be licensed physicians or licensed pharmacists. The committee is~~
99.23 ~~governed by section 15.059, except that committee members do not receive compensation~~
99.24 ~~or reimbursement for expenses. The advisory committee expires on June 30, 2007.~~

99.25 ~~(e) The commissioner shall evaluate the effect of medication therapy management~~
99.26 ~~on quality of care, patient outcomes, and program costs, and shall include a description~~
99.27 ~~of any savings generated in the medical assistance and general assistance medical care~~
99.28 ~~programs that can be attributable to this coverage. The evaluation shall be submitted to~~
99.29 ~~the legislature by December 15, 2007. The commissioner may contract with a vendor~~
99.30 ~~or an academic institution that has expertise in evaluating health care outcomes for the~~
99.31 ~~purpose of completing the evaluation.~~

99.32 (d) The commissioner shall establish a pilot project for an intensive medication
99.33 therapy management program for patients identified by the commissioner with multiple
99.34 chronic conditions and a high number of medications who are at high risk of preventable
99.35 hospitalizations, emergency room use, medication complications, and suboptimal
99.36 treatment outcomes due to medication-related problems. For purposes of the pilot

100.1 project, medication therapy management services may be provided in a patient's home
100.2 or community setting, in addition to other authorized settings. The commissioner may
100.3 waive existing payment policies and establish special payment rates for the pilot project.
100.4 The pilot project must be designed to produce a net savings to the state compared to the
100.5 estimated costs that would otherwise be incurred for similar patients without the program.

100.6 Sec. 32. Minnesota Statutes 2008, section 256B.0625, subdivision 17, is amended to
100.7 read:

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

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

100.14 (2) special transportation; or

100.15 (3) common carrier including, but not limited to, bus, taxicab, other commercial
100.16 carrier, or private automobile.

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

100.21 The commissioner may use an order by the recipient's attending physician to certify that
100.22 the recipient requires special transportation services. Special transportation ~~includes~~
100.23 providers shall perform driver-assisted service to services for eligible individuals.

100.24 Driver-assisted service includes passenger pickup at and return to the individual's
100.25 residence or place of business, assistance with admittance of the individual to the medical
100.26 facility, and assistance in passenger securement or in securing of wheelchairs or stretchers
100.27 in the vehicle. Special transportation providers must obtain written documentation
100.28 from the health care service provider who is serving the recipient being transported,
100.29 identifying the time that the recipient arrived. Special transportation providers may not
100.30 bill for separate base rates for the continuation of a trip beyond the original destination.
100.31 Special transportation providers must take recipients to the nearest appropriate health
100.32 care provider, using the most direct route ~~available~~. The ~~maximum~~ minimum medical
100.33 assistance reimbursement rates for special transportation services are:

100.34 (1) (i) \$17 for the base rate and \$1.35 per mile for special transportation services to
100.35 eligible persons who need a wheelchair-accessible van;

101.1 ~~(2)~~ (ii) \$11.50 for the base rate and \$1.30 per mile for special transportation services
101.2 to eligible persons who do not need a wheelchair-accessible van; and

101.3 ~~(3)~~ (iii) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip,
101.4 for special transportation services to eligible persons who need a stretcher-accessible
101.5 vehicle;

101.6 (2) the base rates for special transportation services in areas defined under RUCA
101.7 to be super rural shall be equal to the reimbursement rate established in clause (1) plus
101.8 11.3 percent; and

101.9 (3) for special transportation services in areas defined under RUCA to be rural
101.10 or super rural areas:

101.11 (i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
101.12 percent of the respective mileage rate in clause (1); and

101.13 (ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
101.14 112.5 percent of the respective mileage rate in clause (1).

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

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

101.21 Sec. 33. Minnesota Statutes 2008, section 256B.0625, subdivision 17a, is amended to
101.22 read:

101.23 Subd. 17a. **Payment for ambulance services.** Medical assistance covers
101.24 ambulance services. Providers shall bill ambulance services according to Medicare
101.25 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
101.26 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
101.27 services shall be paid at the Medicare reimbursement rate or at the medical assistance
101.28 payment rate in effect on July 1, 2000, whichever is greater.

101.29 Sec. 34. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
101.30 subdivision to read:

101.31 Subd. 18b. **Broker dispatching prohibition.** The commissioner shall not use a
101.32 broker or coordinator for any purpose related to transportation services under subdivision
101.33 18.

102.1 Sec. 35. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
102.2 subdivision to read:

102.3 Subd. 25a. **Prior authorization of diagnostic imaging services.** (a) Effective
102.4 January 1, 2010, the commissioner shall require prior authorization or decision support
102.5 for the ordering providers at the time the service is ordered for the following outpatient
102.6 diagnostic imaging services: computerized tomography (CT), magnetic resonance
102.7 imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography
102.8 (PET), cardiac imaging and ultrasound diagnostic imaging.

102.9 (b) Prior authorization under this subdivision is not required for diagnostic imaging
102.10 services performed as part of a hospital emergency room visit, inpatient hospitalization, or
102.11 if concurrent with or on the same day as an urgent care facility visit.

102.12 (c) This subdivision does not apply to services provided to recipients who are
102.13 enrolled in Medicare, the prepaid medical assistance program, the prepaid general
102.14 assistance medical care program, or the MinnesotaCare program.

102.15 (d) The commissioner may contract with a private entity to provide the prior
102.16 authorization or decision support required under this subdivision. The contracting entity
102.17 must incorporate clinical guidelines that are based on evidence-based medical literature, if
102.18 available. By January 1, 2012, the contracting entity shall report to the commissioner the
102.19 results of prior authorization or decision support.

102.20 Sec. 36. Minnesota Statutes 2008, section 256B.0625, subdivision 26, is amended to
102.21 read:

102.22 **Subd. 26. Special education services.** (a) Medical assistance covers medical
102.23 services identified in a recipient's individualized education plan and covered under the
102.24 medical assistance state plan. Covered services include occupational therapy, physical
102.25 therapy, speech-language therapy, clinical psychological services, nursing services,
102.26 school psychological services, school social work services, personal care assistants
102.27 serving as management aides, assistive technology devices, transportation services,
102.28 health assessments, and other services covered under the medical assistance state plan.
102.29 Mental health services eligible for medical assistance reimbursement must be provided or
102.30 coordinated through a children's mental health collaborative where a collaborative exists if
102.31 the child is included in the collaborative operational target population. The provision or
102.32 coordination of services does not require that the individual education plan be developed
102.33 by the collaborative.

102.34 The services may be provided by a Minnesota school district that is enrolled as a
102.35 medical assistance provider or its subcontractor, and only if the services meet all the

103.1 requirements otherwise applicable if the service had been provided by a provider other
103.2 than a school district, in the following areas: medical necessity, physician's orders,
103.3 documentation, personnel qualifications, and prior authorization requirements. The
103.4 nonfederal share of costs for services provided under this subdivision is the responsibility
103.5 of the local school district as provided in section 125A.74. Services listed in a child's
103.6 individual education plan are eligible for medical assistance reimbursement only if those
103.7 services meet criteria for federal financial participation under the Medicaid program.

103.8 (b) Approval of health-related services for inclusion in the individual education plan
103.9 does not require prior authorization for purposes of reimbursement under this chapter.
103.10 The commissioner may require physician review and approval of the plan not more than
103.11 once annually or upon any modification of the individual education plan that reflects a
103.12 change in health-related services.

103.13 (c) Services of a speech-language pathologist provided under this section are covered
103.14 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

103.15 (1) holds a masters degree in speech-language pathology;

103.16 (2) is licensed by the Minnesota Board of Teaching as an educational
103.17 speech-language pathologist; and

103.18 (3) either has a certificate of clinical competence from the American Speech and
103.19 Hearing Association, has completed the equivalent educational requirements and work
103.20 experience necessary for the certificate or has completed the academic program and is
103.21 acquiring supervised work experience to qualify for the certificate.

103.22 (d) Medical assistance coverage for medically necessary services provided under
103.23 other subdivisions in this section may not be denied solely on the basis that the same or
103.24 similar services are covered under this subdivision.

103.25 (e) The commissioner shall develop and implement package rates, bundled rates, or
103.26 per diem rates for special education services under which separately covered services are
103.27 grouped together and billed as a unit in order to reduce administrative complexity.

103.28 (f) The commissioner shall develop a cost-based payment structure for payment
103.29 of these services. The commissioner shall reimburse claims submitted based on an
103.30 interim rate, and shall settle at a final rate once the department has determined it. The
103.31 commissioner shall notify the school district of the final rate. The school district has 60
103.32 days to appeal the final rate. To appeal the final rate, the school district shall file a written
103.33 appeal request to the commissioner within 60 days of the date the final rate determination
103.34 was mailed. The appeal request shall specify (1) the disputed items and (2) the name and
103.35 address of the person to contact regarding the appeal.

104.1 (g) Effective July 1, 2000, medical assistance services provided under an individual
104.2 education plan or an individual family service plan by local school districts shall not count
104.3 against medical assistance authorization thresholds for that child.

104.4 (h) Nursing services as defined in section 148.171, subdivision 15, and provided
104.5 as an individual education plan health-related service, are eligible for medical assistance
104.6 payment if they are otherwise a covered service under the medical assistance program.
104.7 Medical assistance covers the administration of prescription medications by a licensed
104.8 nurse who is employed by or under contract with a school district when the administration
104.9 of medications is identified in the child's individualized education plan. The simple
104.10 administration of medications alone is not covered under medical assistance when
104.11 administered by a provider other than a school district or when it is not identified in the
104.12 child's individualized education plan.

104.13 Sec. 37. Minnesota Statutes 2008, section 256B.08, is amended by adding a
104.14 subdivision to read:

104.15 Subd. 4. **Data from Social Security.** The commissioner shall accept data from the
104.16 Social Security Administration in accordance with United States Code, title 42, section
104.17 1396U-5(a).

104.18 **EFFECTIVE DATE.** This section is effective January 1, 2010.

104.19 Sec. 38. Minnesota Statutes 2008, section 256B.15, subdivision 1, is amended to read:

104.20 Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that
104.21 individuals or couples, either or both of whom participate in the medical assistance
104.22 program, use their own assets to pay their share of the total cost of their care during or
104.23 after their enrollment in the program according to applicable federal law and the laws of
104.24 this state. The following provisions apply:

104.25 (1) subdivisions 1c to 1k shall not apply to claims arising under this section which
104.26 are presented under section 525.313;

104.27 (2) the provisions of subdivisions 1c to 1k expanding the interests included in an
104.28 estate for purposes of recovery under this section give effect to the provisions of United
104.29 States Code, title 42, section 1396p, governing recoveries, but do not give rise to any
104.30 express or implied liens in favor of any other parties not named in these provisions;

104.31 (3) the continuation of a recipient's life estate or joint tenancy interest in real
104.32 property after the recipient's death for the purpose of recovering medical assistance under
104.33 this section modifies common law principles holding that these interests terminate on
104.34 the death of the holder;

105.1 (4) all laws, rules, and regulations governing or involved with a recovery of medical
105.2 assistance shall be liberally construed to accomplish their intended purposes;

105.3 (5) a deceased recipient's life estate and joint tenancy interests continued under this
105.4 section shall be owned by the remaindermen or surviving joint tenants as their interests
105.5 may appear on the date of the recipient's death. They shall not be merged into the
105.6 remainder interest or the interests of the surviving joint tenants by reason of ownership.
105.7 They shall be subject to the provisions of this section. Any conveyance, transfer, sale,
105.8 assignment, or encumbrance by a remainderman, a surviving joint tenant, or their heirs,
105.9 successors, and assigns shall be deemed to include all of their interest in the deceased
105.10 recipient's life estate or joint tenancy interest continued under this section; and

105.11 (6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy
105.12 interests in real property after the recipient's death do not apply to a homestead owned
105.13 of record, on the date the recipient dies, by the recipient and the recipient's spouse as
105.14 joint tenants with a right of survivorship. Homestead means the real property occupied
105.15 by the surviving joint tenant spouse as their sole residence on the date the recipient dies
105.16 and classified and taxed to the recipient and surviving joint tenant spouse as homestead
105.17 property for property tax purposes in the calendar year in which the recipient dies. For
105.18 purposes of this exemption, real property the recipient and their surviving joint tenant
105.19 spouse purchase solely with the proceeds from the sale of their prior homestead, own
105.20 of record as joint tenants, and qualify as homestead property under section 273.124 in
105.21 the calendar year in which the recipient dies and prior to the recipient's death shall be
105.22 deemed to be real property classified and taxed to the recipient and their surviving joint
105.23 tenant spouse as homestead property in the calendar year in which the recipient dies.
105.24 The surviving spouse, or any person with personal knowledge of the facts, may provide
105.25 an affidavit describing the homestead property affected by this clause and stating facts
105.26 showing compliance with this clause. The affidavit shall be prima facie evidence of the
105.27 facts it states.

105.28 (b) For purposes of this section, "medical assistance" includes the medical assistance
105.29 program under this chapter and the general assistance medical care program under chapter
105.30 256D and alternative care for nonmedical assistance recipients under section 256B.0913.

105.31 (c) For purposes of this section, beginning January 1, 2010, "medical assistance"
105.32 does not include Medicare cost-sharing benefits in accordance with United States Code,
105.33 title 42, section 1396p.

105.34 (d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j,
105.35 related to the continuation of a recipient's life estate or joint tenancy interests in real
105.36 property after the recipient's death for the purpose of recovering medical assistance, are

106.1 effective only for life estates and joint tenancy interests established on or after August 1,
106.2 2003. For purposes of this paragraph, medical assistance does not include alternative care.

106.3 Sec. 39. Minnesota Statutes 2008, section 256B.15, subdivision 1a, is amended to read:

106.4 Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance
106.5 hereunder, on the person's death, if single, or on the death of the survivor of a married
106.6 couple, either or both of whom received medical assistance, or as otherwise provided
106.7 for in this section, the total amount paid for medical assistance rendered for the person
106.8 and spouse shall be filed as a claim against the estate of the person or the estate of the
106.9 surviving spouse in the court having jurisdiction to probate the estate or to issue a decree
106.10 of descent according to sections 525.31 to 525.313.

106.11 (b) For the purposes of this section, the person's estate must consist of:

106.12 (1) the person's probate estate;

106.13 (2) all of the person's interests or proceeds of those interests in real property the
106.14 person owned as a life tenant or as a joint tenant with a right of survivorship at the time of
106.15 the person's death;

106.16 (3) all of the person's interests or proceeds of those interests in securities the person
106.17 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time
106.18 of the person's death, to the extent the interests or proceeds of those interests become part
106.19 of the probate estate under section 524.6-307;

106.20 (4) all of the person's interests in joint accounts, multiple-party accounts, and
106.21 pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of
106.22 those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the
106.23 person's death to the extent the interests become part of the probate estate under section
106.24 524.6-207; and

106.25 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,
106.26 living trust, or other arrangements.

106.27 (c) For the purpose of this section and recovery in a surviving spouse's estate for
106.28 medical assistance paid for a predeceased spouse, the estate must consist of all of the legal
106.29 title and interests the deceased individual's predeceased spouse had in jointly owned or
106.30 marital property at the time of the spouse's death, as defined in subdivision 2b, and the
106.31 proceeds of those interests, that passed to the deceased individual or another individual, a
106.32 survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy
106.33 in common, survivorship, life estate, living trust, or other arrangement. A deceased
106.34 recipient who, at death, owned the property jointly with the surviving spouse shall have
106.35 an interest in the entire property.

107.1 (d) For the purpose of recovery in a single person's estate or the estate of a survivor
107.2 of a married couple, "other arrangement" includes any other means by which title to all or
107.3 any part of the jointly owned or marital property or interest passed from the predeceased
107.4 spouse to another including, but not limited to, transfers between spouses which are
107.5 permitted, prohibited, or penalized for purposes of medical assistance.

107.6 (e) A claim shall be filed if medical assistance was rendered for either or both
107.7 persons under one of the following circumstances:

107.8 ~~(a)~~ (1) the person was over 55 years of age, and received services under this chapter;

107.9 ~~(b)~~ (2) the person resided in a medical institution for six months or longer, received
107.10 services under this chapter, and, at the time of institutionalization or application for
107.11 medical assistance, whichever is later, the person could not have reasonably been expected
107.12 to be discharged and returned home, as certified in writing by the person's treating
107.13 physician. For purposes of this section only, a "medical institution" means a skilled
107.14 nursing facility, intermediate care facility, intermediate care facility for persons with
107.15 developmental disabilities, nursing facility, or inpatient hospital; or

107.16 ~~(c)~~ (3) the person received general assistance medical care services under chapter
107.17 256D.

107.18 (f) The claim shall be considered an expense of the last illness of the decedent for the
107.19 purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or
107.20 county agency with a claim under this section must be a creditor under section 524.6-307.

107.21 Any statute of limitations that purports to limit any county agency or the state agency,
107.22 or both, to recover for medical assistance granted hereunder shall not apply to any claim
107.23 made hereunder for reimbursement for any medical assistance granted hereunder. Notice
107.24 of the claim shall be given to all heirs and devisees of the decedent whose identity can be
107.25 ascertained with reasonable diligence. The notice must include procedures and instructions
107.26 for making an application for a hardship waiver under subdivision 5; time frames for
107.27 submitting an application and determination; and information regarding appeal rights and
107.28 procedures. Counties are entitled to one-half of the nonfederal share of medical assistance
107.29 collections from estates that are directly attributable to county effort. Counties are entitled
107.30 to ten percent of the collections for alternative care directly attributable to county effort.

107.31 Sec. 40. Minnesota Statutes 2008, section 256B.15, subdivision 1h, is amended to read:

107.32 Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For
107.33 purposes of this section, paragraphs (b) to ~~(k)~~ (j) apply if a person received medical
107.34 assistance for which a claim may be filed under this section and died single, or the

108.1 surviving spouse of the couple and was not survived by any of the persons described
108.2 in subdivisions 3 and 4.

108.3 ~~(b) For purposes of this section, the person's estate consists of: (1) the person's~~
108.4 ~~probate estate; (2) all of the person's interests or proceeds of those interests in real property~~
108.5 ~~the person owned as a life tenant or as a joint tenant with a right of survivorship at the~~
108.6 ~~time of the person's death; (3) all of the person's interests or proceeds of those interests in~~
108.7 ~~securities the person owned in beneficiary form as provided under sections 524.6-301 to~~
108.8 ~~524.6-311 at the time of the person's death, to the extent they become part of the probate~~
108.9 ~~estate under section 524.6-307; (4) all of the person's interests in joint accounts, multiple~~
108.10 ~~party accounts, and pay on death accounts, or the proceeds of those accounts, as provided~~
108.11 ~~under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent~~
108.12 ~~they become part of the probate estate under section 524.6-207; and (5) the person's~~
108.13 ~~legal title or interest at the time of the person's death in real property transferred under~~
108.14 ~~a transfer on death deed under section 507.071, or in the proceeds from the subsequent~~
108.15 ~~sale of the person's interest in the real property. Notwithstanding any law or rule to the~~
108.16 ~~contrary, a state or county agency with a claim under this section shall be a creditor under~~
108.17 ~~section 524.6-307.~~

108.18 ~~(e)~~ (b) Notwithstanding any law or rule to the contrary, the person's life estate or joint
108.19 tenancy interest in real property not subject to a medical assistance lien under sections
108.20 514.980 to 514.985 on the date of the person's death shall not end upon the person's death
108.21 and shall continue as provided in this subdivision. The life estate in the person's estate
108.22 shall be that portion of the interest in the real property subject to the life estate that is equal
108.23 to the life estate percentage factor for the life estate as listed in the Life Estate Mortality
108.24 Table of the health care program's manual for a person who was the age of the medical
108.25 assistance recipient on the date of the person's death. The joint tenancy interest in real
108.26 property in the estate shall be equal to the fractional interest the person would have owned
108.27 in the jointly held interest in the property had they and the other owners held title to the
108.28 property as tenants in common on the date the person died.

108.29 ~~(d)~~ (c) The court upon its own motion, or upon motion by the personal representative
108.30 or any interested party, may enter an order directing the remaindermen or surviving joint
108.31 tenants and their spouses, if any, to sign all documents, take all actions, and otherwise
108.32 fully cooperate with the personal representative and the court to liquidate the decedent's
108.33 life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of
108.34 those interests to the personal representative and provide for any legal and equitable
108.35 sanctions as the court deems appropriate to enforce and carry out the order, including an
108.36 award of reasonable attorney fees.

109.1 ~~(e)~~ (d) The personal representative may make, execute, and deliver any conveyances
109.2 or other documents necessary to convey the decedent's life estate or joint tenancy interest
109.3 in the estate that are necessary to liquidate and reduce to cash the decedent's interest or
109.4 for any other purposes.

109.5 ~~(f)~~ (e) Subject to administration, all costs, including reasonable attorney fees,
109.6 directly and immediately related to liquidating the decedent's life estate or joint tenancy
109.7 interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation
109.8 allocable to the decedent's interest and the net proceeds shall be turned over to the personal
109.9 representative and applied to payment of the claim presented under this section.

109.10 ~~(g)~~ (f) The personal representative shall bring a motion in the district court in which
109.11 the estate is being probated to compel the remaindermen or surviving joint tenants to
109.12 account for and deliver to the personal representative all or any part of the proceeds of any
109.13 sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the
109.14 decedent's life estate or joint tenancy interest in the decedent's estate, and do everything
109.15 necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of
109.16 the sale or other disposition over to the personal representative. The court may grant any
109.17 legal or equitable relief including, but not limited to, ordering a partition of real estate
109.18 under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy
109.19 interest available to the estate for payment of a claim under this section.

109.20 ~~(h)~~ (g) Subject to administration, the personal representative shall use all of the cash
109.21 or proceeds of interests to pay an allowable claim under this section. The remaindermen
109.22 or surviving joint tenants and their spouses, if any, may enter into a written agreement
109.23 with the personal representative or the claimant to settle and satisfy obligations imposed at
109.24 any time before or after a claim is filed.

109.25 ~~(i)~~ (h) The personal representative may, at their discretion, provide any or all of the
109.26 other owners, remaindermen, or surviving joint tenants with an affidavit terminating the
109.27 decedent's estate's interest in real property the decedent owned as a life tenant or as a joint
109.28 tenant with others, if the personal representative determines in good faith that neither the
109.29 decedent nor any of the decedent's predeceased spouses received any medical assistance
109.30 for which a claim could be filed under this section, or if the personal representative has
109.31 filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as
109.32 presented, or if there is a written agreement under paragraph ~~(h)~~ (g), or if the claim, as
109.33 allowed, has been paid in full or to the full extent of the assets the estate has available
109.34 to pay it. The affidavit may be recorded in the office of the county recorder or filed in
109.35 the Office of the Registrar of Titles for the county in which the real property is located.
109.36 Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit

110.1 shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a
110.2 joint tenant with others. The affidavit shall:

110.3 (1) be signed by the personal representative;

110.4 (2) identify the decedent and the interest being terminated;

110.5 (3) give recording information sufficient to identify the instrument that created the
110.6 interest in real property being terminated;

110.7 (4) legally describe the affected real property;

110.8 (5) state that the personal representative has determined that neither the decedent
110.9 nor any of the decedent's predeceased spouses received any medical assistance for which
110.10 a claim could be filed under this section;

110.11 (6) state that the decedent's estate has other assets sufficient to pay the claim, as
110.12 presented, or that there is a written agreement between the personal representative and
110.13 the claimant and the other owners or remaindermen or other joint tenants to satisfy the
110.14 obligations imposed under this subdivision; and

110.15 (7) state that the affidavit is being given to terminate the estate's interest under this
110.16 subdivision, and any other contents as may be appropriate.

110.17 The recorder or registrar of titles shall accept the affidavit for recording or filing. The
110.18 affidavit shall be effective as provided in this section and shall constitute notice even if it
110.19 does not include recording information sufficient to identify the instrument creating the
110.20 interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

110.21 ~~(f)~~ (i) The holder of a lien arising under subdivision 1c shall release the lien at
110.22 the holder's expense against an interest terminated under paragraph ~~(h)~~ (g) to the extent
110.23 of the termination.

110.24 ~~(k)~~ (j) If a lien arising under subdivision 1c is not released under paragraph ~~(f)~~ (i),
110.25 prior to closing the estate, the personal representative shall deed the interest subject to the
110.26 lien to the remaindermen or surviving joint tenants as their interests may appear. Upon
110.27 recording or filing, the deed shall work a merger of the recipient's life estate or joint
110.28 tenancy interest, subject to the lien, into the remainder interest or interest the decedent and
110.29 others owned jointly. The lien shall attach to and run with the property to the extent of
110.30 the decedent's interest at the time of the decedent's death.

110.31 Sec. 41. Minnesota Statutes 2008, section 256B.15, subdivision 2, is amended to read:

110.32 Subd. 2. **Limitations on claims.** The claim shall include only the total amount
110.33 of medical assistance rendered after age 55 or during a period of institutionalization
110.34 described in subdivision 1a, ~~clause (b)~~ paragraph (e), and the total amount of general
110.35 assistance medical care rendered, and shall not include interest. Claims that have been

111.1 allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A
111.2 claim against the estate of a surviving spouse who did not receive medical assistance, for
111.3 medical assistance rendered for the predeceased spouse, shall be payable from the full
111.4 value of all of the predeceased spouse's assets and interests which are part of the surviving
111.5 spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in
111.6 the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate
111.7 that were marital property or jointly owned property at any time during the marriage. The
111.8 claim is not payable from the value of assets or proceeds of assets in the estate attributable
111.9 to a predeceased spouse whom the individual married after the death of the predeceased
111.10 recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the
111.11 estate which the nonrecipient decedent spouse acquired with assets which were not marital
111.12 property or jointly owned property after the death of the predeceased recipient spouse.
111.13 Claims for alternative care shall be net of all premiums paid under section 256B.0913,
111.14 subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or
111.15 after July 1, 2003. Claims against marital property shall be limited to claims against
111.16 recipients who died on or after July 1, 2009.

111.17 Sec. 42. Minnesota Statutes 2008, section 256B.15, is amended by adding a
111.18 subdivision to read:

111.19 Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and
111.20 subdivisions 1a and 2, paragraphs (b) to (d) apply.

111.21 (b) At the time of death of a recipient spouse and solely for purpose of recovery of
111.22 medical assistance benefits received, a predeceased recipient spouse shall have a legal
111.23 title or interest in the undivided whole of all of the property which the recipient and the
111.24 recipient's surviving spouse owned jointly or which was marital property at any time
111.25 during their marriage regardless of the form of ownership and regardless of whether
111.26 it was owned or titled in the names of one or both the recipient and the recipient's
111.27 spouse. Title and interest in the property of a predeceased recipient spouse shall not end
111.28 or extinguish upon the person's death and shall continue for the purpose of allowing
111.29 recovery of medical assistance in the estate of the surviving spouse. Upon the death of
111.30 the predeceased recipient spouse, title and interest in the predeceased spouse's property
111.31 shall vest in the surviving spouse by operation of law and without the necessity for any
111.32 probate or decree of descent proceedings and shall continue to exist after the death of the
111.33 predeceased spouse and the surviving spouse to permit recovery of medical assistance.
111.34 The recipient spouse and the surviving spouse of a deceased recipient spouse shall not

112.1 encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of
112.2 these interests before or upon death.

112.3 (c) For purposes of this section, "marital property" includes any and all real or
112.4 personal property of any kind or interests in such property the predeceased recipient
112.5 spouse and their spouse, or either of them, owned at the time of their marriage to each
112.6 other or acquired during their marriage regardless of whether it was owned or titled in
112.7 the names of one or both of them. If either or both spouses of a married couple received
112.8 medical assistance, all property owned during the marriage or which either or both spouses
112.9 acquired during their marriage shall be presumed to be marital property for purposes of
112.10 recovering medical assistance unless there is clear and convincing evidence to the contrary.

112.11 (d) The agency responsible for the claim for medical assistance for a recipient spouse
112.12 may, at its discretion, release specific real and personal property from the provisions of
112.13 this section. The release shall extinguish the interest created under paragraph (b) in the
112.14 land it describes upon filing or recording. The release need not be attested, certified, or
112.15 acknowledged as a condition of filing or recording and shall be filed or recorded in the
112.16 office of the county recorder or registrar of titles, as appropriate, in the county where the
112.17 real property is located. The party to whom the release is given shall be responsible for
112.18 paying all fees and costs necessary to record and file the release. If the property described
112.19 in the release is registered property, the registrar of titles shall accept it for recording and
112.20 shall record it on the certificate of title for each parcel of property described in the release.
112.21 If the property described in the release is abstract property, the recorder shall accept it
112.22 for filing and file it in the county's grantor-grantee indexes and any tract index the county
112.23 maintains for each parcel of property described in the release.

112.24 Sec. 43. Minnesota Statutes 2008, section 256B.15, is amended by adding a
112.25 subdivision to read:

112.26 Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to
112.27 intervene as a party in any proceeding involving recovery of medical assistance upon
112.28 filing a notice of intervention and serving such notice on the other parties.

112.29 Sec. 44. **[256B.196] INTERGOVERNMENTAL TRANSFERS; HOSPITAL**
112.30 **PAYMENTS.**

112.31 Subdivision 1. **Federal approval required.** This section is contingent on federal
112.32 approval of the intergovernmental transfers and payments authorized under this section.
112.33 This section is also contingent on current payment by the government entities of the
112.34 intergovernmental transfers under this section.

113.1 Subd. 2. Commissioner's duties. (a) For the purposes of this subdivision and
113.2 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
113.3 services upper payment limit for nonstate government hospitals. The commissioner shall
113.4 then determine the amount of a supplemental payment to Hennepin County Medical
113.5 Center and Regions Hospital for these services that would increase medical assistance
113.6 spending in this category to the aggregate upper payment limit for all nonstate government
113.7 hospitals in Minnesota. In making this determination, the commissioner shall allot the
113.8 available increases between Hennepin County Medical Center and Regions Hospital
113.9 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
113.10 the two facilities. The commissioner shall adjust this allotment as necessary based on
113.11 federal approvals, the amount of intergovernmental transfers received from Hennepin and
113.12 Ramsey Counties, and other factors, in order to maximize the additional total payments.
113.13 The commissioner shall inform Hennepin County and Ramsey County of the periodic
113.14 intergovernmental transfers necessary to match federal Medicaid payments available
113.15 under this subdivision in order to make supplementary medical assistance payments to
113.16 Hennepin County Medical Center and Regions Hospital equal to an amount that when
113.17 combined with existing medical assistance payments to nonstate governmental hospitals
113.18 would increase total payments to hospitals in this category for outpatient services to
113.19 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
113.20 receipt of these periodic transfers, the commissioner shall make supplementary payments
113.21 to Hennepin County Medical Center and Regions Hospital.

113.22 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
113.23 determine an upper payment limit for physicians affiliated with Hennepin County Medical
113.24 Center and with Regions Hospital. The upper payment limit shall be based on the average
113.25 commercial rate or be determined using another method acceptable to the Centers for
113.26 Medicare and Medicaid Services. The commissioner shall inform Hennepin County and
113.27 Ramsey County of the periodic intergovernmental transfers necessary to match the federal
113.28 Medicaid payments available under this subdivision in order to make supplementary
113.29 payments to physicians affiliated with Hennepin County Medical Center and Regions
113.30 Hospital equal to the difference between the established medical assistance payment for
113.31 physician services and the upper payment limit. Upon receipt of these periodic transfers,
113.32 the commissioner shall make supplementary payments to physicians of Hennepin Faculty
113.33 Associates and HealthPartners.

113.34 (c) Beginning January 1, 2010, Hennepin County and Ramsey County shall make
113.35 monthly intergovernmental transfers to the commissioner in the following amounts:
113.36 \$133,333 by Hennepin County and \$100,000 by Ramsey County. The commissioner shall

114.1 increase the medical assistance capitation payments to Metropolitan Health Plan and
114.2 HealthPartners by an amount equal to the annual value of the monthly transfers plus
114.3 federal financial participation.

114.4 (d) The commissioner shall inform Hennepin County and Ramsey County on an
114.5 ongoing basis of the need for any changes needed in the intergovernmental transfers
114.6 in order to continue the payments under paragraphs (a) to (c), at their maximum level,
114.7 including increases in upper payment limits, changes in the federal Medicaid match, and
114.8 other factors.

114.9 (e) The payments in paragraphs (a) to (c) shall be implemented independently of
114.10 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

114.11 Subd. 3. **Intergovernmental transfers.** Based on the determination by the
114.12 commissioner under subdivision 2, Hennepin County and Ramsey County shall make
114.13 periodic intergovernmental transfers to the commissioner for the purposes of subdivision
114.14 2, paragraphs (a) to (c). All of the intergovernmental transfers made by Hennepin County
114.15 shall be used to match federal payments to Hennepin County Medical Center under
114.16 subdivision 2, paragraph (a); to physicians affiliated with Hennepin Faculty Associates
114.17 under subdivision 2, paragraph (b); and to Metropolitan Health Plan under subdivision
114.18 2, paragraph (c). All of the intergovernmental transfers made by Ramsey County shall
114.19 be used to match federal payments to Regions Hospital under subdivision 2, paragraph
114.20 (a); to physicians affiliated with HealthPartners under subdivision 2, paragraph (b); and to
114.21 HealthPartners under subdivision 2, paragraph (c).

114.22 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the
114.23 intergovernmental transfers under subdivision 3 and the payments under subdivision
114.24 2, based on the commissioner's determination of Medicare upper payment limits,
114.25 hospital-specific charge limits, hospital-specific limitations on disproportionate share
114.26 payments, medical inflation, actuarial certification, and cost-effectiveness for purposes
114.27 of federal waivers. Any adjustments must be made on a proportional basis. The
114.28 commissioner may make adjustments under this subdivision only after consultation
114.29 with the affected counties and hospitals. All payments under subdivision 2 and all
114.30 intergovernmental transfers under subdivision 3 are limited to amounts available after all
114.31 other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

114.32 (b) The ratio of medical assistance payments specified in subdivision 2 to the
114.33 voluntary intergovernmental transfers specified in subdivision 3 shall not be reduced
114.34 except as provided under paragraph (a).

115.1 Subd. 5. **Recession period.** Each type of intergovernmental transfer in subdivision
115.2 2, paragraphs (a) to (d), for payment periods from October 1, 2008, through December
115.3 31, 2010, is voluntary on the part of Hennepin and Ramsey Counties, meaning that the
115.4 transfer must be agreed to, in writing, by the counties prior to any payments being issued.
115.5 One agreement on each type of transfer shall cover the entire recession period.

115.6 Sec. 45. Minnesota Statutes 2008, section 256B.199, is amended to read:

115.7 **256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

115.8 (a) Effective July 1, 2007, the commissioner shall apply for federal matching funds
115.9 for the expenditures in paragraphs (b) and (c).

115.10 (b) The commissioner shall apply for federal matching funds for certified public
115.11 expenditures as follows:

115.12 (1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions
115.13 Hospital, the University of Minnesota, and Fairview-University Medical Center shall
115.14 report quarterly to the commissioner beginning June 1, 2007, payments made during the
115.15 second previous quarter that may qualify for reimbursement under federal law;

115.16 (2) based on these reports, the commissioner shall apply for federal matching
115.17 funds. These funds are appropriated to the commissioner for the payments under section
115.18 256.969, subdivision 27; and

115.19 (3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform
115.20 the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share
115.21 hospital payment money expected to be available in the current federal fiscal year.

115.22 (c) The commissioner shall apply for federal matching funds for general assistance
115.23 medical care expenditures as follows:

115.24 (1) for hospital services occurring on or after July 1, 2007, general assistance medical
115.25 care expenditures for fee-for-service inpatient and outpatient hospital payments made by
115.26 the department shall be used to apply for federal matching funds, except as limited below:

115.27 (i) only those general assistance medical care expenditures made to an individual
115.28 hospital that would not cause the hospital to exceed its individual hospital limits under
115.29 section 1923 of the Social Security Act may be considered; and

115.30 (ii) general assistance medical care expenditures may be considered only to the extent
115.31 of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

115.32 (2) all hospitals must provide any necessary expenditure, cost, and revenue
115.33 information required by the commissioner as necessary for purposes of obtaining federal
115.34 Medicaid matching funds for general assistance medical care expenditures.

116.1 (d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall
116.2 apply for additional federal matching funds available as disproportionate share hospital
116.3 payments under the American Recovery and Reinvestment Act of 2009. These funds shall
116.4 be made available as the state share of payments under section 256.969, subdivision 28.
116.5 The entities required to report certified public expenditures under paragraph (b), clause
116.6 (1), shall report additional certified public expenditures as necessary under this paragraph.

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

116.8 Sec. 46. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

116.9 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
116.10 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
116.11 basis beginning January 1, 1996. Managed care contracts which were in effect on June
116.12 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
116.13 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
116.14 commissioner may issue separate contracts with requirements specific to services to
116.15 medical assistance recipients age 65 and older.

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

116.21 (c) Effective for services rendered on or after January 1, 2003, the commissioner shall
116.22 withhold five percent of managed care plan payments under this section and county-based
116.23 purchasing plan's payment rate under section 256B.692 for the prepaid medical assistance
116.24 and general assistance medical care programs pending completion of performance targets.
116.25 Each performance target must be quantifiable, objective, measurable, and reasonably
116.26 attainable, except in the case of a performance target based on a federal or state law or rule.
116.27 Criteria for assessment of each performance target must be outlined in writing prior to the
116.28 contract effective date. The managed care plan must demonstrate, to the commissioner's
116.29 satisfaction, that the data submitted regarding attainment of the performance target is
116.30 accurate. The commissioner shall periodically change the administrative measures used
116.31 as performance targets in order to improve plan performance across a broader range of
116.32 administrative services. The performance targets must include measurement of plan
116.33 efforts to contain spending on health care services and administrative activities. The
116.34 commissioner may adopt plan-specific performance targets that take into account factors
116.35 affecting only one plan, including characteristics of the plan's enrollee population. The

117.1 withheld funds must be returned no sooner than July of the following year if performance
 117.2 targets in the contract are achieved. The commissioner may exclude special demonstration
 117.3 projects under subdivision 23. ~~A managed care plan or a county-based purchasing plan~~
 117.4 ~~under section 256B.692 may include as admitted assets under section 62D.044 any amount~~
 117.5 ~~withheld under this paragraph that is reasonably expected to be returned.~~

117.6 (d)(1) Effective for services rendered on or after January 1, 2009, through December
 117.7 31, 2009, the commissioner shall withhold three percent of managed care plan payments
 117.8 under this section and county-based purchasing plan payments under section 256B.692 for
 117.9 the prepaid medical assistance and general assistance medical care programs. The withheld
 117.10 funds must be returned no sooner than July 1 and no later than July 31 of the following
 117.11 year. The commissioner may exclude special demonstration projects under subdivision 23.

117.12 ~~(2) A managed care plan or a county-based purchasing plan under section 256B.692~~
 117.13 ~~may include as admitted assets under section 62D.044 any amount withheld under~~
 117.14 ~~this paragraph. The return of the withhold under this paragraph is not subject to the~~
 117.15 ~~requirements of paragraph (c).~~

117.16 (e) Effective for services rendered on or after January 1, 2010, through December
 117.17 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments
 117.18 under this section and county-based purchasing plan payments under section 256B.692
 117.19 for the prepaid medical assistance program. The withheld funds must be returned no
 117.20 sooner than July 1 and no later than July 31 of the following year. The commissioner may
 117.21 exclude special demonstration projects under subdivision 23.

117.22 (f) Effective for services rendered on or after January 1, 2011, through December 31,
 117.23 2011, the commissioner shall withhold four percent of managed care plan payments under
 117.24 this section and county-based purchasing plan payments under section 256B.692 for the
 117.25 prepaid medical assistance program. The withheld funds must be returned no sooner than
 117.26 July 1 and no later than July 31 of the following year. The commissioner may exclude
 117.27 special demonstration projects under subdivision 23.

117.28 (g) Effective for services rendered on or after January 1, 2012, through December
 117.29 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
 117.30 under this section and county-based purchasing plan payments under section 256B.692
 117.31 for the prepaid medical assistance program. The withheld funds must be returned no
 117.32 sooner than July 1 and no later than July 31 of the following year. The commissioner may
 117.33 exclude special demonstration projects under subdivision 23.

117.34 (h) Effective for services rendered on or after January 1, 2013, through December
 117.35 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
 117.36 under this section and county-based purchasing plan payments under section 256B.692

118.1 for the prepaid medical assistance program. The withheld funds must be returned no
118.2 sooner than July 1 and no later than July 31 of the following year. The commissioner may
118.3 exclude special demonstration projects under subdivision 23.

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

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

118.13 Sec. 47. Minnesota Statutes 2008, section 256B.69, subdivision 5c, is amended to read:

118.14 Subd. 5c. **Medical education and research fund.** (a) Except as provided in
118.15 paragraph (c), the commissioner of human services shall transfer each year to the medical
118.16 education and research fund established under section 62J.692, the following:

118.17 (1) an amount equal to the reduction in the prepaid medical assistance and prepaid
118.18 general assistance medical care payments as specified in this clause. Until January 1,
118.19 2002, the county medical assistance and general assistance medical care capitation base
118.20 rate prior to plan specific adjustments and after the regional rate adjustments under section
118.21 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin County, two percent for
118.22 the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota
118.23 counties; and after January 1, 2002, the county medical assistance and general assistance
118.24 medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent
118.25 for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent
118.26 for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments
118.27 and demonstration project payments operating under subdivision 23 are excluded from
118.28 this reduction. The amount calculated under this clause shall not be adjusted for periods
118.29 already paid due to subsequent changes to the capitation payments;

118.30 (2) beginning July 1, 2003, ~~\$2,157,000~~ \$4,314,000 from the capitation rates paid
118.31 under this section ~~plus any federal matching funds on this amount;~~

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

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

119.1 (b) This subdivision shall be effective upon approval of a federal waiver which
 119.2 allows federal financial participation in the medical education and research fund. Effective
 119.3 July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4),
 119.4 shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first
 119.5 reduce the amounts otherwise required to be transferred under paragraph (a), clauses
 119.6 (2) to (4). Any excess following this reduction shall proportionally reduce the transfers
 119.7 under paragraph (a), clause (1).

119.8 (c) Effective July 1, 2003, the amount reduced from the prepaid general assistance
 119.9 medical care payments under paragraph (a), clause (1), shall be transferred to the general
 119.10 fund.

119.11 (d) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall
 119.12 transfer \$21,714,000 each fiscal year to the medical education and research fund. The
 119.13 balance of the transfers under paragraph (a) shall be transferred to the medical education
 119.14 and research fund no earlier than July 1 of the following fiscal year.

119.15 Sec. 48. Minnesota Statutes 2008, section 256B.69, subdivision 5f, is amended to read:

119.16 Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid
 119.17 under this section are increased by \$12,700,000 per year. Beginning July 1, 2003, the
 119.18 capitation rates paid under this section are increased by \$4,700,000 per year.

119.19 (b) Beginning July 1, 2009, the capitation rates paid under this section are increased
 119.20 each year by the lesser of \$21,714,000 or an amount equal to the difference between the
 119.21 estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1),
 119.22 and the amount of the limit described in subdivision 5c, paragraph (b).

119.23 Sec. 49. Minnesota Statutes 2008, section 256B.69, subdivision 23, is amended to read:

119.24 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
 119.25 commissioner may implement demonstration projects to create alternative integrated
 119.26 delivery systems for acute and long-term care services to elderly persons and persons
 119.27 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
 119.28 coordination, improve access to quality services, and mitigate future cost increases.
 119.29 The commissioner may seek federal authority to combine Medicare and Medicaid
 119.30 capitation payments for the purpose of such demonstrations and may contract with
 119.31 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
 119.32 services shall be administered according to the terms and conditions of the federal contract
 119.33 and demonstration provisions. For the purpose of administering medical assistance funds,
 119.34 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions

120.1 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
120.2 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
120.3 items B and C, which do not apply to persons enrolling in demonstrations under this
120.4 section. An initial open enrollment period may be provided. Persons who disenroll from
120.5 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
120.6 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
120.7 the health plan's participation is subsequently terminated for any reason, the person shall
120.8 be provided an opportunity to select a new health plan and shall have the right to change
120.9 health plans within the first 60 days of enrollment in the second health plan. Persons
120.10 required to participate in health plans under this section who fail to make a choice of
120.11 health plan shall not be randomly assigned to health plans under these demonstrations.
120.12 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
120.13 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
120.14 the commissioner may contract with managed care organizations, including counties, to
120.15 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
120.16 disabled persons only. For persons with a primary diagnosis of developmental disability,
120.17 serious and persistent mental illness, or serious emotional disturbance, the commissioner
120.18 must ensure that the county authority has approved the demonstration and contracting
120.19 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
120.20 commissioner shall not implement any demonstration project under this subdivision for
120.21 persons with a primary diagnosis of developmental disabilities, serious and persistent
120.22 mental illness, or serious emotional disturbance, without approval of the county board of
120.23 the county in which the demonstration is being implemented.

120.24 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
120.25 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
120.26 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
120.27 under this section projects for persons with developmental disabilities. The commissioner
120.28 may capitate payments for ICF/MR services, waived services for developmental
120.29 disabilities, including case management services, day training and habilitation and
120.30 alternative active treatment services, and other services as approved by the state and by the
120.31 federal government. Case management and active treatment must be individualized and
120.32 developed in accordance with a person-centered plan. Costs under these projects may not
120.33 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
120.34 and until four years after the pilot project implementation date, subcontractor participation
120.35 in the long-term care developmental disability pilot is limited to a nonprofit long-term
120.36 care system providing ICF/MR services, home and community-based waiver services,

121.1 and in-home services to no more than 120 consumers with developmental disabilities in
121.2 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
121.3 prior to expansion of the developmental disability pilot project. This paragraph expires
121.4 four years after the implementation date of the pilot project.

121.5 (c) Before implementation of a demonstration project for disabled persons, the
121.6 commissioner must provide information to appropriate committees of the house of
121.7 representatives and senate and must involve representatives of affected disability groups
121.8 in the design of the demonstration projects.

121.9 (d) A nursing facility reimbursed under the alternative reimbursement methodology
121.10 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
121.11 provide services under paragraph (a). The commissioner shall amend the state plan and
121.12 seek any federal waivers necessary to implement this paragraph.

121.13 (e) The commissioner, in consultation with the commissioners of commerce and
121.14 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
121.15 according to federal laws and regulations governing that program and state laws or rules
121.16 applicable to participating providers. The process for approval of these programs shall
121.17 begin only after the commissioner receives grant money in an amount sufficient to cover
121.18 the state share of the administrative and actuarial costs to implement the programs during
121.19 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
121.20 account in the special revenue fund and are appropriated to the commissioner to be used
121.21 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
121.22 not required to be licensed or certified as a health plan company as defined in section
121.23 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
121.24 and found to be eligible for services under the elderly waiver or community alternatives
121.25 for disabled individuals or who are already eligible for Medicaid but meet level of
121.26 care criteria for receipt of waiver services may choose to enroll in the PACE program.
121.27 Medicare and Medicaid services will be provided according to this subdivision and
121.28 federal Medicare and Medicaid requirements governing PACE providers and programs.
121.29 PACE enrollees will receive Medicaid home and community-based services through the
121.30 PACE provider as an alternative to services for which they would otherwise be eligible
121.31 through home and community-based waiver programs and Medicaid State Plan Services.
121.32 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
121.33 costs that would have been incurred under fee-for-service or other relevant managed care
121.34 programs operated by the state.

121.35 (f) The commissioner shall seek federal approval to expand the Minnesota disability
121.36 health options (MnDHO) program established under this subdivision in stages, first to

122.1 regional population centers outside the seven-county metro area and then to all areas of
 122.2 the state. Until July 1, 2009, expansion for MnDHO projects that include home and
 122.3 community-based services is limited to the two projects and service areas in effect on
 122.4 March 1, 2006. Enrollment in integrated MnDHO programs that include home and
 122.5 community-based services shall remain voluntary. Costs for home and community-based
 122.6 services included under MnDHO must not exceed costs that would have been incurred
 122.7 under the fee-for-service program. Notwithstanding whether expansion occurs under
 122.8 this paragraph, in determining MnDHO payment rates and risk adjustment methods for
 122.9 contract years starting in 2012, the commissioner must consider the methods used to
 122.10 determine county allocations for home and community-based program participants. If
 122.11 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
 122.12 for home and community-based services, the commissioner shall achieve the reduction by
 122.13 maintaining the base rate for contract years 2010 and 2011 for services provided under the
 122.14 community alternatives for disabled individuals waiver at the same level as for contract
 122.15 year 2009. The commissioner may apply other reductions to MnDHO rates to implement
 122.16 decreases in provider payment rates required by state law. In developing program
 122.17 specifications for expansion of integrated programs, the commissioner shall involve and
 122.18 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
 122.19 including consultation on whether and how to include home and community-based waiver
 122.20 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
 122.21 of the house of representatives and senate committees with jurisdiction over health and
 122.22 human services policy and finance by February 1, 2007.

122.23 (g) Notwithstanding section 256B.0261, health plans providing services under this
 122.24 section are responsible for home care targeted case management and relocation targeted
 122.25 case management. Services must be provided according to the terms of the waivers and
 122.26 contracts approved by the federal government.

122.27 Sec. 50. **[256B.756] REIMBURSEMENT RATES FOR BIRTHS.**

122.28 Subdivision 1. Facility rate. (a) Notwithstanding section 256.969, effective for
 122.29 services provided on or after October 1, 2009, the facility payment rate for the following
 122.30 diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean
 122.31 section without complicating diagnosis; (2) 372 vaginal delivery with complicating
 122.32 diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be calculated
 122.33 as provided in paragraph (b).

122.34 (b) The commissioner shall calculate a single rate for all of the diagnostic related
 122.35 groups specified in paragraph (a) consistent with an increase in the proportion of births

123.1 by vaginal delivery and a reduction in the percentage of births by cesarean section. The
123.2 calculated single rate must be based on an expected increase in the number of vaginal
123.3 births and expected reduction in the number of cesarean section such that the reduction
123.4 in cesarean sections is less than or equal to one standard deviation below the average in
123.5 the frequency of cesarean births for Minnesota health care program clients at hospitals
123.6 performing greater than 50 deliveries per year.

123.7 (c) The rates described in this subdivision do not include newborn care.

123.8 Subd. 2. **Provider rate.** Notwithstanding section 256B.76, effective for services
123.9 provided on or after October 1, 2009, the payment rate for professional services related
123.10 to labor, delivery, and antepartum and postpartum care when provided for any of the
123.11 diagnostic categories identified in subdivision 1, paragraph (a), shall be calculated using
123.12 the methodology specified in subdivision 1, paragraph (b).

123.13 Subd. 3. **Health plans.** Payments to managed care and county-based purchasing
123.14 plans under sections 256B.69, 256B.692, or 256L.12 shall be reduced for services
123.15 provided on or after October 1, 2009, to reflect the adjustments in subdivisions 1 and 2.

123.16 Subd. 4. **Prior authorization.** Prior authorization shall not be required before
123.17 reimbursement is paid for a cesarean section delivery.

123.18 Sec. 51. Minnesota Statutes 2008, section 256B.76, subdivision 1, is amended to read:

123.19 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
123.20 or after October 1, 1992, the commissioner shall make payments for physician services
123.21 as follows:

123.22 (1) payment for level one Centers for Medicare and Medicaid Services' common
123.23 procedural coding system codes titled "office and other outpatient services," "preventive
123.24 medicine new and established patient," "delivery, antepartum, and postpartum care,"
123.25 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
123.26 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
123.27 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
123.28 30, 1992. If the rate on any procedure code within these categories is different than the
123.29 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
123.30 then the larger rate shall be paid;

123.31 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
123.32 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

123.33 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
123.34 percentile of 1989, less the percent in aggregate necessary to equal the above increases

124.1 except that payment rates for home health agency services shall be the rates in effect
124.2 on September 30, 1992.

124.3 (b) Effective for services rendered on or after January 1, 2000, payment rates for
124.4 physician and professional services shall be increased by three percent over the rates
124.5 in effect on December 31, 1999, except for home health agency and family planning
124.6 agency services. The increases in this paragraph shall be implemented January 1, 2000,
124.7 for managed care.

124.8 (c) Effective for services rendered on or after July 1, 2009, payment rates for
124.9 physician and professional services shall be reduced by five percent over the rates in effect
124.10 on June 30, 2009. This reduction does not apply to office or other outpatient services
124.11 (procedure codes 99201 to 99215), preventive medicine services (procedure codes 99381
124.12 to 99412) and family planning services billed by the following primary care specialties:
124.13 general practice, internal medicine, pediatrics, geriatrics, family practice, or by an
124.14 advanced practice registered nurse or physician assistant practicing in pediatrics, geriatrics,
124.15 or family practice. This reduction does not apply to federally qualified health centers,
124.16 rural health centers, and Indian health services. Effective October 1, 2009, payments
124.17 made to managed care plans and county-based purchasing plans under sections 256B.69,
124.18 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

124.19 Sec. 52. **[256B.766] REIMBURSEMENT FOR BASIC CARE SERVICES.**

124.20 (a) Effective for services provided on or after July 1, 2009, total payments for basic
124.21 care services, shall be reduced by three percent, prior to third-party liability and spenddown
124.22 calculation. Payments made to managed care plans and county-based purchasing plans
124.23 shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

124.24 (b) This section does not apply to physician and professional services, inpatient
124.25 hospital services, family planning services, mental health services, dental services,
124.26 prescription drugs, and medical transportation.

124.27 Sec. 53. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

124.28 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
124.29 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
124.30 care covers, except as provided in paragraph (c):

124.31 (1) inpatient hospital services;

124.32 (2) outpatient hospital services;

124.33 (3) services provided by Medicare certified rehabilitation agencies;

- 125.1 (4) prescription drugs and other products recommended through the process
125.2 established in section 256B.0625, subdivision 13;
- 125.3 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
125.4 for diabetics to monitor blood sugar level;
- 125.5 (6) eyeglasses and eye examinations provided by a physician or optometrist;
- 125.6 (7) hearing aids;
- 125.7 (8) prosthetic devices;
- 125.8 (9) laboratory and X-ray services;
- 125.9 (10) physician's services;
- 125.10 (11) medical transportation except special transportation;
- 125.11 (12) chiropractic services as covered under the medical assistance program;
- 125.12 (13) podiatric services;
- 125.13 (14) dental services as covered under the medical assistance program;
- 125.14 (15) mental health services covered under chapter 256B;
- 125.15 (16) prescribed medications for persons who have been diagnosed as mentally ill as
125.16 necessary to prevent more restrictive institutionalization;
- 125.17 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
125.18 deductible payments;
- 125.19 (18) medical equipment not specifically listed in this paragraph when the use of
125.20 the equipment will prevent the need for costlier services that are reimbursable under
125.21 this subdivision;
- 125.22 (19) services performed by a certified pediatric nurse practitioner, a certified family
125.23 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
125.24 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
125.25 practitioner in independent practice, if (1) the service is otherwise covered under this
125.26 chapter as a physician service, (2) the service provided on an inpatient basis is not included
125.27 as part of the cost for inpatient services included in the operating payment rate, and (3) the
125.28 service is within the scope of practice of the nurse practitioner's license as a registered
125.29 nurse, as defined in section 148.171;
- 125.30 (20) services of a certified public health nurse or a registered nurse practicing in
125.31 a public health nursing clinic that is a department of, or that operates under the direct
125.32 authority of, a unit of government, if the service is within the scope of practice of the
125.33 public health nurse's license as a registered nurse, as defined in section 148.171;
- 125.34 (21) telemedicine consultations, to the extent they are covered under section
125.35 256B.0625, subdivision 3b;

126.1 (22) care coordination and patient education services provided by a community
126.2 health worker according to section 256B.0625, subdivision 49; and

126.3 (23) regardless of the number of employees that an enrolled health care provider
126.4 may have, sign language interpreter services when provided by an enrolled health care
126.5 provider during the course of providing a direct, person-to-person covered health care
126.6 service to an enrolled recipient who has a hearing loss and uses interpreting services.

126.7 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
126.8 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
126.9 to inpatient hospital services, including physician services provided during the inpatient
126.10 hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

126.11 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
126.12 subdivision.

126.13 (c) In order to contain costs, the commissioner of human services shall select
126.14 vendors of medical care who can provide the most economical care consistent with high
126.15 medical standards and shall where possible contract with organizations on a prepaid
126.16 capitation basis to provide these services. The commissioner shall consider proposals by
126.17 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
126.18 or other vendor payment mechanisms designed to provide services in an economical
126.19 manner or to control utilization, with safeguards to ensure that necessary services are
126.20 provided. Before implementing prepaid programs in counties with a county operated or
126.21 affiliated public teaching hospital or a hospital or clinic operated by the University of
126.22 Minnesota, the commissioner shall consider the risks the prepaid program creates for the
126.23 hospital and allow the county or hospital the opportunity to participate in the program in a
126.24 manner that reflects the risk of adverse selection and the nature of the patients served by
126.25 the hospital, provided the terms of participation in the program are competitive with the
126.26 terms of other participants considering the nature of the population served. Payment for
126.27 services provided pursuant to this subdivision shall be as provided to medical assistance
126.28 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
126.29 payments made during fiscal year 1990 and later years, the commissioner shall consult
126.30 with an independent actuary in establishing prepayment rates, but shall retain final control
126.31 over the rate methodology.

126.32 (d) Effective January 1, 2008, drug coverage under general assistance medical
126.33 care is limited to prescription drugs that:

126.34 (i) are covered under the medical assistance program as described in section
126.35 256B.0625, subdivisions 13 and 13d; and

127.1 (ii) are provided by manufacturers that have fully executed general assistance
127.2 medical care rebate agreements with the commissioner and comply with the agreements.
127.3 Prescription drug coverage under general assistance medical care must conform to
127.4 coverage under the medical assistance program according to section 256B.0625,
127.5 subdivisions 13 to 13g.

127.6 (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
127.7 co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

127.8 (1) \$25 for eyeglasses;

127.9 (2) \$25 for nonemergency visits to a hospital-based emergency room;

127.10 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
127.11 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
127.12 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

127.13 (4) 50 percent coinsurance on restorative dental services.

127.14 (f) Recipients eligible under subdivision 3, paragraph (a), shall include the following
127.15 co-payments for services provided on or after January 1, 2009:

127.16 (1) \$25 for nonemergency visits to a hospital-based emergency room; and

127.17 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
127.18 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
127.19 shall apply to antipsychotic drugs when used for the treatment of mental illness.

127.20 (g) MS 2007 Supp [Expired]

127.21 (h) Effective January 1, 2009, co-payments shall be limited to one per day per
127.22 provider for nonemergency visits to a hospital-based emergency room. Recipients of
127.23 general assistance medical care are responsible for all co-payments in this subdivision.
127.24 The general assistance medical care reimbursement to the provider shall be reduced by the
127.25 amount of the co-payment, except that reimbursement for prescription drugs shall not be
127.26 reduced once a recipient has reached the \$7 per month maximum for prescription drug
127.27 co-payments. The provider collects the co-payment from the recipient. Providers may not
127.28 deny services to recipients who are unable to pay the co-payment.

127.29 (i) General assistance medical care reimbursement to fee-for-service providers
127.30 and payments to managed care plans shall not be increased as a result of the removal of
127.31 the co-payments effective January 1, 2009.

127.32 (j) Any county may, from its own resources, provide medical payments for which
127.33 state payments are not made.

127.34 (k) Chemical dependency services that are reimbursed under chapter 254B must not
127.35 be reimbursed under general assistance medical care.

128.1 (l) The maximum payment for new vendors enrolled in the general assistance
128.2 medical care program after the base year shall be determined from the average usual and
128.3 customary charge of the same vendor type enrolled in the base year.

128.4 (m) The conditions of payment for services under this subdivision are the same
128.5 as the conditions specified in rules adopted under chapter 256B governing the medical
128.6 assistance program, unless otherwise provided by statute or rule.

128.7 (n) Inpatient and outpatient payments shall be reduced by five percent, effective July
128.8 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
128.9 and incorporated by reference in paragraph (l).

128.10 (o) Payments for all other health services except inpatient, outpatient, and pharmacy
128.11 services shall be reduced by five percent, effective July 1, 2003.

128.12 (p) Payments to managed care plans shall be reduced by five percent for services
128.13 provided on or after October 1, 2003.

128.14 (q) A hospital receiving a reduced payment as a result of this section may apply the
128.15 unpaid balance toward satisfaction of the hospital's bad debts.

128.16 (r) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for
128.17 services provided on or after January 1, 2006. For purposes of this subdivision, a visit
128.18 means an episode of service which is required because of a recipient's symptoms,
128.19 diagnosis, or established illness, and which is delivered in an ambulatory setting by
128.20 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
128.21 audiologist, optician, or optometrist.

128.22 (s) Payments to managed care plans shall not be increased as a result of the removal
128.23 of the \$3 nonpreventive visit co-payment effective January 1, 2006.

128.24 (t) Payments for mental health services added as covered benefits after December
128.25 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

128.26 (u) Effective for services provided on or after July 1, 2009, total payment rates for
128.27 basic care services shall be reduced by three percent, in accordance with section 256B.766.
128.28 Payments made to managed care plans shall be reduced for services provided on or after
128.29 October 1, 2009, to reflect this reduction.

128.30 (v) Effective for services provided on or after July 1, 2009, payment rates for
128.31 physician and professional services shall be reduced as described under section 256B.76,
128.32 subdivision 1, paragraph (c). Payments made to managed care plans shall be reduced for
128.33 services provided on or after October 1, 2009, to reflect this reduction.

128.34 Sec. 54. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision
128.35 to read:

129.1 Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic
129.2 services: medically necessary exams, manual manipulation of the spine, and x-rays.

129.3 **EFFECTIVE DATE.** This section is effective January 1, 2010.

129.4 Sec. 55. Minnesota Statutes 2008, section 256L.04, subdivision 1, is amended to read:

129.5 Subdivision 1. **Families with children.** (a) Families with children with family
129.6 income equal to or less than 275 percent of the federal poverty guidelines for the
129.7 applicable family size shall be eligible for MinnesotaCare according to this section. All
129.8 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
129.9 to enrollment under section 256L.07, shall apply unless otherwise specified.

129.10 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
129.11 if the children are eligible. Children may be enrolled separately without enrollment by
129.12 parents. However, if one parent in the household enrolls, both parents must enroll, unless
129.13 other insurance is available. If one child from a family is enrolled, all children must
129.14 be enrolled, unless other insurance is available. If one spouse in a household enrolls,
129.15 the other spouse in the household must also enroll, unless other insurance is available.
129.16 Families cannot choose to enroll only certain uninsured members.

129.17 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies
129.18 to the MinnesotaCare program. These persons are no longer counted in the parental
129.19 household and may apply as a separate household.

129.20 (d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are
129.21 not eligible for MinnesotaCare if their gross income exceeds \$57,500.

129.22 (e) Children formerly enrolled in medical assistance and automatically deemed
129.23 eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt
129.24 from the requirements of this section until renewal.

129.25 (f) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision
129.26 8, are exempt from the eligibility requirements of this subdivision.

129.27 Sec. 56. Minnesota Statutes 2008, section 256L.04, is amended by adding a subdivision
129.28 to read:

129.29 Subd. 1b. **Children with family income greater than 275 percent of federal**
129.30 **poverty guidelines.** Children with family income greater than 275 percent of federal
129.31 poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All
129.32 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
129.33 to enrollment under section 256L.07, shall apply unless otherwise specified.

130.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
130.2 approval, whichever is later.

130.3 Sec. 57. Minnesota Statutes 2008, section 256L.04, subdivision 7a, is amended to read:

130.4 Subd. 7a. **Ineligibility.** ~~Applicants~~ Adults whose income is greater than the limits
130.5 established under this section may not enroll in the MinnesotaCare program.

130.6 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
130.7 approval, whichever is later.

130.8 Sec. 58. Minnesota Statutes 2008, section 256L.04, subdivision 10a, is amended to
130.9 read:

130.10 Subd. 10a. **Sponsor's income and resources deemed available; documentation.**

130.11 When determining eligibility for any federal or state benefits under sections 256L.01 to
130.12 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of
130.13 support as defined under United States Code, title 8, section 1183a, shall be deemed to
130.14 include their sponsors' income and resources as defined in the Personal Responsibility
130.15 and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections
130.16 421 and 422, and subsequently set out in federal rules. To be eligible for the program,
130.17 noncitizens must provide documentation of their immigration status. Beginning July
130.18 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply
130.19 to pregnant women and children who are qualified noncitizens, as described in section
130.20 256B.06, subdivision 4, paragraph (b).

130.21 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
130.22 approval, whichever is later. The commissioner shall notify the revisor of statutes when
130.23 federal approval has been obtained.

130.24 Sec. 59. Minnesota Statutes 2008, section 256L.05, subdivision 1, is amended to read:

130.25 Subdivision 1. **Application assistance and information availability. (a)**
130.26 Applications and application assistance must be made available at provider offices, local
130.27 human services agencies, school districts, public and private elementary schools in which
130.28 25 percent or more of the students receive free or reduced price lunches, community health
130.29 offices, Women, Infants and Children (WIC) program sites, Head Start program sites,
130.30 public housing councils, crisis nurseries, child care centers, early childhood education
130.31 and preschool program sites, legal aid offices, and libraries. These sites may accept
130.32 applications and forward the forms to the commissioner or local county human services

131.1 agencies that choose to participate as an enrollment site. Otherwise, applicants may apply
131.2 directly to the commissioner or to participating local county human services agencies.

131.3 (b) Application assistance must be available for applicants choosing to file an
131.4 online application.

131.5 Sec. 60. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
131.6 to read:

131.7 Subd. 1c. **Open enrollment and streamlined application and enrollment**
131.8 **process.** (a) The commissioner and local agencies working in partnership must develop a
131.9 streamlined and efficient application and enrollment process for medical assistance and
131.10 MinnesotaCare enrollees that meets the criteria specified in this subdivision.

131.11 (b) The commissioners of human services and education shall provide
131.12 recommendations to the legislature by January 15, 2010, on the creation of an open
131.13 enrollment process for medical assistance and MinnesotaCare that is coordinated with
131.14 the public education system. The recommendations must:

131.15 (1) be developed in consultation with medical assistance and MinnesotaCare
131.16 enrollees and representatives from organizations that advocate on behalf of children and
131.17 families, low-income persons and minority populations, counties, school administrators
131.18 and nurses, health plans, and health care providers;

131.19 (2) be based on enrollment and renewal procedures best practices, including express
131.20 lane eligibility as required under subdivision 1d;

131.21 (3) simplify the enrollment and renewal processes wherever possible; and

131.22 (4) establish a process:

131.23 (i) to disseminate information on medical assistance and MinnesotaCare to all
131.24 children in the public education system, including prekindergarten programs; and

131.25 (ii) for the commissioner of human services to enroll children and other household
131.26 members who are eligible.

131.27 The commissioner of human services in coordination with the commissioner of
131.28 education shall implement an open enrollment process by August 1, 2010, to be effective
131.29 beginning with the 2010-2011 school year.

131.30 (c) The commissioner and local agencies shall develop an online application process
131.31 for medical assistance and MinnesotaCare.

131.32 (d) The commissioner shall develop an application that is easily understandable
131.33 and does not exceed four pages in length.

132.1 (e) The commissioner of human services shall present to the legislature, by January
132.2 15, 2010, an implementation plan for the open enrollment period and online application
132.3 process.

132.4 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
132.5 approval, which must be requested by the commissioner, whichever is later.

132.6 Sec. 61. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

132.7 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
132.8 first day of the month following the month in which eligibility is approved and the first
132.9 premium payment has been received. As provided in section 256B.057, coverage for
132.10 newborns is automatic from the date of birth and must be coordinated with other health
132.11 coverage. The effective date of coverage for eligible newly adoptive children added to a
132.12 family receiving covered health services is the month of placement. The effective date
132.13 of coverage for other new members added to the family is the first day of the month
132.14 following the month in which the change is reported. All eligibility criteria must be met
132.15 by the family at the time the new family member is added. The income of the new family
132.16 member is included with the family's gross income and the adjusted premium begins in
132.17 the month the new family member is added.

132.18 (b) The initial premium must be received by the last working day of the month for
132.19 coverage to begin the first day of the following month.

132.20 (c) Benefits are not available until the day following discharge if an enrollee is
132.21 hospitalized on the first day of coverage.

132.22 (d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
132.23 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
132.24 person may have coverage and the commissioner shall use cost avoidance techniques to
132.25 ensure coordination of any other health coverage for eligible persons. The commissioner
132.26 shall identify eligible persons who may have coverage or benefits under other plans of
132.27 insurance or who become eligible for medical assistance.

132.28 (e) The effective date of coverage for single adults and households with no children
132.29 formerly enrolled in general assistance medical care and enrolled in MinnesotaCare
132.30 according to section 256D.03, subdivision 3, is the first day of the month following the
132.31 last day of general assistance medical care coverage.

132.32 (f) The effective date of coverage for children eligible under section 256L.07,
132.33 subdivision 8, is the first day of the month following the date of termination from foster
132.34 care or release from a juvenile residential correctional facility.

133.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
133.2 approval, whichever is later.

133.3 Sec. 62. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

133.4 Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility
133.5 must be renewed every 12 months. The 12-month period begins in the month after the
133.6 month the application is approved.

133.7 (b) Each new period of eligibility must take into account any changes in
133.8 circumstances that impact eligibility and premium amount. An enrollee must provide all
133.9 the information needed to redetermine eligibility by the first day of the month that ends
133.10 the eligibility period. If there is no change in circumstances, the enrollee may renew
133.11 eligibility at designated locations that include community clinics and health care providers'
133.12 offices. The designated sites shall forward the renewal forms to the commissioner. The
133.13 commissioner may establish criteria and timelines for sites to forward applications to the
133.14 commissioner or county agencies. The premium for the new period of eligibility must be
133.15 received as provided in section 256L.06 in order for eligibility to continue.

133.16 (c) For single adults and households with no children formerly enrolled in general
133.17 assistance medical care and enrolled in MinnesotaCare according to section 256D.03,
133.18 subdivision 3, the first period of eligibility begins the month the enrollee submitted the
133.19 application or renewal for general assistance medical care.

133.20 (d) ~~An enrollee~~ Notwithstanding paragraph (e), an enrollee who fails to submit
133.21 renewal forms and related documentation necessary for verification of continued eligibility
133.22 in a timely manner shall remain eligible for one additional month beyond the end of the
133.23 current eligibility period before being disenrolled. The enrollee remains responsible for
133.24 MinnesotaCare premiums for the additional month.

133.25 (e) Children in families with family income equal to or below 275 percent of federal
133.26 poverty guidelines who fail to submit renewal forms and related documentation necessary
133.27 for verification of continued eligibility in a timely manner shall remain eligible for the
133.28 program. The commissioner shall use the means described in subdivision 2 or any other
133.29 means available to verify family income. If the commissioner determines that there has
133.30 been a change in income in which premium payment is required to remain enrolled, the
133.31 commissioner shall notify the family of the premium payment, and that the children
133.32 will be disenrolled if the premium payment is not received effective the first day of the
133.33 calendar month following the calendar month for which the premium is due.

133.34 (f) For children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the
133.35 first period of renewal begins the month the enrollee turns 21 years of age.

134.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
134.2 approval, whichever is later.

134.3 Sec. 63. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

134.4 Subdivision 1. **General requirements.** (a) Children enrolled in the original
134.5 children's health plan as of September 30, 1992, children who enrolled in the
134.6 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
134.7 article 4, section 17, and children who have family gross incomes that are equal to or
134.8 less than ~~150~~ 200 percent of the federal poverty guidelines are eligible without meeting
134.9 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
134.10 long as they maintain continuous coverage in the MinnesotaCare program or medical
134.11 assistance. ~~Children who apply for MinnesotaCare on or after the implementation date~~
134.12 ~~of the employer-subsidized health coverage program as described in Laws 1998, chapter~~
134.13 ~~407, article 5, section 45, who have family gross incomes that are equal to or less than 150~~
134.14 ~~percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to~~
134.15 ~~be eligible for MinnesotaCare.~~

134.16 ~~Families~~ Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1,
134.17 whose income increases above 275 percent of the federal poverty guidelines, are no longer
134.18 eligible for the program and shall be disenrolled by the commissioner. Beginning January
134.19 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision
134.20 7, whose income increases above 200 percent of the federal poverty guidelines or 250
134.21 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for
134.22 the program and shall be disenrolled by the commissioner. For persons disenrolled under
134.23 this subdivision, MinnesotaCare coverage terminates the last day of the calendar month
134.24 following the month in which the commissioner determines that the income of a family or
134.25 individual exceeds program income limits.

134.26 (b) ~~Notwithstanding paragraph (a),~~ Children may remain enrolled in MinnesotaCare
134.27 if ~~ten percent of their gross individual or gross family income as defined in section~~
134.28 ~~256L.01, subdivision 4, is less than the annual premium for a policy with a \$500~~
134.29 ~~deductible available through the Minnesota Comprehensive Health Association. Children~~
134.30 ~~who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month~~
134.31 ~~notice period from the date that ineligibility is determined before disenrollment~~ greater
134.32 than 275 percent of federal poverty guidelines. The premium for children remaining
134.33 eligible under this ~~clause~~ paragraph shall be the maximum premium determined under
134.34 section 256L.15, subdivision 2, paragraph (b).

135.1 (c) Notwithstanding ~~paragraphs~~ paragraph (a) and (b), parents are not eligible for
135.2 MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period
135.3 of eligibility.

135.4 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
135.5 approval, whichever is later.

135.6 Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

135.7 Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be
135.8 eligible, a family or individual must not have access to subsidized health coverage through
135.9 an employer and must not have had access to employer-subsidized coverage through
135.10 a current employer for 18 months prior to application or reapplication. A family or
135.11 individual whose employer-subsidized coverage is lost due to an employer terminating
135.12 health care coverage as an employee benefit during the previous 18 months is not eligible.

135.13 (b) This subdivision does not apply to a family or individual who was enrolled
135.14 in MinnesotaCare within six months or less of reapplication and who no longer has
135.15 employer-subsidized coverage due to the employer terminating health care coverage as an
135.16 employee benefit. This subdivision does not apply to children with family gross incomes
135.17 that are equal to or less than 200 percent of federal poverty guidelines.

135.18 (c) For purposes of this requirement, subsidized health coverage means health
135.19 coverage for which the employer pays at least 50 percent of the cost of coverage for
135.20 the employee or dependent, or a higher percentage as specified by the commissioner.
135.21 Children are eligible for employer-subsidized coverage through either parent, including
135.22 the noncustodial parent. The commissioner must treat employer contributions to Internal
135.23 Revenue Code Section 125 plans and any other employer benefits intended to pay
135.24 health care costs as qualified employer subsidies toward the cost of health coverage for
135.25 employees for purposes of this subdivision.

135.26 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
135.27 approval, whichever is later.

135.28 Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

135.29 Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the
135.30 MinnesotaCare program must have no health coverage while enrolled ~~or for at least four~~
135.31 ~~months prior to application and renewal.~~ Children with family gross incomes equal to or
135.32 greater than 200 percent of federal poverty guidelines, and adults, must have had no health
135.33 coverage for at least four months prior to application and renewal. Children enrolled in the
135.34 original children's health plan and children in families with income equal to or less than

136.1 ~~150~~ 200 percent of the federal poverty guidelines, who have other health insurance, are
136.2 eligible if the coverage:

136.3 (1) lacks two or more of the following:

136.4 (i) basic hospital insurance;

136.5 (ii) medical-surgical insurance;

136.6 (iii) prescription drug coverage;

136.7 (iv) dental coverage; or

136.8 (v) vision coverage;

136.9 (2) requires a deductible of \$100 or more per person per year; or

136.10 (3) lacks coverage because the child has exceeded the maximum coverage for a
136.11 particular diagnosis or the policy excludes a particular diagnosis.

136.12 The commissioner may change this eligibility criterion for sliding scale premiums
136.13 in order to remain within the limits of available appropriations. The requirement of no
136.14 health coverage does not apply to newborns.

136.15 (b) Medical assistance, general assistance medical care, and the Civilian Health and
136.16 Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under
136.17 United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or
136.18 health coverage for purposes of the four-month requirement described in this subdivision.

136.19 (c) For purposes of this subdivision, an applicant or enrollee who is entitled to
136.20 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
136.21 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to
136.22 have health coverage. An applicant or enrollee who is entitled to premium-free Medicare
136.23 Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility
136.24 for MinnesotaCare.

136.25 (d) Applicants who were recipients of medical assistance or general assistance
136.26 medical care within one month of application must meet the provisions of this subdivision
136.27 and subdivision 2.

136.28 (e) Cost-effective health insurance that was paid for by medical assistance is not
136.29 considered health coverage for purposes of the four-month requirement under this
136.30 section, except if the insurance continued after medical assistance no longer considered it
136.31 cost-effective or after medical assistance closed.

136.32 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
136.33 approval, whichever is later.

136.34 Sec. 66. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision
136.35 to read:

137.1 Subd. 8. **Automatic eligibility for certain children.** Any child who was residing
137.2 in foster care or a juvenile residential correctional facility on the child's 18th birthday is
137.3 automatically deemed eligible for MinnesotaCare upon termination or release until the
137.4 child reaches the age of 21, and is exempt from the requirements of this section and
137.5 section 256L.15. To be enrolled under this section, a child must complete an initial
137.6 application for MinnesotaCare. The commissioner shall contact individuals enrolled
137.7 under this section annually to ensure the individual continues to reside in the state and is
137.8 interested in continuing MinnesotaCare coverage.

137.9 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
137.10 approval, whichever is later.

137.11 Sec. 67. Minnesota Statutes 2008, section 256L.11, subdivision 1, is amended to read:

137.12 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under
137.13 sections 256L.01 to 256L.11 shall be at the same rates and conditions established for
137.14 medical assistance, except as provided in subdivisions 2 to 6.

137.15 (b) Effective for services provided on or after July 1, 2009, total payments for basic
137.16 care services shall be reduced by three percent, in accordance with section 256B.766.
137.17 Payments made to managed care plans shall be reduced for services provided on or after
137.18 October 1, 2009, to reflect this reduction.

137.19 Sec. 68. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

137.20 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
137.21 commissioner shall establish a sliding fee scale to determine the percentage of monthly
137.22 gross individual or family income that households at different income levels must pay to
137.23 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
137.24 on the enrollee's monthly gross individual or family income. The sliding fee scale must
137.25 contain separate tables based on enrollment of one, two, or three or more persons. Until
137.26 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
137.27 individual or family income for individuals or families with incomes below the limits for
137.28 the medical assistance program for families and children in effect on January 1, 1999, and
137.29 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
137.30 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
137.31 the medical assistance income limit for families and children in effect on January 1, 1999,
137.32 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
137.33 family size of five. The sliding fee scale for a family of five must be used for families of
137.34 more than five. The sliding fee scale and percentages are not subject to the provisions of

138.1 chapter 14. If a family or individual reports increased income after enrollment, premiums
 138.2 shall be adjusted at the time the change in income is reported.

138.3 (b) Children in families whose gross income is above 275 percent of the federal
 138.4 poverty guidelines shall pay the maximum premium. The maximum premium is defined
 138.5 as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare
 138.6 cases paid the maximum premium, the total revenue would equal the total cost of
 138.7 MinnesotaCare medical coverage and administration. In this calculation, administrative
 138.8 costs shall be assumed to equal ten percent of the total. The costs of medical coverage
 138.9 for pregnant women and children under age two and the enrollees in these groups shall
 138.10 be excluded from the total. The maximum premium for two enrollees shall be twice the
 138.11 maximum premium for one, and the maximum premium for three or more enrollees shall
 138.12 be three times the maximum premium for one.

138.13 (c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according
 138.14 to the premium scale specified in paragraph (d) with the exception that children in families
 138.15 with income at or below ~~150~~ 200 percent of the federal poverty guidelines shall pay
 138.16 ~~a monthly premium of \$4~~ no premiums. For purposes of paragraph (d), "minimum"
 138.17 means a monthly premium of \$4.

138.18 (d) The following premium scale is established for individuals and families with
 138.19 gross family incomes of 300 percent of the federal poverty guidelines or less:

138.20		Percent of Average Gross Monthly
138.21	Federal Poverty Guideline Range	Income
138.22	0-45%	minimum
138.23	46-54%	1.1%
138.24	55-81%	1.6%
138.25	82-109%	2.2%
138.26	110-136%	2.9%
138.27	137-164%	3.6%
138.28	165-191%	4.6%
138.29	192-219%	5.6%
138.30	220-248%	6.5%
138.31	249-274%	7.2%
138.32	275-300%	8.0%

139.1 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
139.2 approval, whichever is later.

139.3 Sec. 69. Minnesota Statutes 2008, section 256L.15, subdivision 3, is amended to read:

139.4 Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below
139.5 ~~150~~ 200 percent of the federal poverty guidelines shall pay a no monthly premium of
139.6 \$4 premiums.

139.7 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
139.8 approval, whichever is later.

139.9 Sec. 70. Minnesota Statutes 2008, section 256L.17, subdivision 3, is amended to read:

139.10 Subd. 3. **Documentation.** (a) The commissioner of human services shall require
139.11 individuals and families, at the time of application or renewal, to indicate on a ~~checkoff~~
139.12 form developed by the commissioner whether they satisfy the MinnesotaCare asset
139.13 requirement.

139.14 (b) The commissioner may require individuals and families to provide any
139.15 information the commissioner determines necessary to verify compliance with the asset
139.16 requirement, if the commissioner determines that there is reason to believe that an
139.17 individual or family has assets that exceed the program limit.

139.18 Sec. 71. Minnesota Statutes 2008, section 256L.17, subdivision 5, is amended to read:

139.19 Subd. 5. **Exemption.** This section does not apply to pregnant women or children.
139.20 For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

139.21 Sec. 72. Minnesota Statutes 2008, section 501B.89, is amended by adding a
139.22 subdivision to read:

139.23 Subd. 4. **Annual filing requirement for supplemental needs trusts.** (a) A trustee
139.24 of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or
139.25 (C), shall submit to the commissioner of human services, at the time of a beneficiary's
139.26 request for medical assistance, the following information about the trust:

139.27 (1) a copy of the trust instrument; and

139.28 (2) an inventory of the beneficiary's trust account assets and the value of those assets.

139.29 (b) A trustee of a trust under subdivision 3 and United States Code, title 42, section
139.30 1396p(d)(4)(A) or (C), shall submit an accounting of the beneficiary's trust account to the
139.31 commissioner of human services at least annually until the trust, or the beneficiary's
139.32 interest in the trust, terminates. Accountings are due on the anniversary of the execution

140.1 date of the trust unless another annual date is established by the terms of the trust. The
140.2 accounting must include the following information for the accounting period:

140.3 (1) an inventory of trust assets and the value of those assets at the beginning of the
140.4 accounting period;

140.5 (2) additions to the trust during the accounting period and the source of those
140.6 additions;

140.7 (3) itemized distributions from the trust during the accounting period, including the
140.8 purpose of the distributions and to whom the distributions were made;

140.9 (4) an inventory of trust assets and the value of those assets at the end of the
140.10 accounting period; and

140.11 (5) changes to the trust instrument during the accounting period.

140.12 (c) For the purpose of paragraph (b), an accounting period is 12 months unless an
140.13 accounting period of a different length is permitted by the commissioner.

140.14 **EFFECTIVE DATE.** This section is effective for applications for medical
140.15 assistance and renewals of medical assistance submitted on or after July 1, 2009.

140.16 Sec. 73. Minnesota Statutes 2008, section 519.05, is amended to read:

140.17 **519.05 LIABILITY OF HUSBAND AND WIFE.**

140.18 (a) A spouse is not liable to a creditor for any debts of the other spouse. Where
140.19 husband and wife are living together, they shall be jointly and severally liable for
140.20 necessary medical services that have been furnished to either spouse, including any claims
140.21 arising under section 246.53, 256B.15, 256D.16, or 261.04, and necessary household
140.22 articles and supplies furnished to and used by the family. Notwithstanding this paragraph,
140.23 in a proceeding under chapter 518 the court may apportion such debt between the spouses.

140.24 (b) Either spouse may close a credit card account or other unsecured consumer line
140.25 of credit on which both spouses are contractually liable, by giving written notice to the
140.26 creditor.

140.27 Sec. 74. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
140.28 1, as amended by Laws 2004, chapter 272, article 2, section 2, is amended to read:

140.29 Subdivision 1. **Total Appropriation** **\$ 3,848,049,000** **\$ 4,135,780,000**

140.30 Summary by Fund

140.31 General 3,301,811,000 3,561,055,000

141.1	State Government		
141.2	Special Revenue	534,000	534,000
141.3	Health Care Access	273,723,000	302,272,000
141.4	Federal TANF	270,425,000	270,363,000
141.5	Lottery Cash Flow	1,556,000	1,556,000

141.6 **Federal Contingency Appropriation. (a)**
 141.7 Federal Medicaid funds made available
 141.8 under title IV of the federal Jobs and Growth
 141.9 Tax Relief Reconciliation Act of 2003
 141.10 are appropriated to the commissioner of
 141.11 human services for use in the state's medical
 141.12 assistance and MinnesotaCare programs.
 141.13 The commissioners of human services and
 141.14 finance shall report to the legislative advisory
 141.15 committee on the additional federal Medicaid
 141.16 matching funds that will be available to the
 141.17 state.

141.18 (b) Because of the availability of these funds,
 141.19 the following policies shall become effective:

141.20 (1) medical assistance and MinnesotaCare
 141.21 eligibility and local financial participation
 141.22 changes provided for in this act may be
 141.23 implemented prior to September 2, 2003, or
 141.24 may be delayed as necessary to maximize
 141.25 the use of federal funds received under
 141.26 title IV of the Jobs and Growth Tax Relief
 141.27 Reconciliation Act of 2003;

141.28 (2) the aggregate cap on the services
 141.29 identified in Minnesota Statutes, section
 141.30 256L.035, paragraph (a), clause (3), shall
 141.31 be increased from \$2,000 to \$5,000. This
 141.32 increase shall expire at the end of fiscal year
 141.33 2007. Funds may be transferred from the

142.1 general fund to the health care access fund as
142.2 necessary to implement this provision; and
142.3 (3) the following payment shifts shall not be
142.4 implemented:
142.5 (i) MFIP payment shift found in subdivision
142.6 11;
142.7 (ii) the county payment shift found in
142.8 subdivision 1; and
142.9 (iii) the delay in medical assistance
142.10 and general assistance medical care
142.11 fee-for-service payments found in
142.12 subdivision 6.
142.13 (c) Notwithstanding section 14, paragraphs
142.14 (a) and (b) shall expire June 30, 2007.

142.15 **Receipts for Systems Projects.**
142.16 Appropriations and federal receipts for
142.17 information system projects for MAXIS,
142.18 PRISM, MMIS, and SSIS must be deposited
142.19 in the state system account authorized in
142.20 Minnesota Statutes, section 256.014. Money
142.21 appropriated for computer projects approved
142.22 by the Minnesota office of technology,
142.23 funded by the legislature, and approved
142.24 by the commissioner of finance may be
142.25 transferred from one project to another
142.26 and from development to operations as the
142.27 commissioner of human services considers
142.28 necessary. Any unexpended balance in
142.29 the appropriation for these projects does
142.30 not cancel but is available for ongoing
142.31 development and operations.

142.32 **Gifts.** Notwithstanding Minnesota Statutes,
142.33 chapter 7, the commissioner may accept
142.34 on behalf of the state additional funding

143.1 from sources other than state funds for the
143.2 purpose of financing the cost of assistance
143.3 program grants or nongrant administration.
143.4 All additional funding is appropriated to the
143.5 commissioner for use as designated by the
143.6 grantor of funding.

143.7 **Systems Continuity.** In the event of
143.8 disruption of technical systems or computer
143.9 operations, the commissioner may use
143.10 available grant appropriations to ensure
143.11 continuity of payments for maintaining the
143.12 health, safety, and well-being of clients
143.13 served by programs administered by the
143.14 department of human services. Grant funds
143.15 must be used in a manner consistent with the
143.16 original intent of the appropriation.

143.17 **Nonfederal Share Transfers.** The
143.18 nonfederal share of activities for which
143.19 federal administrative reimbursement is
143.20 appropriated to the commissioner may be
143.21 transferred to the special revenue fund.

143.22 **TANF Funds Appropriated to Other**
143.23 **Entities.** Any expenditures from the TANF
143.24 block grant shall be expended in accordance
143.25 with the requirements and limitations of part
143.26 A of title IV of the Social Security Act, as
143.27 amended, and any other applicable federal
143.28 requirement or limitation. Prior to any
143.29 expenditure of these funds, the commissioner
143.30 shall assure that funds are expended in
143.31 compliance with the requirements and
143.32 limitations of federal law and that any
143.33 reporting requirements of federal law are
143.34 met. It shall be the responsibility of any entity
143.35 to which these funds are appropriated to

144.1 implement a memorandum of understanding
144.2 with the commissioner that provides the
144.3 necessary assurance of compliance prior to
144.4 any expenditure of funds. The commissioner
144.5 shall receipt TANF funds appropriated
144.6 to other state agencies and coordinate all
144.7 related interagency accounting transactions
144.8 necessary to implement these appropriations.
144.9 Unexpended TANF funds appropriated to
144.10 any state, local, or nonprofit entity cancel
144.11 at the end of the state fiscal year unless
144.12 appropriating language permits otherwise.

144.13 **TANF Funds Transferred to Other Federal**
144.14 **Grants.** The commissioner must authorize
144.15 transfers from TANF to other federal block
144.16 grants so that funds are available to meet the
144.17 annual expenditure needs as appropriated.
144.18 Transfers may be authorized prior to the
144.19 expenditure year with the agreement of the
144.20 receiving entity. Transferred funds must be
144.21 expended in the year for which the funds
144.22 were appropriated unless appropriation
144.23 language permits otherwise. In accelerating
144.24 transfer authorizations, the commissioner
144.25 must aim to preserve the future potential
144.26 transfer capacity from TANF to other block
144.27 grants.

144.28 **TANF Maintenance of Effort.** (a) In
144.29 order to meet the basic maintenance of
144.30 effort (MOE) requirements of the TANF
144.31 block grant specified under Code of Federal
144.32 Regulations, title 45, section 263.1, the
144.33 commissioner may only report nonfederal
144.34 money expended for allowable activities
144.35 listed in the following clauses as TANF/MOE
144.36 expenditures:

- 145.1 (1) MFIP cash, diversionary work program,
145.2 and food assistance benefits under Minnesota
145.3 Statutes, chapter 256J;
- 145.4 (2) the child care assistance programs
145.5 under Minnesota Statutes, sections 119B.03
145.6 and 119B.05, and county child care
145.7 administrative costs under Minnesota
145.8 Statutes, section 119B.15;
- 145.9 (3) state and county MFIP administrative
145.10 costs under Minnesota Statutes, chapters
145.11 256J and 256K;
- 145.12 (4) state, county, and tribal MFIP
145.13 employment services under Minnesota
145.14 Statutes, chapters 256J and 256K;
- 145.15 (5) expenditures made on behalf of
145.16 noncitizen MFIP recipients who qualify
145.17 for the medical assistance without federal
145.18 financial participation program under
145.19 Minnesota Statutes, section 256B.06,
145.20 subdivision 4, paragraphs (d), (e), and (j);
145.21 and
- 145.22 (6) qualifying working family credit
145.23 expenditures under Minnesota Statutes,
145.24 section 290.0671.
- 145.25 (b) The commissioner shall ensure that
145.26 sufficient qualified nonfederal expenditures
145.27 are made each year to meet the state's
145.28 TANF/MOE requirements. For the activities
145.29 listed in paragraph (a), clauses (2) to
145.30 (6), the commissioner may only report
145.31 expenditures that are excluded from the
145.32 definition of assistance under Code of
145.33 Federal Regulations, title 45, section 260.31.

146.1 (c) By August 31 of each year, the
146.2 commissioner shall make a preliminary
146.3 calculation to determine the likelihood
146.4 that the state will meet its annual federal
146.5 work participation requirement under Code
146.6 of Federal Regulations, title 45, sections
146.7 261.21 and 261.23, after adjustment for any
146.8 caseload reduction credit under Code of
146.9 Federal Regulations, title 45, section 261.41.
146.10 If the commissioner determines that the
146.11 state will meet its federal work participation
146.12 rate for the federal fiscal year ending that
146.13 September, the commissioner may reduce the
146.14 expenditure under paragraph (a), clause (1),
146.15 to the extent allowed under Code of Federal
146.16 Regulations, title 45, section 263.1(a)(2).

146.17 (d) For fiscal years beginning with state
146.18 fiscal year 2003, the commissioner shall
146.19 assure that the maintenance of effort used
146.20 by the commissioner of finance for the
146.21 February and November forecasts required
146.22 under Minnesota Statutes, section 16A.103,
146.23 contains expenditures under paragraph (a),
146.24 clause (1), equal to at least 25 percent of
146.25 the total required under Code of Federal
146.26 Regulations, title 45, section 263.1.

146.27 (e) If nonfederal expenditures for the
146.28 programs and purposes listed in paragraph
146.29 (a) are insufficient to meet the state's
146.30 TANF/MOE requirements, the commissioner
146.31 shall recommend additional allowable
146.32 sources of nonfederal expenditures to the
146.33 legislature, if the legislature is or will be in
146.34 session to take action to specify additional
146.35 sources of nonfederal expenditures for
146.36 TANF/MOE before a federal penalty is

147.1 imposed. The commissioner shall otherwise
147.2 provide notice to the legislative commission
147.3 on planning and fiscal policy under paragraph
147.4 (g).

147.5 (f) If the commissioner uses authority
147.6 granted under section 11, or similar authority
147.7 granted by a subsequent legislature, to
147.8 meet the state's TANF/MOE requirement
147.9 in a reporting period, the commissioner
147.10 shall inform the chairs of the appropriate
147.11 legislative committees about all transfers
147.12 made under that authority for this purpose.

147.13 (g) If the commissioner determines that
147.14 nonfederal expenditures under paragraph
147.15 (a) are insufficient to meet TANF/MOE
147.16 expenditure requirements, and if the
147.17 legislature is not or will not be in
147.18 session to take timely action to avoid a
147.19 federal penalty, the commissioner may
147.20 report nonfederal expenditures from
147.21 other allowable sources as TANF/MOE
147.22 expenditures after the requirements of this
147.23 paragraph are met. The commissioner
147.24 may report nonfederal expenditures
147.25 in addition to those specified under
147.26 paragraph (a) as nonfederal TANF/MOE
147.27 expenditures, but only ten days after the
147.28 commissioner of finance has first submitted
147.29 the commissioner's recommendations for
147.30 additional allowable sources of nonfederal
147.31 TANF/MOE expenditures to the members of
147.32 the legislative commission on planning and
147.33 fiscal policy for their review.

147.34 (h) The commissioner of finance shall not
147.35 incorporate any changes in federal TANF

148.1 expenditures or nonfederal expenditures for
148.2 TANF/MOE that may result from reporting
148.3 additional allowable sources of nonfederal
148.4 TANF/MOE expenditures under the interim
148.5 procedures in paragraph (g) into the February
148.6 or November forecasts required under
148.7 Minnesota Statutes, section 16A.103, unless
148.8 the commissioner of finance has approved
148.9 the additional sources of expenditures under
148.10 paragraph (g).

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

148.17 (j) Notwithstanding section 14, paragraph
148.18 (a), clauses (1) to (6), and paragraphs (b) to
148.19 (j) expire June 30, 2007.

148.20 **Working Family Credit Expenditures as**
148.21 **TANF MOE.** The commissioner may claim
148.22 as TANF maintenance of effort up to the
148.23 following amounts of working family credit
148.24 expenditures for the following fiscal years:

- 148.25 (1) fiscal year 2004, \$7,013,000;
148.26 (2) fiscal year 2005, \$25,133,000;
148.27 (3) fiscal year 2006, \$6,942,000; and
148.28 (4) fiscal year 2007, \$6,707,000.

148.29 **Fiscal Year 2003 Appropriations**
148.30 **Carryforward.** Effective the day following
148.31 final enactment, notwithstanding Minnesota
148.32 Statutes, section 16A.28, or any other law to
148.33 the contrary, state agencies and constitutional
148.34 offices may carry forward unexpended

149.1 and unencumbered nongrant operating
149.2 balances from fiscal year 2003 general fund
149.3 appropriations into fiscal year 2004 to offset
149.4 general budget reductions.

149.5 **Transfer of Grant Balances.** Effective
149.6 the day following final enactment, the
149.7 commissioner of human services, with
149.8 the approval of the commissioner of
149.9 finance and after notification of the chair
149.10 of the senate health, human services and
149.11 corrections budget division and the chair
149.12 of the house of representatives health
149.13 and human services finance committee,
149.14 may transfer unencumbered appropriation
149.15 balances for the biennium ending June 30,
149.16 2003, in fiscal year 2003 among the MFIP,
149.17 MFIP child care assistance under Minnesota
149.18 Statutes, section 119B.05, general assistance,
149.19 general assistance medical care, medical
149.20 assistance, Minnesota supplemental aid,
149.21 and group residential housing programs,
149.22 and the entitlement portion of the chemical
149.23 dependency consolidated treatment fund, and
149.24 between fiscal years of the biennium.

149.25 **TANF Appropriation Cancellation.**
149.26 Notwithstanding the provisions of Laws
149.27 2000, chapter 488, article 1, section 16,
149.28 any prior appropriations of TANF funds
149.29 to the department of trade and economic
149.30 development or to the job skills partnership
149.31 board or any transfers of TANF funds from
149.32 another agency to the department of trade
149.33 and economic development or to the job
149.34 skills partnership board are not available
149.35 until expended, and if unobligated as of June

150.1 30, 2003, these appropriations or transfers
150.2 shall cancel to the TANF fund.

150.3 **Shift County Payment.** The commissioner
150.4 shall make up to 100 percent of the
150.5 calendar year 2005 payments to counties for
150.6 developmental disabilities semi-independent
150.7 living services grants, developmental
150.8 disabilities family support grants, and
150.9 adult mental health grants from fiscal year
150.10 2006 appropriations. This is a onetime
150.11 payment shift. Calendar year 2006 and future
150.12 payments for these grants are not affected by
150.13 this shift. This provision expires June 30,
150.14 2006.

150.15 **Capitation Rate Increase.** Of the health care
150.16 access fund appropriations to the University
150.17 of Minnesota in the higher education
150.18 omnibus appropriation bill, ~~\$2,157,000 in~~
150.19 ~~fiscal year 2004 and \$2,157,000 in fiscal year~~
150.20 ~~2005 are to be used to increase the capitation~~
150.21 ~~payments under~~ for fiscal years beginning
150.22 July 1, 2003, and thereafter, \$2,157,000 each
150.23 year shall be transferred to the commissioner
150.24 for purposes of Minnesota Statutes, section
150.25 256B.69. Notwithstanding the provisions of
150.26 section 14, this provision shall not expire.

150.27 Sec. 75. **ASTHMA COVERAGE DEMONSTRATION PROJECT.**

150.28 Subdivision 1. **Medical assistance coverage.** The commissioner of human services
150.29 shall establish a demonstration project to provide additional medical assistance coverage
150.30 for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth
150.31 who are burdened by health disparities associated with the cumulative health impact of
150.32 toxic environmental exposures. Under this demonstration project, the additional medical
150.33 assistance coverage for this population must include, but is not limited to, the following
150.34 durable medical equipment: high efficiency particulate air (HEPA) cleaners, HEPA
150.35 vacuum cleaners, allergy bed and pillow encasements, high filtration filters for forced air

151.1 gas furnaces, and dehumidifiers with medical tubing to connect the appliance to a floor
151.2 drain, if the listed item is medically necessary to reduce asthma symptoms. Provision
151.3 of these items must be preceded by a home environmental assessment for triggers of
151.4 asthma and in-home asthma education on the proper medical management of asthma by a
151.5 Certified Asthma Educator or public health nurse with asthma management training.

151.6 Subd. 2. **Report.** (a) Two years following implementation of the medical assistance
151.7 coverage demonstration project established under this section, the commissioner of health,
151.8 in collaboration with the Department of Human Services, must report to the legislature
151.9 on the number of asthma-related hospital admittances that occurred in the population of
151.10 children described in subdivision 1, before and after implementation of the demonstration
151.11 project, and whether the demonstration project had an impact on asthma-related school
151.12 absenteeism for this population of children.

151.13 (b) The commissioner of health must seek nonstate funding to conduct this report.
151.14 The reporting requirement is contingent upon the availability of nonstate funds.

151.15 **Sec. 76. CLAIMS AND UTILIZATION DATA.**

151.16 The commissioner of human services, in consultation with the Health Services
151.17 Policy Committee, shall develop and provide to the legislature by December 15, 2009, a
151.18 methodology and any draft legislation necessary to allow for the release, upon request, of
151.19 summary data as defined in Minnesota Statutes, section 13.02, subdivision 19, on claims
151.20 and utilization for medical assistance, general assistance medical care, and MinnesotaCare
151.21 enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical
151.22 School, Northwestern Health Sciences University, the Institute for Clinical Systems
151.23 Improvement, and other research institutions, to conduct analyses of health care outcomes
151.24 and treatment effectiveness, provided the research institutions do not release private or
151.25 nonpublic data, or data for which dissemination is prohibited by law.

151.26 **Sec. 77. ADMINISTRATION OF PUBLICLY FUNDED HEALTH CARE**
151.27 **PROGRAMS.**

151.28 (a) The commissioner of human services, in cooperation with the representatives
151.29 of county human services agencies and with input from organizations that advocate on
151.30 behalf of families and children, shall develop a plan that, to the extent feasible, seeks to
151.31 align standards, income and asset methodologies, and procedures for families and children
151.32 under medical assistance and MinnesotaCare. The commissioner shall evaluate the impact
151.33 of different approaches toward alignment on the number of potential medical assistance
151.34 and MinnesotaCare enrollees who are families and children, and on administrative, health

152.1 care, and other costs to the state. The commissioner shall present recommendations to the
152.2 legislative committees with jurisdiction over health care by September 15, 2010.

152.3 (b) The commissioner shall report in detail to the chair of the Health Care and
152.4 Human Services Finance Committee of the house of representatives and to the chair of
152.5 the Health and Human Services Division of the Finance Committee of the senate, prior
152.6 to entering into any contracts involving counties for streamlined electronic enrollment
152.7 and eligibility determinations for publicly funded health care programs, if such contracts
152.8 would require payment from either the general fund, or the health care access fund, as
152.9 described in Minnesota Statutes, sections 295.58 and 297I.05.

152.10 Sec. 78. **COBRA PREMIUM STATE SUBSIDY.**

152.11 Subdivision 1. **Eligibility.** (a) An individual and the individual's qualified
152.12 beneficiaries shall be eligible for a state premium subsidy equal to 35 percent of the
152.13 premiums the individual is required to pay for the continuation of health care coverage
152.14 under COBRA, if the individual and the individual's qualified beneficiaries:

152.15 (1) are eligible for the 65 percent COBRA continuation premium subsidy for health
152.16 care coverage under the American Recovery and Reinvestment Act of 2009;

152.17 (2) elect COBRA continuation health care coverage; and

152.18 (3) are eligible for medical assistance under Minnesota Statutes, chapter 256B;
152.19 general assistance medical care under Minnesota Statutes, section 256D.03; or
152.20 MinnesotaCare under Minnesota Statutes, chapter 256L, except for the four-month barrier
152.21 requirement under Minnesota Statutes, section 256L.07, subdivision 3.

152.22 (b) Eligibility for the state subsidy shall continue for as long as the individual
152.23 remains eligible for the COBRA premium subsidies provided under the American
152.24 Recovery and Reinvestment Act of 2009.

152.25 Subd. 2. **Subsidy.** (a) The commissioner of human services shall pay 35 percent of
152.26 the COBRA premiums that the individual must pay for continuation health care coverage
152.27 for the individual and the individual's qualified beneficiaries, if the individual and the
152.28 individual's qualified beneficiaries meet the requirements in subdivision 1.

152.29 (b) The state subsidy payment required under this section shall be made directly to
152.30 the entity to which the individual is required to make COBRA premium payments.

152.31 (c) If any eligible individual has paid either the full amount of the COBRA premiums
152.32 or 35 percent of the COBRA premiums before the date of enactment of this section, the
152.33 individual is not entitled to a reimbursement of any premium paid.

152.34 Subd. 3. **Notification.** (a) All employers and plan administrators who are required to
152.35 provide notice to all qualified individuals under the American Recovery and Reinvestment

153.1 Act of 2009 must include information to qualified individuals residing in Minnesota of
153.2 the availability of the state subsidy available under this section. The notice shall include
153.3 the eligibility requirements for the state subsidy and that the individual must apply to the
153.4 commissioner of human services to receive the state subsidy.

153.5 (b) The commissioner of employment and economic development must inform an
153.6 applicant for unemployment benefits of the availability of a state subsidy if the applicant
153.7 elects COBRA continuation coverage and the applicant meets the eligibility requirements
153.8 of this section.

153.9 Subd. 4. **Exemption.** Any individual who receives a state subsidy under this
153.10 section is exempt from the four-month requirement under Minnesota Statutes, section
153.11 256L.07, subdivision 3, if the individual or the individual's qualified beneficiaries apply
153.12 for MinnesotaCare after the individual no longer receives COBRA continuation coverage.

153.13 Subd. 5. **Expiration.** This section expires December 31, 2010.

153.14 Sec. 79. **FEDERAL APPROVAL.**

153.15 The commissioner of human services shall resubmit for federal approval the
153.16 elimination of depreciation for self-employed farmers in determining income eligibility
153.17 for MinnesotaCare passed in Laws 2007, chapter 147, article 5, section 19.

153.18 Sec. 80. **REPEALER.**

153.19 Minnesota Statutes 2008, sections 256.962, subdivision 7; and 256L.17, subdivision
153.20 6, are repealed.

153.21 **ARTICLE 6**
153.22 **TECHNICAL**

153.23 Section 1. Minnesota Statutes 2008, section 144A.46, subdivision 1, is amended to
153.24 read:

153.25 Subdivision 1. **License required.** (a) A home care provider may not operate in the
153.26 state without a current license issued by the commissioner of health. A home care provider
153.27 may hold a separate license for each class of home care licensure.

153.28 (b) Within ten days after receiving an application for a license, the commissioner
153.29 shall acknowledge receipt of the application in writing. The acknowledgment must
153.30 indicate whether the application appears to be complete or whether additional information
153.31 is required before the application will be considered complete. Within 90 days after
153.32 receiving a complete application, the commissioner shall either grant or deny the license.
153.33 If an applicant is not granted or denied a license within 90 days after submitting a

154.1 complete application, the license must be deemed granted. An applicant whose license has
154.2 been deemed granted must provide written notice to the commissioner before providing a
154.3 home care service.

154.4 (c) Each application for a home care provider license, or for a renewal of a license,
154.5 shall be accompanied by a fee to be set by the commissioner under section 144.122.

154.6 (d) The commissioner of health, in consultation with the commissioner of human
154.7 services, shall provide recommendations to the legislature by February 15, 2009, for
154.8 provider standards for personal care assistant services as described in section ~~256B.0655~~
154.9 256B.0659.

154.10 Sec. 2. Minnesota Statutes 2008, section 176.011, subdivision 9, is amended to read:

154.11 Subd. 9. **Employee.** "Employee" means any person who performs services for
154.12 another for hire including the following:

154.13 (1) an alien;

154.14 (2) a minor;

154.15 (3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and
154.16 peace officer while engaged in the enforcement of peace or in the pursuit or capture of a
154.17 person charged with or suspected of crime;

154.18 (4) a person requested or commanded to aid an officer in arresting or retaking a
154.19 person who has escaped from lawful custody, or in executing legal process, in which
154.20 cases, for purposes of calculating compensation under this chapter, the daily wage of the
154.21 person shall be the prevailing wage for similar services performed by paid employees;

154.22 (5) a county assessor;

154.23 (6) an elected or appointed official of the state, or of a county, city, town, school
154.24 district, or governmental subdivision in the state. An officer of a political subdivision
154.25 elected or appointed for a regular term of office, or to complete the unexpired portion of a
154.26 regular term, shall be included only after the governing body of the political subdivision
154.27 has adopted an ordinance or resolution to that effect;

154.28 (7) an executive officer of a corporation, except those executive officers excluded
154.29 by section 176.041;

154.30 (8) a voluntary uncompensated worker, other than an inmate, rendering services in
154.31 state institutions under the commissioners of human services and corrections similar to
154.32 those of officers and employees of the institutions, and whose services have been accepted
154.33 or contracted for by the commissioner of human services or corrections as authorized by
154.34 law. In the event of injury or death of the worker, the daily wage of the worker, for the
154.35 purpose of calculating compensation under this chapter, shall be the usual wage paid at

155.1 the time of the injury or death for similar services in institutions where the services are
155.2 performed by paid employees;

155.3 (9) a voluntary uncompensated worker engaged in emergency management as
155.4 defined in section 12.03, subdivision 4, who is:

155.5 (i) registered with the state or any political subdivision of it, according to the
155.6 procedures set forth in the state or political subdivision emergency operations plan; and

155.7 (ii) acting under the direction and control of, and within the scope of duties approved
155.8 by, the state or political subdivision.

155.9 The daily wage of the worker, for the purpose of calculating compensation under this
155.10 chapter, shall be the usual wage paid at the time of the injury or death for similar services
155.11 performed by paid employees;

155.12 (10) a voluntary uncompensated worker participating in a program established by a
155.13 local social services agency. For purposes of this clause, "local social services agency"
155.14 means any agency established under section 393.01. In the event of injury or death of the
155.15 worker, the wage of the worker, for the purpose of calculating compensation under this
155.16 chapter, shall be the usual wage paid in the county at the time of the injury or death for
155.17 similar services performed by paid employees working a normal day and week;

155.18 (11) a voluntary uncompensated worker accepted by the commissioner of natural
155.19 resources who is rendering services as a volunteer pursuant to section 84.089. The daily
155.20 wage of the worker for the purpose of calculating compensation under this chapter, shall
155.21 be the usual wage paid at the time of injury or death for similar services performed by
155.22 paid employees;

155.23 (12) a voluntary uncompensated worker in the building and construction industry
155.24 who renders services for joint labor-management nonprofit community service projects.
155.25 The daily wage of the worker for the purpose of calculating compensation under this
155.26 chapter shall be the usual wage paid at the time of injury or death for similar services
155.27 performed by paid employees;

155.28 (13) a member of the military forces, as defined in section 190.05, while in state
155.29 active service, as defined in section 190.05, subdivision 5a. The daily wage of the member
155.30 for the purpose of calculating compensation under this chapter shall be based on the
155.31 member's usual earnings in civil life. If there is no evidence of previous occupation or
155.32 earning, the trier of fact shall consider the member's earnings as a member of the military
155.33 forces;

155.34 (14) a voluntary uncompensated worker, accepted by the director of the Minnesota
155.35 Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily
155.36 wage of the worker, for the purposes of calculating compensation under this chapter,

156.1 shall be the usual wage paid at the time of injury or death for similar services performed
156.2 by paid employees;

156.3 (15) a voluntary uncompensated worker, other than a student, who renders services
156.4 at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the
156.5 Blind, and whose services have been accepted or contracted for by the commissioner of
156.6 education, as authorized by law. In the event of injury or death of the worker, the daily
156.7 wage of the worker, for the purpose of calculating compensation under this chapter, shall
156.8 be the usual wage paid at the time of the injury or death for similar services performed in
156.9 institutions by paid employees;

156.10 (16) a voluntary uncompensated worker, other than a resident of the veterans home,
156.11 who renders services at a Minnesota veterans home, and whose services have been
156.12 accepted or contracted for by the commissioner of veterans affairs, as authorized by law.
156.13 In the event of injury or death of the worker, the daily wage of the worker, for the purpose
156.14 of calculating compensation under this chapter, shall be the usual wage paid at the time of
156.15 the injury or death for similar services performed in institutions by paid employees;

156.16 (17) a worker performing services under section ~~256B.0655~~ 256B.0659 for a
156.17 recipient in the home of the recipient or in the community under section 256B.0625,
156.18 subdivision 19a, who is paid from government funds through a fiscal intermediary under
156.19 section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33. For purposes of maintaining
156.20 workers' compensation insurance, the employer of the worker is as designated in law
156.21 by the commissioner of the Department of Human Services, notwithstanding any other
156.22 law to the contrary;

156.23 (18) students enrolled in and regularly attending the Medical School of the
156.24 University of Minnesota in the graduate school program or the postgraduate program. The
156.25 students shall not be considered employees for any other purpose. In the event of the
156.26 student's injury or death, the weekly wage of the student for the purpose of calculating
156.27 compensation under this chapter, shall be the annualized educational stipend awarded to
156.28 the student, divided by 52 weeks. The institution in which the student is enrolled shall
156.29 be considered the "employer" for the limited purpose of determining responsibility for
156.30 paying benefits under this chapter;

156.31 (19) a faculty member of the University of Minnesota employed for an academic
156.32 year is also an employee for the period between that academic year and the succeeding
156.33 academic year if:

156.34 (a) the member has a contract or reasonable assurance of a contract from the
156.35 University of Minnesota for the succeeding academic year; and

157.1 (b) the personal injury for which compensation is sought arises out of and in the
157.2 course of activities related to the faculty member's employment by the University of
157.3 Minnesota;

157.4 (20) a worker who performs volunteer ambulance driver or attendant services is an
157.5 employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other
157.6 entity for which the worker performs the services. The daily wage of the worker for the
157.7 purpose of calculating compensation under this chapter shall be the usual wage paid at the
157.8 time of injury or death for similar services performed by paid employees;

157.9 (21) a voluntary uncompensated worker, accepted by the commissioner of
157.10 administration, rendering services as a volunteer at the Department of Administration. In
157.11 the event of injury or death of the worker, the daily wage of the worker, for the purpose of
157.12 calculating compensation under this chapter, shall be the usual wage paid at the time of the
157.13 injury or death for similar services performed in institutions by paid employees;

157.14 (22) a voluntary uncompensated worker rendering service directly to the Pollution
157.15 Control Agency. The daily wage of the worker for the purpose of calculating compensation
157.16 payable under this chapter is the usual going wage paid at the time of injury or death for
157.17 similar services if the services are performed by paid employees;

157.18 (23) a voluntary uncompensated worker while volunteering services as a first
157.19 responder or as a member of a law enforcement assistance organization while acting
157.20 under the supervision and authority of a political subdivision. The daily wage of the
157.21 worker for the purpose of calculating compensation payable under this chapter is the
157.22 usual going wage paid at the time of injury or death for similar services if the services
157.23 are performed by paid employees;

157.24 (24) a voluntary uncompensated member of the civil air patrol rendering service on
157.25 the request and under the authority of the state or any of its political subdivisions. The
157.26 daily wage of the member for the purposes of calculating compensation payable under this
157.27 chapter is the usual going wage paid at the time of injury or death for similar services if
157.28 the services are performed by paid employees; and

157.29 (25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in
157.30 sections 145A.04 and 145A.06, responding at the request of or engaged in training
157.31 conducted by the commissioner of health. The daily wage of the volunteer for the purposes
157.32 of calculating compensation payable under this chapter is established in section 145A.06.
157.33 A person who qualifies under this clause and who may also qualify under another clause
157.34 of this subdivision shall receive benefits in accordance with this clause.

157.35 If it is difficult to determine the daily wage as provided in this subdivision, the trier
157.36 of fact may determine the wage upon which the compensation is payable.

158.1 Sec. 3. Minnesota Statutes 2008, section 245C.03, subdivision 2, is amended to read:

158.2 Subd. 2. **Personal care provider organizations.** The commissioner shall conduct
158.3 background studies on any individual required under sections 256B.0651 ~~and 256B.0653~~
158.4 to 256B.0656 and 256B.0659 to have a background study completed under this chapter.

158.5 Sec. 4. Minnesota Statutes 2008, section 245C.04, subdivision 3, is amended to read:

158.6 Subd. 3. **Personal care provider organizations.** (a) The commissioner shall
158.7 conduct a background study of an individual required to be studied under section 245C.03,
158.8 subdivision 2, at least upon application for initial enrollment under sections 256B.0651
158.9 ~~and 256B.0653~~ to 256B.0656 and 256B.0659.

158.10 (b) Organizations required to initiate background studies under sections 256B.0651
158.11 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 for individuals described in section 245C.03,
158.12 subdivision 2, must submit a completed background study form to the commissioner
158.13 before those individuals begin a position allowing direct contact with persons served
158.14 by the organization.

158.15 Sec. 5. Minnesota Statutes 2008, section 245C.10, subdivision 3, is amended to read:

158.16 Subd. 3. **Personal care provider organizations.** The commissioner shall recover
158.17 the cost of background studies initiated by a personal care provider organization under
158.18 sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 through a fee of no
158.19 more than \$20 per study charged to the organization responsible for submitting the
158.20 background study form. The fees collected under this subdivision are appropriated to the
158.21 commissioner for the purpose of conducting background studies.

158.22 Sec. 6. Minnesota Statutes 2008, section 256B.04, subdivision 16, is amended to read:

158.23 Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in
158.24 this paragraph, the commissioner of human services and the commissioner of health shall
158.25 jointly promulgate rules to be applied to the licensure of personal care services provided
158.26 under the medical assistance program. The rules shall consider standards for personal care
158.27 services that are based on the World Institute on Disability's recommendations regarding
158.28 personal care services. These rules shall at a minimum consider the standards and
158.29 requirements adopted by the commissioner of health under section 144A.45, which the
158.30 commissioner of human services determines are applicable to the provision of personal
158.31 care services, in addition to other standards or modifications which the commissioner of
158.32 human services determines are appropriate.

159.1 The commissioner of human services shall establish an advisory group including
159.2 personal care consumers and providers to provide advice regarding which standards or
159.3 modifications should be adopted. The advisory group membership must include not less
159.4 than 15 members, of which at least 60 percent must be consumers of personal care services
159.5 and representatives of recipients with various disabilities and diagnoses and ages. At least
159.6 51 percent of the members of the advisory group must be recipients of personal care.

159.7 The commissioner of human services may contract with the commissioner of health
159.8 to enforce the jointly promulgated licensure rules for personal care service providers.

159.9 Prior to final promulgation of the joint rule the commissioner of human services
159.10 shall report preliminary findings along with any comments of the advisory group and a
159.11 plan for monitoring and enforcement by the Department of Health to the legislature by
159.12 February 15, 1992.

159.13 Limits on the extent of personal care services that may be provided to an individual
159.14 must be based on the cost-effectiveness of the services in relation to the costs of inpatient
159.15 hospital care, nursing home care, and other available types of care. The rules must
159.16 provide, at a minimum:

159.17 (1) that agencies be selected to contract with or employ and train staff to provide and
159.18 supervise the provision of personal care services;

159.19 (2) that agencies employ or contract with a qualified applicant that a qualified
159.20 recipient proposes to the agency as the recipient's choice of assistant;

159.21 (3) that agencies bill the medical assistance program for a personal care service
159.22 by a personal care assistant and supervision by a qualified professional supervising the
159.23 personal care assistant unless the recipient selects the fiscal agent option under section
159.24 ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33;

159.25 (4) that agencies establish a grievance mechanism; and

159.26 (5) that agencies have a quality assurance program.

159.27 (b) The commissioner may waive the requirement for the provision of personal care
159.28 services through an agency in a particular county, when there are less than two agencies
159.29 providing services in that county and shall waive the requirement for personal care
159.30 assistants required to join an agency for the first time during 1993 when personal care
159.31 services are provided under a relative hardship waiver under Minnesota Statutes 1992,
159.32 section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies
159.33 providing personal care services have refused to employ or contract with the independent
159.34 personal care assistant.

159.35 Sec. 7. Minnesota Statutes 2008, section 256B.055, subdivision 12, is amended to read:

160.1 Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the
160.2 person is under age 19 and qualifies as a disabled individual under United States Code,
160.3 title 42, section 1382c(a), and would be eligible for medical assistance under the state
160.4 plan if residing in a medical institution, and the child requires a level of care provided in
160.5 a hospital, nursing facility, or intermediate care facility for persons with developmental
160.6 disabilities, for whom home care is appropriate, provided that the cost to medical
160.7 assistance under this section is not more than the amount that medical assistance would pay
160.8 for if the child resides in an institution. After the child is determined to be eligible under
160.9 this section, the commissioner shall review the child's disability under United States Code,
160.10 title 42, section 1382c(a) and level of care defined under this section no more often than
160.11 annually and may elect, based on the recommendation of health care professionals under
160.12 contract with the state medical review team, to extend the review of disability and level of
160.13 care up to a maximum of four years. The commissioner's decision on the frequency of
160.14 continuing review of disability and level of care is not subject to administrative appeal
160.15 under section 256.045. The county agency shall send a notice of disability review to the
160.16 enrollee six months prior to the date the recertification of disability is due. Nothing in this
160.17 subdivision shall be construed as affecting other redeterminations of medical assistance
160.18 eligibility under this chapter and annual cost-effective reviews under this section.

160.19 (b) For purposes of this subdivision, "hospital" means an institution as defined
160.20 in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part
160.21 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this
160.22 subdivision, a child requires a level of care provided in a hospital if the child is determined
160.23 by the commissioner to need an extensive array of health services, including mental health
160.24 services, for an undetermined period of time, whose health condition requires frequent
160.25 monitoring and treatment by a health care professional or by a person supervised by a
160.26 health care professional, who would reside in a hospital or require frequent hospitalization
160.27 if these services were not provided, and the daily care needs are more complex than
160.28 a nursing facility level of care.

160.29 A child with serious emotional disturbance requires a level of care provided in a
160.30 hospital if the commissioner determines that the individual requires 24-hour supervision
160.31 because the person exhibits recurrent or frequent suicidal or homicidal ideation or
160.32 behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that
160.33 may become life threatening, recurrent or frequent severe socially unacceptable behavior
160.34 associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing
160.35 and chronic developmental problems requiring continuous skilled observation, or severe

161.1 disabling symptoms for which office-centered outpatient treatment is not adequate, and
161.2 which overall severely impact the individual's ability to function.

161.3 (c) For purposes of this subdivision, "nursing facility" means a facility which
161.4 provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to
161.5 sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative
161.6 treatment; is in need of special treatments provided or supervised by a licensed nurse; or
161.7 has unpredictable episodes of active disease processes requiring immediate judgment
161.8 by a licensed nurse. For purposes of this subdivision, a child requires the level of care
161.9 provided in a nursing facility if the child is determined by the commissioner to meet
161.10 the requirements of the preadmission screening assessment document under section
161.11 256B.0911 ~~and the home care independent rating document under section 256B.0655,~~
161.12 ~~subdivision 4, clause (3),~~ adjusted to address age-appropriate standards for children age 18
161.13 and under, ~~pursuant to section 256B.0655, subdivision 3.~~

161.14 (d) For purposes of this subdivision, "intermediate care facility for persons with
161.15 developmental disabilities" or "ICF/MR" means a program licensed to provide services to
161.16 persons with developmental disabilities under section 252.28, and chapter 245A, and a
161.17 physical plant licensed as a supervised living facility under chapter 144, which together
161.18 are certified by the Minnesota Department of Health as meeting the standards in Code of
161.19 Federal Regulations, title 42, part 483, for an intermediate care facility which provides
161.20 services for persons with developmental disabilities who require 24-hour supervision
161.21 and active treatment for medical, behavioral, or habilitation needs. For purposes of this
161.22 subdivision, a child requires a level of care provided in an ICF/MR if the commissioner
161.23 finds that the child has a developmental disability in accordance with section 256B.092,
161.24 is in need of a 24-hour plan of care and active treatment similar to persons with
161.25 developmental disabilities, and there is a reasonable indication that the child will need
161.26 ICF/MR services.

161.27 (e) For purposes of this subdivision, a person requires the level of care provided
161.28 in a nursing facility if the person requires 24-hour monitoring or supervision and a plan
161.29 of mental health treatment because of specific symptoms or functional impairments
161.30 associated with a serious mental illness or disorder diagnosis, which meet severity criteria
161.31 for mental health established by the commissioner and published in March 1997 as
161.32 the Minnesota Mental Health Level of Care for Children and Adolescents with Severe
161.33 Emotional Disorders.

161.34 (f) The determination of the level of care needed by the child shall be made by
161.35 the commissioner based on information supplied to the commissioner by the parent or
161.36 guardian, the child's physician or physicians, and other professionals as requested by the

162.1 commissioner. The commissioner shall establish a screening team to conduct the level of
162.2 care determinations according to this subdivision.

162.3 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
162.4 must assess the case to determine whether:

162.5 (1) the child qualifies as a disabled individual under United States Code, title 42,
162.6 section 1382c(a), and would be eligible for medical assistance if residing in a medical
162.7 institution; and

162.8 (2) the cost of medical assistance services for the child, if eligible under this
162.9 subdivision, would not be more than the cost to medical assistance if the child resides in a
162.10 medical institution to be determined as follows:

162.11 (i) for a child who requires a level of care provided in an ICF/MR, the cost of
162.12 care for the child in an institution shall be determined using the average payment rate
162.13 established for the regional treatment centers that are certified as ICF's/MR;

162.14 (ii) for a child who requires a level of care provided in an inpatient hospital setting
162.15 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
162.16 Rules, part 9505.3520, items F and G; and

162.17 (iii) for a child who requires a level of care provided in a nursing facility according
162.18 to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota
162.19 Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to
162.20 reflect rates which would be paid for children under age 16. The commissioner may
162.21 authorize an amount up to the amount medical assistance would pay for a child referred to
162.22 the commissioner by the preadmission screening team under section 256B.0911.

162.23 (h) Children eligible for medical assistance services under section 256B.055,
162.24 subdivision 12, as of June 30, 1995, must be screened according to the criteria in this
162.25 subdivision prior to January 1, 1996. Children found to be ineligible may not be removed
162.26 from the program until January 1, 1996.

162.27 Sec. 8. Minnesota Statutes 2008, section 256B.0621, subdivision 2, is amended to read:

162.28 Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3
162.29 to 10, the following terms have the meanings given them:

162.30 (1) "home care service recipients" means those individuals receiving the following
162.31 services under sections 256B.0651 to 256B.0656 and 256B.0659: skilled nursing visits,
162.32 home health aide visits, private duty nursing, personal care assistants, or therapies
162.33 provided through a home health agency;

163.1 (2) "home care targeted case management" means the provision of targeted case
163.2 management services for the purpose of assisting home care service recipients to gain
163.3 access to needed services and supports so that they may remain in the community;

163.4 (3) "institutions" means hospitals, consistent with Code of Federal Regulations, title
163.5 42, section 440.10; regional treatment center inpatient services, consistent with section
163.6 245.474; nursing facilities; and intermediate care facilities for persons with developmental
163.7 disabilities;

163.8 (4) "relocation targeted case management" includes the provision of both county
163.9 targeted case management and public or private vendor service coordination services
163.10 for the purpose of assisting recipients to gain access to needed services and supports if
163.11 they choose to move from an institution to the community. Relocation targeted case
163.12 management may be provided during the lesser of:

163.13 (i) the last 180 consecutive days of an eligible recipient's institutional stay; or

163.14 (ii) the limits and conditions which apply to federal Medicaid funding for this
163.15 service; and

163.16 (5) "targeted case management" means case management services provided to help
163.17 recipients gain access to needed medical, social, educational, and other services and
163.18 supports.

163.19 Sec. 9. Minnesota Statutes 2008, section 256B.0652, subdivision 3, is amended to read:

163.20 Subd. 3. **Assessment and prior authorization process.** Effective January 1, 1996,
163.21 for purposes of providing informed choice, coordinating of local planning decisions, and
163.22 streamlining administrative requirements, the assessment and prior authorization process
163.23 for persons receiving both home care and home and community-based waived services
163.24 for persons with developmental disabilities shall meet the requirements of sections
163.25 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 with the following exceptions:

163.26 (a) Upon request for home care services and subsequent assessment by the public
163.27 health nurse under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659,
163.28 the public health nurse shall participate in the screening process, as appropriate, and,
163.29 if home care services are determined to be necessary, participate in the development
163.30 of a service plan coordinating the need for home care and home and community-based
163.31 waived services with the assigned county case manager, the recipient of services, and
163.32 the recipient's legal representative, if any.

163.33 (b) The public health nurse shall give prior authorization for home care services
163.34 to the extent that home care services are:

163.35 (1) medically necessary;

164.1 (2) chosen by the recipient and their legal representative, if any, from the array of
164.2 home care and home and community-based waived services available;

164.3 (3) coordinated with other services to be received by the recipient as described
164.4 in the service plan; and

164.5 (4) provided within the county's reimbursement limits for home care and home and
164.6 community-based waived services for persons with developmental disabilities.

164.7 (c) If the public health agency is or may be the provider of home care services to the
164.8 recipient, the public health agency shall provide the commissioner of human services with
164.9 a written plan that specifies how the assessment and prior authorization process will be
164.10 held separate and distinct from the provision of services.

164.11 Sec. 10. Minnesota Statutes 2008, section 256B.0657, subdivision 2, is amended to
164.12 read:

164.13 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
164.14 who:

164.15 (1) is a recipient of medical assistance as determined under sections 256B.055,
164.16 256B.056, and 256B.057, subdivision 9;

164.17 (2) is eligible for personal care assistant services under section ~~256B.0655~~
164.18 256B.0659;

164.19 (3) lives in the person's own apartment or home, which is not owned, operated, or
164.20 controlled by a provider of services not related by blood or marriage;

164.21 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
164.22 manage the individuals providing services, and to choose and obtain items, related
164.23 services, and supports as described in the participant's plan. If the recipient is not able to
164.24 carry out these functions but has a legal guardian or parent to carry them out, the guardian
164.25 or parent may fulfill these functions on behalf of the recipient; and

164.26 (5) has not been excluded or disenrolled by the commissioner.

164.27 (b) The commissioner may disenroll or exclude recipients, including guardians and
164.28 parents, under the following circumstances:

164.29 (1) recipients who have been restricted by the Primary Care Utilization Review
164.30 Committee may be excluded for a specified time period;

164.31 (2) recipients who exit the self-directed supports option during the recipient's
164.32 service plan year shall not access the self-directed supports option for the remainder of
164.33 that service plan year; and

164.34 (3) when the department determines that the recipient cannot manage recipient
164.35 responsibilities under the program.

165.1 Sec. 11. Minnesota Statutes 2008, section 256B.0657, subdivision 6, is amended to
165.2 read:

165.3 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
165.4 option include:

- 165.5 (1) personal care assistant services under section ~~256B.0655~~ 256B.0659; and
165.6 (2) items, related services, and supports, including assistive technology, that increase
165.7 independence or substitute for human assistance to the extent expenditures would
165.8 otherwise be used for human assistance.

165.9 (b) Items, supports, and related services purchased under this option shall not be
165.10 considered home care services for the purposes of section 144A.43.

165.11 Sec. 12. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to
165.12 read:

165.13 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
165.14 self-directed service option shall be equal to the greater of either:

- 165.15 (1) the annual amount of personal care assistant services under section ~~256B.0655~~
165.16 256B.0659 that the recipient has used in the most recent 12-month period; or
165.17 (2) the amount determined using the consumer support grant methodology under
165.18 section 256.476, subdivision 11, except that the budget amount shall include the federal
165.19 and nonfederal share of the average service costs.

165.20 Sec. 13. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

165.21 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
165.22 that the average per capita expenditures estimated in any fiscal year for home and
165.23 community-based waiver recipients does not exceed the average per capita expenditures
165.24 that would have been made to provide institutional services for recipients in the absence
165.25 of the waiver.

165.26 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
165.27 need-based methods for allocating to local agencies the home and community-based
165.28 waived service resources available to support recipients with disabilities in need of
165.29 the level of care provided in a nursing facility or a hospital. The commissioner shall
165.30 allocate resources to single counties and county partnerships in a manner that reflects
165.31 consideration of:

- 165.32 (1) an incentive-based payment process for achieving outcomes;
165.33 (2) the need for a state-level risk pool;
165.34 (3) the need for retention of management responsibility at the state agency level; and

166.1 (4) a phase-in strategy as appropriate.

166.2 (c) Until the allocation methods described in paragraph (b) are implemented, the
166.3 annual allowable reimbursement level of home and community-based waiver services
166.4 shall be the greater of:

166.5 (1) the statewide average payment amount which the recipient is assigned under the
166.6 waiver reimbursement system in place on June 30, 2001, modified by the percentage of
166.7 any provider rate increase appropriated for home and community-based services; or

166.8 (2) an amount approved by the commissioner based on the recipient's extraordinary
166.9 needs that cannot be met within the current allowable reimbursement level. The
166.10 increased reimbursement level must be necessary to allow the recipient to be discharged
166.11 from an institution or to prevent imminent placement in an institution. The additional
166.12 reimbursement may be used to secure environmental modifications; assistive technology
166.13 and equipment; and increased costs for supervision, training, and support services
166.14 necessary to address the recipient's extraordinary needs. The commissioner may approve
166.15 an increased reimbursement level for up to one year of the recipient's relocation from an
166.16 institution or up to six months of a determination that a current waiver recipient is at
166.17 imminent risk of being placed in an institution.

166.18 (d) Beginning July 1, 2001, medically necessary private duty nursing services
166.19 will be authorized under this section as complex and regular care according to sections
166.20 ~~256B.0651 and 256B.0653~~ to 256B.0656 and 256B.0659. The rate established by the
166.21 commissioner for registered nurse or licensed practical nurse services under any home and
166.22 community-based waiver as of January 1, 2001, shall not be reduced.

166.23 Sec. 14. Minnesota Statutes 2008, section 256B.501, subdivision 4a, is amended to
166.24 read:

166.25 Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner
166.26 shall adjust the limits of the established average daily reimbursement rates for waived
166.27 services to include the cost of home care services that may be provided to waived
166.28 services recipients. This adjustment must be used to maintain or increase services and
166.29 shall not be used by county agencies for inflation increases for waived services vendors.
166.30 Home care services referenced in this section are those listed in section 256B.0651,
166.31 subdivision 2. The average daily reimbursement rates established in accordance with
166.32 the provisions of this subdivision apply only to the combined average, daily costs of
166.33 waived and home care services and do not change home care limitations under sections
166.34 ~~256B.0651 and 256B.0653~~ to 256B.0656 and 256B.0659. Waivered services recipients

167.1 receiving home care as of June 30, 1992, shall not have the amount of their services
167.2 reduced as a result of this section.

167.3 Sec. 15. Minnesota Statutes 2008, section 256G.02, subdivision 6, is amended to read:

167.4 Subd. 6. **Excluded time.** "Excluded time" means:

167.5 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
167.6 other than an emergency shelter, halfway house, foster home, semi-independent living
167.7 domicile or services program, residential facility offering care, board and lodging facility
167.8 or other institution for the hospitalization or care of human beings, as defined in section
167.9 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
167.10 or correctional facility; or any facility based on an emergency hold under sections
167.11 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

167.12 (b) any period an applicant spends on a placement basis in a training and habilitation
167.13 program, including a rehabilitation facility or work or employment program as defined
167.14 in section 268A.01; or receiving personal care assistant services pursuant to section
167.15 ~~256B.0655, subdivision 2~~ 256B.0659; semi-independent living services provided under
167.16 section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and
167.17 habilitation programs and assisted living services; and

167.18 (c) any placement for a person with an indeterminate commitment, including
167.19 independent living.

167.20 Sec. 16. Minnesota Statutes 2008, section 256I.05, subdivision 1a, is amended to read:

167.21 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section
167.22 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37
167.23 for other services necessary to provide room and board provided by the group residence
167.24 if the residence is licensed by or registered by the Department of Health, or licensed by
167.25 the Department of Human Services to provide services in addition to room and board,
167.26 and if the provider of services is not also concurrently receiving funding for services for
167.27 a recipient under a home and community-based waiver under title XIX of the Social
167.28 Security Act; or funding from the medical assistance program under section ~~256B.0655,~~
167.29 ~~subdivision 2~~ 256B.0659, for personal care services for residents in the setting; or residing
167.30 in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000.
167.31 If funding is available for other necessary services through a home and community-based
167.32 waiver, or personal care services under section ~~256B.0655, subdivision 2~~ 256B.0659,
167.33 then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided
167.34 in law, in no case may the supplementary service rate exceed \$426.37. The registration

168.1 and licensure requirement does not apply to establishments which are exempt from state
168.2 licensure because they are located on Indian reservations and for which the tribe has
168.3 prescribed health and safety requirements. Service payments under this section may be
168.4 prohibited under rules to prevent the supplanting of federal funds with state funds. The
168.5 commissioner shall pursue the feasibility of obtaining the approval of the Secretary of
168.6 Health and Human Services to provide home and community-based waiver services under
168.7 title XIX of the Social Security Act for residents who are not eligible for an existing home
168.8 and community-based waiver due to a primary diagnosis of mental illness or chemical
168.9 dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

168.19 Sec. 17. Minnesota Statutes 2008, section 256J.45, subdivision 3, is amended to read:

168.20 Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county
168.21 agency shall not impose the sanction under section 256J.46 if it determines that the
168.22 participant has good cause for failing to attend orientation. Good cause exists when:

168.23 (1) appropriate child care is not available;

168.24 (2) the participant is ill or injured;

168.25 (3) a family member is ill and needs care by the participant that prevents the
168.26 participant from attending orientation. For a caregiver with a child or adult in the
168.27 household who meets the disability or medical criteria for home care services under
168.28 section ~~256B.0655, subdivision 1~~ 256B.0659, or a home and community-based waiver
168.29 services program under chapter 256B, or meets the criteria for severe emotional
168.30 disturbance under section 245.4871, subdivision 6, or for serious and persistent mental
168.31 illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when
168.32 an interruption in the provision of those services occurs which prevents the participant
168.33 from attending orientation;

168.34 (4) the caregiver is unable to secure necessary transportation;

168.35 (5) the caregiver is in an emergency situation that prevents orientation attendance;

169.1 (6) the orientation conflicts with the caregiver's work, training, or school schedule; or
169.2 (7) the caregiver documents other verifiable impediments to orientation attendance
169.3 beyond the caregiver's control.

169.4 (b) Counties must work with clients to provide child care and transportation
169.5 necessary to ensure a caregiver has every opportunity to attend orientation.

169.6 Sec. 18. Minnesota Statutes 2008, section 604A.33, subdivision 1, is amended to read:

169.7 Subdivision 1. **Application.** This section applies to residential treatment programs
169.8 for children or group homes for children licensed under chapter 245A, residential
169.9 services and programs for juveniles licensed under section 241.021, providers licensed
169.10 pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care
169.11 provider organizations under section ~~256B.0655, subdivision 1~~ 256B.0659, providers
169.12 of day training and habilitation services under sections 252.40 to 252.46, board and
169.13 lodging facilities licensed under chapter 157, intermediate care facilities for persons with
169.14 developmental disabilities, and other facilities licensed to provide residential services to
169.15 persons with developmental disabilities.

169.16 Sec. 19. Minnesota Statutes 2008, section 609.232, subdivision 11, is amended to read:

169.17 Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
169.18 age or older who:

169.19 (1) is a resident inpatient of a facility;

169.20 (2) receives services at or from a facility required to be licensed to serve adults
169.21 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
169.22 treatment of chemical dependency or mental illness, or one who is committed as a sexual
169.23 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
169.24 considered a vulnerable adult unless the person meets the requirements of clause (4);

169.25 (3) receives services from a home care provider required to be licensed under section
169.26 144A.46; or from a person or organization that exclusively offers, provides, or arranges
169.27 for personal care assistant services under the medical assistance program as authorized
169.28 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
169.29 ~~256B.0653~~ to 256B.0656 and 256B.0659; or

169.30 (4) regardless of residence or whether any type of service is received, possesses a
169.31 physical or mental infirmity or other physical, mental, or emotional dysfunction:

169.32 (i) that impairs the individual's ability to provide adequately for the individual's
169.33 own care without assistance, including the provision of food, shelter, clothing, health
169.34 care, or supervision; and

170.1 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
170.2 has an impaired ability to protect the individual from maltreatment.

170.3 Sec. 20. Minnesota Statutes 2008, section 626.5572, subdivision 6, is amended to read:

170.4 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be
170.5 licensed under sections 144.50 to 144.58; a nursing home required to be licensed to
170.6 serve adults under section 144A.02; a residential or nonresidential facility required to
170.7 be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider
170.8 licensed or required to be licensed under section 144A.46; a hospice provider licensed
170.9 under sections 144A.75 to 144A.755; or a person or organization that exclusively offers,
170.10 provides, or arranges for personal care assistant services under the medical assistance
170.11 program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision
170.12 19a, 256B.0651, ~~and 256B.0653~~ to 256B.0656, and 256B.0659.

170.13 (b) For home care providers and personal care attendants, the term "facility" refers
170.14 to the provider or person or organization that exclusively offers, provides, or arranges for
170.15 personal care services, and does not refer to the client's home or other location at which
170.16 services are rendered.

170.17 Sec. 21. Minnesota Statutes 2008, section 626.5572, subdivision 21, is amended to
170.18 read:

170.19 Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
170.20 age or older who:

170.21 (1) is a resident or inpatient of a facility;

170.22 (2) receives services at or from a facility required to be licensed to serve adults
170.23 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
170.24 treatment of chemical dependency or mental illness, or one who is served in the Minnesota
170.25 sex offender program on a court-hold order for commitment, or is committed as a sexual
170.26 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
170.27 considered a vulnerable adult unless the person meets the requirements of clause (4);

170.28 (3) receives services from a home care provider required to be licensed under section
170.29 144A.46; or from a person or organization that exclusively offers, provides, or arranges
170.30 for personal care assistant services under the medical assistance program as authorized
170.31 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
170.32 256B.0653 to 256B.0656, and 256B.0659; or

170.33 (4) regardless of residence or whether any type of service is received, possesses a
170.34 physical or mental infirmity or other physical, mental, or emotional dysfunction:

171.1 (i) that impairs the individual's ability to provide adequately for the individual's
171.2 own care without assistance, including the provision of food, shelter, clothing, health
171.3 care, or supervision; and

171.4 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
171.5 has an impaired ability to protect the individual from maltreatment.

171.6 ARTICLE 7

171.7 CHEMICAL AND MENTAL HEALTH

171.8 Section 1. Minnesota Statutes 2008, section 245.462, subdivision 18, is amended to
171.9 read:

171.10 Subd. 18. **Mental health professional.** "Mental health professional" means a
171.11 person providing clinical services in the treatment of mental illness who is qualified in at
171.12 least one of the following ways:

171.13 (1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171
171.14 to 148.285; and:

171.15 (i) who is certified as a clinical specialist or as a nurse practitioner in adult or family
171.16 psychiatric and mental health nursing by a national nurse certification organization; or

171.17 (ii) who has a master's degree in nursing or one of the behavioral sciences or related
171.18 fields from an accredited college or university or its equivalent, with at least 4,000 hours
171.19 of post-master's supervised experience in the delivery of clinical services in the treatment
171.20 of mental illness;

171.21 (2) in clinical social work: a person licensed as an independent clinical social worker
171.22 under chapter 148D, or a person with a master's degree in social work from an accredited
171.23 college or university, with at least 4,000 hours of post-master's supervised experience in
171.24 the delivery of clinical services in the treatment of mental illness;

171.25 (3) in psychology: an individual licensed by the Board of Psychology under sections
171.26 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis
171.27 and treatment of mental illness;

171.28 (4) in psychiatry: a physician licensed under chapter 147 and certified by the
171.29 American Board of Psychiatry and Neurology or eligible for board certification in
171.30 psychiatry;

171.31 (5) in marriage and family therapy: the mental health professional must be a
171.32 marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least
171.33 two years of post-master's supervised experience in the delivery of clinical services in
171.34 the treatment of mental illness; ~~or~~

172.1 (6) in licensed professional clinical counseling, the mental health professional
172.2 shall be a licensed professional clinical counselor under section 148B.5301 with at least
172.3 4,000 hours of postmaster's supervised experience in the delivery of clinical services in
172.4 the treatment of mental illness; or

172.5 (7) in allied fields: a person with a master's degree from an accredited college or
172.6 university in one of the behavioral sciences or related fields, with at least 4,000 hours of
172.7 post-master's supervised experience in the delivery of clinical services in the treatment of
172.8 mental illness.

172.9 Sec. 2. Minnesota Statutes 2008, section 245.470, subdivision 1, is amended to read:

172.10 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide
172.11 or contract for enough outpatient services within the county to meet the needs of adults
172.12 with mental illness residing in the county. Services may be provided directly by the
172.13 county through county-operated mental health centers or mental health clinics approved
172.14 by the commissioner under section 245.69, subdivision 2; by contract with privately
172.15 operated mental health centers or mental health clinics approved by the commissioner
172.16 under section 245.69, subdivision 2; by contract with hospital mental health outpatient
172.17 programs certified by the Joint Commission on Accreditation of Hospital Organizations;
172.18 or by contract with a licensed mental health professional as defined in section 245.462,
172.19 subdivision 18, clauses (1) to ~~(4)~~ (6). Clients may be required to pay a fee according to
172.20 section 245.481. Outpatient services include:

- 172.21 (1) conducting diagnostic assessments;
172.22 (2) conducting psychological testing;
172.23 (3) developing or modifying individual treatment plans;
172.24 (4) making referrals and recommending placements as appropriate;
172.25 (5) treating an adult's mental health needs through therapy;
172.26 (6) prescribing and managing medication and evaluating the effectiveness of
172.27 prescribed medication; and

172.28 (7) preventing placement in settings that are more intensive, costly, or restrictive
172.29 than necessary and appropriate to meet client needs.

172.30 (b) County boards may request a waiver allowing outpatient services to be provided
172.31 in a nearby trade area if it is determined that the client can best be served outside the
172.32 county.

172.33 Sec. 3. Minnesota Statutes 2008, section 245.4871, subdivision 27, is amended to read:

173.1 Subd. 27. **Mental health professional.** "Mental health professional" means a
173.2 person providing clinical services in the diagnosis and treatment of children's emotional
173.3 disorders. A mental health professional must have training and experience in working with
173.4 children consistent with the age group to which the mental health professional is assigned.
173.5 A mental health professional must be qualified in at least one of the following ways:

173.6 (1) in psychiatric nursing, the mental health professional must be a registered nurse
173.7 who is licensed under sections 148.171 to 148.285 and who is certified as a clinical
173.8 specialist in child and adolescent psychiatric or mental health nursing by a national nurse
173.9 certification organization or who has a master's degree in nursing or one of the behavioral
173.10 sciences or related fields from an accredited college or university or its equivalent, with
173.11 at least 4,000 hours of post-master's supervised experience in the delivery of clinical
173.12 services in the treatment of mental illness;

173.13 (2) in clinical social work, the mental health professional must be a person licensed
173.14 as an independent clinical social worker under chapter 148D, or a person with a master's
173.15 degree in social work from an accredited college or university, with at least 4,000 hours of
173.16 post-master's supervised experience in the delivery of clinical services in the treatment
173.17 of mental disorders;

173.18 (3) in psychology, the mental health professional must be an individual licensed by
173.19 the board of psychology under sections 148.88 to 148.98 who has stated to the board of
173.20 psychology competencies in the diagnosis and treatment of mental disorders;

173.21 (4) in psychiatry, the mental health professional must be a physician licensed under
173.22 chapter 147 and certified by the American board of psychiatry and neurology or eligible
173.23 for board certification in psychiatry;

173.24 (5) in marriage and family therapy, the mental health professional must be a
173.25 marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least
173.26 two years of post-master's supervised experience in the delivery of clinical services in the
173.27 treatment of mental disorders or emotional disturbances; ~~or~~

173.28 (6) in licensed professional clinical counseling, the mental health professional shall
173.29 be a licensed professional clinical counselor under section 148B.5301 with at least 4,000
173.30 hours of postmaster's supervised experience in the delivery of clinical services in the
173.31 treatment of mental disorders or emotional disturbances; or

173.32 (7) in allied fields, the mental health professional must be a person with a master's
173.33 degree from an accredited college or university in one of the behavioral sciences or related
173.34 fields, with at least 4,000 hours of post-master's supervised experience in the delivery of
173.35 clinical services in the treatment of emotional disturbances.

174.1 Sec. 4. Minnesota Statutes 2008, section 245.488, subdivision 1, is amended to read:

174.2 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide
174.3 or contract for enough outpatient services within the county to meet the needs of each
174.4 child with emotional disturbance residing in the county and the child's family. Services
174.5 may be provided directly by the county through county-operated mental health centers or
174.6 mental health clinics approved by the commissioner under section 245.69, subdivision 2;
174.7 by contract with privately operated mental health centers or mental health clinics approved
174.8 by the commissioner under section 245.69, subdivision 2; by contract with hospital
174.9 mental health outpatient programs certified by the Joint Commission on Accreditation
174.10 of Hospital Organizations; or by contract with a licensed mental health professional as
174.11 defined in section 245.4871, subdivision 27, clauses (1) to ~~(4)~~ (6). A child or a child's
174.12 parent may be required to pay a fee based in accordance with section 245.481. Outpatient
174.13 services include:

- 174.14 (1) conducting diagnostic assessments;
- 174.15 (2) conducting psychological testing;
- 174.16 (3) developing or modifying individual treatment plans;
- 174.17 (4) making referrals and recommending placements as appropriate;
- 174.18 (5) treating the child's mental health needs through therapy; and
- 174.19 (6) prescribing and managing medication and evaluating the effectiveness of
174.20 prescribed medication.

174.21 (b) County boards may request a waiver allowing outpatient services to be provided
174.22 in a nearby trade area if it is determined that the child requires necessary and appropriate
174.23 services that are only available outside the county.

174.24 (c) Outpatient services offered by the county board to prevent placement must be at
174.25 the level of treatment appropriate to the child's diagnostic assessment.

174.26 Sec. 5. Minnesota Statutes 2008, section 254A.02, is amended by adding a subdivision
174.27 to read:

174.28 Subd. 8a. **Placing authority.** "Placing authority" means a county, prepaid health
174.29 plan, or tribal governing board governed by Minnesota Rules, parts 9530.6600 to
174.30 9530.6655.

174.31 Sec. 6. Minnesota Statutes 2008, section 254A.16, is amended by adding a subdivision
174.32 to read:

174.33 Subd. 6. **Monitoring.** The commissioner shall gather and placing authorities shall
174.34 provide information to measure compliance with Minnesota Rules, parts 9530.6600 to

175.1 9530.6655. The commissioner shall specify the format for data collection to facilitate
175.2 tracking, aggregating, and using the information.

175.3 Sec. 7. Minnesota Statutes 2008, section 254B.03, subdivision 1, is amended to read:

175.4 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
175.5 dependency services to persons residing within its jurisdiction who meet criteria
175.6 established by the commissioner for placement in a chemical dependency residential or
175.7 nonresidential treatment service. Chemical dependency money must be administered
175.8 by the local agencies according to law and rules adopted by the commissioner under
175.9 sections 14.001 to 14.69.

175.10 (b) In order to contain costs, ~~the county board shall, with the approval of the~~
175.11 ~~commissioner of human services;~~ shall select eligible vendors of chemical dependency
175.12 services who can provide economical and appropriate treatment. Unless the local agency
175.13 is a social services department directly administered by a county or human services board,
175.14 the local agency shall not be an eligible vendor under section 254B.05. The commissioner
175.15 may approve proposals from county boards to provide services in an economical manner
175.16 or to control utilization, with safeguards to ensure that necessary services are provided.
175.17 If a county implements a demonstration or experimental medical services funding plan,
175.18 the commissioner shall transfer the money as appropriate. ~~If a county selects a vendor~~
175.19 ~~located in another state, the county shall ensure that the vendor is in compliance with the~~
175.20 ~~rules governing licensure of programs located in the state.~~

175.21 (c) A culturally specific vendor that provides assessments under a variance under
175.22 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
175.23 persons not covered by the variance.

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

175.25 Sec. 8. Minnesota Statutes 2008, section 254B.03, subdivision 3, is amended to read:

175.26 Subd. 3. **Local agencies to pay state for county share.** Local agencies shall pay
175.27 the state for the county share of the services authorized by the local agency, except when
175.28 the payment is made according to section 254B.09, subdivision 8.

175.29 Sec. 9. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
175.30 to read:

175.31 Subd. 9. **Commissioner to select vendors and set rates.** (a) Effective July 1, 2011,
175.32 the commissioner shall:

175.33 (1) enter into agreements with eligible vendors that:

- 176.1 (i) meet the standards in section 254B.05, subdivision 1;
176.2 (ii) have good standing in all applicable licensure; and
176.3 (iii) have a current approved provider agreement as a Minnesota health care program
176.4 provider; and
176.5 (2) set rates for services reimbursed under this chapter.
176.6 (b) When setting rates, the commissioner shall consider the complexity and the
176.7 acuity of the problems presented by the client.
176.8 (c) When rates set under this section and rates set under section 254B.09, subdivision
176.9 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

176.10 Sec. 10. Minnesota Statutes 2008, section 254B.05, subdivision 1, is amended to read:

176.11 Subdivision 1. **Licensure required.** Programs licensed by the commissioner are
176.12 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
176.13 notwithstanding the provisions of section 245A.03. American Indian programs located on
176.14 federally recognized tribal lands that provide chemical dependency primary treatment,
176.15 extended care, transitional residence, or outpatient treatment services, and are licensed by
176.16 tribal government are eligible vendors. Detoxification programs are not eligible vendors.
176.17 Programs that are not licensed as a chemical dependency residential or nonresidential
176.18 treatment program by the commissioner or by tribal government are not eligible vendors.
176.19 To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund,
176.20 a vendor of a chemical dependency service must participate in the Drug and Alcohol
176.21 Abuse Normative Evaluation System and the treatment accountability plan.

176.22 Effective January 1, 2000, vendors of room and board are eligible for chemical
176.23 dependency fund payment if the vendor:

- 176.24 (1) ~~is certified by the county or tribal governing body as having~~ has rules prohibiting
176.25 residents bringing chemicals into the facility or using chemicals while residing in the
176.26 facility and provide consequences for infractions of those rules;
176.27 (2) has a current contract with a county or tribal governing body;
176.28 (3) is determined to meet applicable health and safety requirements;
176.29 (4) is not a jail or prison; and
176.30 (5) is not concurrently receiving funds under chapter 256I for the recipient.

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

176.32 Sec. 11. Minnesota Statutes 2008, section 254B.09, subdivision 2, is amended to read:

176.33 Subd. 2. **American Indian agreements.** The commissioner may enter into
176.34 agreements with federally recognized tribal units to pay for chemical dependency

177.1 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The
177.2 agreements must clarify how the governing body of the tribal unit fulfills local agency
177.3 responsibilities regarding:

177.4 ~~(1) selection of eligible vendors under section 254B.03, subdivision 1;~~
177.5 ~~(2) negotiation of agreements that establish vendor services and rates for programs~~
177.6 ~~located on the tribal governing body's reservation;~~
177.7 ~~(3) (1) the form and manner of invoicing; and~~
177.8 ~~(4) (2) provide that only invoices for eligible vendors according to section 254B.05~~
177.9 will be included in invoices sent to the commissioner for payment, to the extent that
177.10 money allocated under subdivisions 4 and 5 is used.

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

177.12 Sec. 12. **[254B.11] MAXIMUM RATES.**

177.13 The commissioner shall publish maximum rates for vendors of the consolidated
177.14 chemical dependency treatment fund by July 1 of each year for implementation the
177.15 following January 1. Rates for calendar year 2010 must not exceed 185 percent of the
177.16 average rate on January 1, 2009, for each group of vendors with similar attributes. Unless
177.17 a new rate methodology is developed under section 254B.12, rates for services provided on
177.18 and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009,
177.19 for each group of vendors with similar attributes. Payment for services provided by Indian
177.20 Health Services or by agencies operated by Indian tribes for medical assistance-eligible
177.21 individuals must be governed by the applicable federal rate methodology.

177.22 Sec. 13. **[254B.12] RATE METHODOLOGY.**

177.23 The commissioner shall, with broad-based stakeholder input, develop a
177.24 recommendation and present a report to the 2011 legislature, including proposed
177.25 legislation for a new rate methodology for the consolidated chemical dependency
177.26 treatment fund. The new methodology must replace county-negotiated rates with a
177.27 uniform statewide methodology that must include a graduated reimbursement scale based
177.28 on the patients' level of acuity and complexity.

177.29 Sec. 14. Minnesota Statutes 2008, section 256B.0622, subdivision 2, is amended to
177.30 read:

177.31 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
177.32 meanings given them.

178.1 (a) "Intensive nonresidential rehabilitative mental health services" means adult
178.2 rehabilitative mental health services as defined in section 256B.0623, subdivision 2,
178.3 paragraph (a), except that these services are provided by a multidisciplinary staff using
178.4 a total team approach consistent with assertive community treatment, the Fairweather
178.5 Lodge treatment model, as defined by the standards established by the National Coalition
178.6 for Community Living, and other evidence-based practices, and directed to recipients with
178.7 a serious mental illness who require intensive services.

178.8 (b) "Intensive residential rehabilitative mental health services" means short-term,
178.9 time-limited services provided in a residential setting to recipients who are in need of
178.10 more restrictive settings and are at risk of significant functional deterioration if they do
178.11 not receive these services. Services are designed to develop and enhance psychiatric
178.12 stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more
178.13 independent setting. Services must be directed toward a targeted discharge date with
178.14 specified client outcomes and must be consistent with the Fairweather Lodge treatment
178.15 model as defined in paragraph (a), and other evidence-based practices.

178.16 (c) "Evidence-based practices" are nationally recognized mental health services that
178.17 are proven by substantial research to be effective in helping individuals with serious
178.18 mental illness obtain specific treatment goals.

178.19 (d) "Overnight staff" means a member of the intensive residential rehabilitative
178.20 mental health treatment team who is responsible during hours when recipients are
178.21 typically asleep.

178.22 (e) "Treatment team" means all staff who provide services under this section to
178.23 recipients. At a minimum, this includes the clinical supervisor, mental health professionals
178.24 as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~ (6); mental health
178.25 practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation
178.26 workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists
178.27 under section 256B.0615.

178.28 Sec. 15. Minnesota Statutes 2008, section 256B.0623, subdivision 5, is amended to
178.29 read:

178.30 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health
178.31 services must be provided by qualified individual provider staff of a certified provider
178.32 entity. Individual provider staff must be qualified under one of the following criteria:

178.33 (1) a mental health professional as defined in section 245.462, subdivision 18,
178.34 clauses (1) to ~~(5)~~ (6). If the recipient has a current diagnostic assessment by a licensed
178.35 mental health professional as defined in section 245.462, subdivision 18, clauses (1) to ~~(5)~~

179.1 (6), recommending receipt of adult mental health rehabilitative services, the definition of
179.2 mental health professional for purposes of this section includes a person who is qualified
179.3 under section 245.462, subdivision 18, clause ~~(6)~~ (7), and who holds a current and valid
179.4 national certification as a certified rehabilitation counselor or certified psychosocial
179.5 rehabilitation practitioner;

179.6 (2) a mental health practitioner as defined in section 245.462, subdivision 17. The
179.7 mental health practitioner must work under the clinical supervision of a mental health
179.8 professional;

179.9 (3) a certified peer specialist under section 256B.0615. The certified peer specialist
179.10 must work under the clinical supervision of a mental health professional; or

179.11 (4) a mental health rehabilitation worker. A mental health rehabilitation worker
179.12 means a staff person working under the direction of a mental health practitioner or mental
179.13 health professional and under the clinical supervision of a mental health professional in
179.14 the implementation of rehabilitative mental health services as identified in the recipient's
179.15 individual treatment plan who:

179.16 (i) is at least 21 years of age;

179.17 (ii) has a high school diploma or equivalent;

179.18 (iii) has successfully completed 30 hours of training during the past two years in all
179.19 of the following areas: recipient rights, recipient-centered individual treatment planning,
179.20 behavioral terminology, mental illness, co-occurring mental illness and substance abuse,
179.21 psychotropic medications and side effects, functional assessment, local community
179.22 resources, adult vulnerability, recipient confidentiality; and

179.23 (iv) meets the qualifications in subitem (A) or (B):

179.24 (A) has an associate of arts degree in one of the behavioral sciences or human
179.25 services, or is a registered nurse without a bachelor's degree, or who within the previous
179.26 ten years has:

179.27 (1) three years of personal life experience with serious and persistent mental illness;

179.28 (2) three years of life experience as a primary caregiver to an adult with a serious
179.29 mental illness or traumatic brain injury; or

179.30 (3) 4,000 hours of supervised paid work experience in the delivery of mental health
179.31 services to adults with a serious mental illness or traumatic brain injury; or

179.32 (B)(1) is fluent in the non-English language or competent in the culture of the
179.33 ethnic group to which at least 20 percent of the mental health rehabilitation worker's
179.34 clients belong;

179.35 (2) receives during the first 2,000 hours of work, monthly documented individual
179.36 clinical supervision by a mental health professional;

180.1 (3) has 18 hours of documented field supervision by a mental health professional
180.2 or practitioner during the first 160 hours of contact work with recipients, and at least six
180.3 hours of field supervision quarterly during the following year;

180.4 (4) has review and cosignature of charting of recipient contacts during field
180.5 supervision by a mental health professional or practitioner; and

180.6 (5) has 40 hours of additional continuing education on mental health topics during
180.7 the first year of employment.

180.8 Sec. 16. Minnesota Statutes 2008, section 256B.0624, subdivision 5, is amended to
180.9 read:

180.10 Subd. 5. **Mobile crisis intervention staff qualifications.** For provision of adult
180.11 mental health mobile crisis intervention services, a mobile crisis intervention team is
180.12 comprised of at least two mental health professionals as defined in section 245.462,
180.13 subdivision 18, clauses (1) to ~~(5)~~ (6), or a combination of at least one mental health
180.14 professional and one mental health practitioner as defined in section 245.462, subdivision
180.15 17, with the required mental health crisis training and under the clinical supervision of
180.16 a mental health professional on the team. The team must have at least two people with
180.17 at least one member providing on-site crisis intervention services when needed. Team
180.18 members must be experienced in mental health assessment, crisis intervention techniques,
180.19 and clinical decision-making under emergency conditions and have knowledge of local
180.20 services and resources. The team must recommend and coordinate the team's services
180.21 with appropriate local resources such as the county social services agency, mental health
180.22 services, and local law enforcement when necessary.

180.23 Sec. 17. Minnesota Statutes 2008, section 256B.0624, subdivision 8, is amended to
180.24 read:

180.25 Subd. 8. **Adult crisis stabilization staff qualifications.** (a) Adult mental health
180.26 crisis stabilization services must be provided by qualified individual staff of a qualified
180.27 provider entity. Individual provider staff must have the following qualifications:

180.28 (1) be a mental health professional as defined in section 245.462, subdivision 18,
180.29 clauses (1) to ~~(5)~~ (6);

180.30 (2) be a mental health practitioner as defined in section 245.462, subdivision 17.

180.31 The mental health practitioner must work under the clinical supervision of a mental health
180.32 professional; or

180.33 (3) be a mental health rehabilitation worker who meets the criteria in section
180.34 256B.0623, subdivision 5, clause (3); works under the direction of a mental health

181.1 practitioner as defined in section 245.462, subdivision 17, or under direction of a
181.2 mental health professional; and works under the clinical supervision of a mental health
181.3 professional.

181.4 (b) Mental health practitioners and mental health rehabilitation workers must have
181.5 completed at least 30 hours of training in crisis intervention and stabilization during
181.6 the past two years.

181.7 Sec. 18. Minnesota Statutes 2008, section 256B.0625, subdivision 42, is amended to
181.8 read:

181.9 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
181.10 9505.0175, subpart 28, the definition of a mental health professional shall include a person
181.11 who is qualified as specified in section 245.462, subdivision 18, ~~clause~~ clauses (5) and (6);
181.12 or 245.4871, subdivision 27, ~~clause~~ clauses (5) and (6), for the purpose of this section and
181.13 Minnesota Rules, parts 9505.0170 to 9505.0475.

181.14 Sec. 19. Minnesota Statutes 2008, section 256B.0943, subdivision 1, is amended to
181.15 read:

181.16 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
181.17 the meanings given them.

181.18 (a) "Children's therapeutic services and supports" means the flexible package of
181.19 mental health services for children who require varying therapeutic and rehabilitative
181.20 levels of intervention. The services are time-limited interventions that are delivered using
181.21 various treatment modalities and combinations of services designed to reach treatment
181.22 outcomes identified in the individual treatment plan.

181.23 (b) "Clinical supervision" means the overall responsibility of the mental health
181.24 professional for the control and direction of individualized treatment planning, service
181.25 delivery, and treatment review for each client. A mental health professional who is an
181.26 enrolled Minnesota health care program provider accepts full professional responsibility
181.27 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
181.28 and oversees or directs the supervisee's work.

181.29 (c) "County board" means the county board of commissioners or board established
181.30 under sections 402.01 to 402.10 or 471.59.

181.31 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

181.32 (e) "Culturally competent provider" means a provider who understands and can
181.33 utilize to a client's benefit the client's culture when providing services to the client. A
181.34 provider may be culturally competent because the provider is of the same cultural or

182.1 ethnic group as the client or the provider has developed the knowledge and skills through
182.2 training and experience to provide services to culturally diverse clients.

182.3 (f) "Day treatment program" for children means a site-based structured program
182.4 consisting of group psychotherapy for more than three individuals and other intensive
182.5 therapeutic services provided by a multidisciplinary team, under the clinical supervision
182.6 of a mental health professional.

182.7 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
182.8 11.

182.9 (h) "Direct service time" means the time that a mental health professional, mental
182.10 health practitioner, or mental health behavioral aide spends face-to-face with a client
182.11 and the client's family. Direct service time includes time in which the provider obtains
182.12 a client's history or provides service components of children's therapeutic services and
182.13 supports. Direct service time does not include time doing work before and after providing
182.14 direct services, including scheduling, maintaining clinical records, consulting with others
182.15 about the client's mental health status, preparing reports, receiving clinical supervision
182.16 directly related to the client's psychotherapy session, and revising the client's individual
182.17 treatment plan.

182.18 (i) "Direction of mental health behavioral aide" means the activities of a mental
182.19 health professional or mental health practitioner in guiding the mental health behavioral
182.20 aide in providing services to a client. The direction of a mental health behavioral aide
182.21 must be based on the client's individualized treatment plan and meet the requirements in
182.22 subdivision 6, paragraph (b), clause (5).

182.23 (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
182.24 15. For persons at least age 18 but under age 21, mental illness has the meaning given in
182.25 section 245.462, subdivision 20, paragraph (a).

182.26 (k) "Individual behavioral plan" means a plan of intervention, treatment, and
182.27 services for a child written by a mental health professional or mental health practitioner,
182.28 under the clinical supervision of a mental health professional, to guide the work of the
182.29 mental health behavioral aide.

182.30 (l) "Individual treatment plan" has the meaning given in section 245.4871,
182.31 subdivision 21.

182.32 (m) "Mental health professional" means an individual as defined in section 245.4871,
182.33 subdivision 27, clauses (1) to ~~(5)~~ (6), or tribal vendor as defined in section 256B.02,
182.34 subdivision 7, paragraph (b).

182.35 (n) "Preschool program" means a day program licensed under Minnesota Rules,
182.36 parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and

183.1 supports provider to provide a structured treatment program to a child who is at least 33
183.2 months old but who has not yet attended the first day of kindergarten.

183.3 (o) "Skills training" means individual, family, or group training designed to improve
183.4 the basic functioning of the child with emotional disturbance and the child's family in the
183.5 activities of daily living and community living, and to improve the social functioning of the
183.6 child and the child's family in areas important to the child's maintaining or reestablishing
183.7 residency in the community. Individual, family, and group skills training must:

183.8 (1) consist of activities designed to promote skill development of the child and the
183.9 child's family in the use of age-appropriate daily living skills, interpersonal and family
183.10 relationships, and leisure and recreational services;

183.11 (2) consist of activities that will assist the family's understanding of normal child
183.12 development and to use parenting skills that will help the child with emotional disturbance
183.13 achieve the goals outlined in the child's individual treatment plan; and

183.14 (3) promote family preservation and unification, promote the family's integration
183.15 with the community, and reduce the use of unnecessary out-of-home placement or
183.16 institutionalization of children with emotional disturbance.

183.17 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 47, is amended to
183.18 read:

183.19 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2007~~ 2011, and subject
183.20 to federal approval, medical assistance covers treatment foster care services according to
183.21 section 256B.0946.

183.22 Sec. 21. Minnesota Statutes 2008, section 256B.0943, subdivision 12, is amended to
183.23 read:

183.24 Subd. 12. **Excluded services.** The following services are not eligible for medical
183.25 assistance payment as children's therapeutic services and supports:

183.26 (1) service components of children's therapeutic services and supports
183.27 simultaneously provided by more than one provider entity unless prior authorization is
183.28 obtained;

183.29 (2) treatment by multiple providers within the same agency at the same clock time;

183.30 (3) children's therapeutic services and supports provided in violation of medical
183.31 assistance policy in Minnesota Rules, part 9505.0220;

183.32 ~~(3)~~ (4) mental health behavioral aide services provided by a personal care assistant
183.33 who is not qualified as a mental health behavioral aide and employed by a certified
183.34 children's therapeutic services and supports provider entity;

184.1 ~~(4)~~ (5) service components of CTSS that are the responsibility of a residential or
184.2 program license holder, including foster care providers under the terms of a service
184.3 agreement or administrative rules governing licensure;

184.4 ~~(5)~~ (6) adjunctive activities that may be offered by a provider entity but are not
184.5 otherwise covered by medical assistance, including:

184.6 (i) a service that is primarily recreation oriented or that is provided in a setting that
184.7 is not medically supervised. This includes sports activities, exercise groups, activities
184.8 such as craft hours, leisure time, social hours, meal or snack time, trips to community
184.9 activities, and tours;

184.10 (ii) a social or educational service that does not have or cannot reasonably be
184.11 expected to have a therapeutic outcome related to the client's emotional disturbance;

184.12 (iii) consultation with other providers or service agency staff about the care or
184.13 progress of a client;

184.14 (iv) prevention or education programs provided to the community; and

184.15 (v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and

184.16 ~~(6)~~ (7) activities that are not direct service time.

184.17 Sec. 22. Minnesota Statutes 2008, section 256B.0944, is amended by adding a
184.18 subdivision to read:

184.19 Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that,
184.20 due to geographic or other barriers, it is not feasible to provide mobile crisis intervention
184.21 services 24 hours a day, seven days a week, according to the standards in subdivision 4,
184.22 paragraph (b), clause (1), the commissioner may approve a crisis response provider based
184.23 on an alternative plan proposed by a provider entity. The alternative plan must:

184.24 (1) result in increased access and a reduction in disparities in the availability of
184.25 crisis services; and

184.26 (2) provide mobile services outside of the usual nine-to-five office hours and on
184.27 weekends and holidays.

184.28 Sec. 23. Minnesota Statutes 2008, section 256B.0947, subdivision 1, is amended to
184.29 read:

184.30 Subdivision 1. **Scope.** ~~Subject to federal approval~~ Effective November 1, 2010, and
184.31 subject to federal approval, medical assistance covers medically necessary, intensive
184.32 nonresidential rehabilitative mental health services as defined in subdivision 2, for
184.33 recipients as defined in subdivision 3, when the services are provided by an entity meeting
184.34 the standards in this section.

185.1 Sec. 24. Minnesota Statutes 2008, section 256J.08, subdivision 73a, is amended to read:

185.2 Subd. 73a. **Qualified professional.** (a) For physical illness, injury, or incapacity,
185.3 a "qualified professional" means a licensed physician, a physician's assistant, a nurse
185.4 practitioner, or a licensed chiropractor.

185.5 (b) For developmental disability and intelligence testing, a "qualified professional"
185.6 means an individual qualified by training and experience to administer the tests necessary
185.7 to make determinations, such as tests of intellectual functioning, assessments of adaptive
185.8 behavior, adaptive skills, and developmental functioning. These professionals include
185.9 licensed psychologists, certified school psychologists, or certified psychometrists working
185.10 under the supervision of a licensed psychologist.

185.11 (c) For learning disabilities, a "qualified professional" means a licensed psychologist
185.12 or school psychologist with experience determining learning disabilities.

185.13 (d) For mental health, a "qualified professional" means a licensed physician or a
185.14 qualified mental health professional. A "qualified mental health professional" means:

185.15 (1) for children, in psychiatric nursing, a registered nurse who is licensed under
185.16 sections 148.171 to 148.285, and who is certified as a clinical specialist in child
185.17 and adolescent psychiatric or mental health nursing by a national nurse certification
185.18 organization or who has a master's degree in nursing or one of the behavioral sciences
185.19 or related fields from an accredited college or university or its equivalent, with at least
185.20 4,000 hours of post-master's supervised experience in the delivery of clinical services in
185.21 the treatment of mental illness;

185.22 (2) for adults, in psychiatric nursing, a registered nurse who is licensed under
185.23 sections 148.171 to 148.285, and who is certified as a clinical specialist in adult psychiatric
185.24 and mental health nursing by a national nurse certification organization or who has a
185.25 master's degree in nursing or one of the behavioral sciences or related fields from an
185.26 accredited college or university or its equivalent, with at least 4,000 hours of post-master's
185.27 supervised experience in the delivery of clinical services in the treatment of mental illness;

185.28 (3) in clinical social work, a person licensed as an independent clinical social worker
185.29 under chapter 148D, or a person with a master's degree in social work from an accredited
185.30 college or university, with at least 4,000 hours of post-master's supervised experience in
185.31 the delivery of clinical services in the treatment of mental illness;

185.32 (4) in psychology, an individual licensed by the Board of Psychology under sections
185.33 148.88 to 148.98, who has stated to the Board of Psychology competencies in the
185.34 diagnosis and treatment of mental illness;

186.1 (5) in psychiatry, a physician licensed under chapter 147 and certified by the
186.2 American Board of Psychiatry and Neurology or eligible for board certification in
186.3 psychiatry; ~~and~~

186.4 (6) in marriage and family therapy, the mental health professional must be a
186.5 marriage and family therapist licensed under sections 148B.29 to 148B.39, with at least
186.6 two years of post-master's supervised experience in the delivery of clinical services in the
186.7 treatment of mental illness; and

186.8 (7) in licensed professional clinical counseling, the mental health professional
186.9 shall be a licensed professional clinical counselor under section 148B.5301 with at least
186.10 4,000 hours of postmaster's supervised experience in the delivery of clinical services in
186.11 the treatment of mental illness.

186.12 Sec. 25. **AUTISM SPECTRUM DISORDER TASK FORCE.**

186.13 (a) The Autism Spectrum Disorder Task Force is composed of 15 members,
186.14 appointed as follows:

186.15 (1) two members of the senate appointed by the Subcommittee on Committees of the
186.16 Committee on Rules and Administration, one of whom must be a member of the minority;

186.17 (2) two members of the house of representatives, one from the majority party,
186.18 appointed by the speaker of the house, and one from the minority party, appointed by
186.19 the minority leader;

186.20 (3) two members appointed by the legislature, with regard to geographic diversity in
186.21 the state, who are parents of children with autism spectrum disorder (ASD); one member
186.22 shall be appointed by the senate Subcommittee on Committees of the Committee on
186.23 Rules and Administration making appointments for the senate; and one member shall be
186.24 appointed by the speaker of the house making the appointments for the house;

186.25 (4) one member appointed by the Minnesota chapter of the American Academy of
186.26 Pediatrics who is a general primary care pediatrician;

186.27 (5) one member appointed by the Minnesota Academy of Family Physicians who is
186.28 a family practice physician;

186.29 (6) one member appointed by the Minnesota Psychological Association who is a
186.30 neuropsychologist;

186.31 (7) one member appointed by the directors of public school student support services;

186.32 (8) one member appointed by the Somali American Autism Foundation;

186.33 (9) one member appointed by the ARC of Minnesota;

186.34 (10) one member appointed by the Autism Society of Minnesota;

187.1 (11) one member appointed by the Parent Advocacy Coalition for Educational
187.2 Rights; and

187.3 (12) one member appointed by the Minnesota Council of Health Plans.

187.4 Appointments must be made by September 1, 2009. The Legislative Coordinating
187.5 Commission shall provide meeting space for the task force. The senate member appointed
187.6 by the minority leader of the senate shall convene the first meeting of the task force no
187.7 later than October 1, 2009. The task force shall elect a chair at the first meeting.

187.8 (b) If federal or state funding is available, the commissioners of education,
187.9 employment and economic development, health, and human services shall provide
187.10 assistance to the task force.

187.11 (c) The task force shall develop recommendations and report on the following topics:

187.12 (1) ways to improve services provided by all state and political subdivisions;

187.13 (2) sources of public and private funding available for treatment and ways to
187.14 improve efficiency in the use of these funds;

187.15 (3) methods to improve coordination in the delivery of service between public
187.16 and private agencies, health providers, and schools, and to address any geographic
187.17 discrepancies in the delivery of services;

187.18 (4) increasing the availability of and the training for medical providers and educators
187.19 who identify and provide services to individuals with ASD; and

187.20 (5) treatment options supported by peer-reviewed, established scientific research
187.21 for individuals with ASD.

187.22 (d) The task force shall coordinate with existing efforts at the Departments of
187.23 Education, Health, Human Services, and Employment and Economic Development
187.24 related to ASD.

187.25 (e) By January 15 of each year, the task force shall provide a report regarding its
187.26 findings and consideration of the topics listed under paragraph (c), and the action taken
187.27 under paragraph (d), including draft legislation if necessary, to the chairs and ranking
187.28 minority members of the legislative committees with jurisdiction over health and human
187.29 services.

187.30 (f) This section expires June 30, 2011.

187.31 **Sec. 26. STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT**
187.32 **PROJECT.**

187.33 Subdivision 1. **Establishment; purpose.** There is established a state-county
187.34 chemical health care home pilot project. The purpose of the pilot project is for the
187.35 Department of Human Services and counties to authentically and creatively work in

188.1 partnership to redesign the current chemical health service delivery system in a way
188.2 that promotes greater accountability, productivity, and results in the delivery of state
188.3 chemical dependency services. The pilot project or projects must look to provide
188.4 appropriate flexibility in a way that ensures timely access to needed services as well
188.5 as better aligning systems and services to offer the most appropriate level of chemical
188.6 health care services to the client. This may include, but is not limited to, looking into new
188.7 governance agreements, performance agreements, or service level agreements. Pilot
188.8 projects must maintain eligibility requirements for the consolidated chemical dependency
188.9 treatment fund, continue to meet the requirements of Minnesota Rules, parts 9530.6600 to
188.10 9530.6655 (also known as Rule 25) and Minnesota Rules, parts 9530.6405 to 9530.6505
188.11 (also known as Rule 31), and must not put at risk current and future federal funding toward
188.12 chemical health-related services in the state of Minnesota.

188.13 Subd. 2. **Workgroup; report.** A workgroup must be convened on or before July
188.14 15, 2009, consisting of representatives from the Department of Human Services and
188.15 potential participating counties to develop draft proposals for pilot projects meeting the
188.16 requirements of this section. The workgroup shall report back to the legislative committees
188.17 with jurisdiction over chemical health by January 15, 2010, for potential approval of one
188.18 metro and one nonmetro county pilot project to be implemented beginning July 10, 2010.

188.19 Subd. 3. **Report.** The Department of Human Services shall evaluate the efficacy and
188.20 feasibility of the pilot projects and report the results of that evaluation to the legislative
188.21 committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot
188.22 projects may occur only if the department's report finds the pilot projects effective.

188.23 Subd. 4. **Expiration.** This section expires June 30, 2012.

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

188.25 **ARTICLE 8**
188.26 **CONTINUING CARE**

188.27 Section 1. Minnesota Statutes 2008, section 144.0724, subdivision 2, is amended to
188.28 read:

188.29 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
188.30 meanings given.

188.31 (a) "Assessment reference date" means the last day of the minimum data set
188.32 observation period. The date sets the designated endpoint of the common observation
188.33 period, and all minimum data set items refer back in time from that point.

189.1 (b) "Case mix index" means the weighting factors assigned to the RUG-III
189.2 classifications.

189.3 (c) "Index maximization" means classifying a resident who could be assigned to
189.4 more than one category, to the category with the highest case mix index.

189.5 (d) "Minimum data set" means the assessment instrument specified by the Centers for
189.6 Medicare and Medicaid Services and designated by the Minnesota Department of Health.

189.7 (e) "Representative" means a person who is the resident's guardian or conservator,
189.8 the person authorized to pay the nursing home expenses of the resident, a representative
189.9 of the nursing home ombudsman's office whose assistance has been requested, or any
189.10 other individual designated by the resident.

189.11 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
189.12 facility's residents according to their clinical and functional status identified in data
189.13 supplied by the facility's minimum data set.

189.14 (g) "Activities of daily living" means grooming, dressing, bathing, transferring,
189.15 mobility, positioning, eating, and toileting.

189.16 (h) "Nursing facility level of care determination" means the assessment process
189.17 that results in a determination of a resident's or prospective resident's need for nursing
189.18 facility level of care as established in subdivision 11 for purposes of medical assistance
189.19 payment of long-term care services for:

189.20 (1) nursing facility services under section 256B.434 or 256B.441;

189.21 (2) elderly waiver services under section 256B.0915;

189.22 (3) CADI and TBI waiver services under section 256B.49; and

189.23 (4) state payment of alternative care services under section 256B.0913.

189.24 **EFFECTIVE DATE.** The section is effective January 1, 2011.

189.25 Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 4, is amended to read:

189.26 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
189.27 electronically submit to the commissioner of health case mix assessments that conform
189.28 with the assessment schedule defined by Code of Federal Regulations, title 42, section
189.29 483.20, and published by the United States Department of Health and Human Services,
189.30 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
189.31 Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made
189.32 in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0,
189.33 August 1996. The commissioner of health may substitute successor manuals or question
189.34 and answer documents published by the United States Department of Health and Human

190.1 Services, Centers for Medicare and Medicaid Services, to replace or supplement the
190.2 current version of the manual or document.

190.3 (b) The assessments used to determine a case mix classification for reimbursement
190.4 include the following:

190.5 (1) a new admission assessment must be completed by day 14 following admission;

190.6 (2) an annual assessment must be completed within 366 days of the last
190.7 comprehensive assessment;

190.8 (3) a significant change assessment must be completed within 14 days of the
190.9 identification of a significant change; and

190.10 (4) the second quarterly assessment following either a new admission assessment,
190.11 an annual assessment, or a significant change assessment, and all quarterly assessments
190.12 beginning October 1, 2006. Each quarterly assessment must be completed within 92
190.13 days of the previous assessment.

190.14 (c) In addition to the assessments listed in paragraph (b), the assessments used to
190.15 determine nursing facility level of care include the following:

190.16 (1) preadmission screening completed under section 256B.0911, subdivision 4a,
190.17 by a county, tribe, or managed care organization under contract with the Department
190.18 of Human Services; and

190.19 (2) a face-to-face long-term care consultation assessment completed under section
190.20 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization
190.21 under contract with the Department of Human Services.

190.22 **EFFECTIVE DATE.** The section is effective January 1, 2011.

190.23 Sec. 3. Minnesota Statutes 2008, section 144.0724, subdivision 8, is amended to read:

190.24 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident,
190.25 or resident's representative, or the nursing facility or boarding care home may request that
190.26 the commissioner of health reconsider the assigned reimbursement classification. The
190.27 request for reconsideration must be submitted in writing to the commissioner within
190.28 30 days of the day the resident or the resident's representative receives the resident
190.29 classification notice. The request for reconsideration must include the name of the
190.30 resident, the name and address of the facility in which the resident resides, the reasons for
190.31 the reconsideration, the requested classification changes, and documentation supporting
190.32 the requested classification. The documentation accompanying the reconsideration request
190.33 is limited to documentation which establishes that the needs of the resident at the time of
190.34 the assessment justify a classification which is different than the classification established
190.35 by the commissioner of health.

191.1 (b) Upon request, the nursing facility must give the resident or the resident's
191.2 representative a copy of the assessment form and the other documentation that was given
191.3 to the commissioner of health to support the assessment findings. The nursing facility
191.4 shall also provide access to and a copy of other information from the resident's record that
191.5 has been requested by or on behalf of the resident to support a resident's reconsideration
191.6 request. A copy of any requested material must be provided within three working days of
191.7 receipt of a written request for the information. If a facility fails to provide the material
191.8 within this time, it is subject to the issuance of a correction order and penalty assessment
191.9 under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order
191.10 issued under this subdivision must require that the nursing facility immediately comply
191.11 with the request for information and that as of the date of the issuance of the correction
191.12 order, the facility shall forfeit to the state a \$100 fine for the first day of noncompliance, and
191.13 an increase in the \$100 fine by \$50 increments for each day the noncompliance continues.

191.14 (c) In addition to the information required under paragraphs (a) and (b), a
191.15 reconsideration request from a nursing facility must contain the following information: (i)
191.16 the date the reimbursement classification notices were received by the facility; (ii) the date
191.17 the classification notices were distributed to the resident or the resident's representative;
191.18 and (iii) a copy of a notice sent to the resident or to the resident's representative. This
191.19 notice must inform the resident or the resident's representative that a reconsideration of the
191.20 resident's classification is being requested, the reason for the request, that the resident's
191.21 rate will change if the request is approved by the commissioner, the extent of the change,
191.22 that copies of the facility's request and supporting documentation are available for review,
191.23 and that the resident also has the right to request a reconsideration. If the facility fails to
191.24 provide the required information with the reconsideration request, the request must be
191.25 denied, and the facility may not make further reconsideration requests on that specific
191.26 reimbursement classification.

191.27 (d) Reconsideration by the commissioner must be made by individuals not involved
191.28 in reviewing the assessment, audit, or reconsideration that established the disputed
191.29 classification. The reconsideration must be based upon the initial assessment and upon the
191.30 information provided to the commissioner under paragraphs (a) and (b). If necessary for
191.31 evaluating the reconsideration request, the commissioner may conduct on-site reviews.
191.32 Within 15 working days of receiving the request for reconsideration, the commissioner
191.33 shall affirm or modify the original resident classification. The original classification
191.34 must be modified if the commissioner determines that the assessment resulting in the
191.35 classification did not accurately reflect the needs or assessment characteristics of the
191.36 resident at the time of the assessment. The resident and the nursing facility or boarding

192.1 care home shall be notified within five working days after the decision is made. A decision
192.2 by the commissioner under this subdivision is the final administrative decision of the
192.3 agency for the party requesting reconsideration.

192.4 (e) The resident classification established by the commissioner shall be the
192.5 classification that applies to the resident while the request for reconsideration is pending.
192.6 If a request for reconsideration applies to an assessment used to determine nursing facility
192.7 level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible
192.8 for nursing facility level of care while the request for reconsideration is pending.

192.9 (f) The commissioner may request additional documentation regarding a
192.10 reconsideration necessary to make an accurate reconsideration determination.

192.11 **EFFECTIVE DATE.** The section is effective January 1, 2011.

192.12 Sec. 4. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
192.13 to read:

192.14 **Subd. 11. Nursing facility level of care.** (a) For purposes of medical assistance
192.15 payment of long-term care services, a recipient must be determined, using assessments
192.16 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

192.17 (1) the person needs the assistance of another person or constant supervision to begin
192.18 and complete at least four of the following activities of living: bathing, bed mobility,
192.19 dressings, eating, grooming, toileting, transferring, and walking;

192.20 (2) the person needs the assistance of another person or constant supervision to begin
192.21 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

192.22 (3) the person has significant difficulty with memory, using information, daily
192.23 decision making, or behavioral needs that require intervention;

192.24 (4) the person has had a qualifying nursing facility stay of at least 90 days; or

192.25 (5) the person is determined to be at risk for nursing facility admission or
192.26 readmission through a face-to-face long-term care consultation assessment as specified
192.27 in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care
192.28 organization under contract with the Department of Human Services. The person is
192.29 considered at risk under this clause if the person currently lives alone or will live alone
192.30 upon discharge and also meets one of the following criteria:

192.31 (i) the person has experienced a fall resulting in a fracture;

192.32 (ii) the person has been determined to be at risk of maltreatment or neglect,
192.33 including self-neglect; or

192.34 (iii) the person has a sensory impairment that substantially impacts functional ability
192.35 and maintenance of a community residence.

193.1 (b) The assessment used to establish medical assistance payment for nursing facility
193.2 services must be the most recent assessment performed under subdivision 4, paragraph
193.3 (b), that occurred no more than 90 calendar days before the effective date of medical
193.4 assistance eligibility for payment of long-term care services. In no case shall medical
193.5 assistance payment for long-term care services occur prior to the date of the determination
193.6 of nursing facility level of care.

193.7 (c) The assessment used to establish medical assistance payment for long-term care
193.8 services provided under sections 256B.0915 and 256B.49 and alternative care payment
193.9 for services provided under section 256B.0913 must be the most recent face-to-face
193.10 assessment performed under section 256B.0911, subdivision 3a, that occurred no more
193.11 than 60 calendar days before the effective date of medical assistance eligibility for
193.12 payment of long-term care services.

193.13 **EFFECTIVE DATE.** The section is effective January 1, 2011.

193.14 Sec. 5. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
193.15 to read:

193.16 Subd. 12. **Appeal of nursing facility level of care determination.** A resident or
193.17 prospective resident whose level of care determination results in a denial of long-term care
193.18 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
193.19 paragraph (h), clause (7).

193.20 **EFFECTIVE DATE.** The section is effective January 1, 2011.

193.21 Sec. 6. Minnesota Statutes 2008, section 144A.073, is amended by adding a
193.22 subdivision to read:

193.23 Subd. 12. **Extension of approval of moratorium exception projects.**
193.24 Notwithstanding subdivision 3, the commissioner of health shall extend project approval
193.25 by an additional 18 months for an approved proposal for an exception to the nursing home
193.26 licensure and certification moratorium if the proposal was approved under this section
193.27 between July 1, 2007, and June 30, 2009.

193.28 Sec. 7. Minnesota Statutes 2008, section 144A.44, subdivision 2, is amended to read:

193.29 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
193.30 for the benefit of persons who receive home care services. "Home care services" means
193.31 home care services as defined in section 144A.43, subdivision 3, and unlicensed personal
193.32 care assistance services, including services covered by medical assistance under section
193.33 256B.0625, subdivision 19a. A home care provider may not require a person to surrender

194.1 these rights as a condition of receiving services. A guardian or conservator or, when there
 194.2 is no guardian or conservator, a designated person, may seek to enforce these rights. This
 194.3 statement of rights does not replace or diminish other rights and liberties that may exist
 194.4 relative to persons receiving home care services, persons providing home care services, or
 194.5 providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided
 194.6 to an individual at the time home care services, including personal care assistance
 194.7 services, are initiated. The copy shall also contain the address and phone number of the
 194.8 Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care
 194.9 and a brief statement describing how to file a complaint with these offices. Information
 194.10 about how to contact the Office of Ombudsman for Long-Term Care shall be included in
 194.11 notices of change in client fees and in notices where home care providers initiate transfer
 194.12 or discontinuation of services.

194.13 Sec. 8. Minnesota Statutes 2008, section 245A.03, is amended by adding a subdivision
 194.14 to read:

194.15 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
 194.16 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
 194.17 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
 194.18 9555.6265, under this chapter for a physical location that will not be the primary residence
 194.19 of the license holder for the entire period of licensure. If a license is issued during this
 194.20 moratorium, and the license holder changes the license holder's primary residence away
 194.21 from the physical location of the foster care license, the commissioner shall revoke the
 194.22 license according to section 245A.07. Exceptions to the moratorium include:

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

194.24 (2) foster care licenses replacing foster care licenses in existence on the effective
 194.25 date of this section and determined to be needed by the commissioner under paragraph (b);

194.26 (3) new foster care licenses determined to be needed by the commissioner under
 194.27 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;

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

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

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

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

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

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

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

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

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

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

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

195.22 (d) The commissioner shall study the effects of the license moratorium under this
195.23 subdivision and shall report back to the legislature by January 15, 2011.

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

195.25 Sec. 9. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
195.26 to read:

195.27 Subd. 8. **Community residential setting license.** (a) The commissioner shall
195.28 establish provider standards for residential support services that integrate service standards
195.29 and the residential setting under one license. The commissioner shall propose statutory
195.30 language and an implementation plan for licensing requirements for residential support
195.31 services to the legislature by January 15, 2011.

195.32 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
195.33 for services in settings licensed as adult foster care under Minnesota Rules, parts
195.34 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to

196.1 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
196.2 (b), must be required to obtain a community residential setting license.

196.3 Sec. 10. Minnesota Statutes 2008, section 252.46, is amended by adding a subdivision
196.4 to read:

196.5 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
196.6 a statewide rate-setting methodology for all day training and habilitation services. The
196.7 rate-setting methodology must abide by the principles of transparency and equitability
196.8 across the state. The methodology must involve a uniform process of structuring rates for
196.9 each service and must promote quality and participant choice.

196.10 Sec. 11. Minnesota Statutes 2008, section 252.50, subdivision 1, is amended to read:

196.11 Subdivision 1. **Community-based programs established.** The commissioner
196.12 shall establish a system of state-operated, community-based programs for persons with
196.13 developmental disabilities. For purposes of this section, "state-operated, community-based
196.14 program" means a program administered by the state to provide treatment and habilitation
196.15 in noninstitutional community settings to persons with developmental disabilities.
196.16 Employees of the programs, except clients who work within and benefit from these
196.17 treatment and habilitation programs, must be state employees under chapters 43A and
196.18 179A. Although any clients who work within and benefit from these treatment and
196.19 habilitation programs are not employees under chapters 43A and 179A, the Department
196.20 of Human Services may consider clients who work within and benefit from these
196.21 programs employees for federal tax purposes. The establishment of state-operated,
196.22 community-based programs must be within the context of a comprehensive definition of
196.23 the role of state-operated services in the state. The role of state-operated services must
196.24 be defined within the context of a comprehensive system of services for persons with
196.25 developmental disabilities. State-operated, community-based programs may include, but
196.26 are not limited to, community group homes, foster care, supportive living services, day
196.27 training and habilitation programs, and respite care arrangements. The commissioner
196.28 may operate the pilot projects established under Laws 1985, First Special Session
196.29 chapter 9, article 1, section 2, subdivision 6, and shall, within the limits of available
196.30 appropriations, establish additional state-operated, community-based programs for
196.31 persons with developmental disabilities. State-operated, community-based programs may
196.32 accept admissions from regional treatment centers, from the person's own home, or from
196.33 community programs. State-operated, community-based programs offering day program
196.34 services may be provided for persons with developmental disabilities who are living in

197.1 state-operated, community-based residential programs until July 1, 2000. No later than
197.2 1994, the commissioner, together with family members, counties, advocates, employee
197.3 representatives, and other interested parties, shall begin planning so that by July 1, 2000,
197.4 state-operated, community-based residential facilities will be in compliance with section
197.5 252.41, subdivision 9.

197.6 Sec. 12. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
197.7 to read:

197.8 Subd. 29. State medical review team. (a) To ensure the timely processing of
197.9 determinations of disability by the commissioner's state medical review team under
197.10 sections 256B.055, subdivision 7, paragraph (b), 256B.057, subdivision 9, paragraph
197.11 (j), and 256B.055, subdivision 12, the commissioner shall review all medical evidence
197.12 submitted by county agencies with a referral and seek additional information from
197.13 providers, applicants, and enrollees to support the determination of disability where
197.14 necessary. Disability shall be determined according to the rules of title XVI and title
197.15 XIX of the Social Security Act and pertinent rules and policies of the Social Security
197.16 Administration.

197.17 (b) Prior to a denial or withdrawal of a requested determination of disability due
197.18 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
197.19 necessary and appropriate to a determination of disability, and (2) assist applicants and
197.20 enrollees to obtain the evidence, including, but not limited to, medical examinations
197.21 and electronic medical records.

197.22 (c) The commissioner shall provide the chairs of the legislative committees with
197.23 jurisdiction over health and human services finance and budget the following information
197.24 on the activities of the state medical review team by February 1, 2010, and annually
197.25 thereafter:

197.26 (1) the number of applications to the state medical review team that were denied,
197.27 approved, or withdrawn;

197.28 (2) the average length of time from receipt of the application to a decision;

197.29 (3) the number of appeals and appeal results;

197.30 (4) for applicants, their age, health coverage at the time of application, hospitalization
197.31 history within three months of application, and whether an application for Social Security
197.32 or Supplemental Security Income benefits is pending; and

197.33 (5) specific information on the medical certification, licensure, or other credentials
197.34 of the person or persons performing the medical review determinations and length of
197.35 time in that position.

198.1 Sec. 13. [256.0281] INTERAGENCY DATA EXCHANGE.

198.2 The Department of Human Services, the Department of Health, and the Office of the
198.3 Ombudsman for Mental Health and Developmental Disabilities may establish interagency
198.4 agreements governing the electronic exchange of data on providers and individuals
198.5 collected, maintained, or used by each agency when such exchange is outlined by each
198.6 agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

198.7 (1) to improve provider enrollment processes for home and community-based
198.8 services and state plan home care services;

198.9 (2) to improve quality management of providers between state agencies;

198.10 (3) to establish and maintain provider eligibility to participate as providers under
198.11 Minnesota health care programs; or

198.12 (4) to meet the quality assurance reporting requirements under federal law under
198.13 section 1915(c) of the Social Security Act related to home and community-based waiver
198.14 programs.

198.15 Each interagency agreement must include provisions to ensure anonymity of individuals,
198.16 including mandated reporters, and must outline the specific uses of and access to shared
198.17 data within each agency. Electronic interfaces between source data systems developed
198.18 under these interagency agreements must incorporate these provisions as well as other
198.19 HIPPA provisions related to individual data.

198.20 Sec. 14. Minnesota Statutes 2008, section 256.476, subdivision 5, is amended to read:

198.21 Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of
198.22 transferring persons to the consumer support grant program from the family support
198.23 program and personal care assistant services, home health aide services, or private duty
198.24 nursing services, the amount of funds transferred by the commissioner between the
198.25 family support program account, the medical assistance account, or the consumer support
198.26 grant account shall be based on each county's participation in transferring persons to the
198.27 consumer support grant program from those programs and services.

198.28 (b) At the beginning of each fiscal year, county allocations for consumer support
198.29 grants shall be based on:

198.30 (1) the number of persons to whom the county board expects to provide consumer
198.31 supports grants;

198.32 (2) their eligibility for current program and services;

198.33 (3) ~~the amount of nonfederal dollars~~ monthly grant levels allowed under subdivision
198.34 11; and

199.1 (4) projected dates when persons will start receiving grants. County allocations shall
199.2 be adjusted periodically by the commissioner based on the actual transfer of persons or
199.3 service openings, and the ~~nonfederal dollars~~ monthly grant levels associated with those
199.4 persons or service openings, to the consumer support grant program.

199.5 (c) The amount of funds transferred by the commissioner from the medical
199.6 assistance account for an individual may be changed if it is determined by the county or its
199.7 agent that the individual's need for support has changed.

199.8 (d) The authority to utilize funds transferred to the consumer support grant account
199.9 for the purposes of implementing and administering the consumer support grant program
199.10 will not be limited or constrained by the spending authority provided to the program
199.11 of origination.

199.12 (e) The commissioner may use up to five percent of each county's allocation, as
199.13 adjusted, for payments for administrative expenses, to be paid as a proportionate addition
199.14 to reported direct service expenditures.

199.15 (f) The county allocation for each person or the person's legal representative or other
199.16 authorized representative cannot exceed the amount allowed under subdivision 11.

199.17 (g) The commissioner may recover, suspend, or withhold payments if the county
199.18 board, local agency, or grantee does not comply with the requirements of this section.

199.19 (h) Grant funds unexpended by consumers shall return to the state once a year. The
199.20 annual return of unexpended grant funds shall occur in the quarter following the end of
199.21 the state fiscal year.

199.22 Sec. 15. Minnesota Statutes 2008, section 256.476, subdivision 11, is amended to read:

199.23 Subd. 11. **Consumer support grant program after July 1, 2001.** ~~(a)~~ Effective
199.24 July 1, 2001, the commissioner shall allocate consumer support grant resources to
199.25 serve additional individuals based on a review of Medicaid authorization and payment
199.26 information of persons eligible for a consumer support grant from the most recent fiscal
199.27 year. The commissioner shall use the following methodology to calculate maximum
199.28 allowable monthly consumer support grant levels:

199.29 (1) For individuals whose program of origination is medical assistance home care
199.30 under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly
199.31 grant levels are calculated by:

199.32 (i) determining the ~~nonfederal share~~ 50 percent of the average service authorization
199.33 for each home care rating;

199.34 (ii) calculating the overall ratio of actual payments to service authorizations by
199.35 program;

200.1 (iii) applying the overall ratio to the average service authorization level of each
200.2 home care rating;

200.3 (iv) adjusting the result for any authorized rate increases provided by the legislature;
200.4 and

200.5 (v) adjusting the result for the average monthly utilization per recipient.

200.6 (2) The commissioner may review and evaluate the methodology to reflect changes
200.7 in the home care ~~program's overall ratio of actual payments to service authorizations~~
200.8 programs.

200.9 ~~(b) Effective January 1, 2004, persons previously receiving exception grants will~~
200.10 ~~have their grants calculated using the methodology in paragraph (a), clause (1). If a person~~
200.11 ~~currently receiving an exception grant wishes to have their home care rating reevaluated,~~
200.12 ~~they may request an assessment as defined in section 256B.0651, subdivision 1, paragraph~~
200.13 ~~(b).~~

200.14 Sec. 16. Minnesota Statutes 2008, section 256.975, subdivision 7, is amended to read:

200.15 Subd. 7. **Consumer information and assistance and long-term care options**
200.16 **counseling; senior linkage Senior LinkAge Line.** (a) The Minnesota Board on Aging
200.17 shall operate a statewide ~~information and assistance~~ service to aid older Minnesotans and
200.18 their families in making informed choices about long-term care options and health care
200.19 benefits. Language services to persons with limited English language skills may be made
200.20 available. The service, known as Senior LinkAge Line, must be available during business
200.21 hours through a statewide toll-free number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

201.7 (9) incorporate information about housing with services and consumer rights
201.8 within the MinnesotaHelp.info network long-term care database to facilitate consumer
201.9 comparison of services and costs among housing with services establishments and with
201.10 other in-home services and to support financial self-sufficiency as long as possible.
201.11 Housing with services establishments and their arranged home care providers shall provide
201.12 information to the commissioner of human services that is consistent with information
201.13 required by the commissioner of health under section 144G.06, the Uniform Consumer
201.14 Information Guide. The commissioner of human services shall provide the data to the
201.15 Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term
201.16 care database;

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

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

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

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

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

201.34 (11) using risk management and support planning protocols, provide long-term care
201.35 options counseling to current residents of nursing homes deemed appropriate for discharge
201.36 by the commissioner. In order to meet this requirement, the commissioner shall provide

202.1 designated Senior LinkAge Line contact centers with a list of nursing home residents
202.2 appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall
202.3 provide these residents, if they indicate a preference to receive long-term care options
202.4 counseling, with initial assessment, review of risk factors, independent living support
202.5 consultation, or referral to:

202.6 (i) services under section 256B.0911, subdivision 3;

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

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

202.11 ~~(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness~~
202.12 ~~of the statewide information and assistance, and submit this evaluation to the legislature~~
202.13 ~~by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps~~
202.14 ~~in service delivery, continuity in information between the service and identified linkages,~~
202.15 ~~and potential use of private funding to enhance the service.~~

202.16 Sec. 17. Minnesota Statutes 2008, section 256B.055, subdivision 7, is amended to read:

202.17 Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for
202.18 a person who meets the categorical eligibility requirements of the supplemental security
202.19 income program or, who would meet those requirements except for excess income or
202.20 assets, and who meets the other eligibility requirements of this section.

202.21 (b) Following a determination that the applicant is not aged or blind and does not
202.22 meet any other category of eligibility for medical assistance and has not been determined
202.23 disabled by the Social Security Administration, applicants under this subdivision shall be
202.24 referred to the commissioner's state medical review team for a determination of disability.

202.25 Sec. 18. Minnesota Statutes 2008, section 256B.0625, subdivision 6a, is amended to
202.26 read:

202.27 Subd. 6a. **Home health services.** Home health services are those services specified
202.28 in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical
202.29 assistance covers home health services at a recipient's home residence. Medical assistance
202.30 does not cover home health services for residents of a hospital, nursing facility, or
202.31 intermediate care facility, unless the commissioner of human services has ~~prior~~ authorized
202.32 skilled nurse visits for less than 90 days for a resident at an intermediate care facility for
202.33 persons with developmental disabilities, to prevent an admission to a hospital or nursing
202.34 facility or unless a resident who is otherwise eligible is on leave from the facility and the

203.1 facility either pays for the home health services or forgoes the facility per diem for the
203.2 leave days that home health services are used. Home health services must be provided by
203.3 a Medicare certified home health agency. All nursing and home health aide services must
203.4 be provided according to sections 256B.0651 to ~~256B.0656~~ 256B.0653.

203.5 Sec. 19. Minnesota Statutes 2008, section 256B.0625, subdivision 7, is amended to
203.6 read:

203.7 Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing
203.8 services in a recipient's home. Recipients who are authorized to receive private duty
203.9 nursing services in their home may use approved hours outside of the home during hours
203.10 when normal life activities take them outside of their home. To use private duty nursing
203.11 services at school, the recipient or responsible party must provide written authorization in
203.12 the care plan identifying the chosen provider and the daily amount of services to be used at
203.13 school. Medical assistance does not cover private duty nursing services for residents of a
203.14 hospital, nursing facility, intermediate care facility, or a health care facility licensed by the
203.15 commissioner of health, except as authorized in section 256B.64 for ventilator-dependent
203.16 recipients in hospitals or unless a resident who is otherwise eligible is on leave from the
203.17 facility and the facility either pays for the private duty nursing services or forgoes the
203.18 facility per diem for the leave days that private duty nursing services are used. Total hours
203.19 of service and payment allowed for services outside the home cannot exceed that which is
203.20 otherwise allowed in an in-home setting according to sections 256B.0651 and ~~256B.0653~~
203.21 256B.0654 to 256B.0656. All private duty nursing services must be provided according to
203.22 the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private
203.23 duty nursing services may not be reimbursed if the nurse is the family foster care provider
203.24 of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

203.25 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to
203.26 read:

203.27 Subd. 19a. **Personal care ~~assistant~~ assistance services.** Medical assistance covers
203.28 personal care ~~assistant~~ assistance services in a recipient's home. Effective January 1,
203.29 2010, to qualify for personal care ~~assistant~~ assistance services, a recipient must require
203.30 assistance and be determined dependent in one activity of daily living as defined in section
203.31 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section
203.32 256B.0659, subdivision 1, paragraph (c). Beginning July 1, 2011, to qualify for personal
203.33 care assistance services, a recipient must require assistance and be determined dependent
203.34 in at least two activities of daily living as defined in section 256B.0659. Recipients or

204.1 responsible parties must be able to identify the recipient's needs, direct and evaluate task
 204.2 accomplishment, and provide for health and safety. Approved hours may be used outside
 204.3 the home when normal life activities take them outside the home. To use personal care
 204.4 ~~assistant~~ assistance services at school, the recipient or responsible party must provide
 204.5 written authorization in the care plan identifying the chosen provider and the daily amount
 204.6 of services to be used at school. Total hours for services, whether actually performed
 204.7 inside or outside the recipient's home, cannot exceed that which is otherwise allowed for
 204.8 personal care ~~assistant~~ assistance services in an in-home setting according to sections
 204.9 256B.0651 ~~and 256B.0653~~ to 256B.0656. Medical assistance does not cover personal care
 204.10 ~~assistant~~ assistance services for residents of a hospital, nursing facility, intermediate care
 204.11 facility, health care facility licensed by the commissioner of health, or unless a resident
 204.12 who is otherwise eligible is on leave from the facility and the facility either pays for the
 204.13 personal care ~~assistant~~ assistance services or forgoes the facility per diem for the leave
 204.14 days that personal care ~~assistant~~ assistance services are used. All personal care ~~assistant~~
 204.15 assistance services must be provided according to sections 256B.0651 ~~and 256B.0653~~
 204.16 to 256B.0656. Personal care ~~assistant~~ assistance services may not be reimbursed if the
 204.17 personal care assistant is the spouse or ~~legal~~ paid guardian of the recipient or the parent of
 204.18 a recipient under age 18, or the responsible party or the family foster care provider of a
 204.19 recipient who cannot direct the recipient's own care unless, in the case of a foster care
 204.20 provider, a county or state case manager visits the recipient as needed, but not less than
 204.21 every six months, to monitor the health and safety of the recipient and to ensure the goals
 204.22 of the care plan are met. ~~Parents of adult recipients, adult children of the recipient or~~
 204.23 ~~adult siblings of the recipient may be reimbursed for personal care assistant services,~~
 204.24 ~~if they are granted a waiver under sections 256B.0651 and 256B.0653 to 256B.0656.~~
 204.25 Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause~~
 204.26 ~~(4) 256B.0659~~, the ~~noncorporate legal~~ unpaid guardian or conservator of an adult, who is
 204.27 not the responsible party and not the personal care provider organization, may be ~~granted a~~
 204.28 ~~hardship waiver under sections 256B.0651 and 256B.0653 to 256B.0656, to be reimbursed~~
 204.29 to provide personal care ~~assistant~~ assistance services to the recipient if the guardian or
 204.30 conservator meets all criteria for a personal care assistant according to section 256B.0659,
 204.31 and shall not be considered to have a service provider interest for purposes of participation
 204.32 on the screening team under section 256B.092, subdivision 7.

204.33 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 19c, is amended to
 204.34 read:

205.1 Subd. 19c. **Personal care.** Medical assistance covers personal care ~~assistant~~
 205.2 assistance services provided by an individual who is qualified to provide the services
 205.3 according to subdivision 19a and sections 256B.0651 ~~and 256B.0653~~ to 256B.0656,
 205.4 ~~where the services have a statement of need by a physician,~~ provided in accordance with
 205.5 a plan, and ~~are supervised by the recipient or a qualified professional. The physician's~~
 205.6 ~~statement of need for personal care assistant services shall be documented on a form~~
 205.7 ~~approved by the commissioner and include the diagnosis or condition of the person that~~
 205.8 ~~results in a need for personal care assistant services and be updated when the person's~~
 205.9 ~~medical condition requires a change, but at least annually if the need for personal care~~
 205.10 ~~assistant services is ongoing.~~
 205.11 "Qualified professional" means a mental health professional as defined in section 245.462,
 205.12 subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections
 205.13 148.171 to 148.285, ~~or a licensed social worker as defined in section 148B.21, or a~~
 205.14 qualified developmental disabilities specialist undersection 245B.07, subdivision 4.
 205.15 ~~As part of the assessment, the county public health nurse will assist the recipient or~~
 205.16 ~~responsible party to identify the most appropriate person to provide supervision of the~~
 205.17 ~~personal care assistant. The qualified professional shall perform the duties described~~
 205.18 required in Minnesota Rules, part 9505.0335, subpart 4 section 256B.0659.

205.19 Sec. 22. Minnesota Statutes 2008, section 256B.0641, subdivision 3, is amended to
 205.20 read:

205.21 Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of
 205.22 ownership of a facility to a nonrelated organization while the facility to be sold, transferred
 205.23 or reorganized is in receivership under section 144A.14, 144A.15, 245A.12₂ or 245A.13,
 205.24 and the commissioner during the receivership has not determined the need to place
 205.25 residents of the facility into a newly constructed or newly established facility. Nothing
 205.26 in this subdivision limits the liability of a former owner.

205.27 Sec. 23. Minnesota Statutes 2008, section 256B.0651, is amended to read:

205.28 **256B.0651 HOME CARE SERVICES.**

205.29 Subdivision 1. **Definitions.** (a) ~~"Activities of daily living" includes eating, toileting,~~
 205.30 ~~grooming, dressing, bathing, transferring, mobility, and positioning.~~ For the purposes of
 205.31 sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g)
 205.32 have the meanings given.

205.33 (b) "Activities of daily living" has the meaning given in section 256B.0659,
 205.34 subdivision 1, paragraph (b).

206.1 (c) "Assessment" means a review and evaluation of a recipient's need for home care
206.2 services conducted in person. ~~Assessments for home health agency services shall be~~
206.3 ~~conducted by a home health agency nurse. Assessments for medical assistance home care~~
206.4 ~~services for developmental disability and alternative care services for developmentally~~
206.5 ~~disabled home and community-based waived recipients may be conducted by the county~~
206.6 ~~public health nurse to ensure coordination and avoid duplication. Assessments must be~~
206.7 ~~completed on forms provided by the commissioner within 30 days of a request for home~~
206.8 ~~care services by a recipient or responsible party.~~

206.9 ~~(e) (d) "Home care services" means a health service, determined by the commissioner~~
206.10 ~~as medically necessary, that is ordered by a physician and documented in a service plan~~
206.11 ~~that is reviewed by the physician at least once every 60 days for the provision of home~~
206.12 ~~health services, or private duty nursing, or at least once every 365 days for personal care.~~
206.13 ~~Home care services are provided to the recipient at the recipient's residence that is a~~
206.14 ~~place other than a hospital or long-term care facility or as specified in section 256B.0625~~
206.15 ~~means medical assistance covered services that are home health agency services, including~~
206.16 ~~skilled nurse visits; home health aide visits; physical therapy, occupational therapy,~~
206.17 ~~respiratory therapy, and language-speech pathology therapy; private duty nursing; and~~
206.18 ~~personal care assistance.~~

206.19 (e) "Home residence," effective January 1, 2010, means a residence owned or rented
206.20 by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid
206.21 responsible party or legal representative; or a family foster home where the license holder
206.22 lives with the recipient and is not paid to provide home care services for the recipient
206.23 except as allowed under sections 256B.0651, subdivision 9, and 256B.0654, subdivision 4.

206.24 ~~(d) (f) "Medically necessary" has the meaning given in Minnesota Rules, parts~~
206.25 ~~9505.0170 to 9505.0475.~~

206.26 ~~(e) "Telehomecare" means the use of telecommunications technology by a home~~
206.27 ~~health care professional to deliver home health care services, within the professional's~~
206.28 ~~scope of practice, to a patient located at a site other than the site where the practitioner~~
206.29 ~~is located.~~

206.30 (g) "Ventilator-dependent" means an individual who receives mechanical ventilation
206.31 for life support at least six hours per day and is expected to be or has been dependent on a
206.32 ventilator for at least 30 consecutive days.

206.33 Subd. 2. **Services covered.** Home care services covered under this section and
206.34 sections ~~256B.0653~~ 256B.0652 to 256B.0656 and 256B.0659 include:

206.35 (1) nursing services under ~~section~~ sections 256B.0625, subdivision 6a, and
206.36 256B.0653;

207.1 (2) private duty nursing services under ~~section~~ sections 256B.0625, subdivision
207.2 7, and 256B.0654;

207.3 (3) home health services under ~~section~~ sections 256B.0625, subdivision 6a, and
207.4 256B.0653;

207.5 (4) personal care ~~assistant~~ assistance services under ~~section~~ sections 256B.0625,
207.6 subdivision 19a, and 256B.0659;

207.7 (5) supervision of personal care ~~assistant~~ assistance services provided by a qualified
207.8 professional under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659;

207.9 (6) ~~qualified professional of personal care assistant services under the fiscal~~
207.10 ~~intermediary option as specified in section 256B.0655, subdivision 7;~~

207.11 ~~(7)~~ face-to-face assessments by county public health nurses for services under
207.12 ~~section~~ sections 256B.0625, subdivision 19a, 256B.0655, and 256B.0659; and

207.13 ~~(8)~~ (7) service updates and review of temporary increases for personal care ~~assistant~~
207.14 assistance services by the county public health nurse for services under ~~section~~ sections
207.15 256B.0625, subdivision 19a, and 256B.0659.

207.16 Subd. 3. **Noncovered home care services.** The following home care services are
207.17 not eligible for payment under medical assistance:

207.18 ~~(1) skilled nurse visits for the sole purpose of supervision of the home health aide;~~

207.19 ~~(2) a skilled nursing visit:~~

207.20 ~~(i) only for the purpose of monitoring medication compliance with an established~~
207.21 ~~medication program for a recipient; or~~

207.22 ~~(ii) to administer or assist with medication administration, including injections,~~
207.23 ~~prefilling syringes for injections, or oral medication set-up of an adult recipient, when as~~
207.24 ~~determined and documented by the registered nurse, the need can be met by an available~~
207.25 ~~pharmacy or the recipient is physically and mentally able to self-administer or prefill~~
207.26 ~~a medication;~~

207.27 ~~(3) home care services to a recipient who is eligible for covered services under the~~
207.28 ~~Medicare program or any other insurance held by the recipient;~~

207.29 ~~(4) services to other members of the recipient's household;~~

207.30 ~~(5) a visit made by a skilled nurse solely to train other home health agency workers;~~

207.31 ~~(6) any home care service included in the daily rate of the community-based~~
207.32 ~~residential facility where the recipient is residing;~~

207.33 ~~(7) nursing and rehabilitation therapy services that are reasonably accessible to a~~
207.34 ~~recipient outside the recipient's place of residence, excluding the assessment, counseling~~
207.35 ~~and education, and personal assistant care;~~

208.1 ~~(8) any home health agency service, excluding personal care assistant services and~~
208.2 ~~private duty nursing services, which are performed in a place other than the recipient's~~
208.3 ~~residence; and~~

208.4 ~~(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients~~
208.5 ~~that do not qualify for Medicare visit billing.~~

208.6 (1) services provided in a nursing facility, hospital, or intermediate care facility with
208.7 exceptions in section 256B.0653;

208.8 (2) services for the sole purpose of monitoring medication compliance with an
208.9 established medication program for a recipient;

208.10 (3) home care services for covered services under the Medicare program or any other
208.11 insurance held by the recipient;

208.12 (4) services to other members of the recipient's household;

208.13 (5) any home care service included in the daily rate of the community-based
208.14 residential facility where the recipient is residing;

208.15 (6) nursing and rehabilitation therapy services that are reasonably accessible to a
208.16 recipient outside the recipient's place of residence, excluding the assessment, counseling
208.17 and education, and personal assistance care; or

208.18 (7) Medicare evaluation or administrative nursing visits on dual-eligible recipients
208.19 that do not qualify for Medicare visit billing.

208.20 Subd. 4. **Prior Authorization; exceptions.** All home care services above the limits
208.21 in subdivision 11 must receive the commissioner's ~~prior~~ authorization before services
208.22 begin, except when:

208.23 (1) the home care services were required to treat an emergency medical condition
208.24 that if not immediately treated could cause a recipient serious physical or mental disability,
208.25 continuation of severe pain, or death. The provider must request retroactive authorization
208.26 no later than five working days after giving the initial service. The provider must be able
208.27 to substantiate the emergency by documentation such as reports, notes, and admission or
208.28 discharge histories;

208.29 ~~(2) the home care services were provided on or after the date on which the recipient's~~
208.30 ~~eligibility began, but before the date on which the recipient was notified that the case was~~
208.31 ~~opened. Authorization will be considered if the request is submitted by the provider~~
208.32 ~~within 20 working days of the date the recipient was notified that the case was opened;~~
208.33 a recipient's medical assistance eligibility has lapsed, is then retroactively reinstated,
208.34 and an authorization for home care services is completed based on the date of a current
208.35 assessment, eligibility, and request for authorization;

209.1 (3) a third-party payor for home care services has denied or adjusted a payment.
209.2 Authorization requests must be submitted by the provider within 20 working days of the
209.3 notice of denial or adjustment. A copy of the notice must be included with the request;

209.4 (4) the commissioner has determined that a county or state human services agency
209.5 has made an error; or

209.6 (5) ~~the professional nurse determines an immediate need for up to 40 skilled nursing~~
209.7 ~~or home health aide visits per calendar year and submits a request for authorization within~~
209.8 ~~20 working days of the initial service date, and medical assistance is determined to be~~
209.9 ~~the appropriate payer.~~ if a recipient enrolled in managed care experiences a temporary
209.10 disenrollment from a health plan, the commissioner shall accept the current health plan
209.11 authorization for personal care assistance services for up to 60 days. The request must
209.12 be received within the first 30 days of the disenrollment. If the recipient's reenrollment
209.13 in managed care is after the 60 days and before 90 days, the provider shall request an
209.14 additional 30-day extension of the current health plan authorization, for a total limit of
209.15 90 days from the time of disenrollment.

209.16 ~~Subd. 5. **Retroactive authorization.** A request for retroactive authorization will be~~
209.17 ~~evaluated according to the same criteria applied to prior authorization requests.~~

209.18 Subd. 6. **Prior Authorization.** (a) The commissioner, or the commissioner's
209.19 designee, shall review the assessment, ~~service update,~~ request for temporary services,
209.20 ~~request for flexible use option,~~ service plan, and any additional information that is
209.21 submitted. The commissioner shall, within 30 days after receiving a complete request,
209.22 assessment, and service plan, authorize home care services as ~~follows:~~ provided in this
209.23 section.

209.24 ~~(a) **Home health services.** (b) All Home health services provided by a home health~~
209.25 ~~aide including skilled nurse visits and home health aide visits must be prior authorized~~
209.26 ~~by the commissioner or the commissioner's designee. Prior Authorization must be based~~
209.27 ~~on medical necessity and cost-effectiveness when compared with other care options.~~
209.28 The commissioner must receive the request for authorization of skilled nurse visits and
209.29 home health aide visits within 20 working days of the start of service. When home health
209.30 services are used in combination with personal care and private duty nursing, the cost of
209.31 all home care services shall be considered for cost-effectiveness. ~~The commissioner shall~~
209.32 ~~limit home health aide visits to no more than one visit each per day. The commissioner, or~~
209.33 ~~the commissioner's designee, may authorize up to two skilled nurse visits per day.~~

209.34 ~~(b) **Ventilator-dependent recipients.** (c) If the recipient is ventilator-dependent, the~~
209.35 ~~monthly medical assistance authorization for home care services shall not exceed what the~~
209.36 ~~commissioner would pay for care at the highest cost hospital designated as a long-term~~

210.1 hospital under the Medicare program. For purposes of this paragraph, home care services
 210.2 means all direct care services provided in the home that would be included in the payment
 210.3 for care at the long-term hospital. ~~"Ventilator-dependent" means an individual who~~
 210.4 ~~receives mechanical ventilation for life support at least six hours per day and is expected~~
 210.5 ~~to be or has been dependent for at least 30 consecutive days.~~ Recipients who meet the
 210.6 definition of ventilator dependent and the EN home care rating and utilize a combination
 210.7 of home care services are limited up to a total of 24 hours of home care services per day.
 210.8 Additional hours may be authorized when a recipient's assessment indicates a need for two
 210.9 staff to perform activities. Additional time is limited to four hours per day.

210.10 Subd. 7. **Prior Authorization; time limits.** (a) The commissioner or the
 210.11 commissioner's designee shall determine the time period for which ~~a prior~~ an authorization
 210.12 shall be effective ~~and, if flexible use has been requested, whether to allow the flexible use~~
 210.13 ~~option.~~ If the recipient continues to require home care services beyond the duration of
 210.14 the ~~prior~~ authorization, the home care provider must request a new ~~prior~~ authorization.
 210.15 A personal care provider agency must request a new personal care ~~assistant~~ assistance
 210.16 services assessment, or service update if allowed, at least 60 days prior to the end of
 210.17 the current ~~prior~~ authorization time period. The request for the assessment must be
 210.18 made on a form approved by the commissioner. ~~Under no circumstances, other than the~~
 210.19 ~~exceptions in subdivision 4, shall a prior~~ An authorization must be valid ~~prior to the date~~
 210.20 ~~the commissioner receives the request or~~ for no more than 12 months.

210.21 (b) The amount and type of personal care assistance services authorized based
 210.22 upon the assessment and service plan must remain in effect for the recipient whether
 210.23 the recipient chooses a different provider or enrolls or disenrolls from a managed care
 210.24 plan under section 256B.0659, unless the service needs of the recipient change and new
 210.25 assessment is warranted under section 256B.0655, subdivision 1b.

210.26 (c) A recipient who appeals a reduction in previously authorized home care
 210.27 services may continue previously authorized services, other than temporary services
 210.28 under subdivision 8, pending an appeal under section 256.045. The commissioner must
 210.29 provide ensure that the recipient has a copy of the most recent service plan that contains
 210.30 a detailed explanation of why the authorized services which areas of covered personal
 210.31 care assistance tasks are reduced in amount from those requested by the home care
 210.32 provider, and provide notice of the amount of time per day reduced, and the reasons for
 210.33 the reduction in the recipient's notice of denial, termination, or reduction.

210.34 Subd. 8. **Prior Authorization requests; temporary services.** The agency nurse,
 210.35 ~~the~~ independently enrolled private duty nurse, or county public health nurse may request
 210.36 a temporary authorization for home care services ~~by telephone.~~ The commissioner may

211.1 approve a temporary level of home care services based on the assessment, and service
 211.2 or care plan information, and primary payer coverage determination information as
 211.3 required. Authorization for a temporary level of home care services including nurse
 211.4 supervision is limited to the time specified by the commissioner, but shall not exceed
 211.5 45 days, ~~unless extended because the county public health nurse has not completed the~~
 211.6 ~~required assessment and service plan, or the commissioner's determination has not been~~
 211.7 ~~made~~. The level of services authorized under this provision shall have no bearing on a
 211.8 future ~~prior~~ authorization.

211.9 Subd. 9. **Prior Authorization for foster care setting.** (a) Home care services
 211.10 provided in an adult or child foster care setting must receive ~~prior~~ authorization by the
 211.11 ~~department~~ commissioner according to the limits established in subdivision 11.

211.12 (b) The commissioner may not authorize:

211.13 (1) home care services that are the responsibility of the foster care provider under
 211.14 the terms of the foster care placement agreement, difficulty of care rate as of January 1,
 211.15 2010, and administrative rules;

211.16 (2) personal care ~~assistant~~ assistance services when the foster care license holder is
 211.17 also the personal care provider or personal care assistant ~~unless the recipient can direct the~~
 211.18 ~~recipient's own care, or case management is provided as required in section 256B.0625,~~
 211.19 ~~subdivision 19a,~~ unless the foster home is the licensed provider's primary residence as
 211.20 defined in section 256B.0625, subdivision 19a; or

211.21 (3) ~~personal care assistant services when the responsible party is an employee of, or~~
 211.22 ~~under contract with, or has any direct or indirect financial relationship with the personal~~
 211.23 ~~care provider or personal care assistant, unless case management is provided as required~~
 211.24 ~~in section 256B.0625, subdivision 19a; or~~

211.25 (4) ~~(3)~~ personal care assistant and private duty nursing services when the ~~number~~
 211.26 ~~of foster care residents~~ licensed capacity is greater than four ~~unless the county responsible~~
 211.27 ~~for the recipient's foster placement made the placement prior to April 1, 1992, requests~~
 211.28 ~~that personal care assistant and private duty nursing services be provided, and case~~
 211.29 ~~management is provided as required in section 256B.0625, subdivision 19a.~~

211.30 ~~Subd. 10. **Limitation on payments.** Medical assistance payments for home care~~
 211.31 ~~services shall be limited according to subdivisions 4 to 12 and sections 256B.0654,~~
 211.32 ~~subdivision 2, and 256B.0655, subdivisions 3 and 4.~~

211.33 Subd. 11. **Limits on services without prior authorization.** A recipient may receive
 211.34 the following home care services during a calendar year:

212.1 (1) up to two face-to-face assessments to determine a recipient's need for personal
212.2 care ~~assistant~~ assistance services;

212.3 (2) one service update done to determine a recipient's need for personal care ~~assistant~~
212.4 assistance services; and

212.5 (3) up to nine face-to-face skilled nurse visits.

212.6 Subd. 12. **Approval of home care services.** The commissioner or the
212.7 commissioner's designee shall determine the medical necessity of home care services,
212.8 the level of caregiver according to subdivision 2, and the institutional comparison
212.9 according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, ~~and~~ 256B.0655,
212.10 subdivisions 3 and 4, and 256B.0659, the cost-effectiveness of services, and the amount,
212.11 scope, and duration of home care services reimbursable by medical assistance, based
212.12 on the assessment, primary payer coverage determination information as required, the
212.13 service plan, the recipient's age, the cost of services, the recipient's medical condition, and
212.14 diagnosis or disability. The commissioner may publish additional criteria for determining
212.15 medical necessity according to section 256B.04.

212.16 Subd. 13. **Recovery of excessive payments.** The commissioner shall seek
212.17 monetary recovery from providers of payments made for services which exceed the limits
212.18 established in this section and sections 256B.0653 to 256B.0656, and 256B.0659. This
212.19 subdivision does not apply to services provided to a recipient at the previously authorized
212.20 level pending an appeal under section 256.045, subdivision 10.

212.21 Subd. 14. **Referrals to Medicare providers required.** Home care providers that
212.22 do not participate in or accept Medicare assignment must refer and document the referral
212.23 of dual-eligible recipients to Medicare providers when Medicare is determined to be the
212.24 appropriate payer for services and supplies and equipment. Providers must be terminated
212.25 from participation in the medical assistance program for failure to make these referrals.

212.26 Subd. 15. **Quality assurance for program integrity.** The commissioner shall
212.27 establish an ongoing quality assurance process for home care services to monitor program
212.28 integrity, including provider standards and training, consumer surveys, and random
212.29 reviews of documentation.

212.30 Subd. 16. **Oversight of enrolled providers.** The commissioner has the authority to
212.31 request proof of documentation of meeting provider standards, quality standards of care,
212.32 correct billing practices, and other information. Failure to comply with or to provide access
212.33 and information to demonstrate compliance with laws, rules, or policies may result in
212.34 suspension, denial, or termination of the provider agency's enrollment with the department.

213.1 Sec. 24. Minnesota Statutes 2008, section 256B.0652, is amended to read:

213.2 **256B.0652 ~~PRIOR~~ AUTHORIZATION AND REVIEW OF HOME CARE**
213.3 **SERVICES.**

213.4 Subdivision 1. **State coordination.** The commissioner shall supervise the
213.5 coordination of the ~~prior~~ authorization and review of home care services that are
213.6 reimbursed by medical assistance.

213.7 Subd. 2. **Duties.** (a) The commissioner may contract with or employ ~~qualified~~
213.8 ~~registered nurses and necessary support~~ staff, or contract with qualified agencies, to
213.9 provide home care ~~prior~~ authorization and review services for medical assistance
213.10 recipients who are receiving home care services.

213.11 (b) Reimbursement for the ~~prior~~ authorization function shall be made through the
213.12 medical assistance administrative authority. The state shall pay the nonfederal share.
213.13 The functions will be to:

213.14 (1) assess the recipient's individual need for services required to be cared for safely
213.15 in the community;

213.16 (2) ensure that a ~~service~~ care plan that meets the recipient's needs is developed
213.17 by the appropriate agency or individual;

213.18 (3) ensure cost-effectiveness and nonduplication of medical assistance home care
213.19 services;

213.20 (4) recommend the approval or denial of the use of medical assistance funds to pay
213.21 for home care services;

213.22 (5) reassess the recipient's need for and level of home care services at a frequency
213.23 determined by the commissioner; ~~and~~

213.24 (6) conduct on-site assessments when determined necessary by the commissioner
213.25 and recommend changes to care plans that will provide more efficient and appropriate
213.26 home care; and

213.27 (7) on the department's Web site:

213.28 (i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies
213.29 with the following information: main office address, contact information for the agency,
213.30 counties in which services are provided, type of home care services provided, whether
213.31 the personal care assistance choice option is offered, types of qualified professionals
213.32 employed, number of personal care assistants employed, and data on staff turnover; and

213.33 (ii) post data on home care services including information from both fee-for-service
213.34 and managed care plans on recipients as available.

213.35 (c) In addition, the commissioner or the commissioner's designee may:

214.1 (1) review care plans, service plans, and reimbursement data for utilization of
214.2 services that exceed community-based standards for home care, inappropriate home care
214.3 services, medical necessity, home care services that do not meet quality of care standards,
214.4 or unauthorized services and make appropriate referrals within the department or to other
214.5 appropriate entities based on the findings;

214.6 (2) assist the recipient in obtaining services necessary to allow the recipient to
214.7 remain safely in or return to the community;

214.8 (3) coordinate home care services with other medical assistance services under
214.9 section 256B.0625;

214.10 (4) assist the recipient with problems related to the provision of home care services;

214.11 (5) assure the quality of home care services; and

214.12 (6) assure that all liable third-party payers including, but not limited to, Medicare
214.13 have been used prior to medical assistance for home care services, ~~including but not~~
214.14 ~~limited to, home health agency, elected hospice benefit, waived services, alternative care~~
214.15 ~~program services, and personal care services.~~

214.16 (d) For the purposes of this section, "home care services" means medical assistance
214.17 services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

214.18 Subd. 3. **Assessment and ~~prior~~ authorization process for persons receiving**
214.19 **personal care assistance and developmental disabilities services.** ~~Effective January 1,~~
214.20 ~~1996,~~ For purposes of providing informed choice, coordinating of local planning decisions,
214.21 and streamlining administrative requirements, the assessment and ~~prior~~ authorization
214.22 process for persons receiving both home care and home and community-based waived
214.23 services for persons with developmental disabilities shall meet the requirements of
214.24 sections 256B.0651 and 256B.0653 to 256B.0656 with the following exceptions:

214.25 (a) Upon request for home care services and subsequent assessment by the public
214.26 health nurse under sections 256B.0651 and 256B.0653 to 256B.0656, the public health
214.27 nurse shall participate in the screening process, as appropriate, and, if home care
214.28 services are determined to be necessary, participate in the development of a service plan
214.29 coordinating the need for home care and home and community-based waived services
214.30 with the assigned county case manager, the recipient of services, and the recipient's legal
214.31 representative, if any.

214.32 (b) The public health nurse shall give ~~prior~~ authorization for home care services
214.33 to the extent that home care services are:

214.34 (1) medically necessary;

214.35 (2) chosen by the recipient and their legal representative, if any, from the array of
214.36 home care and home and community-based waived services available;

215.1 (3) coordinated with other services to be received by the recipient as described
215.2 in the service plan; and

215.3 (4) provided within the county's reimbursement limits for home care and home and
215.4 community-based waived services for persons with developmental disabilities.

215.5 (c) If the public health agency is or may be the provider of home care services to the
215.6 recipient, the public health agency shall provide the commissioner of human services with
215.7 a written plan that specifies how the assessment and ~~prior~~ authorization process will be
215.8 held separate and distinct from the provision of services.

215.9 Sec. 25. Minnesota Statutes 2008, section 256B.0653, is amended to read:

215.10 **256B.0653 HOME HEALTH AGENCY ~~COVERED~~ SERVICES.**

215.11 Subdivision 1. ~~Homecare; skilled nurse visits~~ Scope. ~~"Skilled nurse visits" are~~
215.12 ~~provided in a recipient's residence under a plan of care or service plan that specifies a level~~
215.13 ~~of care which the nurse is qualified to provide. These services are:~~

215.14 ~~(1) nursing services according to the written plan of care or service plan and accepted~~
215.15 ~~standards of medical and nursing practice in accordance with chapter 148;~~

215.16 ~~(2) services which due to the recipient's medical condition may only be safely and~~
215.17 ~~effectively provided by a registered nurse or a licensed practical nurse;~~

215.18 ~~(3) assessments performed only by a registered nurse; and~~

215.19 ~~(4) teaching and training the recipient, the recipient's family, or other caregivers~~
215.20 ~~requiring the skills of a registered nurse or licensed practical nurse. This section applies to~~
215.21 ~~home health agency services including, home health aide, skilled nursing visits, physical~~
215.22 ~~therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.~~

215.23 Subd. 2. ~~Telehomecare; skilled nurse visits~~ Definitions. ~~Medical assistance~~
215.24 ~~covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via~~
215.25 ~~telehomecare, for services which do not require hands-on care between the home care~~
215.26 ~~nurse and recipient. The provision of telehomecare must be made via live, two-way~~
215.27 ~~interactive audiovisual technology and may be augmented by utilizing store-and-forward~~
215.28 ~~technologies. Store-and-forward technology includes telehomecare services that do not~~
215.29 ~~occur in real time via synchronous transmissions, and that do not require a face-to-face~~
215.30 ~~encounter with the recipient for all or any part of any such telehomecare visit. Individually~~
215.31 ~~identifiable patient data obtained through real-time or store-and-forward technology must~~
215.32 ~~be maintained as health records according to sections 144.291 to 144.298. If the video~~
215.33 ~~is used for research, training, or other purposes unrelated to the care of the patient, the~~
215.34 ~~identity of the patient must be concealed. A communication between the home care nurse~~
215.35 ~~and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or~~

216.1 ~~a consultation between two health care practitioners, is not to be considered a telehomecare~~
216.2 ~~visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage~~
216.3 ~~of telehomecare is limited to two visits per day. All skilled nurse visits provided via~~
216.4 ~~telehomecare must be prior authorized by the commissioner or the commissioner's~~
216.5 ~~designee and will be covered at the same allowable rate as skilled nurse visits provided~~
216.6 ~~in-person.~~ For the purposes of this section, the following terms have the meanings given.

216.7 (a) "Assessment" means an evaluation of the recipient's medical need for home
216.8 health agency services by a registered nurse or appropriate therapist that is conducted
216.9 within 30 days of a request.

216.10 (b) "Home care therapies" means occupational, physical, and respiratory therapy
216.11 and speech-language pathology services provided in the home by a Medicare certified
216.12 home health agency.

216.13 (c) "Home health agency services" means services delivered in the recipient's home
216.14 residence, except as specified in section 256B.0625, by a home health agency to a recipient
216.15 with medical needs due to illness, disability, or physical conditions.

216.16 (d) "Home health aide" means an employee of a home health agency who completes
216.17 medically oriented tasks written in the plan of care for a recipient.

216.18 (e) "Home health agency" means a home care provider agency that is
216.19 Medicare-certified.

216.20 (f) "Occupational therapy services" mean the services defined in Minnesota Rules,
216.21 part 9505.0390.

216.22 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
216.23 9505.0390.

216.24 (h) "Respiratory therapy services" mean the services defined in chapter 147C and
216.25 Minnesota Rules, part 4668.0003, subpart 37.

216.26 (i) "Speech-language pathology services" mean the services defined in Minnesota
216.27 Rules, part 9505.0390.

216.28 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
216.29 required due to a recipient's medical condition that can only be safely provided by a
216.30 professional nurse to restore and maintain optimal health.

216.31 (k) "Store-and-forward technology" means telehomecare services that do not occur
216.32 in real time via synchronous transmissions such as diabetic and vital sign monitoring.

216.33 (l) "Telehomecare" means the use of telecommunications technology via
216.34 live, two-way interactive audiovisual technology which may be augmented by
216.35 store-and-forward technology.

217.1 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to
217.2 deliver a skilled nurse visit to a recipient located at a site other than the site where the
217.3 nurse is located and is used in combination with face-to-face skilled nurse visits to
217.4 adequately meet the recipient's needs.

217.5 Subd. 3. ~~Therapies through home health agencies~~ Home health aide visits.

217.6 ~~(a) Medical assistance covers physical therapy and related services, including specialized~~
217.7 ~~maintenance therapy. Services provided by a physical therapy assistant shall be~~
217.8 ~~reimbursed at the same rate as services performed by a physical therapist when the~~
217.9 ~~services of the physical therapy assistant are provided under the direction of a physical~~
217.10 ~~therapist who is on the premises. Services provided by a physical therapy assistant that are~~
217.11 ~~provided under the direction of a physical therapist who is not on the premises shall be~~
217.12 ~~reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy~~
217.13 ~~assistant must be provided by the physical therapist as described in Minnesota Rules, part~~
217.14 ~~9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may~~
217.15 ~~not both bill for services provided to a recipient on the same day.~~

217.16 ~~(b) Medical assistance covers occupational therapy and related services, including~~
217.17 ~~specialized maintenance therapy. Services provided by an occupational therapy assistant~~
217.18 ~~shall be reimbursed at the same rate as services performed by an occupational therapist~~
217.19 ~~when the services of the occupational therapy assistant are provided under the direction of~~
217.20 ~~the occupational therapist who is on the premises. Services provided by an occupational~~
217.21 ~~therapy assistant under the direction of an occupational therapist who is not on the~~
217.22 ~~premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction~~
217.23 ~~of the occupational therapy assistant must be provided by the occupational therapist as~~
217.24 ~~described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational~~
217.25 ~~therapist and occupational therapist assistant may not both bill for services provided~~
217.26 ~~to a recipient on the same day.~~

217.27 (a) Home health aide visits must be provided by a certified home health aide
217.28 using a written plan of care that is updated in compliance with Medicare regulations.
217.29 A home health aide shall provide hands-on personal care, perform simple procedures
217.30 as an extension of therapy or nursing services, and assist in instrumental activities of
217.31 daily living as defined in section 256B.0659. Home health aide visits must be provided
217.32 in the recipient's home.

217.33 (b) All home health aide visits must have authorization under section 256B.0652.
217.34 The commissioner shall limit home health aide visits to no more than one visit per day
217.35 per recipient.

218.1 (c) Home health aides must be supervised by a registered nurse or an appropriate
218.2 therapist when providing services that are an extension of therapy.

218.3 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be
218.4 provided by a registered nurse or a licensed practical nurse under the supervision of a
218.5 registered nurse, according to the written plan of care and accepted standards of medical
218.6 and nursing practice according to chapter 148. Skilled nurse visit services must be ordered
218.7 by a physician and documented in a plan of care that is reviewed and approved by the
218.8 ordering physician at least once every 60 days. All skilled nurse visits must be medically
218.9 necessary and provided in the recipient's home residence except as allowed under section
218.10 256B.0625, subdivision 6a.

218.11 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of
218.12 up to two visits per day per recipient. All visits must be based on assessed needs.

218.13 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status
218.14 can be accurately measured and assessed without a need for a face-to-face, hands-on
218.15 encounter. All telehomecare skilled nurse visits must have authorization and are paid at
218.16 the same allowable rates as face-to-face skilled nurse visits.

218.17 (d) The provision of telehomecare must be made via live, two-way interactive
218.18 audiovisual technology and may be augmented by utilizing store-and-forward
218.19 technologies. Individually identifiable patient data obtained through real-time or
218.20 store-and-forward technology must be maintained as health records according to sections
218.21 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated
218.22 to the care of the patient, the identity of the patient must be concealed.

218.23 (e) Authorization for skilled nurse visits must be completed under section
218.24 256B.0652. A total of nine face-to-face skilled nurses visits per calendar year do not
218.25 require authorization. All telehomecare skilled nurse visits require authorization.

218.26 Subd. 5. **Home care therapies.** (a) Home care therapies include the following:
218.27 physical therapy, occupational therapy, respiratory therapy, and speech and language
218.28 pathology therapy services.

218.29 (b) Home care therapies must be:

218.30 (1) provided in the recipient's residence after it has been determined the recipient is
218.31 unable to access outpatient therapy;

218.32 (2) prescribed, ordered, or referred by a physician and documented in a plan of care
218.33 and reviewed, according to Minnesota Rules, part 9505.0390;

218.34 (3) assessed by an appropriate therapist; and

218.35 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid
218.36 provider agency.

219.1 (c) Restorative and specialized maintenance therapies must be provided according to
219.2 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be
219.3 used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

219.4 (d) For both physical and occupational therapies, the therapist and the therapist's
219.5 assistant may not both bill for services provided to a recipient on the same day.

219.6 Subd. 6. **Noncovered home health agency services.** The following are not eligible
219.7 for payment under medical assistance as a home health agency service:

219.8 (1) telehomecare skilled nurses services that is communication between the home
219.9 care nurse and recipient that consists solely of a telephone conversation, facsimile,
219.10 electronic mail, or a consultation between two health care practitioners;

219.11 (2) the following skilled nurse visits:

219.12 (i) for the purpose of monitoring medication compliance with an established
219.13 medication program for a recipient;

219.14 (ii) administering or assisting with medication administration, including injections,
219.15 prefilling syringes for injections, or oral medication setup of an adult recipient, when,
219.16 as determined and documented by the registered nurse, the need can be met by an
219.17 available pharmacy or the recipient or a family member is physically and mentally able
219.18 to self-administer or refill a medication;

219.19 (iii) services done for the sole purpose of supervision of the home health aide or
219.20 personal care assistant;

219.21 (iv) services done for the sole purpose to train other home health agency workers;

219.22 (v) services done for the sole purpose of blood samples or lab draw when the
219.23 recipient is able to access these services outside the home; and

219.24 (vi) Medicare evaluation or administrative nursing visits required by Medicare;

219.25 (3) home health aide visits when the following activities are the sole purpose for the
219.26 visit: companionship, socialization, household tasks, transportation, and education; and

219.27 (4) home care therapies provided in other settings such as a clinic, day program, or as
219.28 an inpatient or when the recipient can access therapy outside of the recipient's residence.

219.29 Sec. 26. Minnesota Statutes 2008, section 256B.0654, is amended to read:

219.30 **256B.0654 PRIVATE DUTY NURSING.**

219.31 Subdivision 1. **Definitions.** ~~(a) "Assessment" means a review and evaluation of a~~
219.32 ~~recipient's need for home care services conducted in person. Assessments for private duty~~
219.33 ~~nursing shall be conducted by a registered private duty nurse. Assessments for medical~~
219.34 ~~assistance home care services for developmental disabilities and alternative care services~~

220.1 ~~for developmentally disabled home and community-based waived recipients may be~~
220.2 ~~conducted by the county public health nurse to ensure coordination and avoid duplication.~~

220.3 ~~(b) (a) "Complex and regular private duty nursing care" means:~~

220.4 ~~(1) complex care is private duty nursing services provided to recipients who are~~
220.5 ~~ventilator dependent or for whom a physician has certified that were it not for private duty~~
220.6 ~~nursing the recipient would meet the criteria for inpatient hospital intensive care unit~~
220.7 ~~(ICU) level of care; and~~

220.8 ~~(2) regular care is private duty nursing provided to all other recipients.~~

220.9 ~~(b) "Private duty nursing" means ongoing professional nursing services by a~~
220.10 ~~registered or licensed practical nurse including assessment, professional nursing tasks, and~~
220.11 ~~education, based on an assessment and physician orders to maintain or restore optimal~~
220.12 ~~health of the recipient.~~

220.13 ~~(c) "Private duty nursing agency" means a medical assistance enrolled provider~~
220.14 ~~licensed under chapter 144A to provide private duty nursing services.~~

220.15 ~~(d) "Regular private duty nursing" means nursing services provided to a recipient~~
220.16 ~~who is considered stable and not at an inpatient hospital intensive care unit level of care,~~
220.17 ~~but may have episodes of instability that are not life threatening.~~

220.18 ~~(e) "Shared private duty nursing" means the provision of nursing services by a~~
220.19 ~~private duty nurse to two recipients at the same time and in the same setting.~~

220.20 Subd. 2. **Authorization; private duty nursing services.** (a) All private duty
220.21 nursing services shall be ~~prior~~ authorized by the commissioner or the commissioner's
220.22 designee. ~~Prior~~ Authorization for private duty nursing services shall be based on
220.23 medical necessity and cost-effectiveness when compared with alternative care options.
220.24 The commissioner may authorize medically necessary private duty nursing services in
220.25 quarter-hour units when:

220.26 (1) the recipient requires more individual and continuous care than can be provided
220.27 during a skilled nurse visit; or

220.28 (2) the cares are outside of the scope of services that can be provided by a home
220.29 health aide or personal care assistant.

220.30 (b) The commissioner may authorize:

220.31 (1) up to two times the average amount of direct care hours provided in nursing
220.32 facilities statewide for case mix classification "K" as established by the annual cost report
220.33 submitted to the department by nursing facilities in May 1992;

220.34 (2) private duty nursing in combination with other home care services up to the total
220.35 cost allowed under section 256B.0655, subdivision 4;

221.1 (3) up to 16 hours per day if the recipient requires more nursing than the maximum
221.2 number of direct care hours as established in clause (1) and the recipient meets the hospital
221.3 admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

221.4 (c) The commissioner may authorize up to 16 hours per day of medically necessary
221.5 private duty nursing services or up to 24 hours per day of medically necessary private duty
221.6 nursing services until such time as the commissioner is able to make a determination of
221.7 eligibility for recipients who are cooperatively applying for home care services under
221.8 the community alternative care program developed under section 256B.49, or until it is
221.9 determined by the appropriate regulatory agency that a health benefit plan is or is not
221.10 required to pay for appropriate medically necessary health care services. Recipients
221.11 or their representatives must cooperatively assist the commissioner in obtaining this
221.12 determination. Recipients who are eligible for the community alternative care program
221.13 may not receive more hours of nursing under this section and sections 256B.0651,
221.14 256B.0653, ~~256B.0655~~, and 256B.0656, and 256B.0659 than would otherwise be
221.15 authorized under section 256B.49.

221.16 Subd. 2a. Private duty nursing services. (a) Private duty nursing services must
221.17 be used:

221.18 (1) in the recipient's home or outside the home when normal life activities require;

221.19 (2) when the recipient requires more individual and continuous care than can be
221.20 provided during a skilled nurse visit; and

221.21 (3) when the care required is outside of the scope of services that can be provided by
221.22 a home health aide or personal care assistant.

221.23 (b) Private duty nursing services must be:

221.24 (1) assessed by a registered nurse on a form approved by the commissioner;

221.25 (2) ordered by a physician and documented in a plan of care that is reviewed by the
221.26 physician at least once every 60 days; and

221.27 (3) authorized by the commissioner under section 256B.0652.

221.28 Subd. 2b. Noncovered private duty nursing services. Private duty nursing
221.29 services do not cover the following:

221.30 (1) nursing services by a nurse who is the family foster care provider of a person
221.31 who has not reached 18 years of age unless allowed under subdivision 4;

221.32 (2) nursing services to more than two persons receiving shared private duty nursing
221.33 services from a private duty nurse in a single setting; and

221.34 (3) nursing services provided by a registered nurse or licensed practical nurse who is
221.35 the recipient's legal guardian or related to the recipient as spouse, parent, or family foster

222.1 parent whether by blood, marriage, or adoption except as specified in section 256B.0652,
222.2 subdivision 4.

222.3 Subd. 3. **Shared private duty nursing care option.** (a) Medical assistance
222.4 payments for shared private duty nursing services by a private duty nurse shall be limited
222.5 according to this subdivision. ~~For the purposes of this section and sections 256B.0651,~~
222.6 ~~256B.0653, 256B.0655, and 256B.0656, "private duty nursing agency" means an agency~~
222.7 ~~licensed under chapter 144A to provide private duty nursing services.~~ Unless otherwise
222.8 provided in this subdivision, all other statutory and regulatory provisions relating to
222.9 private duty nursing services apply to shared private duty nursing services. Nothing in
222.10 this subdivision shall be construed to reduce the total number of private duty nursing
222.11 hours authorized for an individual recipient.

222.12 ~~(b) Recipients of private duty nursing services may share nursing staff and the~~
222.13 ~~commissioner shall provide a rate methodology for shared private duty nursing. For two~~
222.14 ~~persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the~~
222.15 ~~regular private duty nursing rates paid for serving a single individual by a registered nurse~~
222.16 ~~or licensed practical nurse. These rates apply only to situations in which both recipients~~
222.17 ~~are present and receive shared private duty nursing care on the date for which the service~~
222.18 ~~is billed. No more than two persons may receive shared private duty nursing services~~
222.19 ~~from a private duty nurse in a single setting.~~

222.20 ~~(e)~~ (b) Shared private duty nursing care is the provision of nursing services by a
222.21 private duty nurse to two medical assistance eligible recipients at the same time and in
222.22 the same setting. This subdivision does not apply when a private duty nurse is caring for
222.23 multiple recipients in more than one setting.

222.24 (c) For the purposes of this subdivision, "setting" means:

222.25 (1) the home residence or foster care home of one of the individual recipients as
222.26 defined in section 256B.0651; ~~or~~

222.27 (2) a child care program licensed under chapter 245A or operated by a local school
222.28 district or private school; ~~or~~

222.29 (3) an adult day care service licensed under chapter 245A; or

222.30 (4) outside the home residence or foster care home of one of the recipients when
222.31 normal life activities take the recipients outside the home.

222.32 ~~This subdivision does not apply when a private duty nurse is caring for multiple~~
222.33 ~~recipients in more than one setting.~~

222.34 (d) The private duty nursing agency must offer the recipient the option of shared or
222.35 one-on-one private duty nursing services. The recipient may withdraw from participating
222.36 in a shared service arrangement at any time.

223.1 ~~(d)~~ (e) The recipient or the recipient's legal representative, and the recipient's
223.2 physician, in conjunction with the ~~home health care~~ private duty nursing agency, shall
223.3 determine:

223.4 (1) whether shared private duty nursing care is an appropriate option based on the
223.5 individual needs and preferences of the recipient; and

223.6 (2) the amount of shared private duty nursing services authorized as part of the
223.7 overall authorization of nursing services.

223.8 ~~(e)~~ (f) The recipient or the recipient's legal representative, in conjunction with the
223.9 private duty nursing agency, shall approve the setting, grouping, and arrangement of
223.10 shared private duty nursing care based on the individual needs and preferences of the
223.11 recipients. Decisions on the selection of recipients to share services must be based on the
223.12 ages of the recipients, compatibility, and coordination of their care needs.

223.13 ~~(f)~~ (g) The following items must be considered by the recipient or the recipient's
223.14 legal representative and the private duty nursing agency, and documented in the recipient's
223.15 health service record:

223.16 (1) the additional training needed by the private duty nurse to provide care to
223.17 two recipients in the same setting and to ensure that the needs of the recipients are met
223.18 appropriately and safely;

223.19 (2) the setting in which the shared private duty nursing care will be provided;

223.20 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness
223.21 of the service and process used to make changes in service or setting;

223.22 (4) a contingency plan which accounts for absence of the recipient in a shared private
223.23 duty nursing setting due to illness or other circumstances;

223.24 (5) staffing backup contingencies in the event of employee illness or absence; and

223.25 (6) arrangements for additional assistance to respond to urgent or emergency care
223.26 needs of the recipients.

223.27 ~~(g) The provider must offer the recipient or responsible party the option of shared or~~
223.28 ~~one-on-one private duty nursing services. The recipient or responsible party can withdraw~~
223.29 ~~from participating in a shared service arrangement at any time.~~

223.30 (h) ~~The private duty nursing agency must document the following in the~~
223.31 ~~health service record for each individual recipient sharing private duty nursing care~~
223.32 The documentation for shared private duty nursing must be on a form approved by
223.33 the commissioner for each individual recipient sharing private duty nursing. The
223.34 documentation must be part of the recipient's health service record and include:

223.35 (1) permission by the recipient or the recipient's legal representative for the
223.36 maximum number of shared nursing ~~care~~ hours per week chosen by the recipient and

224.1 permission for shared private duty nursing services provided in and outside the recipient's
224.2 home residence;

224.3 ~~(2) permission by the recipient or the recipient's legal representative for shared~~
224.4 ~~private duty nursing services provided outside the recipient's residence;~~

224.5 ~~(3) permission by the recipient or the recipient's legal representative for others to~~
224.6 ~~receive shared private duty nursing services in the recipient's residence;~~

224.7 ~~(4) revocation by the recipient or the recipient's legal representative of~~ for the shared
224.8 private duty nursing care authorization, or the shared care to be provided to others in the
224.9 recipient's residence, or the shared private duty nursing services to be provided outside
224.10 permission, or services provided to others in and outside the recipient's residence; and

224.11 ~~(5)~~ (3) daily documentation of the shared private duty nursing services provided by
224.12 each identified private duty nurse, including:

224.13 (i) the names of each recipient receiving shared private duty nursing services
224.14 ~~together;~~

224.15 (ii) the setting for the shared services, including the starting and ending times that
224.16 the recipient received shared private duty nursing care; and

224.17 (iii) notes by the private duty nurse regarding changes in the recipient's condition,
224.18 problems that may arise from the sharing of private duty nursing services, and scheduling
224.19 and care issues.

224.20 ~~(i) Unless otherwise provided in this subdivision, all other statutory and regulatory~~
224.21 ~~provisions relating to private duty nursing services apply to shared private duty nursing~~
224.22 ~~services.~~

224.23 ~~Nothing in this subdivision shall be construed to reduce the total number of private~~
224.24 ~~duty nursing hours authorized for an individual recipient under subdivision 2.~~

224.25 (i) The commissioner shall provide a rate methodology for shared private duty
224.26 nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed
224.27 1.5 times the regular private duty nursing rates paid for serving a single individual by a
224.28 registered nurse or licensed practical nurse. These rates apply only to situations in which
224.29 both recipients are present and receive shared private duty nursing care on the date for
224.30 which the service is billed.

224.31 **Subd. 4. Hardship criteria; private duty nursing.** (a) Payment is allowed for
224.32 extraordinary services that require specialized nursing skills and are provided by parents
224.33 of minor children, family foster parents, spouses, and legal guardians who are providing
224.34 private duty nursing care under the following conditions:

224.35 (1) the provision of these services is not legally required of the parents, spouses,
224.36 or legal guardians;

225.1 (2) the services are necessary to prevent hospitalization of the recipient; and
225.2 (3) the recipient is eligible for state plan home care or a home and community-based
225.3 waiver and one of the following hardship criteria are met:

225.4 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
225.5 provide nursing care for the recipient; ~~or~~

225.6 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
225.7 less compensation to provide nursing care for the recipient; ~~or~~

225.8 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to
225.9 provide nursing care for the recipient; or

225.10 (iv) because of labor conditions, special language needs, or intermittent hours of
225.11 care needed, the parent, spouse, or legal guardian is needed in order to provide adequate
225.12 private duty nursing services to meet the medical needs of the recipient.

225.13 (b) Private duty nursing may be provided by a parent, spouse, family foster parent,
225.14 or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services
225.15 provided by a parent, spouse, family foster parent, or legal guardian cannot be used in
225.16 lieu of nursing services covered and available under liable third-party payors, including
225.17 Medicare. The private duty nursing provided by a parent, spouse, family foster parent, or
225.18 legal guardian must be included in the service ~~plan~~ agreement. Authorized ~~skilled~~ nursing
225.19 services for a single recipient or recipients with the same residence and provided by the
225.20 parent, spouse, family foster parent, or legal guardian may not exceed 50 percent of the
225.21 total approved nursing hours, or eight hours per day, whichever is less, up to a maximum
225.22 of 40 hours per week. A parent or parents, spouse, family foster parent, or legal guardian
225.23 shall not provide more than 40 hours of services in a seven-day period. For parents, family
225.24 foster parents, and legal guardians, 40 hours is the total amount allowed regardless of the
225.25 number of children or adults who receive services. Nothing in this subdivision precludes
225.26 the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family
225.27 responsibilities of emergency backup caregiver and primary caregiver.

225.28 (c) A parent, family foster parent, or a spouse may not be paid to provide private
225.29 duty nursing care if:

225.30 (1) the parent or spouse fails to pass a criminal background check according to
225.31 chapter 245C, ~~or if~~;

225.32 (2) it has been determined by the ~~home health~~ private duty nursing agency, the
225.33 case manager, or the physician that the private duty nursing ~~care~~ provided by the parent,
225.34 family foster parent, spouse, or legal guardian is unsafe; or

225.35 (3) the parent, family foster parent, spouse, or legal guardian do not follow physician
225.36 orders.

226.1 (d) For purposes of this section, "assessment" means a review and evaluation of a
226.2 recipient's need for home care services conducted in person. Assessments for private duty
226.3 nursing must be conducted by a registered nurse.

226.4 Sec. 27. Minnesota Statutes 2008, section 256B.0655, subdivision 1b, is amended to
226.5 read:

226.6 Subd. 1b. **Assessment.** "Assessment" means a review and evaluation of a recipient's
226.7 need for home care services conducted in person. Assessments for personal care assistant
226.8 services shall be conducted by the county public health nurse or a certified public
226.9 health nurse under contract with the county. ~~A face-to-face~~ An in-person assessment
226.10 must include: documentation of health status, determination of need, evaluation of
226.11 service effectiveness, identification of appropriate services, service plan development
226.12 or modification, coordination of services, referrals and follow-up to appropriate payers
226.13 and community resources, completion of required reports, recommendation of service
226.14 authorization, and consumer education. Once the need for personal care assistant
226.15 services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654,
226.16 and 256B.0656, the county public health nurse or certified public health nurse under
226.17 contract with the county is responsible for communicating this recommendation to the
226.18 commissioner and the recipient. ~~A face-to-face assessment for personal care assistant~~
226.19 ~~services is conducted on those recipients who have never had a county public health~~
226.20 ~~nurse assessment. A face-to-face~~ An in-person assessment must occur at least annually or
226.21 when there is a significant change in the recipient's condition or when there is a change
226.22 in the need for personal care assistant services. A service update may substitute for
226.23 the annual face-to-face assessment when there is not a significant change in recipient
226.24 condition or a change in the need for personal care assistant service. A service update
226.25 may be completed by telephone, used when there is no need for an increase in personal
226.26 care assistant services, and used for two consecutive assessments if followed by a
226.27 face-to-face assessment. A service update must be completed on a form approved by the
226.28 commissioner. A service update or review for temporary increase includes a review of
226.29 initial baseline data, evaluation of service effectiveness, redetermination of service need,
226.30 modification of service plan and appropriate referrals, update of initial forms, obtaining
226.31 service authorization, and on going consumer education. Assessments must be completed
226.32 on forms provided by the commissioner within 30 days of a request for home care services
226.33 by a recipient or responsible party or personal care provider agency.

227.1 Sec. 28. Minnesota Statutes 2008, section 256B.0655, subdivision 4, is amended to
227.2 read:

227.3 Subd. 4. **Prior Authorization; personal care assistance and qualified**
227.4 **professional.** ~~The commissioner, or the commissioner's designee, shall review the~~
227.5 ~~assessment, service update, request for temporary services, request for flexible use option,~~
227.6 ~~service plan, and any additional information that is submitted. The commissioner shall,~~
227.7 ~~within 30 days after receiving a complete request, assessment, and service plan, authorize~~
227.8 ~~home care services as follows:~~

227.9 ~~(+)~~ (a) All personal care ~~assistant~~ assistance services and supervision by a
227.10 qualified professional, if requested by the recipient, and additional services beyond the
227.11 limits established in section 256B.0651, subdivision 11, must be prior authorized by
227.12 the commissioner or the commissioner's designee before services begin except for the
227.13 assessments established in ~~section~~ sections 256B.0651, subdivision 11, and 256B.0911.
227.14 The authorization for personal care assistance and qualified professional services under
227.15 section 256B.0659 must be completed within 30 days after receiving a complete request.

227.16 (b) The amount of personal care ~~assistant~~ assistance services authorized must be
227.17 based on the recipient's home care rating. The home care rating shall be determined by
227.18 the commissioner or the commissioner's designee based on information submitted to the
227.19 commissioner identifying the following:

227.20 (1) total number of dependencies of activities of daily living as defined in section
227.21 256B.0659;

227.22 (2) number of complex health-related functions as defined in section 256B.0659; and

227.23 (3) number of behavior descriptions as defined in section 256B.0659.

227.24 (c) The methodology to determine total time for personal care assistance services for
227.25 each home care rating is based on the median paid units per day for each home care rating
227.26 from fiscal year 2007 data for the personal care assistance program. Each home care rating
227.27 has a base level of hours assigned. Additional time is added through the assessment and
227.28 identification of the following:

227.29 (1) 30 additional minutes per day for a dependency in each critical activity of daily
227.30 living as defined in section 256B.0659;

227.31 (2) 30 additional minutes per day for each complex health-related function as
227.32 defined in section 256B.0659; and

227.33 (3) 30 additional minutes per day for each behavior issue as defined in section
227.34 256B.0659.

227.35 (d) A limit of 96 units of qualified professional supervision may be authorized for
227.36 each recipient receiving personal care assistance services. A request to the commissioner

228.1 to exceed this total in a calendar year must be requested by the personal care provider
228.2 agency on a form approved by the commissioner.

228.3 ~~A child may not be found to be dependent in an activity of daily living if because~~
228.4 ~~of the child's age an adult would either perform the activity for the child or assist the~~
228.5 ~~child with the activity and the amount of assistance needed is similar to the assistance~~
228.6 ~~appropriate for a typical child of the same age. Based on medical necessity, the~~
228.7 ~~commissioner may authorize:~~

228.8 ~~(A) up to two times the average number of direct care hours provided in nursing~~
228.9 ~~facilities for the recipient's comparable case mix level; or~~

228.10 ~~(B) up to three times the average number of direct care hours provided in nursing~~
228.11 ~~facilities for recipients who have complex medical needs or are dependent in at least seven~~
228.12 ~~activities of daily living and need physical assistance with eating or have a neurological~~
228.13 ~~diagnosis; or~~

228.14 ~~(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care~~
228.15 ~~provided in a regional treatment center for recipients who have Level I behavior, plus any~~
228.16 ~~inflation adjustment as provided by the legislature for personal care service; or~~

228.17 ~~(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any~~
228.18 ~~inflation adjustment provided for home care services, for care provided in a regional~~
228.19 ~~treatment center for recipients referred to the commissioner by a regional treatment center~~
228.20 ~~preadmission evaluation team. For purposes of this clause, home care services means~~
228.21 ~~all services provided in the home or community that would be included in the payment~~
228.22 ~~to a regional treatment center; or~~

228.23 ~~(E) up to the amount medical assistance would reimburse for facility care for~~
228.24 ~~recipients referred to the commissioner by a preadmission screening team established~~
228.25 ~~under section 256B.0911 or 256B.092; and~~

228.26 ~~(F) a reasonable amount of time for the provision of supervision by a qualified~~
228.27 ~~professional of personal care assistant services, if a qualified professional is requested by~~
228.28 ~~the recipient or responsible party.~~

228.29 ~~(2) The number of direct care hours shall be determined according to the annual cost~~
228.30 ~~report submitted to the department by nursing facilities. The average number of direct care~~
228.31 ~~hours, as established by May 1, 1992, shall be calculated and incorporated into the home~~
228.32 ~~care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.~~

228.33 ~~(3) The home care rating shall be determined by the commissioner or the~~
228.34 ~~commissioner's designee based on information submitted to the commissioner by the~~
228.35 ~~county public health nurse on forms specified by the commissioner. The home care rating~~
228.36 ~~shall be a combination of current assessment tools developed under sections 256B.0911~~

229.1 ~~and 256B.501 with an addition for seizure activity that will assess the frequency and~~
229.2 ~~severity of seizure activity and with adjustments, additions, and clarifications that are~~
229.3 ~~necessary to reflect the needs and conditions of recipients who need home care including~~
229.4 ~~children and adults under 65 years of age. The commissioner shall establish these forms~~
229.5 ~~and protocols under this section and sections 256B.0651, 256B.0653, 256B.0654, and~~
229.6 ~~256B.0656 and shall use an advisory group, including representatives of recipients,~~
229.7 ~~providers, and counties, for consultation in establishing and revising the forms and~~
229.8 ~~protocols.~~

229.9 ~~(4) A recipient shall qualify as having complex medical needs if the care required is~~
229.10 ~~difficult to perform and because of recipient's medical condition requires more time than~~
229.11 ~~community-based standards allow or requires more skill than would ordinarily be required~~
229.12 ~~and the recipient needs or has one or more of the following:~~

229.13 ~~(A) daily tube feedings;~~

229.14 ~~(B) daily parenteral therapy;~~

229.15 ~~(C) wound or decubiti care;~~

229.16 ~~(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy~~
229.17 ~~care, oxygen, mechanical ventilation;~~

229.18 ~~(E) catheterization;~~

229.19 ~~(F) ostomy care;~~

229.20 ~~(G) quadriplegia; or~~

229.21 ~~(H) other comparable medical conditions or treatments the commissioner determines~~
229.22 ~~would otherwise require institutional care.~~

229.23 ~~(5) A recipient shall qualify as having Level I behavior if there is reasonable~~
229.24 ~~supporting evidence that the recipient exhibits, or that without supervision, observation, or~~
229.25 ~~redirection would exhibit, one or more of the following behaviors that cause, or have the~~
229.26 ~~potential to cause:~~

229.27 ~~(A) injury to the recipient's own body;~~

229.28 ~~(B) physical injury to other people; or~~

229.29 ~~(C) destruction of property.~~

229.30 ~~(6) Time authorized for personal care relating to Level I behavior in paragraph~~
229.31 ~~(5), clauses (A) to (C), shall be based on the predictability, frequency, and amount of~~
229.32 ~~intervention required.~~

229.33 ~~(7) A recipient shall qualify as having Level II behavior if the recipient exhibits on a~~
229.34 ~~daily basis one or more of the following behaviors that interfere with the completion of~~
229.35 ~~personal care assistant services under subdivision 2, paragraph (a):~~

229.36 ~~(A) unusual or repetitive habits;~~

230.1 ~~(B) withdrawn behavior; or~~
230.2 ~~(C) offensive behavior.~~
230.3 ~~(8) A recipient with a home care rating of Level II behavior in paragraph (7), clauses~~
230.4 ~~(A) to (C), shall be rated as comparable to a recipient with complex medical needs under~~
230.5 ~~paragraph (4). If a recipient has both complex medical needs and Level II behavior, the~~
230.6 ~~home care rating shall be the next complex category up to the maximum rating under~~
230.7 ~~paragraph (1), clause (B).~~

230.8 EFFECTIVE DATE. The amendments to paragraphs (a) and (b) are effective
230.9 January 1, 2010.

230.10 Sec. 29. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to
230.11 read:

230.12 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
230.13 self-directed service option shall be equal to the greater of either established based on:

230.14 (1) ~~the annual amount of personal care assistant services under section 256B.0655~~
230.15 ~~that the recipient has used in the most recent 12-month period~~ assessed personal care
230.16 assistance units, not to exceed the maximum number of personal care assistance units
230.17 available, as determined by section 256B.0655; or and

230.18 (2) ~~the amount determined using the consumer support grant methodology under~~
230.19 ~~section 256.476, subdivision 11, except that the budget amount shall include the federal~~
230.20 ~~and nonfederal share of the average service costs.~~ the personal care assistance unit rate:

230.21 (i) with a reduction to the unit rate to pay for a program administrator as defined in
230.22 subdivision 10; and

230.23 (ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for
230.24 the state.

230.25 Sec. 30. Minnesota Statutes 2008, section 256B.0657, is amended by adding a
230.26 subdivision to read:

230.27 Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports
230.28 option is available to current personal care assistance recipients upon annual personal care
230.29 assistance reassessment, with a maximum enrollment of 1,000 people in the first fiscal
230.30 year of implementation and an additional 1,000 people in the second fiscal year. The
230.31 commissioner shall evaluate the self-directed supports option during the first two years of
230.32 implementation and make any necessary changes prior to the option becoming available
230.33 statewide.

231.1 Sec. 31. [256B.0659] PERSONAL CARE ASSISTANCE PROGRAM.

231.2 Subdivision 1. Definitions. (a) For the purposes of this section, the terms defined in
231.3 paragraphs (b) to (p) have the meanings given unless otherwise provided in text.

231.4 (b) "Activities of daily living" means grooming, dressing, bathing, transferring,
231.5 mobility, positioning, eating, and toileting.

231.6 (c) "Behavior," effective January 1, 2010, means a category to determine the home
231.7 care rating and is based on the criteria found in this section. "Level I behavior" means
231.8 physical aggression towards self, others, or destruction of property that requires the
231.9 immediate response of another person.

231.10 (d) "Complex health-related needs," effective January 1, 2010, means a category to
231.11 determine the home care rating and is based on the criteria found in this section.

231.12 (e) "Critical activities of daily living," effective January 1, 2010, means transferring,
231.13 mobility, eating, and toileting.

231.14 (f) "Dependency in activities of daily living" means a person requires assistance to
231.15 begin and complete one or more of the activities of daily living.

231.16 (g) "Health-related procedures and tasks" means procedures and tasks that can
231.17 be delegated or assigned by a licensed health care professional under state law to be
231.18 performed by a personal care assistant.

231.19 (h) "Instrumental activities of daily living" means activities to include meal planning
231.20 and preparation; basic assistance with paying bills; shopping for food, clothing, and
231.21 other essential items; performing household tasks integral to the personal care assistance
231.22 services; communication by telephone and other media; and traveling, including to
231.23 medical appointments and to participate in the community.

231.24 (i) "Managing employee" has the same definition as Code of Federal Regulations,
231.25 title 42, section 455.

231.26 (j) "Qualified professional" means a professional providing supervision of personal
231.27 care assistance services and staff as defined in section 256B.0625, subdivision 19c.

231.28 (k) "Personal care assistance provider agency" means a medical assistance enrolled
231.29 provider that provides or assists with providing personal care assistance services and
231.30 includes personal care assistance provider organizations, personal care assistance choice
231.31 agency, class A licensed nursing agency, and Medicare-certified home health agency.

231.32 (l) "Personal care assistant" or "PCA" means an individual employed by a personal
231.33 care assistance agency who provides personal care assistance services.

231.34 (m) "Personal care assistance care plan" means a written description of personal
231.35 care assistance services developed by the personal care assistance provider according
231.36 to the service plan.

232.1 (n) "Responsible party" means an individual who is capable of providing the support
232.2 necessary to assist the recipient to live in the community.

232.3 (o) "Self-administered medication" means medication taken orally, by injection or
232.4 insertion, or applied topically without the need for assistance.

232.5 (p) "Service plan" means a written summary of the assessment and description of the
232.6 services needed by the recipient.

232.7 **Subd. 2. Personal care assistance services; covered services.** (a) The personal
232.8 care assistance services eligible for payment include services and supports furnished
232.9 to an individual, as needed, to assist in:

232.10 (1) activities of daily living;

232.11 (2) health-related procedures and tasks;

232.12 (3) observation and redirection of behaviors; and

232.13 (4) instrumental activities of daily living.

232.14 (b) Activities of daily living include the following covered services:

232.15 (1) dressing, including assistance with choosing, application, and changing of
232.16 clothing and application of special appliances, wraps, or clothing;

232.17 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
232.18 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
232.19 except for recipients who are diabetic or have poor circulation;

232.20 (3) bathing, including assistance with basic personal hygiene and skin care;

232.21 (4) eating, including assistance with hand washing and application of orthotics
232.22 required for eating, transfers, and feeding;

232.23 (5) transfers, including assistance with transferring the recipient from one seating or
232.24 reclining area to another;

232.25 (6) mobility, including assistance with ambulation, including use of a wheelchair.
232.26 Mobility does not include providing transportation for a recipient;

232.27 (7) positioning, including assistance with positioning or turning a recipient for
232.28 necessary care and comfort; and

232.29 (8) toileting, including assistance with helping recipient with bowel or bladder
232.30 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
232.31 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
232.32 adjusting clothing.

232.33 (c) Health-related procedures and tasks include the following covered services:

232.34 (1) range of motion and passive exercise to maintain a recipient's strength and
232.35 muscle functioning;

233.1 (2) assistance with self-administered medication as defined by this section, including
233.2 reminders to take medication, bringing medication to the recipient, and assistance with
233.3 opening medication under the direction of the recipient or responsible party;

233.4 (3) interventions for seizure disorders, including monitoring and observation; and

233.5 (4) other activities considered within the scope of the personal care service and
233.6 meeting the definition of health-related procedures and tasks under this section.

233.7 (d) A personal care assistant may provide health-related procedures and tasks
233.8 associated with the complex health-related needs of a recipient if the procedures and
233.9 tasks meet the definition of health-related procedures and tasks under this section and the
233.10 personal care assistant is trained by a qualified professional and demonstrates competency
233.11 to safely complete the procedures and tasks. Delegation of health-related procedures and
233.12 tasks and all training must be documented in the personal care assistance care plan and the
233.13 recipient's and personal care assistant's files.

233.14 (e) Effective January 1, 2010, for a personal care assistant to provide the
233.15 health-related procedures and tasks of tracheostomy suctioning and services to recipients
233.16 on ventilator support there must be:

233.17 (1) delegation and training by a registered nurse, certified or licensed respiratory
233.18 therapist, or a physician;

233.19 (2) utilization of clean rather than sterile procedure;

233.20 (3) specialized training about the health-related procedures and tasks and equipment,
233.21 including ventilator operation and maintenance;

233.22 (4) individualized training regarding the needs of the recipient; and

233.23 (5) supervision by a qualified professional who is a registered nurse.

233.24 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
233.25 recipient for episodes where there is a need for redirection due to behaviors. Training of
233.26 the personal care assistant must occur based on the needs of the recipient, the personal
233.27 care assistance care plan, and any other support services provided.

233.28 (g) Instrumental activities of daily living under subdivision 1, paragraph (h).

233.29 **Subd. 3. Noncovered personal care assistance services.** (a) Personal care
233.30 assistance services are not eligible for medical assistance payment under this section
233.31 when provided:

233.32 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
233.33 guardian, licensed foster provider, except as allowed under section 256B.0651, subdivision
233.34 9a, or responsible party;

233.35 (2) in lieu of other staffing options in a residential or child care setting;

233.36 (3) solely as a child care or babysitting service; or

234.1 (4) without authorization by the commissioner or the commissioner's designee.

234.2 (b) The following personal care services are not eligible for medical assistance
234.3 payment under this section when provided in residential settings:

234.4 (1) effective January 1, 2010, when the provider of home care services who is not
234.5 related by blood, marriage, or adoption owns or otherwise controls the living arrangement,
234.6 including licensed or unlicensed services; or

234.7 (2) when personal care assistance services are the responsibility of a residential or
234.8 program license holder under the terms of a service agreement and administrative rules.

234.9 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible
234.10 for medical assistance reimbursement for personal care assistance services under this
234.11 section include:

234.12 (1) sterile procedures;

234.13 (2) injections of fluids and medications into veins, muscles, or skin;

234.14 (3) home maintenance or chore services;

234.15 (4) homemaker services not an integral part of assessed personal care assistance
234.16 services needed by a recipient;

234.17 (5) application of restraints or implementation of procedures under section 245.825;

234.18 (6) instrumental activities of daily living for children under the age of 18; and

234.19 (7) assessments for personal care assistance services by personal care assistance
234.20 provider agencies or by independently enrolled registered nurses.

234.21 Subd. 4. **Assessment for personal care assistance services.** (a) An assessment
234.22 as defined in section 256B.0655, subdivision 1b, must be completed for personal care
234.23 assistance services.

234.24 (b) The following limitations apply to the assessment:

234.25 (1) a person must be assessed as dependent in an activity of daily living based
234.26 on the person's need, on a daily basis, for:

234.27 (i) cueing and constant supervision to complete the task; or

234.28 (ii) hands-on assistance to complete the task; and

234.29 (2) a child may not be found to be dependent in an activity of daily living if because
234.30 of the child's age an adult would either perform the activity for the child or assist the child
234.31 with the activity. Assistance needed is the assistance appropriate for a typical child of
234.32 the same age.

234.33 (c) Assessment for complex health-related needs must meet the criteria in this
234.34 paragraph. During the assessment process, a recipient qualifies as having complex
234.35 health-related needs if the recipient has one or more of the interventions that are ordered by
234.36 a physician, specified in a personal care assistance care plan, and found in the following:

- 235.1 (1) tube feedings requiring:
235.2 (i) a gastro/jejunostomy tube; or
235.3 (ii) continuous tube feeding lasting longer than 12 hours per day;
235.4 (2) wounds described as:
235.5 (i) stage III or stage IV;
235.6 (ii) multiple wounds;
235.7 (iii) requiring sterile or clean dressing changes or a wound vac; or
235.8 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
235.9 specialized care;
235.10 (3) parenteral therapy described as:
235.11 (i) IV therapy more than two times per week lasting longer than four hours for
235.12 each treatment; or
235.13 (ii) total parenteral nutrition (TPN) daily;
235.14 (4) respiratory interventions including:
235.15 (i) oxygen required more than eight hours per day;
235.16 (ii) respiratory vest more than one time per day;
235.17 (iii) bronchial drainage treatments more than two times per day;
235.18 (iv) sterile or clean suctioning more than six times per day;
235.19 (v) dependence on another to apply respiratory ventilation augmentation devices
235.20 such as BiPAP and CPAP; and
235.21 (vi) ventilator dependence under section 256B.0652;
235.22 (5) insertion and maintenance of catheter including:
235.23 (i) sterile catheter changes more than one time per month;
235.24 (ii) clean self-catheterization more than six times per day; or
235.25 (iii) bladder irrigations;
235.26 (6) bowel program more than two times per week requiring more than 30 minutes to
235.27 perform each time;
235.28 (7) neurological intervention including:
235.29 (i) seizures more than two times per week and requiring significant physical
235.30 assistance to maintain safety; or
235.31 (ii) swallowing disorders diagnosed by a physician and requiring specialized
235.32 assistance from another on a daily basis; and
235.33 (8) other congenital or acquired diseases creating a need for significantly increased
235.34 direct hands-on assistance and interventions in six to eight activities of daily living.

236.1 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
236.2 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
236.3 assistance at least four times per week and shows one or more of the following behaviors:

236.4 (1) physical aggression towards self or others, or destruction of property that requires
236.5 the immediate response of another person;

236.6 (2) increased vulnerability due to cognitive deficits or socially inappropriate
236.7 behavior; or

236.8 (3) verbally aggressive and resistive to care.

236.9 Subd. 5. **Service, support planning, and referral.** (a) The assessor, with the
236.10 recipient or responsible party, shall review the assessment information and determine
236.11 referrals for other payers, services, and community supports as appropriate.

236.12 (b) The recipient must be referred for evaluation, services, or supports that are
236.13 appropriate to help meet the recipient's needs including, but not limited to, the following
236.14 circumstances:

236.15 (1) when there is another payer who is responsible to provide the service to meet
236.16 the recipient's needs;

236.17 (2) when the recipient qualifies for assistance due to mental illness or behaviors
236.18 under this section, a referral for a mental health diagnostic and functional assessment
236.19 must be completed, or referral must be made for other specific mental health services or
236.20 other community services;

236.21 (3) when the recipient is eligible for medical assistance and meets medical assistance
236.22 eligibility for a home health aide or skilled nurse visit;

236.23 (4) when the recipient would benefit from an evaluation for another service; and

236.24 (5) when there is a more appropriate service to meet the assessed needs.

236.25 (c) The reimbursement rates for public health nurse visits that relate to the provision
236.26 of personal care assistance services under this section and section 256B.0625, subdivision
236.27 19a, are:

236.28 (1) \$210.50 for a face-to-face assessment visit;

236.29 (2) \$105.25 for each service update; and

236.30 (3) \$105.25 for each request for a temporary service increase.

236.31 (d) The rates specified in paragraph (c) must be adjusted to reflect provider rate
236.32 increases for personal care assistance services that are approved by the legislature for the
236.33 fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied
236.34 by the legislature to provider rate increases for personal care assistance services also
236.35 apply to adjustments under this paragraph.

237.1 (e) Effective July 1, 2008, the payment rate for an assessment under this section and
237.2 section 256B.0651 shall be reduced by 25 percent when the assessment is not completed
237.3 on time and the service agreement documentation is not submitted in time to continue
237.4 services. The commissioner shall reduce the amount of the claim for those assessments
237.5 that are not submitted on time.

237.6 Subd. 6. **Service plan.** The service plan must be completed by the assessor with the
237.7 recipient and responsible party on a form determined by the commissioner and include
237.8 a summary of the assessment with a description of the need, authorized amount, and
237.9 expected outcomes and goals of personal care assistance services. The recipient and
237.10 the provider chosen by the recipient or responsible party must be given a copy of the
237.11 completed service plan within ten working days of the assessment. The recipient or
237.12 responsible party must be given information by the assessor about the options in the
237.13 personal care assistance program to allow for review and decision making.

237.14 Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a
237.15 current personal care assistance care plan based on the service plan in subdivision 6 that is
237.16 developed by the qualified professional with the recipient and responsible party. A copy of
237.17 the most current personal care assistance care plan is required to be in the recipient's home
237.18 and in the recipient's file at the provider agency.

237.19 (b) The personal care assistance care plan must have the following components:

237.20 (1) start and end date of the care plan;

237.21 (2) recipient demographic information, including name and telephone number;

237.22 (3) emergency numbers, procedures, and a description of measures to address
237.23 identified safety and vulnerability issues, including a backup staffing plan;

237.24 (4) name of responsible party and instructions for contact;

237.25 (5) description of the recipient's individualized needs for assistance with activities of
237.26 daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

237.27 (6) dated signatures of recipient or responsible party and qualified professional.

237.28 (c) The personal care assistance care plan must have instructions and comments
237.29 about the recipient's needs for assistance and any special instructions or procedures
237.30 required. The month-to-month plan for the use of personal care assistance services is part
237.31 of the personal care assistance care plan. The personal care assistance care plan must
237.32 be completed within the first week after start of services with a personal care provider
237.33 agency and must be updated as needed when there is a change in need for personal care
237.34 assistance services. A new personal care assistance care plan is required annually at the
237.35 time of the reassessment.

238.1 Subd. 8. **Communication with recipient's physician.** The personal care assistance
238.2 program requires communication with the recipient's physician about a recipient's assessed
238.3 needs for personal care assistance services. The commissioner shall work with the state
238.4 medical director to develop options for communication with the recipient's physician.

238.5 Subd. 9. **Responsible party; generally.** (a) "Responsible party," effective January
238.6 1, 2010, means an individual who is capable of providing the support necessary to assist
238.7 the recipient to live in the community.

238.8 (b) A responsible party must be 18 years of age, actively participate in planning and
238.9 directing of personal care assistance services, and attend all assessments for the recipient.

238.10 (c) A responsible party must not be the:

238.11 (1) personal care assistant;

238.12 (2) home care provider agency owner or staff; or

238.13 (3) county staff acting as part of employment.

238.14 (d) A licensed family foster parent who lives with the recipient may be the
238.15 responsible party as long as the family foster parent meets the other responsible party
238.16 requirements.

238.17 (e) A responsible party is required when:

238.18 (1) the person is a minor according to section 524.5-102, subdivision 10;

238.19 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
238.20 6, resulting in a court-appointed guardian; or

238.21 (3) the assessment according to section 256B.0655, subdivision 1b, determines that
238.22 the recipient is in need of a responsible party to direct the recipient's care.

238.23 (f) There may be two persons designated as the responsible party for reasons such
238.24 as divided households and court-ordered custodies. Each person named as responsible
238.25 party must meet the program criteria and responsibilities.

238.26 (g) The recipient or the recipient's legal representative shall appoint a responsible
238.27 party if necessary to direct and supervise the care provided to the recipient. The
238.28 responsible party must be identified at the time of assessment and listed on the recipient's
238.29 service agreement and personal care assistance care plan.

238.30 Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall
238.31 enter into a written agreement with a personal care assistance provider agency, on a form
238.32 determined by the commissioner, to perform the following duties:

238.33 (1) be available while care is provided in a method agreed upon by the individual
238.34 or the individual's legal representative and documented in the recipient's personal care
238.35 assistance care plan;

239.1 (2) monitor personal care assistance services to ensure the recipient's personal care
239.2 assistance care plan is being followed; and

239.3 (3) review and sign personal care assistance time sheets after services are provided
239.4 to provide verification of the personal care assistance services.

239.5 Failure to provide the support required by the recipient must result in a referral to the
239.6 county common entry point.

239.7 (b) Responsible parties who are parents of minors or guardians of minors or
239.8 incapacitated persons may delegate the responsibility to another adult who is not the
239.9 personal care assistant during a temporary absence of at least 24 hours but not more
239.10 than six months. The person delegated as a responsible party must be able to meet the
239.11 definition of the responsible party, except that the delegated responsible party is required
239.12 to reside with the recipient only while serving as the responsible party. The responsible
239.13 party must ensure that the delegate performs the functions of the responsible party, is
239.14 identified at the time of the assessment, and is listed on the personal care assistance
239.15 care plan. The responsible party must communicate to the personal care assistance
239.16 provider agency about the need for a delegate responsible party, including the name of the
239.17 delegated responsible party, dates the delegated responsible party will be living with the
239.18 recipient, and contact numbers.

239.19 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
239.20 must meet the following requirements:

239.21 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
239.22 of age with these additional requirements:

239.23 (i) supervision by a qualified professional every 60 days; and

239.24 (ii) employment by only one personal care assistance provider agency responsible
239.25 for compliance with current labor laws;

239.26 (2) be employed by a personal care assistance provider agency;

239.27 (3) enroll with the department as a personal care assistant after clearing a background
239.28 study. Before a personal care assistant provides services, the personal care assistance
239.29 provider agency must initiate a background study on the personal care assistant under
239.30 chapter 245C, and the personal care assistance provider agency must have received a
239.31 notice from the commissioner that the personal care assistant is:

239.32 (i) not disqualified under section 245C.14; or

239.33 (ii) is disqualified, but the personal care assistant has received a set aside of the
239.34 disqualification under section 245C.22;

239.35 (4) be able to effectively communicate with the recipient and personal care
239.36 assistance provider agency;

240.1 (5) be able to provide covered personal care assistance services according to the
240.2 recipient's personal care assistance care plan, respond appropriately to recipient needs,
240.3 and report changes in the recipient's condition to the supervising qualified professional
240.4 or physician;

240.5 (6) not be a consumer of personal care assistance services;

240.6 (7) maintain daily written records including, but not limited to, time sheets under
240.7 subdivision 12;

240.8 (8) effective January 1, 2010, complete standardized training as determined by the
240.9 commissioner before completing enrollment. Personal care assistant training must include
240.10 successful completion of the following training components: basic first aid, vulnerable
240.11 adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of
240.12 personal care assistants including information about assistance with lifting and transfers
240.13 for recipients, emergency preparedness, orientation to positive behavioral practices, fraud
240.14 issues, and completion of time sheets. Upon completion of the training components,
240.15 the personal care assistant must demonstrate the competency to provide assistance to
240.16 recipients;

240.17 (9) complete training and orientation on the needs of the recipient within the first
240.18 seven days after the services begin; and

240.19 (10) be limited to providing and being paid for up to 310 hours per month of personal
240.20 care assistance services regardless of the number of recipients being served or the number
240.21 of personal care assistance provider agencies enrolled with.

240.22 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
240.23 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

240.24 (c) Effective January 1, 2010, persons who do not qualify as a personal care assistant
240.25 include parents and stepparents of minors, spouses, paid legal guardians, family foster
240.26 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or
240.27 staff of a residential setting.

240.28 **Subd. 12. Documentation of personal care assistance services provided. (a)**
240.29 **Personal care assistance services for a recipient must be documented daily by each personal**
240.30 **care assistant, on a time sheet form approved by the commissioner. All documentation**
240.31 **may be Web-based, electronic, or paper documentation. The completed form must be**
240.32 **submitted on a monthly basis to the provider and kept in the recipient's health record.**

240.33 **(b) The activity documentation must correspond to the personal care assistance care**
240.34 **plan and be reviewed by the qualified professional.**

241.1 (c) The personal care assistant time sheet must be on a form approved by the
241.2 commissioner documenting time the personal care assistant provides services in the home.

241.3 The following criteria must be included in the time sheet:

241.4 (1) full name of personal care assistant and individual provider number;

241.5 (2) provider name and telephone numbers;

241.6 (3) full name of recipient;

241.7 (4) consecutive dates, including month, day, and year, and arrival and departure
241.8 time with a.m. or p.m. notations;

241.9 (5) signatures of recipient or the responsible party;

241.10 (6) personal signature of the personal care assistant;

241.11 (7) any shared care provided, if applicable;

241.12 (8) a statement that it is a federal crime to provide false information on personal
241.13 care service billings for medical assistance payments; and

241.14 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

241.15 **Subd. 13. Qualified professional; qualifications.** (a) The qualified professional
241.16 must be employed by a personal care assistance provider agency and meet the definition
241.17 under section 256B.0625, subdivision 19c. Before a qualified professional provides
241.18 services, the personal care assistance provider agency must initiate a background study on
241.19 the qualified professional under chapter 245C, and the personal care assistance provider
241.20 agency must have received a notice from the commissioner that the qualified professional:

241.21 (1) is not disqualified under section 245C.14; or

241.22 (2) is disqualified, but the qualified professional has received a set aside of the
241.23 disqualification under section 245C.22.

241.24 (b) The qualified professional shall perform the duties of training, supervision, and
241.25 evaluation of the personal care assistance staff and evaluation of the effectiveness of
241.26 personal care assistance services. The qualified professional shall:

241.27 (1) develop and monitor with the recipient a personal care assistance care plan based
241.28 on the service plan and individualized needs of the recipient;

241.29 (2) develop and monitor with the recipient a monthly plan for the use of personal
241.30 care assistance services;

241.31 (3) review documentation of personal care assistance services provided;

241.32 (4) provide training and ensure competency for the personal care assistant in the
241.33 individual needs of the recipient; and

241.34 (5) document all training, communication, evaluations, and needed actions to
241.35 improve performance of the personal care assistants.

242.1 (c) The qualified professional shall complete the provider training with basic
242.2 information about the personal care assistance program approved by the commissioner
242.3 within six months of the date hired by a personal care assistance provider agency.
242.4 Qualified professionals who have completed the required trainings as an employee with a
242.5 personal care assistance provider agency do not need to repeat the required trainings if they
242.6 are hired by another agency, if they have completed the training within the last three years.

242.7 Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal
242.8 care assistants must be supervised by a qualified professional.

242.9 (b) Through direct training, observation, return demonstrations, and consultation
242.10 with the staff and the recipient, the qualified professional must ensure and document
242.11 that the personal care assistant is:

242.12 (1) capable of providing the required personal care assistance services;

242.13 (2) knowledgeable about the plan of personal care assistance services before services
242.14 are performed; and

242.15 (3) able to identify conditions that should be immediately brought to the attention of
242.16 the qualified professional.

242.17 (c) The qualified professional shall evaluate the personal care assistant within the
242.18 first 14 days of starting to provide services for a recipient except for the personal care
242.19 assistance choice option under subdivision 19, paragraph (a), clause (4). The qualified
242.20 professional shall evaluate the personal care assistance services for a recipient through
242.21 direct observation of a personal care assistant's work:

242.22 (1) at least every 90 days thereafter for the first year of a recipient's services; and

242.23 (2) every 120 days after the first year of a recipient's service or whenever needed for
242.24 response to a recipient's request for increased supervision of the personal care assistance
242.25 staff.

242.26 (d) Communication with the recipient is a part of the evaluation process of the
242.27 personal care assistance staff.

242.28 (e) At each supervisory visit, the qualified professional shall evaluate personal care
242.29 assistance services including the following information:

242.30 (1) satisfaction level of the recipient with personal care assistance services;

242.31 (2) review of the month-to-month plan for use of personal care assistance services;

242.32 (3) review of documentation of personal care assistance services provided;

242.33 (4) whether the personal care assistance services are meeting the goals of the service
242.34 as stated in the personal care assistance care plan and service plan;

242.35 (5) a written record of the results of the evaluation and actions taken to correct any
242.36 deficiencies in the work of a personal care assistant; and

243.1 (6) revision of the personal care assistance care plan as necessary in consultation
243.2 with the recipient or responsible party, to meet the needs of the recipient.

243.3 (f) The qualified professional shall complete the required documentation in the
243.4 agency recipient and employee files and the recipient's home, including the following
243.5 documentation:

243.6 (1) the personal care assistance care plan based on the service plan and individualized
243.7 needs of the recipient;

243.8 (2) a month-to-month plan for use of personal care assistance services;

243.9 (3) changes in need of the recipient requiring a change to the level of service and the
243.10 personal care assistance care plan;

243.11 (4) evaluation results of supervision visits and identified issues with personal care
243.12 assistance staff with actions taken;

243.13 (5) all communication with the recipient and personal care assistance staff; and

243.14 (6) hands-on training or individualized training for the care of the recipient.

243.15 (g) The documentation in paragraph (f) must be done on agency forms.

243.16 (h) The services that are not eligible for payment as qualified professional services
243.17 include:

243.18 (1) direct professional nursing tasks that could be assessed and authorized as skilled
243.19 nursing tasks;

243.20 (2) supervision of personal care assistance completed by telephone;

243.21 (3) agency administrative activities;

243.22 (4) training other than the individualized training required to provide care for a
243.23 recipient; and

243.24 (5) any other activity that is not described in this section.

243.25 Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized
243.26 hours of personal care assistance services, which vary within a service authorization
243.27 period covering no more than six months, in order to more effectively meet the needs and
243.28 schedule of the recipient. Each 12-month service agreement is divided into two six-month
243.29 authorization date spans. No more than 75 percent of the total authorized units for a
243.30 12-month service agreement may be used in a six-month date span.

243.31 (b) Authorization of flexible use occurs during the authorization process under
243.32 section 256B.0652. The flexible use of authorized hours does not increase the total
243.33 amount of authorized hours available to a recipient. The commissioner shall not authorize
243.34 additional personal care assistance services to supplement a service authorization that
243.35 is exhausted before the end date under a flexible service use plan, unless the assessor
243.36 determines a change in condition and a need for increased services is established.

244.1 Authorized hours not used within the six-month period must not be carried over to another
244.2 time period.

244.3 (c) A recipient who has terminated personal care assistance services before the end
244.4 of the 12-month authorization period must not receive additional hours upon reapplying
244.5 during the same 12-month authorization period, except if a change in condition is
244.6 documented. Services must be prorated for the remainder of the 12-month authorization
244.7 period based on the first six-month assessment.

244.8 (d) The recipient, responsible party, and qualified professional must develop a
244.9 written month-to-month plan of the projected use of personal care assistance services that
244.10 is part of the personal care assistance care plan and ensures:

244.11 (1) that the health and safety needs of the recipient are met throughout both date
244.12 spans of the authorization period; and

244.13 (2) that the total authorized amount of personal care assistance services for each date
244.14 span must not be used before the end of each date span in the authorization period.

244.15 (e) The personal care assistance provider agency shall monitor the use of personal
244.16 care assistance services to ensure health and safety needs of the recipient are met
244.17 throughout both date spans of the authorization period. The commissioner or the
244.18 commissioner's designee shall provide written notice to the provider and the recipient or
244.19 responsible party when a recipient is at risk of exceeding the personal care assistance
244.20 services prior to the end of the six-month period.

244.21 (f) Misuse and abuse of the flexible use of personal care assistance services resulting
244.22 in the overuse of units in a manner where the recipient will not have enough units to meet
244.23 their needs for assistance and ensure health and safety for the entire six-month date span
244.24 may lead to an action by the commissioner. The commissioner may take action including,
244.25 but not limited to: (1) restricting recipients to service authorizations of no more than one
244.26 month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring
244.27 a qualified professional to monitor and report services on a monthly basis.

244.28 Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal
244.29 care assistance services are limited according to this subdivision.

244.30 (b) Shared service is the provision of personal care assistance services by a personal
244.31 care assistant to two or three recipients, eligible for medical assistance, who voluntarily
244.32 enter into an agreement to receive services at the same time and in the same setting.

244.33 (c) For the purposes of this subdivision, "setting" means:

244.34 (1) the home residence or family foster care home of one or more of the individual
244.35 recipients; or

245.1 (2) a child care program licensed under chapter 245A or operated by a local school
245.2 district or private school.

245.3 (d) Shared personal care assistance services follow the same criteria for covered
245.4 services as subdivision 2.

245.5 (e) Noncovered shared personal care assistance services include the following:

245.6 (1) services for more than three recipients by one personal care assistant at one time;

245.7 (2) staff requirements for child care programs under chapter 245C;

245.8 (3) caring for multiple recipients in more than one setting;

245.9 (4) additional units of personal care assistance based on the selection of the option;

245.10 and

245.11 (5) use of more than one personal care assistance provider agency for the shared
245.12 care services.

245.13 (f) The option of shared personal care assistance is elected by the recipient or the
245.14 responsible party with the assistance of the assessor. The option must be determined
245.15 appropriate based on the ages of the recipients, compatibility, and coordination of their
245.16 assessed care needs. The recipient or the responsible party, in conjunction with the
245.17 qualified professional, shall arrange the setting and grouping of shared services based
245.18 on the individual needs and preferences of the recipients. The personal care assistance
245.19 provider agency shall offer the recipient or the responsible party the option of shared or
245.20 one-on-one personal care assistance services or a combination of both. The recipient or
245.21 the responsible party may withdraw from participating in a shared services arrangement at
245.22 any time.

245.23 (g) Authorization for the shared service option must be determined by the
245.24 commissioner based on the criteria that the shared service is appropriate to meet all of the
245.25 recipients' needs and their health and safety is maintained. The authorization of shared
245.26 services is part of the overall authorization of personal care assistance services. Nothing
245.27 in this subdivision must be construed to reduce the total number of hours authorized for
245.28 an individual recipient.

245.29 (h) A personal care assistant providing shared personal care assistance services must:

245.30 (1) receive training specific for each recipient served; and

245.31 (2) follow all required documentation requirements for time and services provided.

245.32 (i) A qualified professional shall:

245.33 (1) evaluate the ability of the personal care assistant to provide services for all of
245.34 the recipients in a shared setting;

246.1 (2) visit the shared setting as services are being provided at least once every six
246.2 months or whenever needed for response to a recipient's request for increased supervision
246.3 of the personal care assistance staff;

246.4 (3) provide ongoing monitoring and evaluation of the effectiveness and
246.5 appropriateness of the shared services;

246.6 (4) develop a contingency plan with each of the recipients which accounts for
246.7 absence of the recipient in a share services setting due to illness or other circumstances;

246.8 (5) obtain permission from each of the recipients who are sharing a personal care
246.9 assistant for number of shared hours for services provided inside and outside the home
246.10 residence; and

246.11 (6) document the training completed by the personal care assistants specific to the
246.12 shared setting and recipients sharing services.

246.13 Subd. 17. **Shared services; rates.** The commissioner shall provide a rate system for
246.14 shared personal care assistance services. For two persons sharing services, the rate paid
246.15 to a provider must not exceed one and one-half times the rate paid for serving a single
246.16 individual, and for three persons sharing services, the rate paid to a provider must not
246.17 exceed twice the rate paid for serving a single individual. These rates apply only when all
246.18 of the criteria for the shared care personal care assistance service have been met.

246.19 Subd. 18. **Personal care assistance choice option; generally.** (a) The
246.20 commissioner may allow a recipient of personal care assistance services to use a fiscal
246.21 intermediary to assist the recipient in paying and accounting for medically necessary
246.22 covered personal care assistance services. Unless otherwise provided in this section, all
246.23 other statutory and regulatory provisions relating to personal care assistance services apply
246.24 to a recipient using the personal care assistance choice option.

246.25 (b) Personal care assistance choice is an option of the personal care assistance
246.26 program that allows the recipient who receives personal care assistance services to be
246.27 responsible for the hiring, training, scheduling, and firing of personal care assistants. This
246.28 program offers greater control and choice for the recipient in who provides the personal
246.29 care assistance service and when the service is scheduled. The recipient or the recipient's
246.30 responsible party must choose a personal care assistance choice provider agency as
246.31 a fiscal intermediary. This personal care assistance choice provider agency manages
246.32 payroll, invoices the state, is responsible for all payroll related taxes and insurance, and is
246.33 responsible for providing the consumer training and support in managing the recipient's
246.34 personal care assistance services.

247.1 Subd. 19. Personal care assistance choice option; qualifications; duties. (a)

247.2 Under personal care assistance choice, the recipient or responsible party shall:

247.3 (1) recruit, hire, schedule, and terminate personal care assistants and a qualified
247.4 professional;

247.5 (2) develop a personal care assistance care plan based on the assessed needs
247.6 and addressing the health and safety of the recipient with the assistance of a qualified
247.7 professional as needed;

247.8 (3) orient and train the personal care assistant with assistance as needed from the
247.9 qualified professional;

247.10 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with
247.11 the qualified professional, who is required to visit the recipient at least every 180 days;

247.12 (5) monitor and verify in writing and report to the personal care assistance choice
247.13 agency the number of hours worked by the personal care assistant and the qualified
247.14 professional;

247.15 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
247.16 and service authorization; and

247.17 (7) use the same personal care assistance choice provider agency if shared personal
247.18 assistance care is being used.

247.19 (b) The personal care assistance choice provider agency shall:

247.20 (1) meet all personal care assistance provider agency standards;

247.21 (2) enter into a written agreement with the recipient, responsible party, and personal
247.22 care assistants;

247.23 (3) not be related as a parent, child, sibling, or spouse to the recipient, qualified
247.24 professional, or the personal care assistant; and

247.25 (4) ensure arm's-length transactions without undue influence or coercion with the
247.26 recipient and personal care assistant.

247.27 (c) The duties of the personal care assistance choice provider agency are to:

247.28 (1) be the employer of the personal care assistant and the qualified professional for
247.29 employment law and related regulations including, but not limited to, purchasing and
247.30 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
247.31 and liability insurance, and submit any or all necessary documentation including, but not
247.32 limited to, workers' compensation and unemployment insurance;

247.33 (2) bill the medical assistance program for personal care assistance services and
247.34 qualified professional services;

247.35 (3) request and complete background studies that comply with the requirements for
247.36 personal care assistants and qualified professionals;

- 248.1 (4) pay the personal care assistant and qualified professional based on actual hours
248.2 of services provided;
- 248.3 (5) withhold and pay all applicable federal and state taxes;
- 248.4 (6) verify and keep records of hours worked by the personal care assistant and
248.5 qualified professional;
- 248.6 (7) make the arrangements and pay taxes and other benefits, if any; and comply with
248.7 any legal requirements for a Minnesota employer;
- 248.8 (8) enroll in the medical assistance program as a personal care assistance choice
248.9 agency; and
- 248.10 (9) enter into a written agreement as specified in subdivision 20 before services
248.11 are provided.

248.12 Subd. 20. **Personal care assistance choice option; administration.** (a) Before
248.13 services commence under the personal care assistance choice option, and annually
248.14 thereafter, the personal care assistance choice provider agency, recipient, or responsible
248.15 party, each personal care assistant, and the qualified professional shall enter into a written
248.16 agreement. The agreement must include at a minimum:

- 248.17 (1) duties of the recipient, qualified professional, personal care assistant, and
248.18 personal care assistance choice provider agency;
- 248.19 (2) salary and benefits for the personal care assistant and the qualified professional;
- 248.20 (3) administrative fee of the personal care assistance choice provider agency and
248.21 services paid for with that fee, including background study fees;
- 248.22 (4) grievance procedures to respond to complaints;
- 248.23 (5) procedures for hiring and terminating the personal care assistant; and
- 248.24 (6) documentation requirements including, but not limited to, time sheets, activity
248.25 records, and the personal care assistance care plan.

248.26 (b) Effective January 1, 2010, except for the administrative fee of the personal care
248.27 assistance choice provider agency as reported on the written agreement, the remainder
248.28 of the rates paid to the personal care assistance choice provider agency must be used to
248.29 pay for the salary and benefits for the personal care assistant or the qualified professional.
248.30 The provider agency must use a minimum of 72.5 percent of the revenue generated by
248.31 the medical assistance rate for personal care assistance services for employee personal
248.32 care assistant wages and benefits.

248.33 (c) The commissioner shall deny, revoke, or suspend the authorization to use the
248.34 personal care assistance choice option if:

- 248.35 (1) it has been determined by the qualified professional or public health nurse that
248.36 the use of this option jeopardizes the recipient's health and safety;

249.1 (2) the parties have failed to comply with the written agreement specified in this
249.2 subdivision;

249.3 (3) the use of the option has led to abusive or fraudulent billing for personal care
249.4 assistance services; or

249.5 (4) the department terminates the personal care assistance choice option.

249.6 (d) The recipient or responsible party may appeal the commissioner's decision in
249.7 paragraph (c) according to section 256.045. The denial, revocation, or suspension to
249.8 use the personal care assistance choice option must not affect the recipient's authorized
249.9 level of personal care assistance services.

249.10 Subd. 21. **Requirements for initial enrollment of personal care assistance**
249.11 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
249.12 time of enrollment as a personal care assistance provider agency in a format determined
249.13 by the commissioner, information and documentation that includes, but is not limited to,
249.14 the following:

249.15 (1) the personal care assistance provider agency's current contact information
249.16 including address, telephone number, and e-mail address;

249.17 (2) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
249.18 provider's payments from Medicaid in the previous year, whichever is less;

249.19 (3) proof of fidelity bond coverage in the amount of \$20,000;

249.20 (4) proof of workers' compensation insurance coverage;

249.21 (5) a description of the personal care assistance provider agency's organization
249.22 identifying the names of all owners, managing employees, staff, board of directors, and
249.23 the affiliations of the directors, owners, or staff to other service providers;

249.24 (6) a copy of the personal care assistance provider agency's written policies and
249.25 procedures including: hiring of employees; training requirements; service delivery;
249.26 and employee and consumer safety including process for notification and resolution
249.27 of consumer grievances, identification and prevention of communicable diseases, and
249.28 employee misconduct;

249.29 (7) copies of all other forms the personal care assistance provider agency uses in
249.30 the course of daily business including, but not limited to:

249.31 (i) a copy of the personal care assistance provider agency's time sheet if the time
249.32 sheet varies from the standard time sheet for personal care assistance services approved
249.33 by the commissioner, and a letter requesting approval of the personal care assistance
249.34 provider agency's nonstandard time sheet;

249.35 (ii) the personal care assistance provider agency's template for the personal care
249.36 assistance care plan; and

250.1 (iii) the personal care assistance provider agency's template and the written
250.2 agreement in subdivision 20 for recipients using the personal care assistance choice
250.3 option, if applicable;

250.4 (8) a list of all trainings and classes that the personal care assistance provider agency
250.5 requires of its staff providing personal care assistance services;

250.6 (9) documentation that the personal care assistance provider agency and staff have
250.7 successfully completed all the training required by this section;

250.8 (10) documentation of the agency's marketing practices;

250.9 (11) disclosure of ownership, leasing, or management of all residential properties
250.10 that is used or could be used for providing home care services; and

250.11 (12) documentation that the agency will use the following percentages of revenue
250.12 generated from the medical assistance rate paid for personal care assistance services
250.13 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
250.14 personal care assistance choice option and 72.5 percent of revenue from other personal
250.15 care assistance providers.

250.16 (b) Personal care assistance provider agencies shall provide the information specified
250.17 in paragraph (a) to the commissioner at the time the personal care assistance provider
250.18 agency enrolls as a vendor or upon request from the commissioner. The commissioner
250.19 shall collect the information specified in paragraph (a) from all personal care assistance
250.20 providers beginning upon enactment of this section.

250.21 (c) All personal care assistance provider agencies shall complete mandatory training
250.22 as determined by the commissioner before enrollment as a provider. Personal care
250.23 assistance provider agencies are required to send all owners, qualified professionals
250.24 employed by the agency, and all other managing employees to the initial and subsequent
250.25 trainings. Personal care assistance provider agency billing staff shall complete training
250.26 about personal care assistance program financial management. This training is effective
250.27 upon enactment of this section. Any personal care assistance provider agency enrolled
250.28 before that date shall, if it has not already, complete the provider training within 18 months
250.29 of the effective date of this section. Any new owners, new qualified professionals, and new
250.30 managing employees are required to complete mandatory training as a requisite of hiring.

250.31 Subd. 22. **Annual review for personal care providers.** (a) All personal care
250.32 assistance provider agencies shall resubmit, on an annual basis, the information specified
250.33 in subdivision 21, in a format determined by the commissioner, and provide a copy of the
250.34 personal care assistance provider agency's most current version of its grievance policies
250.35 and procedures along with a written record of grievances and resolutions of the grievances

251.1 that the personal care assistance provider agency has received in the previous year and any
251.2 other information requested by the commissioner.

251.3 (b) The commissioner shall send annual review notification to personal care
251.4 assistance provider agencies 30 days prior to renewal. The notification must:

251.5 (1) list the materials and information the personal care assistance provider agency is
251.6 required to submit;

251.7 (2) provide instructions on submitting information to the commissioner; and

251.8 (3) provide a due date by which the commissioner must receive the requested
251.9 information.

251.10 Personal care assistance provider agencies shall submit required documentation for
251.11 annual review within 30 days of notification from the commissioner. If no documentation
251.12 is submitted, the personal care assistance provider agency enrollment number must be
251.13 terminated or suspended.

251.14 (c) Personal care assistance provider agencies also currently licensed under
251.15 Minnesota Rules, part 4668.0012, as a class A provider or currently certified for
251.16 participation in Medicare as a home health agency are deemed in compliance with
251.17 the personal care assistance requirements for enrollment, annual review process, and
251.18 documentation.

251.19 Subd. 23. **Enrollment requirements following termination.** (a) A terminated
251.20 personal care assistance provider agency, including all named individuals on the current
251.21 enrollment disclosure form and known or discovered affiliates of the personal care
251.22 assistance provider agency, is not eligible to enroll as a personal care assistance provider
251.23 agency for two years following the termination.

251.24 (b) After the two-year period in paragraph (a), if the provider seeks to reenroll
251.25 as a personal care assistance provider agency, the personal care assistance provider
251.26 agency must be placed on a one-year probation period, beginning after completion of
251.27 the following:

251.28 (1) the department's provider trainings under this section; and

251.29 (2) initial enrollment requirements under subdivision 21.

251.30 (c) During the probationary period the commissioner shall complete site visits and
251.31 request submission of documentation to review compliance with program policy.

251.32 Subd. 24. **Personal care assistance provider agency; general duties.** A personal
251.33 care assistance provider agency shall:

251.34 (1) enroll as a Medicaid provider meeting all provider standards, including
251.35 completion of the required provider training;

251.36 (2) comply with general medical assistance coverage requirements;

- 252.1 (3) demonstrate compliance with law and policies of the personal care assistance
252.2 program to be determined by the commissioner;
- 252.3 (4) comply with background study requirements;
- 252.4 (5) verify and keep records of hours worked by the personal care assistant and
252.5 qualified professional;
- 252.6 (6) market agency services only through printed information in brochures and on
252.7 Web sites and not engage in any agency-initiated direct contact or marketing in person, by
252.8 phone, or other electronic means to potential recipients, guardians, or family members;
- 252.9 (7) pay the personal care assistant and qualified professional based on actual hours
252.10 of services provided;
- 252.11 (8) withhold and pay all applicable federal and state taxes;
- 252.12 (9) effective January 1, 2010, document that the agency uses a minimum of 72.5
252.13 percent of the revenue generated by the medical assistance rate for personal care assistance
252.14 services for employee personal care assistant wages and benefits;
- 252.15 (10) make the arrangements and pay unemployment insurance, taxes, workers'
252.16 compensation, liability insurance, and other benefits, if any;
- 252.17 (11) enter into a written agreement under subdivision 20 before services are provided;
- 252.18 (12) report suspected neglect and abuse to the common entry point according to
252.19 section 256B.0651;
- 252.20 (13) provide the recipient with a copy of the home care bill of rights at start of
252.21 service; and
- 252.22 (14) request reassessments at least 60 days prior to the end of the current
252.23 authorization for personal care assistance services, on forms provided by the commissioner.

252.24 **Subd. 25. Personal care assistance provider agency; background studies.**

252.25 Personal care assistance provider agencies enrolled to provide personal care assistance
252.26 services under the medical assistance program shall comply with the following:

252.27 (1) owners who have a five percent interest or more and all managing employees
252.28 are subject to a background study as provided in chapter 245C. This applies to currently
252.29 enrolled personal care assistance provider agencies and those agencies seeking enrollment
252.30 as a personal care assistance provider agency. Managing employee has the same meaning
252.31 as Code of Federal Regulations, title 42, section 455. An organization is barred from
252.32 enrollment if:

252.33 (i) the organization has not initiated background studies on owners and managing
252.34 employees; or

252.35 (ii) the organization has initiated background studies on owners and managing
252.36 employees, but the commissioner has sent the organization a notice that an owner or

253.1 managing employee of the organization has been disqualified under section 245C.14,
253.2 and the owner or managing employee has not received a set aside of the disqualification
253.3 under section 245C.22;

253.4 (2) a background study must be initiated and completed for all qualified
253.5 professionals; and

253.6 (3) a background study must be initiated and completed for all personal care
253.7 assistants.

253.8 **Subd. 26. Personal care assistance provider agency; communicable disease**
253.9 **prevention.** A personal care assistance provider agency shall establish and implement
253.10 policies and procedures for prevention, control, and investigation of infections and
253.11 communicable diseases according to current nationally recognized infection control
253.12 practices or guidelines established by the United States Centers for Disease Control and
253.13 Prevention, as well as applicable regulations of other federal or state agencies.

253.14 **Subd. 27. Personal care assistance provider agency; ventilator training.** The
253.15 personal care assistance provider agency is required to provide training for the personal
253.16 care assistant responsible for working with a recipient who is ventilator dependent. All
253.17 training must be administered by a respiratory therapist, nurse, or physician. Qualified
253.18 professional supervision by a nurse must be completed and documented on file in the
253.19 personal care assistant's employment record and the recipient's health record. If offering
253.20 personal care services to a ventilator-dependent recipient, the personal care assistance
253.21 provider agency shall demonstrate the ability to:

253.22 (1) train the personal care assistant;

253.23 (2) supervise the personal care assistant in ventilator operation and maintenance; and

253.24 (3) supervise the recipient and responsible party in ventilator operation and
253.25 maintenance.

253.26 **Subd. 28. Personal care assistance provider agency; required documentation.**
253.27 Required documentation must be completed and kept in the personal care assistance
253.28 provider agency file or the recipient's home residence. The required documentation
253.29 consists of:

253.30 (1) employee files, including:

253.31 (i) applications for employment;

253.32 (ii) background study requests and results;

253.33 (iii) orientation records about the agency policies;

253.34 (iv) trainings completed with demonstration of competence;

253.35 (v) supervisory visits;

- 254.1 (vi) evaluations of employment; and
- 254.2 (vii) signature on fraud statement;
- 254.3 (2) recipient files, including:
- 254.4 (i) demographics;
- 254.5 (ii) emergency contact information and emergency backup plan;
- 254.6 (iii) personal care assistance service plan;
- 254.7 (iv) personal care assistance care plan;
- 254.8 (v) month-to-month service use plan;
- 254.9 (vi) all communication records;
- 254.10 (vii) start of service information, including the written agreement with recipient; and
- 254.11 (viii) date the home care bill of rights was given to the recipient;
- 254.12 (3) agency policy manual, including:
- 254.13 (i) policies for employment and termination;
- 254.14 (ii) grievance policies with resolution of consumer grievances;
- 254.15 (iii) staff and consumer safety;
- 254.16 (iv) staff misconduct; and
- 254.17 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
- 254.18 resolution of consumer grievances;
- 254.19 (4) time sheets for each personal care assistant along with completed activity sheets
- 254.20 for each recipient served; and
- 254.21 (5) agency marketing and advertising materials and documentation of marketing
- 254.22 activities and costs.

254.23 Subd. 29. **Transitional assistance.** The commissioner, counties, health plans,

254.24 tribes, and personal care assistance providers shall work together to provide transitional

254.25 assistance for recipients and families to come into compliance with the new requirements

254.26 of this section and ensure the personal care assistance services are not provided by the

254.27 housing provider.

254.28 Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

- 254.29 (1) by October 31, 2009, information to recipients likely to be affected that (i)
- 254.30 describes the changes to the personal care assistance program that may result in the
- 254.31 loss of access to personal care assistance services, and (ii) includes resources to obtain
- 254.32 further information; and

- 254.33 (2) notice of changes in medical assistance home care services to each affected
- 254.34 recipient at least 30 days before the effective date of the change.

254.35 The notice shall include how to get further information on the changes, how to get help to

254.36 obtain other services, a list of community resources, and appeal rights. Notwithstanding

255.1 section 256.045, a recipient may request continued services pending appeal within the
255.2 time period allowed to request an appeal.

255.3 **EFFECTIVE DATE.** Subdivisions 4, 22, and 27 are effective January 1, 2010.

255.4 Sec. 32. Minnesota Statutes 2008, section 256B.0911, subdivision 1, is amended to
255.5 read:

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

255.17 (b) These services must be coordinated with ~~services~~ long-term care options
255.18 counseling provided under section 256.975, subdivision 7, and ~~with services provided by~~
255.19 ~~other public and private agencies in the community~~ section 256.01, subdivision 24, for
255.20 telephone assistance and follow up and to offer a variety of cost-effective alternatives to
255.21 persons with disabilities and elderly persons. The county or tribal agency or managed
255.22 care plan providing long-term care consultation services shall encourage the use of
255.23 volunteers from families, religious organizations, social clubs, and similar civic and
255.24 service organizations to provide community-based services.

255.25 Sec. 33. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, is amended to
255.26 read:

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

255.28 (a) "Long-term care consultation services" means:

255.29 (1) ~~providing information and education to the general public regarding availability~~
255.30 ~~of the services authorized under this section;~~

255.31 (2) ~~an intake process that provides access to the services described in this section;~~

255.32 (3) ~~assessment of the health, psychological, and social needs of referred individuals;~~

255.33 (4) assistance in identifying services needed to maintain an individual in the ~~least~~
255.34 ~~restrictive~~ most inclusive environment;

256.1 ~~(5)~~ (2) providing recommendations on cost-effective community services that are
256.2 available to the individual;

256.3 ~~(6)~~ (3) development of an individual's person-centered community support plan;

256.4 ~~(7)~~ (4) providing information regarding eligibility for Minnesota health care
256.5 programs;

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

256.10 ~~(8) preadmission~~ (6) federally mandated screening to determine the need for
256.11 a nursing facility institutional level of care under section 256B.0911, subdivision 4,
256.12 paragraph (a);

256.13 ~~(9) preliminary~~ (7) determination of Minnesota health care programs home and
256.14 community-based waiver service eligibility including level of care determination for
256.15 individuals who need a nursing facility an institutional level of care as defined under
256.16 section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan
256.17 home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs
256.18 (a) and (c), based on assessment and support plan development with appropriate referrals
256.19 for final determination;

256.20 ~~(10)~~ (8) providing recommendations for nursing facility placement when there are
256.21 no cost-effective community services available; and

256.22 ~~(11)~~ (9) assistance to transition people back to community settings after facility
256.23 admission.

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

256.28 ~~(b)~~ (c) "Minnesota health care programs" means the medical assistance program
256.29 under chapter 256B and the alternative care program under section 256B.0913.

256.30 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
256.31 plans administering long-term care consultation assessment and support planning services.

256.32 **EFFECTIVE DATE.** This section is effective January 1, 2011.

256.33 Sec. 34. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
256.34 subdivision to read:

257.1 Subd. 2b. **Certified assessors.** (a) Beginning January 1, 2011, each lead agency
257.2 shall use certified assessors who have completed training and certification process
257.3 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
257.4 best practices in assessment and support planning including person-centered planning
257.5 principals and have a common set of skills that must ensure consistency and equitable
257.6 access to services statewide. Assessors must be part of a multidisciplinary team of
257.7 professionals that includes public health nurses, social workers, and other professionals
257.8 as defined in paragraph (b). For persons with complex health care needs, a public health
257.9 nurse or registered nurse from a multidisciplinary team must be consulted.

257.10 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
257.11 work, nursing with a public health nursing certificate, or other closely related field with at
257.12 least one year of home and community-based experience or a two-year registered nursing
257.13 degree with at least three years of home and community-based experience that have
257.14 received training and certification specific to assessment and consultation for long-term
257.15 care services in the state.

257.16 Sec. 35. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
257.17 subdivision to read:

257.18 Subd. 2c. **Assessor training and certification.** The commissioner shall develop a
257.19 curriculum and an assessor certification process to begin no later than January 1, 2010.
257.20 All existing lead agency staff designated to provide the services defined in subdivision
257.21 1a must be certified by December 30, 2010. Each lead agency is required to ensure that
257.22 they have sufficient numbers of certified assessors to provide long-term consultation
257.23 assessment and support planning within the timelines and parameters of the service by
257.24 January 1, 2011. Certified assessors are required to be recertified every three years.

257.25 Sec. 36. Minnesota Statutes 2008, section 256B.0911, subdivision 3, is amended to
257.26 read:

257.27 Subd. 3. **Long-term care consultation team.** (a) Until January 1, 2011, a long-term
257.28 care consultation team shall be established by the county board of commissioners. Each
257.29 local consultation team shall consist of at least one social worker and at least one public
257.30 health nurse from their respective county agencies. The board may designate public
257.31 health or social services as the lead agency for long-term care consultation services. If a
257.32 county does not have a public health nurse available, it may request approval from the
257.33 commissioner to assign a county registered nurse with at least one year experience in

258.1 home care to participate on the team. Two or more counties may collaborate to establish
258.2 a joint local consultation team or teams.

258.3 (b) The team is responsible for providing long-term care consultation services to
258.4 all persons located in the county who request the services, regardless of eligibility for
258.5 Minnesota health care programs.

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

258.11 Sec. 37. Minnesota Statutes 2008, section 256B.0911, subdivision 3a, is amended to
258.12 read:

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

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

258.26 (c) ~~The long-term care consultation team must assess the health and social needs of~~
258.27 ~~the person~~ assessment must be comprehensive and include a person-centered assessment
258.28 of the health, psychological, functional, environmental, and social needs of referred
258.29 individuals and provide information necessary to develop a support plan that meets the
258.30 consumers needs, using an assessment form provided by the commissioner.

258.31 (d) ~~The team must conduct the assessment~~ must be conducted in a face-to-face
258.32 interview with the person being assessed and the person's legal representative, ~~if applicable~~
258.33 as required by legally executed documents, and other individuals as requested by the
258.34 person, who can provide information on the needs, strengths, and preferences of the

259.1 person necessary to develop a support plan that ensures the person's health and safety, but
259.2 who is not a provider of service or has any financial interest in the provision of services.

259.3 (e) ~~The team must provide the person, or the person's legal representative, must~~
259.4 be provided with written recommendations for ~~facility- or~~ community-based services:
259.5 ~~The team must document~~ or institutional care that include documentation that the most
259.6 cost-effective alternatives available were offered to the individual. For purposes of
259.7 this requirement, "cost-effective alternatives" means community services and living
259.8 arrangements that cost the same as or less than ~~nursing facility~~ institutional care.

259.9 (f) If the person chooses to use community-based services, ~~the team must provide~~
259.10 ~~the person or the person's legal representative~~ must be provided with a written community
259.11 support plan, regardless of whether the individual is eligible for Minnesota health care
259.12 programs. ~~The~~ A person may request assistance in ~~developing a community support plan~~
259.13 identifying community supports without participating in a complete assessment. Upon
259.14 a request for assistance identifying community support, the person must be transferred
259.15 or referred to the services available under sections 256.975, subdivision 7, and 256.01,
259.16 subdivision 24, for telephone assistance and follow up.

259.17 (g) The person has the right to make the final decision between ~~nursing~~
259.18 ~~facility~~ institutional placement and community placement after the ~~screening team's~~
259.19 ~~recommendation~~ recommendations have been provided, except as provided in subdivision
259.20 4a, paragraph (c).

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

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

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

259.28 (3) information about Minnesota health care programs;

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

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

259.32 (6) the long-term care consultant's decision regarding the person's need for ~~nursing~~
259.33 ~~facility~~ institutional level of care as determined under criteria established in section
259.34 144.0724, subdivision 11, or 256B.092; and

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

260.4 (i) Face-to-face assessment completed as part of eligibility determination for
260.5 the alternative care, elderly waiver, community alternatives for disabled individuals,
260.6 community alternative care, and traumatic brain injury waiver programs under sections
260.7 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
260.8 than 60 calendar days after the date of assessment. The effective eligibility start date
260.9 for these programs can never be prior to the date of assessment. If an assessment was
260.10 completed more than 60 days before the effective waiver or alternative care program
260.11 eligibility start date, assessment and support plan information must be updated in a
260.12 face-to-face visit and documented in the department's Medicaid Management Information
260.13 System (MMIS). The effective date of program eligibility in this case cannot be prior to
260.14 the date the updated assessment is completed.

260.15 Sec. 38. Minnesota Statutes 2008, section 256B.0911, subdivision 3b, is amended to
260.16 read:

260.17 Subd. 3b. **Transition assistance.** (a) A long-term care consultation team shall
260.18 provide assistance to persons residing in a nursing facility, hospital, regional treatment
260.19 center, or intermediate care facility for persons with developmental disabilities who
260.20 request or are referred for assistance. Transition assistance must include assessment,
260.21 community support plan development, referrals to long-term care options counseling
260.22 under section 256B.975, subdivision 10, for community support plan implementation and
260.23 to Minnesota health care programs, and referrals to programs that provide assistance
260.24 with housing. Transition assistance must also include information about the Centers for
260.25 Independent Living and the Senior LinkAge Line, and about other organizations that
260.26 can provide assistance with relocation efforts, and information about contacting these
260.27 organizations to obtain their assistance and support.

260.28 (b) The county shall develop transition processes with institutional social workers
260.29 and discharge planners to ensure that:

260.30 (1) persons admitted to facilities receive information about transition assistance
260.31 that is available;

260.32 (2) the assessment is completed for persons within ten working days of the date of
260.33 request or recommendation for assessment; and

260.34 (3) there is a plan for transition and follow-up for the individual's return to the
260.35 community. The plan must require notification of other local agencies when a person

261.1 who may require assistance is screened by one county for admission to a facility located
261.2 in another county.

261.3 (c) If a person who is eligible for a Minnesota health care program is admitted to a
261.4 nursing facility, the nursing facility must include a consultation team member or the case
261.5 manager in the discharge planning process.

261.6 Sec. 39. Minnesota Statutes 2008, section 256B.0911, subdivision 3c, is amended to
261.7 read:

261.8 Subd. 3c. **Transition to housing with services.** (a) Housing with services
261.9 establishments offering or providing assisted living under chapter 144G shall inform
261.10 all prospective residents of the availability of and contact information for transitional
261.11 consultation services under this subdivision prior to executing a lease or contract with the
261.12 prospective resident. The purpose of transitional long-term care consultation is to support
261.13 persons with current or anticipated long-term care needs in making informed choices
261.14 among options that include the most cost-effective and least restrictive settings, and to
261.15 delay spenddown to eligibility for publicly funded programs by connecting people to
261.16 alternative services in their homes before transition to housing with services. Regardless
261.17 of the consultation, prospective residents maintain the right to choose housing with
261.18 services or assisted living if that option is their preference.

261.19 (b) Transitional consultation services are provided as determined by the
261.20 commissioner of human services in partnership with county long-term care consultation
261.21 units, and the Area Agencies on Aging, and are a combination of telephone-based
261.22 and in-person assistance provided under models developed by the commissioner. The
261.23 consultation shall be performed in a manner that provides objective and complete
261.24 information. Transitional consultation must be provided within five working days of the
261.25 request of the prospective resident as follows:

261.26 (1) the consultation must be provided by a qualified professional as determined by
261.27 the commissioner;

261.28 (2) the consultation must include a review of the prospective resident's reasons for
261.29 considering assisted living, the prospective resident's personal goals, a discussion of the
261.30 prospective resident's immediate and projected long-term care needs, and alternative
261.31 community services or assisted living settings that may meet the prospective resident's
261.32 needs; and

261.33 (3) the prospective resident shall be informed of the availability of long-term care
261.34 consultation services described in subdivision 3a that are available at no charge to the
261.35 prospective resident to assist the prospective resident in assessment and planning to meet

262.1 the prospective resident's long-term care needs. The Senior LinkAge Line and long-term
262.2 care consultation team shall give the highest priority to referrals who are at highest risk of
262.3 nursing facility placement or as needed for determining eligibility.

262.4 Sec. 40. Minnesota Statutes 2008, section 256B.0911, subdivision 4a, is amended to
262.5 read:

262.6 Subd. 4a. **Preadmission screening activities related to nursing facility**

262.7 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
262.8 boarding care facilities, must be screened prior to admission regardless of income, assets,
262.9 or funding sources for nursing facility care, except as described in subdivision 4b. The
262.10 purpose of the screening is to determine the need for nursing facility level of care as
262.11 described in paragraph (d) and to complete activities required under federal law related to
262.12 mental illness and developmental disability as outlined in paragraph (b).

262.13 (b) A person who has a diagnosis or possible diagnosis of mental illness or
262.14 developmental disability must receive a preadmission screening before admission
262.15 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need
262.16 for further evaluation and specialized services, unless the admission prior to screening is
262.17 authorized by the local mental health authority or the local developmental disabilities case
262.18 manager, or unless authorized by the county agency according to Public Law 101-508.

262.19 The following criteria apply to the preadmission screening:

262.20 (1) the county must use forms and criteria developed by the commissioner to identify
262.21 persons who require referral for further evaluation and determination of the need for
262.22 specialized services; and

262.23 (2) the evaluation and determination of the need for specialized services must be
262.24 done by:

262.25 (i) a qualified independent mental health professional, for persons with a primary or
262.26 secondary diagnosis of a serious mental illness; or

262.27 (ii) a qualified developmental disability professional, for persons with a primary or
262.28 secondary diagnosis of developmental disability. For purposes of this requirement, a
262.29 qualified developmental disability professional must meet the standards for a qualified
262.30 developmental disability professional under Code of Federal Regulations, title 42, section
262.31 483.430.

262.32 (c) The local county mental health authority or the state developmental disability
262.33 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
262.34 nursing facility if the individual does not meet the nursing facility level of care criteria or
262.35 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For

263.1 purposes of this section, "specialized services" for a person with developmental disability
263.2 means active treatment as that term is defined under Code of Federal Regulations, title
263.3 42, section 483.440 (a)(1).

263.4 (d) The determination of the need for nursing facility level of care must be made
263.5 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
263.6 using forms developed by the commissioner. In assessing a person's needs, consultation
263.7 team members shall have a physician available for consultation and shall consider the
263.8 assessment of the individual's attending physician, if any. The individual's physician must
263.9 be included if the physician chooses to participate. Other personnel may be included on
263.10 the team as deemed appropriate by the county.

263.11 **EFFECTIVE DATE.** The section is effective January 1, 2011.

263.12 Sec. 41. Minnesota Statutes 2008, section 256B.0911, subdivision 5, is amended to
263.13 read:

263.14 Subd. 5. **Administrative activity.** The commissioner shall ~~minimize the number~~
263.15 ~~of forms required in the provision of long-term care consultation services and shall~~
263.16 ~~limit the screening document to items necessary for community support plan approval,~~
263.17 ~~reimbursement, program planning, evaluation, and policy development~~ streamline the
263.18 processes, including timelines for when assessments need to be completed, required to
263.19 provide the services in this section and shall implement integrated solutions to automate
263.20 the business processes to the extent necessary for community support plan approval,
263.21 reimbursement, program planning, evaluation, and policy development.

263.22 Sec. 42. Minnesota Statutes 2008, section 256B.0911, subdivision 6, is amended to
263.23 read:

263.24 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
263.25 for each county must be paid monthly by certified nursing facilities in the county. The
263.26 monthly amount to be paid by each nursing facility for each fiscal year must be determined
263.27 by dividing the county's annual allocation for long-term care consultation services by 12
263.28 to determine the monthly payment and allocating the monthly payment to each nursing
263.29 facility based on the number of licensed beds in the nursing facility. Payments to counties
263.30 in which there is no certified nursing facility must be made by increasing the payment
263.31 rate of the two facilities located nearest to the county seat.

263.32 (b) The commissioner shall include the total annual payment determined under
263.33 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
263.34 according to section 256B.431, subdivision 2b, paragraph (g).

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

264.7 (d) Payments for long-term care consultation services are available to the county
264.8 or counties to cover staff salaries and expenses to provide the services described in
264.9 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
264.10 the limits of available funding, sufficient personnel to provide long-term care consultation
264.11 services while meeting the state's long-term care outcomes and objectives as defined in
264.12 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
264.13 objectives as approved by the commissioner in the biennial home and community-based
264.14 services quality assurance plan on a form provided by the commissioner.

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

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

264.19 (g) The county may bill, as case management services, assessments, support
264.20 planning, and follow-along provided to persons determined to be eligible for case
264.21 management under Minnesota health care programs. No individual or family member
264.22 shall be charged for an initial assessment or initial support plan development provided
264.23 under subdivision 3a or 3b.

264.24 (h) The commissioner shall develop an alternative payment methodology for
264.25 long-term care consultation services that includes the funding available under this
264.26 subdivision, and sections 256B.092 and 256B.0659. In developing the new payment
264.27 methodology, the commissioner shall consider the maximization of federal funding for
264.28 this activity.

264.29 Sec. 43. Minnesota Statutes 2008, section 256B.0911, subdivision 7, is amended to
264.30 read:

264.31 **Subd. 7. Reimbursement for certified nursing facilities.** (a) Medical assistance
264.32 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
264.33 only if a preadmission screening has been conducted prior to admission or the county has
264.34 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
264.35 not be provided for any recipient who the local screener has determined does not meet the

265.1 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,
265.2 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
265.3 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
265.4 mental illness is approved by the local mental health authority or an admission for a
265.5 recipient with developmental disability is approved by the state developmental disability
265.6 authority.

265.7 (b) The nursing facility must not bill a person who is not a medical assistance
265.8 recipient for resident days that preceded the date of completion of screening activities as
265.9 required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed
265.10 resident days in the nursing facility resident day totals reported to the commissioner.

265.11 **EFFECTIVE DATE.** The section is effective January 1, 2011.

265.12 Sec. 44. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to
265.13 read:

265.14 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

265.15 (a) Funding for services under the alternative care program is available to persons who
265.16 meet the following criteria:

265.17 (1) the person has been determined by a community assessment under section
265.18 256B.0911 to be a person who would require the level of care provided in a nursing
265.19 facility, but for the provision of services under the alternative care program. Effective
265.20 January 1, 2011, this determination must be made according to the criteria established in
265.21 section 144.0724, subdivision 11;

265.22 (2) the person is age 65 or older;

265.23 (3) the person would be eligible for medical assistance within 135 days of admission
265.24 to a nursing facility;

265.25 (4) the person is not ineligible for the payment of long-term care services by the
265.26 medical assistance program due to an asset transfer penalty under section 256B.0595 or
265.27 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

265.28 (5) the person needs long-term care services that are not funded through other state
265.29 or federal funding;

265.30 (6) except for individuals described in clause (7), the monthly cost of the alternative
265.31 care services funded by the program for this person does not exceed 75 percent of the
265.32 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
265.33 does not prohibit the alternative care client from payment for additional services, but in no
265.34 case may the cost of additional services purchased under this section exceed the difference
265.35 between the client's monthly service limit defined under section 256B.0915, subdivision

266.1 3, and the alternative care program monthly service limit defined in this paragraph. If
266.2 care-related supplies and equipment or environmental modifications and adaptations are or
266.3 will be purchased for an alternative care services recipient, the costs may be prorated on a
266.4 monthly basis for up to 12 consecutive months beginning with the month of purchase.
266.5 If the monthly cost of a recipient's other alternative care services exceeds the monthly
266.6 limit established in this paragraph, the annual cost of the alternative care services shall be
266.7 determined. In this event, the annual cost of alternative care services shall not exceed 12
266.8 times the monthly limit described in this paragraph; ~~and~~

266.9 (7) for individuals assigned a case mix classification A as described under section
266.10 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
266.11 living, (ii) only one dependency in bathing, dressing, grooming, or walking, or (iii) a
266.12 dependency score of less than three if eating is the only dependency as determined by an
266.13 assessment performed under section 256B.0911, the monthly cost of alternative care
266.14 services funded by the program cannot exceed \$600 per month for all new participants
266.15 enrolled in the program on or after July 1, 2009. This monthly limit shall be applied to
266.16 all other participants who meet this criteria at reassessment. This monthly limit shall be
266.17 increased annually as described in section 256B.0915, subdivision 3a, paragraph (a). This
266.18 monthly limit does not prohibit the alternative care client from payment for additional
266.19 services, but in no case may the cost of additional services purchased exceed the difference
266.20 between the client's monthly service limit defined in this clause and the limit described in
266.21 clause (6) for case mix classification A; and

266.22 (8) the person is making timely payments of the assessed monthly fee.

266.23 A person is ineligible if payment of the fee is over 60 days past due, unless the person
266.24 agrees to:

- 266.25 (i) the appointment of a representative payee;
266.26 (ii) automatic payment from a financial account;
266.27 (iii) the establishment of greater family involvement in the financial management of
266.28 payments; or
266.29 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

266.30 The lead agency may extend the client's eligibility as necessary while making
266.31 arrangements to facilitate payment of past-due amounts and future premium payments.
266.32 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
266.33 reinstated for a period of 30 days.

266.34 (b) Alternative care funding under this subdivision is not available for a person
266.35 who is a medical assistance recipient or who would be eligible for medical assistance
266.36 without a spenddown or waiver obligation. A person whose initial application for medical

267.1 assistance and the elderly waiver program is being processed may be served under the
267.2 alternative care program for a period up to 60 days. If the individual is found to be eligible
267.3 for medical assistance, medical assistance must be billed for services payable under the
267.4 federally approved elderly waiver plan and delivered from the date the individual was
267.5 found eligible for the federally approved elderly waiver plan. Notwithstanding this
267.6 provision, alternative care funds may not be used to pay for any service the cost of which:
267.7 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
267.8 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
267.9 to participate in the federally approved elderly waiver program under the special income
267.10 standard provision.

267.11 (c) Alternative care funding is not available for a person who resides in a licensed
267.12 nursing home, certified boarding care home, hospital, or intermediate care facility, except
267.13 for case management services which are provided in support of the discharge planning
267.14 process for a nursing home resident or certified boarding care home resident to assist with
267.15 a relocation process to a community-based setting.

267.16 (d) Alternative care funding is not available for a person whose income is greater
267.17 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
267.18 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal
267.19 year for which alternative care eligibility is determined, who would be eligible for the
267.20 elderly waiver with a waiver obligation.

267.21 Sec. 45. Minnesota Statutes 2008, section 256B.0915, subdivision 3a, is amended to
267.22 read:

267.23 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
267.24 waived services to an individual elderly waiver client except for individuals described
267.25 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
267.26 mix resident class to which the elderly waiver client would be assigned under Minnesota
267.27 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
267.28 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
267.29 which the resident assessment system as described in section 256B.438 for nursing home
267.30 rate determination is implemented. Effective on the first day of the state fiscal year in
267.31 which the resident assessment system as described in section 256B.438 for nursing home
267.32 rate determination is implemented and the first day of each subsequent state fiscal year, the
267.33 monthly limit for the cost of waived services to an individual elderly waiver client shall
267.34 be the rate of the case mix resident class to which the waiver client would be assigned
267.35 under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the

268.1 previous state fiscal year, adjusted by the greater of any legislatively adopted home and
 268.2 community-based services percentage rate increase or the average statewide percentage
 268.3 increase in nursing facility payment rates.

268.4 (b) The monthly limit for the cost of waived services to an individual elderly
 268.5 waiver client assigned to a case mix classification A under paragraph (a) with (1) no
 268.6 dependencies in activities of daily living, (2) only one dependency in bathing, dressing,
 268.7 grooming, or walking, or (3) a dependency score of less than three if eating is the only
 268.8 dependency, shall be the lower of the case mix classification amount for case mix A as
 268.9 determined under paragraph (a) or the case mix classification amount for case mix A
 268.10 effective on October 1, 2008, per month for all new participants enrolled in the program
 268.11 on or after July 1, 2009. This monthly limit shall be applied to all other participants who
 268.12 meet this criteria at reassessment.

268.13 (c) If extended medical supplies and equipment or environmental modifications are
 268.14 or will be purchased for an elderly waiver client, the costs may be prorated for up to
 268.15 12 consecutive months beginning with the month of purchase. If the monthly cost of a
 268.16 recipient's waived services exceeds the monthly limit established in paragraph (a) or (b),
 268.17 the annual cost of all waived services shall be determined. In this event, the annual cost
 268.18 of all waived services shall not exceed 12 times the monthly limit of waived services
 268.19 as described in paragraph (a) or (b).

268.20 Sec. 46. Minnesota Statutes 2008, section 256B.0915, subdivision 3e, is amended to
 268.21 read:

268.22 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
 268.23 services shall be a monthly rate ~~negotiated and~~ authorized by the lead agency within the
 268.24 parameters established by the commissioner. The payment agreement must delineate the
 268.25 ~~services that have been customized for each recipient and specify the amount of each~~
 268.26 component service included in the recipient's customized living service to be provided
 268.27 plan. The lead agency shall ensure that there is a documented need ~~for all~~ within the
 268.28 parameters established by the commissioner for all component customized living services
 268.29 authorized. Customized living services must not include rent or raw food costs.

268.30 (b) The ~~negotiated~~ payment rate must be based on the amount of component services
 268.31 to be provided utilizing component rates established by the commissioner. Counties and
 268.32 tribes shall use tools issued by the commissioner to develop and document customized
 268.33 living service plans and rates.

269.1 ~~Negotiated~~ (c) Component service rates must not exceed payment rates for
 269.2 comparable elderly waiver or medical assistance services and must reflect economies of
 269.3 scale. Customized living services must not include rent or raw food costs.

269.4 ~~(b)~~ (d) The individualized monthly ~~negotiated~~ authorized payment for the
 269.5 customized living ~~services~~ service plan shall not exceed ~~the nonfederal share, in effect~~
 269.6 ~~on July 1 of the state fiscal year for which the rate limit is being calculated,~~ 50 percent
 269.7 of the greater of either the statewide or any of the geographic groups' weighted average
 269.8 monthly nursing facility rate of the case mix resident class to which the elderly waiver
 269.9 eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
 269.10 less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until
 269.11 the July 1 of the state fiscal year in which the resident assessment system as described
 269.12 in section 256B.438 for nursing home rate determination is implemented. Effective on
 269.13 July 1 of the state fiscal year in which the resident assessment system as described in
 269.14 section 256B.438 for nursing home rate determination is implemented and July 1 of each
 269.15 subsequent state fiscal year, the individualized monthly ~~negotiated~~ authorized payment
 269.16 for the services described in this clause shall not exceed the limit ~~described in this clause~~
 269.17 which was in effect on June 30 of the previous state fiscal year ~~and which has been~~
 269.18 ~~adjusted by the greater of any legislatively adopted home and community-based services~~
 269.19 ~~cost-of-living percentage increase or any legislatively adopted statewide percent rate~~
 269.20 ~~increase for nursing facilities~~ updated annually based on legislatively adopted changes to
 269.21 all service rate maximums for home and community-based service providers.

269.22 ~~(e)~~ (e) Customized living services are delivered by a provider licensed by the
 269.23 Department of Health as a class A or class F home care provider and provided in a
 269.24 building that is registered as a housing with services establishment under chapter 144D.

269.25 Sec. 47. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to
 269.26 read:

269.27 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
 269.28 payment ~~rates~~ rate for 24-hour customized living services is a monthly rate ~~negotiated~~
 269.29 ~~and~~ authorized by the lead agency within the parameters established by the commissioner
 269.30 of human services. The payment agreement must delineate the ~~services that have been~~
 269.31 ~~customized for each recipient and specify the~~ amount of each component service included
 269.32 in each recipient's customized living service to be provided plan. The lead agency
 269.33 shall ensure that there is a documented need within the parameters established by the
 269.34 commissioner for all component customized living services authorized. The lead agency

270.1 shall not authorize 24-hour customized living services unless there is a documented need
270.2 for 24-hour supervision.

270.3 (b) For purposes of this section, "24-hour supervision" means that the recipient
270.4 requires assistance due to needs related to one or more of the following:

270.5 (1) intermittent assistance with toileting, positioning, or transferring;

270.6 (2) cognitive or behavioral issues;

270.7 (3) a medical condition that requires clinical monitoring; or

270.8 (4) ~~other conditions or needs as defined by the commissioner of human services for~~

270.9 all new participants enrolled in the program on or after January 1, 2011, and all other

270.10 participants at their first reassessment after January 1, 2011, dependency in at least two

270.11 of the following activities of daily living as determined by assessment under section

270.12 256B.0911: bathing; dressing; grooming; walking; or eating; and needs medication

270.13 management and at least 50 hours of service per month. The lead agency shall ensure that

270.14 the frequency and mode of supervision of the recipient and the qualifications of staff

270.15 providing supervision are described and meet the needs of the recipient. ~~Customized~~

270.16 ~~living services must not include rent or raw food costs.~~

270.17 (c) The ~~negotiated~~ payment rate for 24-hour customized living services must be

270.18 based on the amount of component services to be provided utilizing component rates

270.19 established by the commissioner. Counties and tribes will use tools issued by the

270.20 commissioner to develop and document customized living plans and authorize rates.

270.21 ~~Negotiated~~ (d) Component service rates must not exceed payment rates for

270.22 comparable elderly waiver or medical assistance services and must reflect economies

270.23 of scale.

270.24 (e) The individually ~~negotiated~~ authorized 24-hour customized living payments,

270.25 in combination with the payment for other elderly waiver services, including case

270.26 management, must not exceed the recipient's community budget cap specified in

270.27 subdivision 3a. Customized living services must not include rent or raw food costs.

270.28 (f) The individually authorized 24-hour customized living payment rates shall not

270.29 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized

270.30 living services in effect and in the Medicaid management information systems on March

270.31 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050

270.32 to 9549.0059, to which elderly waiver service clients are assigned. When there are

270.33 fewer than 50 authorizations in effect in the case mix resident class, the commissioner

270.34 shall multiply the calculated service payment rate maximum for the A classification by

270.35 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to

270.36 9549.0059, to determine the applicable payment rate maximum. Service payment rate

271.1 maximums shall be updated annually based on legislatively adopted changes to all service
271.2 rates for home and community-based service providers.

271.3 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
271.4 may establish alternative payment rate systems for 24-hour customized living services in
271.5 housing with services establishments which are freestanding buildings with a capacity of
271.6 16 or fewer, by applying a single hourly rate for covered component services provided
271.7 in either:

271.8 (1) licensed corporate adult foster homes; or

271.9 (2) specialized dementia care units which meet the requirements of section 144D.065

271.10 and in which:

271.11 (i) each resident is offered the option of having their own apartment; or

271.12 (ii) the units are licensed as board and lodge establishments with maximum capacity
271.13 of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
271.14 subparts 1, 2, 3, and 4, item A.

271.15 Sec. 48. Minnesota Statutes 2008, section 256B.0915, subdivision 5, is amended to
271.16 read:

271.17 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
271.18 shall receive an initial assessment of strengths, informal supports, and need for services
271.19 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
271.20 client served under the elderly waiver must be conducted at least every 12 months and at
271.21 other times when the case manager determines that there has been significant change in
271.22 the client's functioning. This may include instances where the client is discharged from
271.23 the hospital. There must be a determination that the client requires nursing facility level of
271.24 care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments
271.25 to initiate and maintain participation in the waiver program.

271.26 (b) Regardless of other assessments identified in section 144.0724, subdivision
271.27 4, as appropriate to determine nursing facility level of care for purposes of medical
271.28 assistance payment for nursing facility services, only face-to-face assessments conducted
271.29 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
271.30 level of care determination will be accepted for purposes of initial and ongoing access to
271.31 waiver service payment.

271.32 **EFFECTIVE DATE.** This section is effective January 1, 2011.

271.33 Sec. 49. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
271.34 subdivision to read:

272.1 Subd. 10. Waiver payment rates; managed care organizations. The
272.2 commissioner shall adjust the elderly waiver capitation payment rates for managed care
272.3 organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum
272.4 service rate limits for customized living services and 24-hour customized living services
272.5 under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical
272.6 assistance rates paid to customized living providers by managed care organizations
272.7 under this section shall not exceed the maximum service rate limits determined by the
272.8 commissioner under subdivisions 3e and 3h.

272.9 Sec. 50. Minnesota Statutes 2008, section 256B.0916, subdivision 2, is amended to
272.10 read:

272.11 **Subd. 2. Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000,
272.12 the commissioner shall distribute all funding available for home and community-based
272.13 waiver services for persons with developmental disabilities to individual counties or to
272.14 groups of counties that form partnerships to jointly plan, administer, and authorize funding
272.15 for eligible individuals. The commissioner shall encourage counties to form partnerships
272.16 that have a sufficient number of recipients and funding to adequately manage the risk
272.17 and maximize use of available resources.

272.18 (b) Counties must submit a request for funds and a plan for administering the
272.19 program as required by the commissioner. The plan must identify the number of clients to
272.20 be served, their ages, and their priority listing based on:

272.21 (1) requirements in Minnesota Rules, part 9525.1880; and

272.22 (2) ~~unstable living situations due to the age or incapacity of the primary caregiver;~~
272.23 statewide priorities identified in section 256B.092, subdivision 12.

272.24 (3) ~~the need for services to avoid out-of-home placement of children;~~

272.25 (4) ~~the need to serve persons affected by private sector ICF/MR closures; and~~

272.26 (5) ~~the need to serve persons whose consumer support grant exception amount~~
272.27 ~~was eliminated in 2004.~~

272.28 The plan must also identify changes made to improve services to eligible persons and to
272.29 improve program management.

272.30 (c) In allocating resources to counties, priority must be given to groups of counties
272.31 that form partnerships to jointly plan, administer, and authorize funding for eligible
272.32 individuals and to counties determined by the commissioner to have sufficient waiver
272.33 capacity to maximize resource use.

273.1 (d) Within 30 days after receiving the county request for funds and plans, the
273.2 commissioner shall provide a written response to the plan that includes the level of
273.3 resources available to serve additional persons.

273.4 (e) Counties are eligible to receive medical assistance administrative reimbursement
273.5 for administrative costs under criteria established by the commissioner.

273.6 Sec. 51. Minnesota Statutes 2008, section 256B.0917, is amended by adding a
273.7 subdivision to read:

273.8 Subd. 14. Essential community supports grants. (a) The purpose of the essential
273.9 community supports grant program is to provide targeted services to persons 65 years and
273.10 older who need essential community support, but whose needs do not meet the level of
273.11 care required for nursing facility placement under section 144.0724, subdivision 11.

273.12 (b) Within the limits of the appropriation and not to exceed \$400 per person per
273.13 month, funding must be available to a person who:

273.14 (1) is age 65 or older;

273.15 (2) is not eligible for medical assistance;

273.16 (3) would otherwise be financially eligible for the alternative care program under
273.17 section 256B.0913, subdivision 4;

273.18 (4) has received a community assessment under section 256B.0911, subdivision 3a
273.19 or 3b, and does not require the level of care provided in a nursing facility;

273.20 (5) has a community support plan; and

273.21 (6) has been determined by a community assessment under section 256B.0911,
273.22 subdivision 3a or 3b, to be a person who would require provision of at least one of the
273.23 following services, as defined in the approved elderly waiver plan, in order to maintain
273.24 their community residence:

273.25 (i) caregiver support;

273.26 (ii) homemaker;

273.27 (iii) chore; or

273.28 (iv) a personal emergency response device or system.

273.29 (c) The person receiving any of the essential community supports in this subdivision
273.30 must also receive service coordination as part of their community support plan.

273.31 (d) A person who has been determined to be eligible for an essential community
273.32 support grant must be reassessed at least annually and continue to meet the criteria in
273.33 paragraph (b) to remain eligible for an essential community support grant.

274.1 (e) The commissioner shall allocate grants to counties and tribes under contract with
274.2 the department based upon the historic use of the medical assistance elderly waiver and
274.3 alternative care grant programs and other criteria as determined by the commissioner.

274.4 **EFFECTIVE DATE.** This section is effective January 1, 2011.

274.5 Sec. 52. Minnesota Statutes 2008, section 256B.092, subdivision 8a, is amended to
274.6 read:

274.7 Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes
274.8 to place a person in another county for services, the county of financial responsibility shall
274.9 seek concurrence from the proposed county of service and the placement shall be made
274.10 cooperatively between the two counties. Arrangements shall be made between the two
274.11 counties for ongoing social service, including annual reviews of the person's individual
274.12 service plan. The county where services are provided may not make changes in the
274.13 person's service plan without approval by the county of financial responsibility.

274.14 (b) When a person has been screened and authorized for services in an intermediate
274.15 care facility for persons with developmental disabilities or for home and community-based
274.16 services for persons with developmental disabilities, the case manager shall assist that
274.17 person in identifying a service provider who is able to meet the needs of the person
274.18 according to the person's individual service plan. If the identified service is to be provided
274.19 in a county other than the county of financial responsibility, the county of financial
274.20 responsibility shall request concurrence of the county where the person is requesting to
274.21 receive the identified services. The county of service may refuse to concur if:

274.22 (1) it can demonstrate that the provider is unable to provide the services identified in
274.23 the person's individual service plan as services that are needed and are to be provided; or

274.24 (2) in the case of an intermediate care facility for persons with developmental
274.25 disabilities, there has been no authorization for admission by the admission review team
274.26 as required in section 256B.0926; or

274.27 ~~(3) in the case of home and community-based services for persons with~~
274.28 ~~developmental disabilities, the county of service can demonstrate that the prospective~~
274.29 ~~provider has failed to substantially comply with the terms of a past contract or has had a~~
274.30 ~~prior contract terminated within the last 12 months for failure to provide adequate services,~~
274.31 ~~or has received a notice of intent to terminate the contract.~~

274.32 (c) The county of service shall notify the county of financial responsibility of
274.33 concurrence or refusal to concur no later than 20 working days following receipt of the
274.34 written request. Unless other mutually acceptable arrangements are made by the involved
274.35 county agencies, the county of financial responsibility is responsible for costs of social

275.1 services and the costs associated with the development and maintenance of the placement.
275.2 The county of service may request that the county of financial responsibility purchase
275.3 case management services from the county of service or from a contracted provider
275.4 of case management when the county of financial responsibility is not providing case
275.5 management as defined in this section and rules adopted under this section, unless other
275.6 mutually acceptable arrangements are made by the involved county agencies. Standards
275.7 for payment limits under this section may be established by the commissioner. Financial
275.8 disputes between counties shall be resolved as provided in section 256G.09.

275.9 Sec. 53. Minnesota Statutes 2008, section 256B.092, is amended by adding a
275.10 subdivision to read:

275.11 Subd. 11. Residential support services. (a) Upon federal approval, there is
275.12 established a new service called residential support that is available on the CAC, CADI,
275.13 DD, and TBI waivers. Existing waiver service descriptions must be modified to the extent
275.14 necessary to ensure there is no duplication between other services. Residential support
275.15 services must be provided by vendors licensed as a community residential setting as
275.16 defined in section 245A.11, subdivision 8.

275.17 (b) Residential support services must meet the following criteria:

275.18 (1) providers of residential support services must own or control the residential site;

275.19 (2) the residential site must not be the primary residence of the license holder;

275.20 (3) the residential site must have a designated program supervisor responsible for
275.21 program oversight, development, and implementation of policies and procedures;

275.22 (4) the provider of residential support services must provide supervision, training,
275.23 and assistance as described in the person's community support plan; and

275.24 (5) the provider of residential support services must meet the requirements of
275.25 licensure and additional requirements of the person's community support plan.

275.26 (c) Providers of residential support services that meet the definition in paragraph (a)
275.27 must be registered using a process determined by the commissioner beginning July 1, 2009.

275.28 Sec. 54. Minnesota Statutes 2008, section 256B.092, is amended by adding a
275.29 subdivision to read:

275.30 Subd. 12. Waivered services statewide priorities. (a) The commissioner shall
275.31 establish statewide priorities for individuals on the waiting list for developmental
275.32 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
275.33 include, but are not limited to, individuals who continue to have a need for waiver services
275.34 after they have maximized the use of state plan services and other funding resources,

276.1 including natural supports, prior to accessing waiver services, and who meet at least one
276.2 of the following criteria:

276.3 (1) have unstable living situations due to the age, incapacity, or sudden loss of
276.4 the primary caregivers;

276.5 (2) are moving from an institution due to bed closures;

276.6 (3) experience a sudden closure of their current living arrangement;

276.7 (4) require protection from confirmed abuse, neglect, or exploitation;

276.8 (5) experience a sudden change in need that can no longer be met through state plan
276.9 services or other funding resources alone; or

276.10 (6) meet other priorities established by the department.

276.11 (b) When allocating resources to lead agencies, the commissioner must take into
276.12 consideration the number of individuals waiting who meet statewide priorities and the
276.13 lead agencies' current use of waiver funds and existing service options.

276.14 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
276.15 provide recommendations to the legislature on whether to continue the use of statewide
276.16 priorities in the November 1, 2011, annual report required by the commissioner in sections
276.17 256B.0916, subdivision 7, and 256B.49, subdivision 21.

276.18 Sec. 55. **[256B.0948] FOSTER CARE RATE LIMITS.**

276.19 The commissioner shall decrease by five percent rates for adult foster care and
276.20 supportive living services that are reimbursed under section 256B.092 or 256B.49, and
276.21 are above the 95th percentile of the statewide rates for the service. The reduction in rates
276.22 shall take into account the acuity of individuals served based on the methodology used to
276.23 allocate dollars to local lead agency budgets, and assure that affected service rates are not
276.24 reduced below the rate level represented by the above percentile due to this rate change.
276.25 Lead agency contracts for services specified in this section shall be amended to implement
276.26 these rate changes for services rendered on or after July 1, 2009. The commissioner shall
276.27 make corresponding reductions to waiver allocations and capitated rates.

276.28 Sec. 56. Minnesota Statutes 2008, section 256B.37, subdivision 1, is amended to read:

276.29 Subdivision 1. **Subrogation.** Upon furnishing medical assistance or alternative
276.30 care services under section 256B.0913 to any person who has private accident or health
276.31 care coverage, or receives or has a right to receive health or medical care from any
276.32 type of organization or entity, or has a cause of action arising out of an occurrence that
276.33 necessitated the payment of medical assistance, the state agency or the state agency's agent
276.34 shall be subrogated, to the extent of the cost of medical care furnished, to any rights the

277.1 person may have under the terms of the coverage, or against the organization or entity
277.2 providing or liable to provide health or medical care, or under the cause of action.

277.3 The right of subrogation created in this section includes all portions of the cause
277.4 of action, notwithstanding any settlement allocation or apportionment that purports to
277.5 dispose of portions of the cause of action not subject to subrogation.

277.6 Sec. 57. Minnesota Statutes 2008, section 256B.37, subdivision 5, is amended to read:

277.7 Subd. 5. **Private benefits to be used first.** Private accident and health care coverage
277.8 including Medicare for medical services is primary coverage and must be exhausted before
277.9 medical assistance ~~is~~ or alternative care services are paid for medical services including
277.10 home health care, personal care assistant services, hospice, supplies and equipment, or
277.11 services covered under a Centers for Medicare and Medicaid Services waiver. When a
277.12 person who is otherwise eligible for medical assistance has private accident or health care
277.13 coverage, including Medicare or a prepaid health plan, the private health care benefits
277.14 available to the person must be used first and to the fullest extent.

277.15 Sec. 58. Minnesota Statutes 2008, section 256B.434, subdivision 4, is amended to read:

277.16 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
277.17 have their payment rates determined under this section rather than section 256B.431, the
277.18 commissioner shall establish a rate under this subdivision. The nursing facility must enter
277.19 into a written contract with the commissioner.

277.20 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
277.21 contract under this section is the payment rate the facility would have received under
277.22 section 256B.431.

277.23 (c) A nursing facility's case mix payment rates for the second and subsequent years
277.24 of a facility's contract under this section are the previous rate year's contract payment
277.25 rates plus an inflation adjustment and, for facilities reimbursed under this section or
277.26 section 256B.431, an adjustment to include the cost of any increase in Health Department
277.27 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
277.28 inflation adjustment must be based on the change in the Consumer Price Index-All Items
277.29 (United States City average) (CPI-U) forecasted by the commissioner of finance's national
277.30 economic consultant, as forecasted in the fourth quarter of the calendar year preceding
277.31 the rate year. The inflation adjustment must be based on the 12-month period from the
277.32 midpoint of the previous rate year to the midpoint of the rate year for which the rate is
277.33 being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001,
277.34 July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1,

278.1 2008, October 1, 2009, ~~and~~ October 1, 2010, October 1, 2011, and October 1, 2012. This
278.2 paragraph shall apply only to the property-related payment rate, except that adjustments
278.3 to include the cost of any increase in Health Department licensing fees taking effect on
278.4 or after July 1, 2001, shall be provided. Beginning in 2005, adjustment to the property
278.5 payment rate under this section and section 256B.431 shall be effective on October 1.
278.6 In determining the amount of the property-related payment rate adjustment under this
278.7 paragraph, the commissioner shall determine the proportion of the facility's rates that are
278.8 property-related based on the facility's most recent cost report.

278.9 (d) The commissioner shall develop additional incentive-based payments of up to
278.10 five percent above a facility's operating payment rate for achieving outcomes specified
278.11 in a contract. The commissioner may solicit contract amendments and implement those
278.12 which, on a competitive basis, best meet the state's policy objectives. The commissioner
278.13 shall limit the amount of any incentive payment and the number of contract amendments
278.14 under this paragraph to operate the incentive payments within funds appropriated for this
278.15 purpose. The contract amendments may specify various levels of payment for various
278.16 levels of performance. Incentive payments to facilities under this paragraph may be in the
278.17 form of time-limited rate adjustments or onetime supplemental payments. In establishing
278.18 the specified outcomes and related criteria, the commissioner shall consider the following
278.19 state policy objectives:

278.20 (1) successful diversion or discharge of residents to the residents' prior home or other
278.21 community-based alternatives;

278.22 (2) adoption of new technology to improve quality or efficiency;

278.23 (3) improved quality as measured in the Nursing Home Report Card;

278.24 (4) reduced acute care costs; and

278.25 (5) any additional outcomes proposed by a nursing facility that the commissioner
278.26 finds desirable.

278.27 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
278.28 take action to come into compliance with existing or pending requirements of the life
278.29 safety code provisions or federal regulations governing sprinkler systems must receive
278.30 reimbursement for the costs associated with compliance if all of the following conditions
278.31 are met:

278.32 (1) the expenses associated with compliance occurred on or after January 1, 2005,
278.33 and before December 31, 2008;

278.34 (2) the costs were not otherwise reimbursed under subdivision 4f or section
278.35 144A.071 or 144A.073; and

279.1 (3) the total allowable costs reported under this paragraph are less than the minimum
 279.2 threshold established under section 256B.431, subdivision 15, paragraph (e), and
 279.3 subdivision 16.

279.4 The commissioner shall use money appropriated for this purpose to provide to qualifying
 279.5 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
 279.6 2008. Nursing facilities that have spent money or anticipate the need to spend money
 279.7 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
 279.8 system or (2) replacing all or portions of an existing sprinkler system may submit to the
 279.9 commissioner by June 30, 2007, on a form provided by the commissioner the actual
 279.10 costs of a completed project or the estimated costs, based on a project bid, of a planned
 279.11 project. The commissioner shall calculate a rate adjustment equal to the allowable
 279.12 costs of the project divided by the resident days reported for the report year ending
 279.13 September 30, 2006. If the costs from all projects exceed the appropriation for this
 279.14 purpose, the commissioner shall allocate the money appropriated on a pro rata basis
 279.15 to the qualifying facilities by reducing the rate adjustment determined for each facility
 279.16 by an equal percentage. Facilities that used estimated costs when requesting the rate
 279.17 adjustment shall report to the commissioner by January 31, 2009, on the use of this
 279.18 money on a form provided by the commissioner. If the nursing facility fails to provide
 279.19 the report, the commissioner shall recoup the money paid to the facility for this purpose.
 279.20 If the facility reports expenditures allowable under this subdivision that are less than
 279.21 the amount received in the facility's annualized rate adjustment, the commissioner shall
 279.22 recoup the difference.

279.23 Sec. 59. Minnesota Statutes 2008, section 256B.434, is amended by adding a
 279.24 subdivision to read:

279.25 Subd. 21. Payment of post-PERA pension benefit costs. Nursing facilities that
 279.26 convert or converted after September 30, 2006, from public to private ownership shall
 279.27 have a portion of their post-PERA pension costs treated as a component of the historic
 279.28 operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior
 279.29 to October 1, 2016, the commissioner shall determine the pension costs to be included
 279.30 in the facility's base for determining rates under this section by using the following
 279.31 formula: post-privatization pension benefit costs as a percent of salary shall be determined
 279.32 from either the cost report for the first full reporting year after privatization or the most
 279.33 recent report year available, whichever is later. This percentage shall be applied to the
 279.34 salary costs of the alternative payment system base rate year to determine the allowable
 279.35 amount of pension costs. The adjustments provided for in sections 256B.431, 256B.434,

280.1 256B.441, and any other law enacted after the base rate year and prior to the year for
280.2 which rates are being determined shall be applied to the allowable amount. The adjusted
280.3 allowable amount shall be added to the operating rate effective the first rate year PERA
280.4 ceases to remain as a pass-through component of the rate.

280.5 Sec. 60. Minnesota Statutes 2008, section 256B.437, subdivision 6, is amended to read:

280.6 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
280.7 services shall calculate the amount of the planned closure rate adjustment available under
280.8 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

280.9 (1) the amount available is the net reduction of nursing facility beds multiplied
280.10 by \$2,080;

280.11 (2) the total number of beds in the nursing facility or facilities receiving the planned
280.12 closure rate adjustment must be identified;

280.13 (3) capacity days are determined by multiplying the number determined under
280.14 clause (2) by 365; and

280.15 (4) the planned closure rate adjustment is the amount available in clause (1), divided
280.16 by capacity days determined under clause (3).

280.17 (b) A planned closure rate adjustment under this section is effective on the first day
280.18 of the month following completion of closure of the facility designated for closure in the
280.19 application and becomes part of the nursing facility's total operating payment rate.

280.20 (c) Applicants may use the planned closure rate adjustment to allow for a property
280.21 payment for a new nursing facility or an addition to an existing nursing facility or as an
280.22 operating payment rate adjustment. Applications approved under this subdivision are
280.23 exempt from other requirements for moratorium exceptions under section 144A.073,
280.24 subdivisions 2 and 3.

280.25 (d) Upon the request of a closing facility, the commissioner must allow the facility a
280.26 closure rate adjustment as provided under section 144A.161, subdivision 10.

280.27 (e) A facility that has received a planned closure rate adjustment may reassign it
280.28 to another facility that is under the same ownership at any time within three years of its
280.29 effective date. The amount of the adjustment shall be computed according to paragraph (a).

280.30 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
280.31 the commissioner shall recalculate planned closure rate adjustments for facilities that
280.32 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
280.33 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
280.34 from the date the per bed dollar amount is increased.

281.1 (g) For planned closures approved after June 30, 2009, the commissioner of human
281.2 services shall calculate the amount of the planned closure rate adjustment available under
281.3 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

281.4 Sec. 61. Minnesota Statutes 2008, section 256B.441, subdivision 55, is amended to
281.5 read:

281.6 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
281.7 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
281.8 under this section shall be phased in by blending the operating rate with the operating
281.9 payment rate determined under section 256B.434. For purposes of this subdivision, the
281.10 rate to be used that is determined under section 256B.434 shall not include the portion of
281.11 the operating payment rate related to performance-based incentive payments under section
281.12 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the
281.13 operating payment rate for each facility shall be 13 percent of the operating payment rate
281.14 from this section, and 87 percent of the operating payment rate from section 256B.434.
281.15 For the rate ~~year~~ period beginning October 1, 2009, through September 30, 2013, the
281.16 operating payment rate for each facility shall be 14 percent of the operating payment rate
281.17 from this section, and 86 percent of the operating payment rate from section 256B.434.
281.18 ~~For the rate year beginning October 1, 2010, the operating payment rate for each facility~~
281.19 ~~shall be 14 percent of the operating payment rate from this section, and 86 percent of the~~
281.20 ~~operating payment rate from section 256B.434. For the rate year beginning October 1,~~
281.21 ~~2011, the operating payment rate for each facility shall be 31 percent of the operating~~
281.22 ~~payment rate from this section, and 69 percent of the operating payment rate from section~~
281.23 ~~256B.434. For the rate year beginning October 1, 2012, the operating payment rate for~~
281.24 ~~each facility shall be 48 percent of the operating payment rate from this section, and 52~~
281.25 ~~percent of the operating payment rate from section 256B.434. For the rate year beginning~~
281.26 October 1, 2013, the operating payment rate for each facility shall be 65 percent of the
281.27 operating payment rate from this section, and 35 percent of the operating payment rate
281.28 from section 256B.434. For the rate year beginning October 1, 2014, the operating
281.29 payment rate for each facility shall be 82 percent of the operating payment rate from this
281.30 section, and 18 percent of the operating payment rate from section 256B.434. For the rate
281.31 year beginning October 1, 2015, the operating payment rate for each facility shall be the
281.32 operating payment rate determined under this section. The blending of operating payment
281.33 rates under this section shall be performed separately for each RUG's class.

282.1 (b) For the rate year beginning October 1, 2008, the commissioner shall apply limits
282.2 to the operating payment rate increases under paragraph (a) by creating a minimum
282.3 percentage increase and a maximum percentage increase.

282.4 (1) Each nursing facility that receives a blended October 1, 2008, operating payment
282.5 rate increase under paragraph (a) of less than one percent, when compared to its operating
282.6 payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00,
282.7 shall receive a rate adjustment of one percent.

282.8 (2) The commissioner shall determine a maximum percentage increase that will
282.9 result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing
282.10 facilities with a blended October 1, 2008, operating payment rate increase under paragraph
282.11 (a) greater than the maximum percentage increase determined by the commissioner, when
282.12 compared to its operating payment rate on September 30, 2008, computed using rates with
282.13 a RUG's weight of 1.00, shall receive the maximum percentage increase.

282.14 (3) Nursing facilities with a blended October 1, 2008, operating payment rate
282.15 increase under paragraph (a) greater than one percent and less than the maximum
282.16 percentage increase determined by the commissioner, when compared to its operating
282.17 payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00,
282.18 shall receive the blended October 1, 2008, operating payment rate increase determined
282.19 under paragraph (a).

282.20 (4) The October 1, 2009, through October 1, 2015, operating payment rate for
282.21 facilities receiving the maximum percentage increase determined in clause (2) shall be
282.22 the amount determined under paragraph (a) less the difference between the amount
282.23 determined under paragraph (a) for October 1, 2008, and the amount allowed under clause
282.24 (2). This rate restriction does not apply to rate increases provided in any other section.

282.25 (c) A portion of the funds received under this subdivision that are in excess of
282.26 operating payment rates that a facility would have received under section 256B.434, as
282.27 determined in accordance with clauses (1) to (3), shall be subject to the requirements in
282.28 section 256B.434, subdivision 19, paragraphs (b) to (h).

282.29 (1) Determine the amount of additional funding available to a facility, which shall be
282.30 equal to total medical assistance resident days from the most recent reporting year times
282.31 the difference between the blended rate determined in paragraph (a) for the rate year being
282.32 computed and the blended rate for the prior year.

282.33 (2) Determine the portion of all operating costs, for the most recent reporting year,
282.34 that are compensation related. If this value exceeds 75 percent, use 75 percent.

282.35 (3) Subtract the amount determined in clause (2) from 75 percent.

283.1 (4) The portion of the fund received under this subdivision that shall be subject to
283.2 the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal
283.3 the amount determined in clause (1) times the amount determined in clause (3).

283.4 Sec. 62. Minnesota Statutes 2008, section 256B.441, subdivision 58, is amended to
283.5 read:

283.6 Subd. 58. **Implementation delay.** Within six months prior to the effective date of
283.7 (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits
283.8 under subdivision 50; and (3) the removal of planned closure rate adjustments and single
283.9 bed room incentives from external fixed costs under subdivision 53, the commissioner
283.10 shall compare the average operating cost for all facilities combined from the most recent
283.11 cost reports to the average medical assistance operating payment rates for all facilities
283.12 combined from the same time period. Each provision shall not go into effect until the
283.13 average medical assistance operating payment rate is at least 92 percent of the average
283.14 operating cost. The rebasing of property payment rates under subdivision 1, and the
283.15 removal of planned closure rate adjustments and single-bed room incentives from external
283.16 fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating
283.17 payment rate from this section is phased in as described in subdivision 55.

283.18 Sec. 63. Minnesota Statutes 2008, section 256B.441, is amended by adding a
283.19 subdivision to read:

283.20 Subd. 59. **Single-bed payments for medical assistance recipients.** Effective
283.21 October 1, 2009, the amount paid for a private room under Minnesota Rules, part
283.22 9549.0070, subpart 3, is reduced from 115 percent to 111.5 percent.

283.23 Sec. 64. Minnesota Statutes 2008, section 256B.49, is amended by adding a
283.24 subdivision to read:

283.25 Subd. 11a. **Waivered services waiting list.** (a) The commissioner shall establish
283.26 statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver
283.27 services, as of January 1, 2010. The statewide priorities must include, but are not limited
283.28 to, individuals who continue to have a need for waiver services after they have maximized
283.29 the use of state plan services and other funding resources, including natural supports, prior
283.30 to accessing waiver services, and who meet at least one of the following criteria:

283.31 (1) have unstable living situations due to the age, incapacity, or sudden loss of
283.32 the primary caregivers;

283.33 (2) are moving from an institution due to bed closures;

- 284.1 (3) experience a sudden closure of their current living arrangement;
284.2 (4) require protection from confirmed abuse, neglect, or exploitation;
284.3 (5) experience a sudden change in need that can no longer be met through state plan
284.4 services or other funding resources alone; or
284.5 (6) meet other priorities established by the department.
284.6 (b) When allocating resources to lead agencies, the commissioner must take into
284.7 consideration the number of individuals waiting who meet statewide priorities and the
284.8 lead agencies' current use of waiver funds and existing service options.
284.9 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
284.10 provide recommendations to the legislature on whether to continue the use of statewide
284.11 priorities in the November 1, 2011, annual report required by the commissioner in sections
284.12 256B.0916, subdivision 7, and 256B.49, subdivision 21.

284.13 Sec. 65. Minnesota Statutes 2008, section 256B.49, subdivision 12, is amended to read:

284.14 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
284.15 of care provided in a nursing facility as determined under sections 144.0724, subdivision
284.16 11, and 256B.0911, or hospital shall be informed of the home and community-based
284.17 support alternatives to the provision of inpatient hospital services or nursing facility
284.18 services. Each person must be given the choice of either institutional or home and
284.19 community-based services using the provisions described in section 256B.77, subdivision
284.20 2, paragraph (p).

284.21 **EFFECTIVE DATE.** This section is effective January 1, 2011.

284.22 Sec. 66. Minnesota Statutes 2008, section 256B.49, subdivision 13, is amended to read:

284.23 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
284.24 waiver shall be provided case management services by qualified vendors as described
284.25 in the federally approved waiver application. The case management service activities
284.26 provided will include:

- 284.27 (1) assessing the needs of the individual within 20 working days of a recipient's
284.28 request;
284.29 (2) developing the written individual service plan within ten working days after the
284.30 assessment is completed;
284.31 (3) informing the recipient or the recipient's legal guardian or conservator of service
284.32 options;
284.33 (4) assisting the recipient in the identification of potential service providers;
284.34 (5) assisting the recipient to access services;

285.1 (6) coordinating, evaluating, and monitoring of the services identified in the service
285.2 plan;

285.3 (7) completing the annual reviews of the service plan; and

285.4 (8) informing the recipient or legal representative of the right to have assessments
285.5 completed and service plans developed within specified time periods, and to appeal county
285.6 action or inaction under section 256.045, subdivision 3, including the determination of
285.7 nursing facility level of care.

285.8 (b) The case manager may delegate certain aspects of the case management service
285.9 activities to another individual provided there is oversight by the case manager. The case
285.10 manager may not delegate those aspects which require professional judgment including
285.11 assessments, reassessments, and care plan development.

285.12 **EFFECTIVE DATE.** This section is effective January 1, 2011.

285.13 Sec. 67. Minnesota Statutes 2008, section 256B.49, subdivision 14, is amended to read:

285.14 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
285.15 strengths, informal support systems, and need for services shall be completed within
285.16 20 working days of the recipient's request. Reassessment of each recipient's strengths,
285.17 support systems, and need for services shall be conducted at least every 12 months and at
285.18 other times when there has been a significant change in the recipient's functioning.

285.19 (b) There must be a determination that the client requires a hospital level of care or a
285.20 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
285.21 subsequent assessments to initiate and maintain participation in the waiver program.

285.22 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
285.23 appropriate to determine nursing facility level of care for purposes of medical assistance
285.24 payment for nursing facility services, only face-to-face assessments conducted according
285.25 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
285.26 determination or a nursing facility level of care determination must be accepted for
285.27 purposes of initial and ongoing access to waiver services payment.

285.28 (d) Persons with developmental disabilities who apply for services under the nursing
285.29 facility level waiver programs shall be screened for the appropriate level of care according
285.30 to section 256B.092.

285.31 ~~(e)~~ (e) Recipients who are found eligible for home and community-based services
285.32 under this section before their 65th birthday may remain eligible for these services after
285.33 their 65th birthday if they continue to meet all other eligibility factors.

285.34 **EFFECTIVE DATE.** The section is effective January 1, 2011.

286.1 Sec. 68. Minnesota Statutes 2008, section 256B.49, is amended by adding a
286.2 subdivision to read:

286.3 Subd. 22. Residential support services. For the purposes of this section, the
286.4 provisions of section 256B.092, subdivision 11, are controlling.

286.5 Sec. 69. **[256B.4912] HOME AND COMMUNITY-BASED WAIVERS;**
286.6 **PROVIDERS AND PAYMENT.**

286.7 Subdivision 1. Provider qualifications. For the home and community-based
286.8 waivers providing services to seniors and individuals with disabilities, the commissioner
286.9 shall establish:

286.10 (1) agreements with enrolled waiver service providers to ensure providers meet
286.11 qualifications defined in the waiver plans;

286.12 (2) regular reviews of provider qualifications; and

286.13 (3) processes to gather the necessary information to determine provider
286.14 qualifications.

286.15 By July 2010, staff that provide direct contact, as defined in section 245C.02, subdivision
286.16 11, that are employees of waiver service providers must meet the requirements of chapter
286.17 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal
286.18 approval, this requirement must also apply to consumer-directed community supports.

286.19 Subd. 2. Rate-setting methodologies. The commissioner shall establish
286.20 statewide rate-setting methodologies that meet federal waiver requirements for home
286.21 and community-based waiver services for individuals with disabilities. The rate-setting
286.22 methodologies must abide by the principles of transparency and equitability across the
286.23 state. The methodologies must involve a uniform process of structuring rates for each
286.24 service and must promote quality and participant choice.

286.25 Sec. 70. Minnesota Statutes 2008, section 256B.5011, subdivision 2, is amended to
286.26 read:

286.27 **Subd. 2. Contract provisions.** (a) The service contract with each intermediate
286.28 care facility must include provisions for:

286.29 (1) modifying payments when significant changes occur in the needs of the
286.30 consumers;

286.31 ~~(2) the establishment and use of a quality improvement plan. Using criteria and~~
286.32 ~~options for performance measures developed by the commissioner, each intermediate care~~
286.33 ~~facility must identify a minimum of one performance measure on which to focus its efforts~~
286.34 ~~for quality improvement during the contract period;~~

287.1 ~~(3)~~ appropriate and necessary statistical information required by the commissioner;
287.2 ~~(4)~~ (3) annual aggregate facility financial information; and
287.3 ~~(5)~~ (4) additional requirements for intermediate care facilities not meeting the
287.4 standards set forth in the service contract.

287.5 (b) The commissioner of human services and the commissioner of health, in
287.6 consultation with representatives from counties, advocacy organizations, and the provider
287.7 community, shall review the consolidated standards under chapter 245B and the supervised
287.8 living facility rule under Minnesota Rules, chapter 4665, to determine what provisions
287.9 in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for
287.10 intermediate care facilities in order to enable facilities to implement the performance
287.11 measures in their contract and provide quality services to residents without a duplication
287.12 of or increase in regulatory requirements.

287.13 Sec. 71. Minnesota Statutes 2008, section 256B.5012, is amended by adding a
287.14 subdivision to read:

287.15 Subd. 8. **ICF/MR rate decreases effective July 1, 2009.** Effective July 1, 2009,
287.16 the commissioner shall decrease each facility reimbursed under this section operating
287.17 payment adjustments equal to 2.58 percent of the operating payment rates in effect on
287.18 June 30, 2009. For each facility, the commissioner shall implement the rate reduction,
287.19 based on occupied beds, using the percentage specified in this subdivision multiplied by
287.20 the total payment rate, including the variable rate but excluding the property-related
287.21 payment rate, in effect on the preceding date. The total rate reduction shall include the
287.22 adjustment provided in section 256B.502, subdivision 7.

287.23 Sec. 72. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

287.24 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
287.25 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
287.26 basis beginning January 1, 1996. Managed care contracts which were in effect on June
287.27 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
287.28 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
287.29 commissioner may issue separate contracts with requirements specific to services to
287.30 medical assistance recipients age 65 and older.

287.31 (b) A prepaid health plan providing covered health services for eligible persons
287.32 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
287.33 of its contract with the commissioner. Requirements applicable to managed care programs

288.1 under chapters 256B, 256D, and 256L, established after the effective date of a contract
288.2 with the commissioner take effect when the contract is next issued or renewed.

288.3 (c) Effective for services rendered on or after January 1, 2003, the commissioner
288.4 shall withhold five percent of managed care plan payments under this section for the
288.5 prepaid medical assistance and general assistance medical care programs pending
288.6 completion of performance targets. Each performance target must be quantifiable,
288.7 objective, measurable, and reasonably attainable, except in the case of a performance
288.8 target based on a federal or state law or rule. Criteria for assessment of each performance
288.9 target must be outlined in writing prior to the contract effective date. The managed
288.10 care plan must demonstrate, to the commissioner's satisfaction, that the data submitted
288.11 regarding attainment of the performance target is accurate. The commissioner shall
288.12 periodically change the administrative measures used as performance targets in order
288.13 to improve plan performance across a broader range of administrative services. The
288.14 performance targets must include measurement of plan efforts to contain spending
288.15 on health care services and administrative activities. The commissioner may adopt
288.16 plan-specific performance targets that take into account factors affecting only one plan,
288.17 including characteristics of the plan's enrollee population. The withheld funds must be
288.18 returned no sooner than July of the following year if performance targets in the contract
288.19 are achieved. The commissioner may exclude special demonstration projects under
288.20 subdivision 23. A managed care plan or a county-based purchasing plan under section
288.21 256B.692 may include as admitted assets under section 62D.044 any amount withheld
288.22 under this paragraph that is reasonably expected to be returned.

288.23 (d)(1) Effective for services rendered on or after January 1, 2009, the commissioner
288.24 shall withhold three percent of managed care plan payments under this section for the
288.25 prepaid medical assistance and general assistance medical care programs. The withheld
288.26 funds must be returned no sooner than July 1 and no later than July 31 of the following
288.27 year. The commissioner may exclude special demonstration projects under subdivision 23.

288.28 (2) A managed care plan or a county-based purchasing plan under section 256B.692
288.29 may include as admitted assets under section 62D.044 any amount withheld under
288.30 this paragraph. The return of the withhold under this paragraph is not subject to the
288.31 requirements of paragraph (c).

288.32 (e) Effective for services provided on or after January 1, 2010, the commissioner
288.33 shall require that managed care plans use the assessment and authorization processes,
288.34 forms, timelines, standards, documentation, and data reporting requirements, protocols,
288.35 billing processes, and policies consistent with medical assistance fee-for-service or the
288.36 Department of Human Services contract requirements consistent with medical assistance

289.1 fee-for-service or the Department of Human Services contract requirements for all
289.2 personal care assistance services under section 256B.0659.

289.3 Sec. 73. Minnesota Statutes 2008, section 256D.44, subdivision 5, is amended to read:

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

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

- 289.15 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
289.16 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
289.17 of thrifty food plan;
289.18 (3) controlled protein diet, less than 40 grams and requires special products, 125
289.19 percent of thrifty food plan;
289.20 (4) low cholesterol diet, 25 percent of thrifty food plan;
289.21 (5) high residue diet, 20 percent of thrifty food plan;
289.22 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
289.23 (7) gluten-free diet, 25 percent of thrifty food plan;
289.24 (8) lactose-free diet, 25 percent of thrifty food plan;
289.25 (9) antidumping diet, 15 percent of thrifty food plan;
289.26 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
289.27 (11) ketogenic diet, 25 percent of thrifty food plan.

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

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

290.1 (d) The county agency shall continue to pay a monthly allowance of \$68 for
290.2 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
290.3 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
290.4 until the person has not received Minnesota supplemental aid for one full calendar month
290.5 or until the person's living arrangement changes and the person no longer meets the criteria
290.6 for the restaurant meal allowance, whichever occurs first.

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

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

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

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

290.33 (g) Notwithstanding this subdivision, recipients of home and community-based
290.34 services may relocate to services without 24-hour supervision and receive the equivalent
290.35 of the recipient's group residential housing allocation in Minnesota supplemental
290.36 assistance shelter needy funding if the cost of the services and housing is equal to or less

291.1 than provided to the recipient in home and community-based services and the relocation is
291.2 the recipient's choice and is approved by the recipient or guardian.

291.3 (h) To access housing and services as provided in paragraph (g), the recipient may
291.4 choose housing that may or may not be owned, operated, or controlled by the recipient's
291.5 service provider.

291.6 (i) The provisions in paragraphs (g) and (h) are effective to June 30, 2011. The
291.7 commissioner shall assess the development of publicly owned housing, other housing
291.8 alternatives, and whether a public equity housing fund may be established that would
291.9 maintain the state's interest, to the extent paid from group residential housing and
291.10 Minnesota supplemental aid shelter needy funds in provider-owned housing so that when
291.11 sold, the state would recover its share for a public equity fund to be used for future public
291.12 needs under this chapter. The commissioner shall report findings and recommendations to
291.13 the legislative committees and budget divisions with jurisdiction over health and human
291.14 services policy and financing by January 15, 2012.

291.15 (j) In selecting prospective services needed by recipients for whom home and
291.16 community-based services have been authorized, the recipient and the recipient's guardian
291.17 shall first consider alternatives to home and community-based services. Minnesota
291.18 supplemental aid shelter needy funding for recipients who utilize Minnesota supplemental
291.19 aid shelter needy funding as provided in this section shall remain permanent unless the
291.20 recipient with the recipient's guardian later chooses to access home and community-based
291.21 services.

291.22 Sec. 74. Minnesota Statutes 2008, section 626.556, subdivision 3c, is amended to read:

291.23 Subd. 3c. **Local welfare agency, Department of Human Services or Department**
291.24 **of Health responsible for assessing or investigating reports of maltreatment. (a)**

291.25 The county local welfare agency is the agency responsible for assessing or investigating
291.26 allegations of maltreatment in child foster care, family child care, ~~and~~ legally unlicensed
291.27 child care ~~and in~~ juvenile correctional facilities licensed under section 241.021 located
291.28 in the local welfare agency's county, and unlicensed personal care assistance provider
291.29 organizations providing services and receiving reimbursements under chapter 256B.

291.30 (b) The Department of Human Services is the agency responsible for assessing or
291.31 investigating allegations of maltreatment in facilities licensed under chapters 245A and
291.32 245B, except for child foster care and family child care.

291.33 (c) The Department of Health is the agency responsible for assessing or investigating
291.34 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58;
291.35 ~~and in unlicensed home health care and 144A.46.~~

292.1 (d) The commissioners of human services, public safety, and education must
292.2 jointly submit a written report by January 15, 2007, to the education policy and finance
292.3 committees of the legislature recommending the most efficient and effective allocation
292.4 of agency responsibility for assessing or investigating reports of maltreatment and must
292.5 specifically address allegations of maltreatment that currently are not the responsibility
292.6 of a designated agency.

292.7 Sec. 75. Minnesota Statutes 2008, section 626.5572, subdivision 13, is amended to
292.8 read:

292.9 Subd. 13. **Lead agency.** "Lead agency" is the primary administrative agency
292.10 responsible for investigating reports made under section 626.557.

292.11 (a) The Department of Health is the lead agency for the facilities which are licensed
292.12 or are required to be licensed as hospitals, home care providers, nursing homes, residential
292.13 care homes, or boarding care homes.

292.14 (b) The Department of Human Services is the lead agency for the programs licensed
292.15 or required to be licensed as adult day care, adult foster care, programs for people with
292.16 developmental disabilities, mental health programs, or chemical health programs,~~or~~
292.17 ~~personal care provider organizations.~~

292.18 (c) The county social service agency or its designee is the lead agency for all
292.19 other reports, including reports involving vulnerable adults receiving services from an
292.20 unlicensed personal care provider organization under section 256B.0659.

292.21 Sec. 76. **DEVELOPMENT OF ALTERNATIVE SERVICES.**

292.22 The commissioner of human services, in consultation with advocates, consumers,
292.23 and legislators, shall develop alternative services to personal care assistance services for
292.24 persons with mental health and other behavioral challenges who can benefit from other
292.25 services that more appropriately meet their needs and assist them in living independently
292.26 in the community. In the development of these services, the commissioner shall:

292.27 (1) take into consideration ways in which these alternative services will qualify for
292.28 federal financial participation; and

292.29 (2) analyze a variety of alternatives, including but not limited to a 1915(i) state
292.30 plan option.

292.31 The commissioner shall report to the legislature by January 15, 2011, with plans for
292.32 implementation of these services by July 1, 2011.

292.33 Sec. 77. **30-DAY NOTICE REQUIRED.**

293.1 Notwithstanding any contrary provision in law, persons impacted by amendments
293.2 in this article to Minnesota Statutes, sections 256B.0625, subdivision 19c; 256B.0655,
293.3 subdivision 4; 256B.0659; and 256B.0911, subdivision 1, must be given a 30-day notice
293.4 of action by the commissioner. This section expires July 1, 2011.

293.5 **Sec. 78. COLA COMPENSATION REQUIREMENTS.**

293.6 Effective July 1, 2009, providers who received rate increases under Laws 2007,
293.7 chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15,
293.8 section 17, and Minnesota Statutes, section 256B.5012, subdivision 7, for state fiscal years
293.9 2008 and 2009 are no longer required to continue or retain employee compensation or
293.10 wage-related increases required by those sections. This paragraph shall not apply to
293.11 employees covered by a collective bargaining agreement.

293.12 **Sec. 79. PROVIDER RATE AND GRANT REDUCTIONS.**

293.13 (a) The commissioner of human services shall decrease grants, allocations,
293.14 reimbursement rates, or rate limits, as applicable, by 2.58 percent effective July 1, 2009,
293.15 for services rendered on or after that date. County or tribal contracts for services specified
293.16 in this section must be amended to pass through these rate reductions within 60 days of
293.17 the effective date of the decrease and must be retroactive from the effective date of the
293.18 rate decrease.

293.19 (b) The annual rate decreases described in this section must be provided to:

293.20 (1) home and community-based waived services for persons with developmental
293.21 disabilities or related conditions, including consumer-directed community supports, under
293.22 Minnesota Statutes, section 256B.501;

293.23 (2) home and community-based waived services for the elderly, including
293.24 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

293.25 (3) waived services under community alternatives for disabled individuals,
293.26 including consumer-directed community supports, under Minnesota Statutes, section
293.27 256B.49;

293.28 (4) community alternative care waived services, including consumer-directed
293.29 community supports, under Minnesota Statutes, section 256B.49;

293.30 (5) traumatic brain injury waived services, including consumer-directed
293.31 community supports, under Minnesota Statutes, section 256B.49;

293.32 (6) nursing services and home health services under Minnesota Statutes, section
293.33 256B.0625, subdivision 6a;

293.34 (7) personal care services and qualified professional supervision of personal care
293.35 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

- 294.1 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
294.2 subdivision 7;
- 294.3 (9) day training and habilitation services for adults with developmental disabilities
294.4 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
294.5 additional cost of rate adjustments on day training and habilitation services, provided as a
294.6 social service under Minnesota Statutes, section 256M.60;
- 294.7 (10) alternative care services under Minnesota Statutes, section 256B.0913;
- 294.8 (11) the group residential housing supplementary service rate under Minnesota
294.9 Statutes, section 256I.05, subdivision 1a;
- 294.10 (12) semi-independent living services (SILS) under Minnesota Statutes, section
294.11 252.275, including SILS funding under county social services grants formerly funded
294.12 under Minnesota Statutes, chapter 256I;
- 294.13 (13) community support services for deaf and hard-of-hearing adults with mental
294.14 illness who use or wish to use sign language as their primary means of communication
294.15 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
294.16 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
294.17 and Laws 1997, First Special Session chapter 5, section 20;
- 294.18 (14) physical therapy services under Minnesota Statutes, sections 256B.0625,
294.19 subdivision 8, and 256D.03, subdivision 4;
- 294.20 (15) occupational therapy services under Minnesota Statutes, sections 256B.0625,
294.21 subdivision 8a, and 256D.03, subdivision 4;
- 294.22 (16) speech-language therapy services under Minnesota Statutes, section 256D.03,
294.23 subdivision 4, and Minnesota Rules, part 9505.0390;
- 294.24 (17) respiratory therapy services under Minnesota Statutes, section 256D.03,
294.25 subdivision 4, and Minnesota Rules, part 9505.0295;
- 294.26 (18) consumer support grants under Minnesota Statutes, section 256.476;
- 294.27 (19) family support grants under Minnesota Statutes, section 252.32;
- 294.28 (20) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
294.29 and 256B.0928;
- 294.30 (21) disability linkage line grants under Minnesota Statutes, section 256.01,
294.31 subdivision 24; and
- 294.32 (22) housing access grants under Minnesota Statutes, section 256B.0658.
- 294.33 (c) A managed care plan receiving state payments for the services in this section
294.34 must include these decreases in their payments to providers effective on October 1
294.35 following the effective date of the rate decrease.

295.1 Sec. 80. **RECOMMENDATIONS FOR PERSONAL CARE ASSISTANCE**
295.2 **SERVICES CHANGES, CONSULTATION WITH STAKEHOLDERS, AND DATA**
295.3 **REPORTING.**

295.4 The commissioner shall:

295.5 (1) consult with existing stakeholder groups convened under the commissioner's
295.6 authority, including the home and community-based expert services panel beginning in
295.7 August 2009 on implementation of the changes in the personal care assistance program,
295.8 assistance for recipients whose services and housing must change, alternative services
295.9 for those whose personal care assistance services are terminated or reduced, costs for
295.10 those whose services will change, data on the effects of the changes in the personal care
295.11 assistance program for recipients, and ongoing data on personal care assistance services
295.12 for public reporting; and

295.13 (2) report data on the training developed and delivered for all types of participants in
295.14 the personal care assistance program, audit and financial integrity measures and results,
295.15 information developed for consumers and responsible parties, available demographic,
295.16 health care service use, and housing information about individuals who no longer qualify
295.17 for personal care assistance, and quality assurance measures and results to the legislative
295.18 committees with jurisdiction over health and human services policy and finance by
295.19 January 15, 2010, and January 15, 2011.

295.20 Sec. 81. **ESTABLISHING A SINGLE SET OF STANDARDS.**

295.21 (a) The commissioner of human services shall consult with disability service
295.22 providers, advocates, counties, and consumer families to develop a single set of standards
295.23 governing services for people with disabilities receiving services under the home and
295.24 community-based waiver services program to replace all or portions of existing laws and
295.25 rules including, but not limited to, data practices, licensure of facilities and providers,
295.26 background studies, reporting of maltreatment of minors, reporting of maltreatment of
295.27 vulnerable adults, and the psychotropic medication checklist. The standards must:

295.28 (1) enable optimum consumer choice;

295.29 (2) be consumer driven;

295.30 (3) link services to individual needs and life goals;

295.31 (4) be based on quality assurance and individual outcomes;

295.32 (5) utilize the people closest to the recipient, who may include family, friends, and
295.33 health and service providers, in conjunction with the recipient's risk management plan to
295.34 assist the recipient or the recipient's guardian in making decisions that meet the recipient's
295.35 needs in a cost-effective manner and assure the recipient's health and safety;

296.1 (6) utilize person-centered planning; and
296.2 (7) maximize federal financial participation.

296.3 (b) The commissioner may consult with existing stakeholder groups convened under
296.4 the commissioner's authority, including the home and community-based expert services
296.5 panel established by the commissioner in 2008, to meet all or some of the requirements
296.6 of this section.

296.7 (c) The commissioner shall provide the reports and plans required by this section to
296.8 the legislative committees and budget divisions with jurisdiction over health and human
296.9 services policy and finance by January 15, 2012.

296.10 Sec. 82. **COMMON SERVICE MENU FOR HOME AND COMMUNITY-BASED**
296.11 **WAIVER PROGRAMS.**

296.12 The commissioner of human services shall confer with representatives of recipients,
296.13 advocacy groups, counties, providers, and health plans to develop and update a common
296.14 service menu for home and community-based waiver programs. The commissioner may
296.15 consult with existing stakeholder groups convened under the commissioner's authority to
296.16 meet all or some of the requirements of this section.

296.17 Sec. 83. **INTERMEDIATE CARE FACILITIES FOR PERSONS WITH**
296.18 **DEVELOPMENTAL DISABILITIES REPORT.**

296.19 The commissioner of human services shall consult with providers and advocates of
296.20 intermediate care facilities for persons with developmental disabilities to monitor progress
296.21 made in response to the commissioner's December 15, 2008, report to the legislature
296.22 regarding intermediate care facilities for persons with developmental disabilities.

296.23 Sec. 84. **HOUSING OPTIONS.**

296.24 The commissioner of human services, in consultation with the commissioner of
296.25 administration and the Minnesota Housing Finance Agency, and representatives of
296.26 counties, residents' advocacy groups, consumers of housing services, and provider
296.27 agencies shall explore ways to maximize the availability and affordability of housing
296.28 choices available to persons with disabilities or who need care assistance due to other
296.29 health challenges. A goal shall also be to minimize state physical plant costs in order to
296.30 serve more persons with appropriate program and care support. Consideration shall be
296.31 given to:

- 296.32 (1) improved access to rent subsidies;
296.33 (2) use of cooperatives, land trusts, and other limited equity ownership models;

297.1 (3) whether a public equity housing fund should be established that would maintain
 297.2 the state's interest, to the extent paid from state funds, including group residential housing
 297.3 and Minnesota supplemental aid shelter-needy funds in provider-owned housing, so that
 297.4 when sold, the state would recover its share for a public equity fund to be used for future
 297.5 public needs under this chapter;

297.6 (4) the desirability of the state acquiring an ownership interest or promoting the
 297.7 use of publicly owned housing;

297.8 (5) promoting more choices in the market for accessible housing that meets the
 297.9 needs of persons with physical challenges; and

297.10 (6) what consumer ownership models, if any, are appropriate.

297.11 The commissioner shall provide a written report on the findings of the evaluation of
 297.12 housing options to the chairs and ranking minority members of the house of representatives
 297.13 and senate standing committees with jurisdiction over health and human services policy
 297.14 and funding by December 15, 2010. This report shall replace the November 1, 2010,
 297.15 annual report by the commissioner required in Minnesota Statutes, sections 256B.0916,
 297.16 subdivision 7, and 256B.49, subdivision 21.

297.17 Sec. 85. **REVISOR'S INSTRUCTION.**

297.18 **Subdivision 1. Renumbering of Minnesota Statutes, section 256B.0652,**
 297.19 **authorization and review of home care services.** (a) The revisor of statutes shall
 297.20 renumber each section of Minnesota Statutes listed in column A with the number in
 297.21 column B.

<u>Column A</u>	<u>Column B</u>
297.22 <u>256B.0652, subdivision 3</u>	<u>256B.0652, subdivision 14</u>
297.23 <u>256B.0651, subdivision 6, paragraph (a)</u>	<u>256B.0652, subdivision 3</u>
297.24 <u>256B.0651, subdivision 6, paragraph (b)</u>	<u>256B.0652, subdivision 4</u>
297.25 <u>256B.0651, subdivision 6, paragraph (c)</u>	<u>256B.0652, subdivision 7</u>
297.26 <u>256B.0651, subdivision 7, paragraph (a)</u>	<u>256B.0652, subdivision 8</u>
297.27 <u>256B.0651, subdivision 7, paragraph (b)</u>	<u>256B.0652, subdivision 14</u>
297.28 <u>256B.0651, subdivision 8</u>	<u>256B.0652, subdivision 9</u>
297.29 <u>256B.0651, subdivision 9</u>	<u>256B.0652, subdivision 10</u>
297.30 <u>256B.0651, subdivision 11</u>	<u>256B.0652, subdivision 11</u>

298.1 256B.0654, subdivision 2 256B.0652, subdivision 5

298.2 256B.0655, subdivision 4 256B.0652, subdivision 6

298.3 (b) The revisor of statutes shall make necessary cross-reference changes in statutes
298.4 and rules consistent with the renumbering in paragraph (a). The Department of Human
298.5 Services shall assist the revisor with any cross-reference changes. The revisor may make
298.6 changes necessary to correct the punctuation, grammar, or structure of the remaining text
298.7 to conform with the intent of the renumbering in paragraph (a).

298.8 Subd. 2. **Renumbering personal care assistance services.** The revisor of statutes
298.9 shall replace any reference to Minnesota Statutes, section 256B.0655 with section
298.10 256B.0659, wherever it appears in statutes or rules. The revisor shall correct any cross
298.11 reference changes that are necessary as a result of this section. The Department of Human
298.12 Services shall assist the revisor in making these changes, and if necessary, shall draft a
298.13 corrections bill with changes for introduction in the 2010 legislative session. The revisor
298.14 may make changes to punctuation, grammar, or sentence structure to preserve the integrity
298.15 of statutes and effectuate the intention of this section.

298.16 Sec. 86. **REPEALER.**

298.17 (a) Minnesota Statutes 2008, sections 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e,
298.18 1h, 1i, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13; and 256B.071, subdivisions 1, 2, 3, and 4, are
298.19 repealed.

298.20 (b) Minnesota Statutes 2008, sections 256B.19, subdivision 1d; and 256B.431,
298.21 subdivision 23, are repealed effective May 1, 2009.

298.22 (c) Minnesota Statutes 2008, section 256B.0655, subdivisions 1f, 1g, and 2, are
298.23 repealed effective January 1, 2010.

298.24 **ARTICLE 9**

298.25 **STATE-COUNTY RESULTS, ACCOUNTABILITY, AND SERVICE** 298.26 **DELIVERY REFORM ACT**

298.27 Section 1. **[402A.01] CITATION.**

298.28 Sections 402A.01 to 402A.50 may be cited as the "State-County Results,
298.29 Accountability, and Service Delivery Reform Act."

298.30 Sec. 2. **[402A.10] DEFINITIONS.**

298.31 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined
298.32 in this section have the meanings given.

299.1 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
299.2 services.

299.3 Subd. 3. **Council.** "Council" means the State-County Results, Accountability, and
299.4 Service Delivery Redesign Council established in section 402A.20.

299.5 Subd. 4. **Essential human services or essential services.** "Essential human
299.6 services" or "essential services" means assistance and services to recipients or potential
299.7 recipients of public welfare and other services delivered by counties that are mandated in
299.8 federal and state law that are to be available in all counties of the state.

299.9 Subd. 5. **Service delivery authority.** "Service delivery authority" means a single
299.10 county, or group of counties operating by execution of a joint powers agreement under
299.11 section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of
299.12 the county board of commissioners to participate in the redesign under this chapter.

299.13 Subd. 6. **Steering committee.** "Steering committee" means the Steering Committee
299.14 on Performance and Outcome Reforms.

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

299.16 Sec. 3. **[402A.15] STEERING COMMITTEE ON PERFORMANCE AND**
299.17 **OUTCOME REFORMS.**

299.18 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome
299.19 Reforms shall develop a uniform process to establish and review performance and
299.20 outcome standards for all essential human services based on the current level of resources
299.21 available, and to develop appropriate reporting measures and a uniform accountability
299.22 process for responding to a county's or human service authority's failure to make adequate
299.23 progress on achieving performance measures. The accountability process shall focus on
299.24 the performance measures rather than inflexible implementation requirements.

299.25 (b) The steering committee shall:

299.26 (1) by November 1, 2009, establish an agreed upon list of essential services;

299.27 (2) by February 15, 2010, develop and recommend to the legislature a uniform,
299.28 graduated process, in addition to the remedies identified in section 402A.18, for responding
299.29 to a county's failure to make adequate progress on achieving performance measures; and

299.30 (3) by December 15, 2012, for each essential service make recommendations to the
299.31 legislature regarding (1) performance measures and goals based on those measures for
299.32 each essential service, (2) a system for reporting on the performance measures and goals,
299.33 and (3) appropriate resources, including funding, needed to achieve those performance
299.34 measures and goals. The resource recommendations shall take into consideration program

300.1 demand and the unique differences of local areas in geography and the populations
300.2 served. Priority shall be given to services with the greatest variation in availability and
300.3 greatest administrative demands. By January 15 of each year starting January 15, 2011,
300.4 the steering committee shall report its recommendations to the governor and legislative
300.5 committees with jurisdiction over health and human services. As part of its report, the
300.6 steering committee shall, as appropriate, recommend statutory provisions, rules and
300.7 requirements, and reports that should be repealed or eliminated.

300.8 (c) As far as possible, the performance measures, reporting system, and funding
300.9 shall be consistent across program areas. The development of performance measures shall
300.10 consider the manner in which data will be collected and performance will be reported.
300.11 The steering committee shall consider state and local administrative costs related to
300.12 collecting data and reporting outcomes when developing performance measures. The
300.13 steering committee shall correlate the performance measures and goals to available
300.14 levels of resources, including state and local funding. The steering committee shall
300.15 take into consideration that the goal of implementing changes to program monitoring
300.16 and reporting the progress toward achieving outcomes is to significantly minimize the
300.17 cost of administrative requirements and to allow funds freed by reduced administrative
300.18 expenditures to be used to provide additional services, allow flexibility in service design
300.19 and management, and focus energies on achieving program and client outcomes.

300.20 (d) In making its recommendations, the steering committee shall consider input from
300.21 the council established in section 402A.20. The steering committee shall review the
300.22 measurable goals established in a memorandum of understanding entered into under
300.23 section 402A.30, subdivision 2, paragraph (b), and consider whether they may be applied
300.24 as statewide performance outcomes.

300.25 (e) The steering committee shall form work groups that include persons who provide
300.26 or receive essential services and representatives of organizations who advocate on behalf
300.27 of those persons.

300.28 (f) By December 15, 2009, the steering committee shall establish a three-year
300.29 schedule for completion of its work. The schedule shall be published on the Department of
300.30 Human Services Web site and reported to the legislative committees with jurisdiction over
300.31 health and human services. In addition, the commissioner shall post quarterly updates on
300.32 the progress of the steering committee on the Department of Human Services Web site.

300.33 Subd. 2. **Composition.** (a) The steering committee shall include:

300.34 (1) the commissioner of human services, or designee, and two additional
300.35 representatives of the department;

301.1 (2) two county commissioners, representative of rural and urban counties, selected
301.2 by the Association of Minnesota Counties;

301.3 (3) two county directors of human services, representative of rural and urban
301.4 counties, selected by the Minnesota Association of County Social Service Administrators;
301.5 and

301.6 (4) three clients or client advocates representing different populations receiving
301.7 services from the Department of Human Services, who are appointed by the commissioner.

301.8 (b) The commissioner, or designee, and a county commissioner shall serve as
301.9 cochairs of the committee. The committee shall be convened within 60 days of final
301.10 enactment of this legislation.

301.11 (c) State agency staff shall serve as informational resources and staff to the steering
301.12 committee. Statewide county associations may assemble county program data as required.

301.13 (d) To promote information sharing and coordination between the steering committee
301.14 and council, one of the county representatives from paragraph (a), clause (2), and one of the
301.15 county representatives from paragraph (a), clause (3), must also serve as a representative
301.16 on the council under section 402A.20, subdivision 1, paragraph (b), clause (5) or (6).

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

301.18 **Sec. 4. [402A.18] COMMISSIONER POWER TO REMEDY FAILURE TO**
301.19 **MEET PERFORMANCE OUTCOMES.**

301.20 **Subdivision 1. Underperforming county; specific service.** If the commissioner
301.21 determines that a county or service delivery authority is deficient in achieving minimum
301.22 performance outcomes for a specific essential service, the commissioner may impose
301.23 the following remedies:

301.24 (1) voluntary incorporation of the administration and operation of the specific
301.25 essential service with an existing service delivery authority or another county. A
301.26 service delivery authority or county incorporating an underperforming county shall
301.27 not be financially liable for the costs associated with remedying performance outcome
301.28 deficiencies;

301.29 (2) mandatory incorporation of the administration and operation of the specific
301.30 essential service with an existing service delivery authority or another county. A
301.31 service delivery authority or county incorporating an underperforming county shall
301.32 not be financially liable for the costs associated with remedying performance outcome
301.33 deficiencies; or

301.34 (3) transfer of authority for program administration and operation of the specific
301.35 essential service to the commissioner.

302.1 Subd. 2. Underperforming county; more than one-half of service. If the
302.2 commissioner determines that a county or service delivery authority is deficient in
302.3 achieving minimum performance outcomes for more than one-half of the defined essential
302.4 service, the commissioner may impose the following remedies:

302.5 (1) voluntary incorporation of the administration and operation of the specific
302.6 essential service with an existing service delivery authority or another county. A
302.7 service delivery authority or county incorporating an underperforming county shall
302.8 not be financially liable for the costs associated with remedying performance outcome
302.9 deficiencies;

302.10 (2) mandatory incorporation of the administration and operation of the specific
302.11 essential service with an existing service delivery authority or another county. A
302.12 service delivery authority or county incorporating an underperforming county shall
302.13 not be financially liable for the costs associated with remedying performance outcome
302.14 deficiencies; or

302.15 (3) transfer of authority for program administration and operation of the specific
302.16 essential service to the commissioner.

302.17 Subd. 3. Conditions prior to imposing remedies. Before the commissioner may
302.18 impose the remedies authorized under this section, the following conditions must be met:

302.19 (1) the county or service delivery authority determined by the commissioner
302.20 to be deficient in achieving minimum performance outcomes has the opportunity, in
302.21 coordination with the council, to develop a program outcome improvement plan. The
302.22 program outcome improvement plan must be developed no later than six months from the
302.23 date of the deficiency determination; and

302.24 (2) the council has conducted an assessment of the program outcome improvement
302.25 plan to determine if the county or service delivery authority has made satisfactory progress
302.26 toward performance outcomes and has made a recommendation about remedies to the
302.27 commissioner. The review and recommendation must be made to the commissioner within
302.28 12 months from the date of the deficiency determination.

302.29 Sec. 5. [402A.20] COUNCIL.

302.30 Subdivision 1. Council. (a) The State-County Results, Accountability, and Service
302.31 Delivery Redesign Council is established. Appointed council members must be appointed
302.32 by their respective agencies, associations, or governmental units by November 1, 2009.
302.33 The council shall be cochaired by the commissioner of human services, or designee, and a
302.34 county representative from paragraph (b), clause (4) or (5), appointed by the Association
302.35 of Minnesota Counties. Recommendations of the council must be approved by a majority

303.1 of the council members. The provisions of section 15.059 do not apply to this council,
303.2 and this council does not expire.

303.3 (b) The council must consist of the following members:

303.4 (1) two legislators appointed by the speaker of the house, one from the minority
303.5 and one from the majority;

303.6 (2) two legislators appointed by the Senate Rules Committee, one from the majority
303.7 and one from the minority;

303.8 (3) the commissioner of human services, or designee, and three employees from
303.9 the department;

303.10 (4) two county commissioners appointed by the Association of Minnesota Counties;

303.11 (5) two county representatives appointed by the Minnesota Association of County
303.12 Social Service Administrators;

303.13 (6) one representative appointed by AFSCME as a nonvoting member; and

303.14 (7) one representative appointed by the Teamsters as a nonvoting member.

303.15 (c) Administrative support to the council may be provided by the Association of
303.16 Minnesota Counties and affiliates.

303.17 (d) Member agencies and associations are responsible for initial and subsequent
303.18 appointments to the council.

303.19 Subd. 2. **Council duties.** The council shall:

303.20 (1) provide review of the redesign process;

303.21 (2) certify, in accordance with section 402A.30, subdivision 4, the formation of
303.22 a service delivery authority, including the memorandum of understanding in section
303.23 402A.30, subdivision 2, paragraph (b);

303.24 (3) ensure the consistency of the memoranda of understanding entered into
303.25 under section 402A.30, subdivision 2, paragraph (b), with the performance standards
303.26 recommended by the steering committee and enacted by the legislature;

303.27 (4) ensure the consistency of the memoranda of understanding, to the extent
303.28 appropriate, or other memoranda of understanding entered into by other service delivery
303.29 authorities;

303.30 (5) establish a process to take public input on the service delivery framework
303.31 specified in the memorandum of understanding in section 402A.30, subdivision 2,
303.32 paragraph (b);

303.33 (6) form work groups as necessary to carry out the duties of the council under the
303.34 redesign;

304.1 (7) serve as a forum for resolving conflicts among participating counties or between
304.2 participating counties and the commissioner of human services, provided nothing in this
304.3 section is intended to create a formal binding legal process;

304.4 (8) engage in the program improvement process established in section 402A.18,
304.5 subdivision 3; and

304.6 (9) identify and recommend incentives for counties to participate in human services
304.7 authorities.

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

304.9 **Sec. 6. [402A.30] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

304.10 Subdivision 1. **Establishment.** After certification by the council and approval by
304.11 the commissioner, in accordance with subdivision 4, a county or consortium of counties
304.12 may establish a service delivery authority to redesign the delivery of some or all essential
304.13 services. Once a county or consortium of counties establishes a service delivery authority,
304.14 no county that is a participant in the service delivery authority may participate in or be
304.15 a member of any other service delivery authority. The service delivery authority may
304.16 allow an additional county or counties to join the service delivery authority subject to the
304.17 approval of the council and the commissioner.

304.18 Subd. 2. **New state-county governance framework.** (a) To establish a service
304.19 delivery authority, each participating county and the state must enter into a binding
304.20 memorandum of understanding to establish a joint state-county service delivery
304.21 framework:

304.22 (b) The memorandum of understanding must:

304.23 (1) comply with current state and federal law except where waivers are approved
304.24 under clause (7);

304.25 (2) define the scope of essential services over which the service delivery authority
304.26 has jurisdiction;

304.27 (3) designate a single administrative structure to oversee the delivery of services over
304.28 which the service delivery authority has jurisdiction and identify a single administrative
304.29 agent for purposes of contact and communication with the department;

304.30 (4) define measurable performance and outcome goals in key operational areas
304.31 that the service delivery authority is expected to achieve, provided that the performance
304.32 goals must, at a minimum, satisfy performance outcomes recommended by the steering
304.33 committee and enacted into law;

305.1 (5) identify the state and local resources, including funding and administrative and
305.2 information technology support, and other requirements necessary for the service delivery
305.3 authority to achieve the performance and outcome goals;

305.4 (6) state the relief available to the service delivery authority if the resource
305.5 commitments identified in clause (5) are not met;

305.6 (7) identify in the agreement the waivers from statutory requirements that are needed
305.7 to ensure greater local control and flexibility to determine the most cost-effective means
305.8 of achieving specified measurable goals and the date by which the commissioner shall
305.9 grant the identified waivers;

305.10 (8) set forth a graduated accountability process and penalties for responding to a
305.11 county's failure to make adequate progress on achieving performance and outcome goals;

305.12 (9) set forth a reasonable level of targeted reductions in overhead and administrative
305.13 costs for each county participating in the service delivery authority; and

305.14 (10) set forth the terms under which a county may withdraw from participation.

305.15 The memorandum of understanding may be later amended to add additional services over
305.16 which the service delivery authority has jurisdiction.

305.17 (c) Nothing in this chapter precludes local governments from utilizing sections
305.18 465.81 and 465.82 to establish procedures for local governments to merge, with the
305.19 consent of the voters. Any agreement under paragraph (b) must be governed by this
305.20 chapter. Nothing in this chapter limits the authority of a county board to enter into
305.21 contractual agreements for services not covered by the provisions of a memorandum of
305.22 understanding establishing a service delivery authority with other agencies or with other
305.23 units of government.

305.24 Subd. 3. **Duties.** The service delivery authority shall:

305.25 (1) within the scope of essential services set forth in the memorandum of
305.26 understanding establishing the authority, carry out the responsibilities required of local
305.27 agencies under chapter 393 and human services boards under chapter 402;

305.28 (2) manage the public resources devoted to human services and other public services
305.29 delivered or purchased by the counties that are subsidized or regulated by the Department
305.30 of Human Services under chapters 245 and 267;

305.31 (3) employ staff to assist in carrying out its duties;

305.32 (4) develop and maintain a continuity of operations plan to ensure the continued
305.33 operation or resumption of essential human services functions in the event of any business
305.34 interruption according to local, state, and federal emergency planning requirements;

305.35 (5) receive and expend funds received for the redesign process under the
305.36 memorandum of understanding;

306.1 (6) plan and deliver services directly or through contract with other governmental
306.2 or nongovernmental providers;

306.3 (7) rent, purchase, sell, and otherwise dispose of real and personal property as
306.4 necessary to carry out the redesign; and

306.5 (8) carry out any other service designated as a responsibility of a county.

306.6 Subd. 4. **Process for establishing a service delivery authority.** (a) The county or
306.7 consortium of counties proposing to form a service delivery authority shall, in conjunction
306.8 with the commissioner, prevent a proposed memorandum of understanding to the council
306.9 accompanied by a resolution from the board of commissioners of each participating
306.10 county stating the county's intent to participate in a service delivery authority.

306.11 (b) The council shall certify a county or consortium of counties as a service delivery
306.12 authority if:

306.13 (1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and

306.14 (2) the county or consortium of counties are:

306.15 (i) a single county with a population of 55,000 or more;

306.16 (ii) a consortium of counties with a total combined population of 55,000 or more and
306.17 the counties comprising the consortium are in reasonable geographic proximity; or

306.18 (iii) four or more counties in reasonable geographic proximity without regard
306.19 to population.

306.20 The council may recommend that the commissioner of human services exempt a
306.21 single county or multicounty service delivery authority from the minimum population
306.22 standard if that service delivery authority can demonstrate that it can otherwise meet
306.23 the requirements of this chapter.

306.24 (c) After the council has certified a county or consortium of counties as a service
306.25 delivery authority, the commissioner may enter into the memoranda of understanding with
306.26 the participating counties to form the service delivery authority.

306.27 Subd. 5. **Single county service delivery authority.** For counties with populations
306.28 over 55,000, the board of county commissioners may be the service delivery authority and
306.29 retain existing authority under law.

306.30 Sec. 7. **[402A.45] ESSENTIAL SERVICES OUTSIDE THE JURISDICTION OF**
306.31 **A SERVICE DELIVERY AUTHORITY.**

306.32 (a) With the approval of the council, a county that is a participant in a service
306.33 delivery authority may enter into cooperative arrangements with other service delivery
306.34 authorities or other counties to provide essential services that are not within the jurisdiction
306.35 and duties of the service delivery authority.

307.1 (b) With the approval of the council, a service delivery authority may enter into a
307.2 cooperative arrangement with a nonparticipating county to provide an essential service
307.3 within the jurisdiction and duties of the service delivery authority.

307.4 Sec. 8. **[402A.50] PRIVATE SECTOR FUNDING.**

307.5 The council may support stakeholder agencies, if not otherwise prohibited by law, to
307.6 separately or jointly seek and receive funds to provide expert technical assistance to the
307.7 council, the council's work group, and any subwork groups for executing the provisions
307.8 of the redesign.

307.9 Sec. 9. **APPROPRIATION.**

307.10 \$350,000 is appropriated for the biennium beginning July 1, 2009, from the general
307.11 fund to the State-County Results, Accountability, and Service Delivery Redesign Council,
307.12 for the purposes of the State-County Results, Accountability, and Service Delivery Reform
307.13 Act under Minnesota Statutes, sections 402A.01 to 402A.50. The council shall establish a
307.14 methodology for distributing funds to certified service delivery authorities for the purposes
307.15 of carrying out the requirements of the redesign.

307.16 **ARTICLE 10**
307.17 **PUBLIC HEALTH**

307.18 Section 1. Minnesota Statutes 2008, section 103I.208, subdivision 2, is amended to
307.19 read:

307.20 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

307.21 (1) for a water supply well that is not in use under a maintenance permit, \$175
307.22 annually;

307.23 (2) for construction of a monitoring well, \$215, which includes the state core
307.24 function fee;

307.25 (3) for a monitoring well that is unsealed under a maintenance permit, \$175 annually;

307.26 (4) for a monitoring well owned by a federal agency, state agency, or local unit of
307.27 government that is unsealed under a maintenance permit, \$50 annually. "Local unit of
307.28 government" means a statutory or home rule charter city, town, county, or soil and water
307.29 conservation district, watershed district, an organization formed for the joint exercise of
307.30 powers under section 471.59, a board of health or community health board, or other
307.31 special purpose district or authority with local jurisdiction in water and related land
307.32 resources management;

307.33 (5) for monitoring wells used as a leak detection device at a single motor fuel retail
307.34 outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural

308.1 chemical facility site, the construction permit fee is \$215, which includes the state core
 308.2 function fee, per site regardless of the number of wells constructed on the site, and
 308.3 the annual fee for a maintenance permit for unsealed monitoring wells is \$175 per site
 308.4 regardless of the number of monitoring wells located on site;

308.5 ~~(5)~~ (6) for a groundwater thermal exchange device, in addition to the notification fee
 308.6 for water supply wells, \$215, which includes the state core function fee;

308.7 ~~(6)~~ (7) for a vertical heat exchanger with less than ten tons of heating/cooling
 308.8 capacity, \$215;

308.9 (8) for a vertical heat exchanger with ten to 50 tons of heating/cooling capacity, \$425;

308.10 (9) for a vertical heat exchanger with greater than 50 tons of heating/cooling
 308.11 capacity, \$650;

308.12 ~~(7)~~ (10) for a dewatering well that is unsealed under a maintenance permit, \$175
 308.13 annually for each dewatering well, except a dewatering project comprising more than five
 308.14 dewatering wells shall be issued a single permit for \$875 annually for dewatering wells
 308.15 recorded on the permit; and

308.16 ~~(8)~~ (11) for an elevator boring, \$215 for each boring.

308.17 Sec. 2. Minnesota Statutes 2008, section 144.121, subdivision 1a, is amended to read:

308.18 Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with
 308.19 ionizing radiation-producing equipment must pay an annual initial or annual renewal
 308.20 registration fee consisting of a base facility fee of ~~\$66~~ \$100 and an additional fee for
 308.21 each radiation source, as follows:

308.22 (1) medical or veterinary equipment \$ ~~53~~ 100

308.23 (2) dental x-ray equipment \$ ~~33~~ 40

308.24 ~~(3) accelerator~~ \$ ~~66~~

308.25 ~~(4) radiation therapy equipment~~ \$ ~~66~~

308.26 ~~(5)~~ (3) x-ray equipment not used on \$ ~~53~~ 100

308.27 humans or animals

308.28 ~~(6)~~ (4) devices with sources of ionizing \$ ~~53~~ 100

308.29 radiation not used on humans or

308.30 animals

308.31 (b) A facility with radiation therapy and accelerator equipment must pay an annual

308.32 registration fee of \$500. A facility with an industrial accelerator must pay an annual

308.33 registration fee of \$150.

309.1 (c) Electron microscopy equipment is exempt from the registration fee requirements
309.2 of this section.

309.3 Sec. 3. Minnesota Statutes 2008, section 144.121, subdivision 1b, is amended to read:

309.4 Subd. 1b. **Penalty fee for late registration.** Applications for initial or renewal
309.5 registrations submitted to the commissioner after the time specified by the commissioner
309.6 shall be accompanied by ~~a penalty fee of \$20~~ an amount equal to 25 percent of the fee
309.7 due in addition to the fees prescribed in subdivision 1a.

309.8 Sec. 4. Minnesota Statutes 2008, section 144.1222, subdivision 1a, is amended to read:

309.9 Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction,
309.10 installation, or alteration or requests for a variance that are submitted to the commissioner
309.11 according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate
309.12 fees. All public pool construction plans submitted for review after January 1, 2009,
309.13 must be certified by a professional engineer registered in the state of Minnesota. If the
309.14 commissioner determines, upon review of the plans, that inadequate fees were paid, the
309.15 necessary additional fees shall be paid before plan approval. For purposes of determining
309.16 fees, a project is defined as a proposal to construct or install a public pool, spa, special
309.17 purpose pool, or wading pool and all associated water treatment equipment and drains,
309.18 gutters, decks, water recreation features, spray pads, and those design and safety features
309.19 that are within five feet of any pool or spa. The commissioner shall charge the following
309.20 fees for plan review and inspection of public pools and spas and for requests for variance
309.21 from the public pool and spa rules:

- 309.22 (1) each pool, ~~\$800~~ \$1,500;
- 309.23 (2) each spa pool, ~~\$500~~ \$800;
- 309.24 (3) each slide, ~~\$400~~ \$600;
- 309.25 (4) projects valued at \$250,000 or more, the greater of the sum of the fees in clauses
309.26 (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum
309.27 fee of ~~\$10,000~~ \$15,000;
- 309.28 (5) alterations to an existing pool without changing the size or configuration of
309.29 the pool, ~~\$400~~ \$600;
- 309.30 (6) removal or replacement of pool disinfection equipment only, ~~\$75~~ \$100; and
309.31 (7) request for variance from the public pool and spa rules, \$500.

309.32 Sec. 5. Minnesota Statutes 2008, section 144.125, subdivision 1, is amended to read:

310.1 Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative
310.2 officer or other person in charge of each institution caring for infants 28 days or less
310.3 of age, (2) the person required in pursuance of the provisions of section 144.215, to
310.4 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
310.5 birth, to arrange to have administered to every infant or child in its care tests for heritable
310.6 and congenital disorders according to subdivision 2 and rules prescribed by the state
310.7 commissioner of health. Testing and the recording and reporting of test results shall be
310.8 performed at the times and in the manner prescribed by the commissioner of health. The
310.9 commissioner shall charge a fee so that the total of fees collected will approximate the
310.10 costs of conducting the tests and implementing and maintaining a system to follow-up
310.11 infants with heritable or congenital disorders, including hearing loss detected through the
310.12 early hearing detection and intervention program under section 144.966. The fee is \$101
310.13 per specimen. Effective July 1, 2010, the fee shall be increased to \$106 per specimen. The
310.14 increased fee amount shall be deposited in the general fund. Costs associated with capital
310.15 expenditures and the development of new procedures may be prorated over a three-year
310.16 period when calculating the amount of the fees.

310.17 **EFFECTIVE DATE.** This section is effective July 1, 2010.

310.18 Sec. 6. Minnesota Statutes 2008, section 144.72, subdivision 1, is amended to read:

310.19 Subdivision 1. **Permits License required.** The state commissioner of health is
310.20 authorized to issue ~~permits for the operation of youth camps which are required to obtain~~
310.21 ~~the permits~~ a license according to chapter 157.

310.22 Sec. 7. Minnesota Statutes 2008, section 144.72, subdivision 3, is amended to read:

310.23 Subd. 3. **Issuance of permits license.** If the commissioner should determine from
310.24 the application that the health and safety of the persons using the camp will be properly
310.25 safeguarded, the commissioner may, prior to actual inspection of the camp, issue the
310.26 permit license in writing. ~~No fee shall be charged for the permit.~~ The permit license shall
310.27 be posted in a conspicuous place on the premises occupied by the camp.

310.28 Sec. 8. Minnesota Statutes 2008, section 144.9501, is amended by adding a subdivision
310.29 to read:

310.30 Subd. 8a. **Disclosure pamphlet.** "Disclosure pamphlet" means the EPA pamphlet
310.31 titled "Renovate Right: Important Lead Hazard Information for Families, Child Care
310.32 Providers and Schools" developed under section 406(a) of the Toxic Substance Control
310.33 Act.

311.1 Sec. 9. Minnesota Statutes 2008, section 144.9501, subdivision 22b, is amended to
311.2 read:

311.3 Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an
311.4 individual who performs clearance inspections for ~~nonabatement or nonorder lead hazard~~
311.5 ~~reduction~~ renovation sites, and lead dust sampling ~~in other settings~~, or visual assessment
311.6 ~~for deteriorated paint~~ for nonabatement sites, and who is registered with the commissioner
311.7 under section 144.9505.

311.8 Sec. 10. Minnesota Statutes 2008, section 144.9501, subdivision 26a, is amended to
311.9 read:

311.10 Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

- 311.11 (1) abatement;
311.12 (2) interim controls;
311.13 (3) a clearance inspection;
311.14 (4) a lead hazard screen;
311.15 (5) a lead inspection;
311.16 (6) a lead risk assessment;
311.17 (7) lead project designer services;
311.18 (8) lead sampling technician services; ~~or~~
311.19 (9) swab team services;
311.20 (10) renovation activities; or
311.21 (11) activities performed to comply with lead orders issued by a board of health.

311.22 (b) Regulated lead work does not include abatement, interim controls, swab team
311.23 services, or renovation activities that disturb painted surfaces that total no more than:

311.24 ~~(1) activities such as remodeling, renovation, installation, rehabilitation, or~~
311.25 ~~landscaping activities, the primary intent of which is to remodel, repair, or restore a~~
311.26 ~~structure or dwelling, rather than to permanently eliminate lead hazards, even though these~~
311.27 ~~activities may incidentally result in a reduction in lead hazards; or~~

311.28 ~~(2) interim control activities that are not performed as a result of a lead order and~~
311.29 ~~that do not disturb painted surfaces that total more than:~~

311.30 ~~(i) (1) 20 square feet (two square meters) on exterior surfaces; or~~

311.31 ~~(ii) two (2) six square feet (0.2 0.6 square meters) in an interior room; or~~

311.32 ~~(iii) ten percent of the total surface area on an interior or exterior type of component~~
311.33 ~~with a small surface area.~~

312.1 Sec. 11. Minnesota Statutes 2008, section 144.9501, is amended by adding a
312.2 subdivision to read:

312.3 Subd. 26b. **Renovation.** "Renovation" means the modification of any affected
312.4 property that results in the disturbance of painted surfaces, unless that activity is performed
312.5 as an abatement. A renovation performed for the purpose of converting a building or part
312.6 of a building into an affected property is a renovation under this subdivision.

312.7 Sec. 12. Minnesota Statutes 2008, section 144.9505, subdivision 1g, is amended to
312.8 read:

312.9 ~~Subd. 1g. **Certified lead firm.** A person within the state intending to directly~~
312.10 ~~perform or cause to be performed through subcontracting or similar delegation any~~
312.11 ~~regulated lead work shall first obtain certification from the commissioner~~ A person who
312.12 employs individuals to perform regulated lead work outside of the person's property must
312.13 obtain certification as a lead firm. The certificate must be in writing, contain an expiration
312.14 date, be signed by the commissioner, and give the name and address of the person to
312.15 whom it is issued. The certification fee is \$100, is nonrefundable, and must be submitted
312.16 with each application. The certificate or a copy of the certificate must be readily available
312.17 at the worksite for review by the contracting entity, the commissioner, and other public
312.18 health officials charged with the health, safety, and welfare of the state's citizens.

312.19 Sec. 13. Minnesota Statutes 2008, section 144.9505, subdivision 4, is amended to read:

312.20 Subd. 4. **Notice of regulated lead work.** (a) At least five working days before
312.21 starting work at each regulated lead worksite, the person performing the regulated lead
312.22 work shall give written notice to the commissioner and the appropriate board of health.

312.23 (b) This provision does not apply to lead hazard screen, lead inspection, lead risk
312.24 assessment, lead sampling technician, renovation, or lead project design activities.

312.25 Sec. 14. Minnesota Statutes 2008, section 144.9508, subdivision 2, is amended to read:

312.26 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner
312.27 shall adopt rules establishing regulated lead work standards and methods in accordance
312.28 with the provisions of this section, for lead in paint, dust, drinking water, and soil in
312.29 a manner that protects public health and the environment for all residences, including
312.30 residences also used for a commercial purpose, child care facilities, playgrounds, and
312.31 schools.

312.32 (b) In the rules required by this section, the commissioner shall require lead hazard
312.33 reduction of intact paint only if the commissioner finds that the intact paint is on a

313.1 chewable or lead-dust producing surface that is a known source of actual lead exposure to
313.2 a specific individual. The commissioner shall prohibit methods that disperse lead dust into
313.3 the air that could accumulate to a level that would exceed the lead dust standard specified
313.4 under this section. The commissioner shall work cooperatively with the commissioner
313.5 of administration to determine which lead hazard reduction methods adopted under this
313.6 section may be used for lead-safe practices including prohibited practices, preparation,
313.7 disposal, and cleanup. The commissioner shall work cooperatively with the commissioner
313.8 of the Pollution Control Agency to develop disposal procedures. In adopting rules under
313.9 this section, the commissioner shall require the best available technology for regulated
313.10 lead work methods, paint stabilization, and repainting.

313.11 (c) The commissioner of health shall adopt regulated lead work standards and
313.12 methods for lead in bare soil in a manner to protect public health and the environment.
313.13 The commissioner shall adopt a maximum standard of 100 parts of lead per million in
313.14 bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts
313.15 of lead per million. Soil lead hazard reduction methods shall focus on erosion control
313.16 and covering of bare soil.

313.17 (d) The commissioner shall adopt regulated lead work standards and methods for
313.18 lead in dust in a manner to protect the public health and environment. Dust standards
313.19 shall use a weight of lead per area measure and include dust on the floor, on the window
313.20 sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust
313.21 removal and other practices which minimize the formation of lead dust from paint, soil, or
313.22 other sources.

313.23 (e) The commissioner shall adopt lead hazard reduction standards and methods for
313.24 lead in drinking water both at the tap and public water supply system or private well
313.25 in a manner to protect the public health and the environment. The commissioner may
313.26 adopt the rules for controlling lead in drinking water as contained in Code of Federal
313.27 Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include
313.28 an educational approach of minimizing lead exposure from lead in drinking water.

313.29 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
313.30 removal of exterior lead-based coatings from residences and steel structures by abrasive
313.31 blasting methods is conducted in a manner that protects health and the environment.

313.32 (g) All regulated lead work standards shall provide reasonable margins of safety that
313.33 are consistent with more than a summary review of scientific evidence and an emphasis on
313.34 overprotection rather than underprotection when the scientific evidence is ambiguous.

313.35 (h) No unit of local government shall have an ordinance or regulation governing
313.36 regulated lead work standards or methods for lead in paint, dust, drinking water, or soil

314.1 that require a different regulated lead work standard or method than the standards or
314.2 methods established under this section.

314.3 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit
314.4 of local government of an innovative lead hazard reduction method which is consistent
314.5 in approach with methods established under this section.

314.6 (j) The commissioner shall adopt rules for issuing lead orders required under section
314.7 144.9504, rules for notification of abatement or interim control activities requirements,
314.8 and other rules necessary to implement sections 144.9501 to 144.9512.

314.9 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the
314.10 Toxic Substances Control Act to ensure that renovation in a pre-1978 affected property
314.11 where a child or pregnant female resides is conducted in a manner that protects health
314.12 and the environment.

314.13 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of
314.14 the Toxic Substances Control Act.

314.15 Sec. 15. Minnesota Statutes 2008, section 144.9508, subdivision 3, is amended to read:

314.16 Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to
314.17 license lead supervisors, lead workers, lead project designers, lead inspectors, ~~and~~ lead
314.18 risk assessors, and lead sampling technicians. The commissioner shall also adopt rules
314.19 requiring certification of firms that perform regulated lead work ~~and rules requiring~~
314.20 ~~registration of lead sampling technicians~~. The commissioner shall require periodic renewal
314.21 of licenses, and certificates, ~~and registrations~~ and shall establish the renewal periods.

314.22 Sec. 16. Minnesota Statutes 2008, section 144.9508, subdivision 4, is amended to read:

314.23 Subd. 4. **Lead training course.** The commissioner shall establish by rule
314.24 requirements for training course providers and the renewal period for each lead-related
314.25 training course required for certification or licensure. The commissioner shall establish
314.26 criteria in rules for the content and presentation of training courses intended to qualify
314.27 trainees for licensure under subdivision 3. The commissioner shall establish criteria
314.28 in rules for the content and presentation of training courses for lead ~~interim control~~
314.29 ~~workers~~ renovation and lead sampling technicians. Training course permit fees shall be
314.30 nonrefundable and must be submitted with each application in the amount of \$500 for an
314.31 initial training course, \$250 for renewal of a permit for an initial training course, \$250 for
314.32 a refresher training course, and \$125 for renewal of a permit of a refresher training course.

314.33 Sec. 17. Minnesota Statutes 2008, section 144.9512, subdivision 2, is amended to read:

315.1 Subd. 2. **Grants; administration.** Within the limits of the available appropriation,
315.2 the commissioner shall make grants to a nonprofit organization currently operating the
315.3 ~~CLEARCorps lead hazard reduction project~~ organizations to train workers to provide lead
315.4 screening, education, outreach, and swab team services for residential property. Projects
315.5 that provide Americorps funding or positions, or leverage matching funds, as part of the
315.6 delivery of the services must be given priority for the grant funds.

315.7 Sec. 18. Minnesota Statutes 2008, section 144.966, is amended by adding a subdivision
315.8 to read:

315.9 Subd. 3a. **Support services to families.** The commissioner shall contract with
315.10 a nonprofit organization to provide support and assistance to families with children
315.11 who are deaf or have a hearing loss. The family support provided must include direct
315.12 parent-to-parent assistance and information on communication, educational, and medical
315.13 options. The commissioner shall give preference to a nonprofit organization that has the
315.14 ability to provide these services throughout the state.

315.15 Sec. 19. Minnesota Statutes 2008, section 144.97, subdivision 2, is amended to read:

315.16 Subd. 2. **Certification Accreditation.** ~~"Certification" means written~~
315.17 ~~acknowledgment of a laboratory's demonstrated capability to perform tests for a specific~~
315.18 ~~purpose~~ "Accreditation" means written acknowledgment that a laboratory has the
315.19 policies, procedures, equipment, and practices to produce reliable data in the analysis of
315.20 environmental samples.

315.21 **EFFECTIVE DATE.** This section is effective July 1, 2009.

315.22 Sec. 20. Minnesota Statutes 2008, section 144.97, subdivision 4, is amended to read:

315.23 Subd. 4. **Contract Commercial laboratory.** ~~Contract Commercial~~ laboratory"
315.24 means a laboratory that performs tests on samples on a contract or fee-for-service basis.

315.25 **EFFECTIVE DATE.** This section is effective July 1, 2009.

315.26 Sec. 21. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision
315.27 to read:

315.28 Subd. 5a. **Field of testing.** "Field of testing" means the combination of analyte,
315.29 method, matrix, and test category for which a laboratory may hold accreditation.

315.30 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.1 Sec. 22. Minnesota Statutes 2008, section 144.97, subdivision 6, is amended to read:

316.2 Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other
316.3 entity, including governmental, that examines, analyzes, or tests samples in a specified
316.4 physical location.

316.5 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.6 Sec. 23. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision
316.7 to read:

316.8 Subd. 8. **Test category.** "Test category" means the combination of program and
316.9 category as provided by section 144.98, subdivisions 3, paragraph (b), clauses (1) to (10),
316.10 and 3a, paragraph (a), clauses (1) to (5).

316.11 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.12 Sec. 24. Minnesota Statutes 2008, section 144.98, subdivision 1, is amended to read:

316.13 Subdivision 1. **Authorization.** The commissioner of health ~~may certify~~ shall
316.14 accredit environmental laboratories that test environmental samples according to national
316.15 standards developed using a consensus process as established by Circular A-119,
316.16 published by the United States Office of Management and Budget.

316.17 **EFFECTIVE DATE.** This section is effective July 1, 2009.

316.18 Sec. 25. Minnesota Statutes 2008, section 144.98, subdivision 2, is amended to read:

316.19 Subd. 2. **Rules and standards.** The commissioner may adopt rules to ~~implement~~
316.20 ~~this section, including:~~ carry out the commissioner's responsibilities under the national
316.21 standards specified in subdivisions 1 and 2a.

316.22 ~~(1) procedures, requirements, and fee adjustments for laboratory certification,~~
316.23 ~~including provisional status and recertification;~~

316.24 ~~(2) standards and fees for certificate approval, suspension, and revocation;~~

316.25 ~~(3) standards for environmental samples;~~

316.26 ~~(4) analysis methods that assure reliable test results;~~

316.27 ~~(5) laboratory quality assurance, including internal quality control, proficiency~~
316.28 ~~testing, and personnel training; and~~

316.29 ~~(6) criteria for recognition of certification programs of other states and the federal~~
316.30 ~~government.~~

316.31 **EFFECTIVE DATE.** This section is effective July 1, 2009.

317.1 Sec. 26. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
 317.2 to read:

317.3 Subd. 2a. **Standards.** The commissioner shall accredit laboratories according to
 317.4 the most current environmental laboratory accreditation standards under subdivision 1
 317.5 and as accepted by the accreditation bodies recognized by the National Environmental
 317.6 Laboratory Accreditation Program (NELAP) of the NELAC Institute.

317.7 **EFFECTIVE DATE.** This section is effective July 1, 2009.

317.8 Sec. 27. Minnesota Statutes 2008, section 144.98, subdivision 3, is amended to read:

317.9 Subd. 3. **Annual fees.** (a) An application for certification accreditation under
 317.10 subdivision ~~4~~ 6 must be accompanied by the ~~biennial fee~~ annual fees specified in this
 317.11 subdivision. ~~The fees are for~~ annual fees include:

- 317.12 (1) base certification accreditation fee, ~~\$1,600~~ \$1,500;
- 317.13 (2) sample preparation techniques ~~fees~~ fee, ~~\$100~~ \$200 per technique; ~~and~~
- 317.14 (3) an administrative fee for laboratories located outside this state, \$3,750; and
- 317.15 (4) test category certification fees.

317.16 Test Category	Certification Fee
317.17 Clean water program bacteriology	\$800
317.18 Safe drinking water program bacteriology	\$800
317.19 Clean water program inorganic chemistry	\$800
317.20 Safe drinking water program inorganic chemistry	\$800
317.21 Clean water program chemistry metals	\$1,200
317.22 Safe drinking water program chemistry metals	\$1,200
317.23 Resource conservation and recovery program chemistry metals	\$1,200
317.24 Clean water program volatile organic compounds	\$1,500
317.25 Safe drinking water program volatile organic compounds	\$1,500
317.26 Resource conservation and recovery program volatile organic	
317.27 compounds	\$1,500
317.28 Underground storage tank program volatile organic compounds	\$1,500
317.29 Clean water program other organic compounds	\$1,500
317.30 Safe drinking water program other organic compounds	\$1,500
317.31 Resource conservation and recovery program other organic compounds	\$1,500

318.1	Clean water program radiochemistry	\$2,500
318.2	Safe drinking water program radiochemistry	\$2,500
318.3	Resource conservation and recovery program agricultural contaminants	\$2,500
318.4	Resource conservation and recovery program emerging contaminants	\$2,500

318.5 ~~(b) Laboratories located outside of this state that require an on-site inspection shall be~~
 318.6 ~~assessed an additional \$3,750 fee. For the programs in subdivision 3a, the commissioner~~
 318.7 ~~may accredit laboratories for fields of testing under the categories listed in clauses (1) to~~
 318.8 ~~(10) upon completion of the application requirements provided by subdivision 6 and~~
 318.9 ~~receipt of the fees for each category under each program that accreditation is requested.~~

318.10 The categories offered and related fees include:

- 318.11 (1) microbiology, \$450;
- 318.12 (2) inorganics, \$450;
- 318.13 (3) metals, \$1,000;
- 318.14 (4) volatile organics, \$1,300;
- 318.15 (5) other organics, \$1,300;
- 318.16 (6) radiochemistry, \$1,500;
- 318.17 (7) emerging contaminants, \$1,500;
- 318.18 (8) agricultural contaminants, \$1,250;
- 318.19 (9) toxicity (bioassay), \$1,000; and
- 318.20 (10) physical characterization, \$250.

318.21 ~~(c) The total biennial certification annual fee includes the base fee, the sample~~
 318.22 ~~preparation techniques fees, the test category fees per program, and, when applicable, the~~
 318.23 ~~on-site inspection fee an administrative fee for out-of-state laboratories.~~

318.24 ~~(d) Fees must be set so that the total fees support the laboratory certification program.~~
 318.25 ~~Direct costs of the certification service include program administration, inspections, the~~
 318.26 ~~agency's general support costs, and attorney general costs attributable to the fee function.~~

318.27 ~~(e) A change fee shall be assessed if a laboratory requests additional analytes~~
 318.28 ~~or methods at any time other than when applying for or renewing its certification. The~~
 318.29 ~~change fee is equal to the test category certification fee for the analyte.~~

318.30 ~~(f) A variance fee shall be assessed if a laboratory requests and is granted a variance~~
 318.31 ~~from a rule adopted under this section. The variance fee is \$500 per variance.~~

318.32 ~~(g) Refunds or credits shall not be made for analytes or methods requested but~~
 318.33 ~~not approved.~~

318.34 ~~(h) Certification of a laboratory shall not be awarded until all fees are paid.~~

319.1 Sec. 28. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
319.2 to read:

319.3 Subd. 3a. Available programs, categories, and analytes. (a) The commissioner
319.4 shall accredit laboratories that test samples under the following programs:

319.5 (1) the clean water program, such as compliance monitoring under the federal Clean
319.6 Water Act, and ambient monitoring of surface and groundwater, or analysis of biological
319.7 tissue;

319.8 (2) the safe drinking water program, including compliance monitoring under the
319.9 federal Safe Drinking Water Act, and the state requirements for monitoring private wells;

319.10 (3) the resource conservation and recovery program, including federal and state
319.11 requirements for monitoring solid and hazardous wastes, biological tissue, leachates, and
319.12 groundwater monitoring wells not intended as drinking water sources;

319.13 (4) the underground storage tank program; and

319.14 (5) the clean air program, including air and emissions testing under the federal Clean
319.15 Air Act, and state and federal requirements for vapor intrusion monitoring.

319.16 (b) The commissioner shall maintain and publish a list of analytes available for
319.17 accreditation. The list must be reviewed at least once every six months and the changes
319.18 published in the State Register and posted on the program's Web site. The commissioner
319.19 shall publish the notification of changes and review comments on the changes no less than
319.20 30 days from the date the list is published.

319.21 Sec. 29. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
319.22 to read:

319.23 Subd. 3b. Additional fees. (a) Laboratories located outside of this state that require
319.24 an on-site assessment more frequent than once every two years must pay an additional
319.25 assessed fee of \$3,000 per assessment for each additional on-site assessment conducted.
319.26 The laboratory must pay the fee within 15 business days of receiving the commissioner's
319.27 notification that an on-site assessment is required. The commissioner may conduct
319.28 additional on-site assessments to determine a laboratory's continued compliance with
319.29 the standards provided in subdivision 2a.

319.30 (b) A late fee of \$200 shall be added to the annual fee for accredited laboratories
319.31 submitting renewal applications to the commissioner after November 1.

319.32 (c) A change fee shall be assessed if a laboratory requests additional fields of testing
319.33 at any time other than when initially applying for or renewing its accreditation. A change
319.34 fee does not apply for applications to add fields of testing for new analytes in response
319.35 to the published notice under subdivision 3a, paragraph (b), if the laboratory holds valid

320.1 accreditation for the changed test category and applies for additional analytes within the
320.2 same test category. The change fee is equal to the applicable test category fee for the
320.3 field of testing requested. An application that requests accreditation of multiple fields of
320.4 testing within a test category requires a single payment of the applicable test category fee
320.5 per application submitted.

320.6 (d) A variance fee shall be assessed if a laboratory requests a variance from a
320.7 standard provided in subdivision 2a. The variance fee is \$500 per variance.

320.8 (e) The commissioner shall assess a fee for changes to laboratory information
320.9 regarding ownership, name, address, or personnel. Laboratories must submit changes
320.10 through the application process under subdivision 6. The information update fee is \$250
320.11 per application.

320.12 (f) Fees must be set so that the total fees support the laboratory accreditation
320.13 program. Direct costs of the accreditation service include program administration,
320.14 assessments, the agency's general support costs, and attorney general costs attributable
320.15 to the fee function.

320.16 Sec. 30. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
320.17 to read:

320.18 Subd. 3c. **Refunds and nonpayment.** Refunds or credits shall not be made for
320.19 applications received but not approved. Accreditation of a laboratory shall not be awarded
320.20 until all fees are paid.

320.21 Sec. 31. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
320.22 to read:

320.23 Subd. 6. **Application.** (a) Laboratories seeking accreditation must apply on a form
320.24 provided by the commissioner, include the laboratory's procedures and quality manual,
320.25 and pay the applicable fees.

320.26 (b) Laboratories may be fixed-base or mobile. The commissioner shall accredit
320.27 mobile laboratories individually and require a vehicle identification number, license
320.28 plate number, or other uniquely identifying information in addition to the application
320.29 requirements of paragraph (a).

320.30 (c) Laboratories maintained on separate properties, even though operated under the
320.31 same management or ownership, must apply separately. Laboratories with more than one
320.32 building on the same or adjoining properties do not need to submit a separate application.

320.33 (d) The commissioner may accredit laboratories located out-of-state. Accreditation
320.34 for out-of-state laboratories may be obtained directly from the commissioner following

321.1 the requirements in paragraph (a), or out-of-state laboratories may be accredited through
321.2 a reciprocal agreement if the laboratory:

321.3 (1) is accredited by a NELAP-recognized accreditation body for those fields of
321.4 testing in which the laboratory requests accreditation from the commissioner;

321.5 (2) submits an application and documentation according to this subdivision; and

321.6 (3) submits a current copy of the laboratory's unexpired accreditation from a
321.7 NELAP-recognized accreditation body showing the fields of accreditation for which the
321.8 laboratory is currently accredited.

321.9 (e) Under the conflict of interest determinations provided in section 43A.38,
321.10 subdivision 6, clause (a), the commissioner shall not accredit governmental laboratories
321.11 operated by agencies of the executive branch of the state. If accreditation is required,
321.12 laboratories operated by agencies of the executive branch of the state must apply for
321.13 accreditation through any other NELAP-recognized accreditation body.

321.14 **EFFECTIVE DATE.** This section is effective July 1, 2009.

321.15 Sec. 32. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
321.16 to read:

321.17 **Subd. 6a. Implementation and effective date.** All laboratories must comply with
321.18 standards under this section by July 1, 2009. Fees under subdivisions 3 and 3b apply to
321.19 applications received and accreditations issued after June 30, 2009. Accreditations issued
321.20 on or before June 30, 2009, shall expire upon their current expiration date.

321.21 Sec. 33. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision
321.22 to read:

321.23 **Subd. 7. Initial accreditation and annual accreditation renewal.** (a) The
321.24 commissioner shall issue or renew accreditation after receipt of the completed application
321.25 and documentation required in this section, provided the laboratory maintains compliance
321.26 with the standards specified in subdivision 2a, and attests to the compliance on the
321.27 application form.

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

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

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

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

322.5 (e) The accreditation of any laboratory that fails to submit a renewal application
322.6 and fees to the commissioner expires automatically on December 31 without notice or
322.7 further proceeding. Any person who operates a laboratory as accredited after expiration of
322.8 accreditation or without having submitted an application and paid the fees is in violation
322.9 of the provisions of this section and is subject to enforcement action under sections
322.10 144.989 to 144.993, the Health Enforcement Consolidation Act. A laboratory with expired
322.11 accreditation may reapply under subdivision 6.

322.12 **EFFECTIVE DATE.** This section is effective July 1, 2009.

322.13 Sec. 34. Minnesota Statutes 2008, section 144.99, subdivision 1, is amended to read:

322.14 Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and
322.15 sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12),
322.16 (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to
322.17 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97
322.18 to 144.98; 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and
322.19 all rules, orders, stipulation agreements, settlements, compliance agreements, licenses,
322.20 registrations, certificates, and permits adopted or issued by the department or under any
322.21 other law now in force or later enacted for the preservation of public health may, in
322.22 addition to provisions in other statutes, be enforced under this section.

322.23 **EFFECTIVE DATE.** This section is effective July 1, 2009.

322.24 Sec. 35. Minnesota Statutes 2008, section 153A.17, is amended to read:

322.25 **153A.17 EXPENSES; FEES.**

322.26 ~~The expenses for administering the certification requirements including the~~
322.27 ~~complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15~~
322.28 ~~and the Consumer Information Center under section 153A.18 must be paid from~~
322.29 ~~initial application and examination fees, renewal fees, penalties, and fines. All fees~~
322.30 ~~are nonrefundable. The certificate application fee is \$350, the examination fee is \$250~~
322.31 ~~for the written portion and \$250 for the practical portion each time one or the other is~~
322.32 ~~taken, and the trainee application fee is \$200. The penalty fee for late submission of a~~
322.33 ~~renewal application is \$200. The fee for verification of certification to other jurisdictions~~
322.34 ~~or entities is \$25. All fees, penalties, and fines received must be deposited in the state~~

323.1 ~~government special revenue fund. The commissioner may prorate the certification fee for~~
323.2 ~~new applicants based on the number of quarters remaining in the annual certification~~
323.3 ~~period.~~ (a) The expenses for administering the certification requirements, including the
323.4 complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15,
323.5 and the Consumer Information Center under section 153A.18, must be paid from initial
323.6 application and examination fees, renewal fees, penalties, and fines.

323.7 (b) The fees are as follows:

323.8 (1) the initial and annual renewal certification application fee is \$600;

323.9 (2) the initial examination fee for the written portion is \$500, and for each time it
323.10 is taken, thereafter;

323.11 (3) the initial examination fee for the practical portion is \$1,200, and \$600 for each
323.12 time it is taken, thereafter; for individuals meeting the requirements of section 148.515,
323.13 subdivision 2, the fee for the practical portion of the hearing instrument dispensing
323.14 examination is \$250 each time it is taken;

323.15 (4) the trainee application fee is \$200;

323.16 (5) the penalty fee for late submission of a renewal application is \$200; and

323.17 (6) the fee for verification of certification to other jurisdictions or entities is \$25.

323.18 (c) The commissioner may prorate the certification fee for new applicants based on
323.19 the number of quarters remaining in the annual certification period.

323.20 (d) All fees are nonrefundable. All fees, penalties, and fines received must be
323.21 deposited in the state government special revenue fund.

323.22 (e) Beginning July 1, 2009, until June 30, 2016, a surcharge of \$100 shall be paid
323.23 at the time of initial certification application or renewal to recover the commissioner's
323.24 accumulated direct expenditures for administering the requirements of this chapter.

323.25 Sec. 36. Minnesota Statutes 2008, section 157.15, is amended by adding a subdivision
323.26 to read:

323.27 Subd. 20. **Youth camp.** "Youth camp" has the meaning given in section 144.71,
323.28 subdivision 2.

323.29 Sec. 37. Minnesota Statutes 2008, section 157.16, is amended to read:

323.30 **157.16 LICENSES REQUIRED; FEES.**

323.31 Subdivision 1. **License required annually.** A license is required annually for every
323.32 person, firm, or corporation engaged in the business of conducting a food and beverage
323.33 service establishment, youth camp, hotel, motel, lodging establishment, public pool, or
323.34 resort. Any person wishing to operate a place of business licensed in this section shall

324.1 first make application, pay the required fee specified in this section, and receive approval
 324.2 for operation, including plan review approval. ~~Seasonal and temporary food stands and~~
 324.3 Special event food stands are not required to submit plans. Nonprofit organizations
 324.4 operating a special event food stand with multiple locations at an annual one-day event
 324.5 shall be issued only one license. Application shall be made on forms provided by the
 324.6 commissioner and shall require the applicant to state the full name and address of the
 324.7 owner of the building, structure, or enclosure, the lessee and manager of the food and
 324.8 beverage service establishment, hotel, motel, lodging establishment, public pool, or resort;
 324.9 the name under which the business is to be conducted; and any other information as may
 324.10 be required by the commissioner to complete the application for license.

324.11 Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage
 324.12 service establishments, youth camps, hotels, motels, lodging establishments, public pools,
 324.13 and resorts shall be issued ~~for the calendar year for which application is made and shall~~
 324.14 ~~expire on December 31 of such year~~ on an annual basis. Any person who operates a place
 324.15 of business after the expiration date of a license or without having submitted an application
 324.16 and paid the fee shall be deemed to have violated the provisions of this chapter and shall
 324.17 be subject to enforcement action, as provided in the Health Enforcement Consolidation
 324.18 Act, sections 144.989 to 144.993. In addition, a penalty of ~~\$50~~ \$60 shall be added to the
 324.19 total of the license fee for any food and beverage service establishment operating without
 324.20 a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or
 324.21 a special event food stand, and a penalty of ~~\$100~~ \$120 shall be added to the total of the
 324.22 license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth
 324.23 camps, public pools, and resorts operating without a license for a period of up to 30 days.
 324.24 A late fee of ~~\$300~~ \$360 shall be added to the license fee for establishments operating more
 324.25 than 30 days without a license.

324.26 Subd. 2a. **Food manager certification.** An applicant for certification or certification
 324.27 renewal as a food manager must submit to the commissioner a ~~\$28~~ \$35 nonrefundable
 324.28 certification fee payable to the Department of Health. The commissioner shall issue a
 324.29 duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant
 324.30 submits a completed application on a form provided by the commissioner for a duplicate
 324.31 certificate and pays \$20 to the department for the cost of duplication.

324.32 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required
 324.33 for food and beverage service establishments, youth camps, hotels, motels, lodging
 324.34 establishments, public pools, and resorts licensed under this chapter. Food and beverage
 324.35 service establishments must pay the highest applicable fee under paragraph (d), clause

325.1 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
325.2 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
325.3 licensed under this chapter for the same calendar year is one-half of the appropriate annual
325.4 license fee, plus any penalty that may be required. The license fee for operators opening
325.5 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
325.6 that may be required.

325.7 (b) All food and beverage service establishments, except special event food stands,
325.8 and all hotels, motels, lodging establishments, public pools, and resorts shall pay an
325.9 annual base fee of \$150.

325.10 (c) A special event food stand shall pay a flat fee of ~~\$40~~ \$50 annually. "Special event
325.11 food stand" means a fee category where food is prepared or served in conjunction with
325.12 celebrations, county fairs, or special events from a special event food stand as defined
325.13 in section 157.15.

325.14 (d) In addition to the base fee in paragraph (b), each food and beverage service
325.15 establishment, other than a special event food stand, and each hotel, motel, lodging
325.16 establishment, public pool, and resort shall pay an additional annual fee for each fee
325.17 category, additional food service, or required additional inspection specified in this
325.18 paragraph:

325.19 (1) Limited food menu selection, ~~\$50~~ \$60. "Limited food menu selection" means a
325.20 fee category that provides one or more of the following:

- 325.21 (i) prepackaged food that receives heat treatment and is served in the package;
- 325.22 (ii) frozen pizza that is heated and served;
- 325.23 (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;
- 325.24 (iv) soft drinks, coffee, or nonalcoholic beverages; or
- 325.25 (v) cleaning for eating, drinking, or cooking utensils, when the only food served
325.26 is prepared off site.

325.27 (2) Small establishment, including boarding establishments, ~~\$100~~ \$120. "Small
325.28 establishment" means a fee category that has no salad bar and meets one or more of
325.29 the following:

- 325.30 (i) possesses food service equipment that consists of no more than a deep fat fryer, a
325.31 grill, two hot holding containers, and one or more microwave ovens;
- 325.32 (ii) serves dipped ice cream or soft serve frozen desserts;
- 325.33 (iii) serves breakfast in an owner-occupied bed and breakfast establishment;
- 325.34 (iv) is a boarding establishment; or
- 325.35 (v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum
325.36 patron seating capacity of not more than 50.

326.1 (3) Medium establishment, ~~\$260~~ \$310. "Medium establishment" means a fee
326.2 category that meets one or more of the following:

326.3 (i) possesses food service equipment that includes a range, oven, steam table, salad
326.4 bar, or salad preparation area;

326.5 (ii) possesses food service equipment that includes more than one deep fat fryer,
326.6 one grill, or two hot holding containers; or

326.7 (iii) is an establishment where food is prepared at one location and served at one or
326.8 more separate locations.

326.9 Establishments meeting criteria in clause (2), item (v), are not included in this fee
326.10 category.

326.11 (4) Large establishment, ~~\$460~~ \$540. "Large establishment" means either:

326.12 (i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a
326.13 medium establishment, (B) seats more than 175 people, and (C) offers the full menu
326.14 selection an average of five or more days a week during the weeks of operation; or

326.15 (ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium
326.16 establishment, and (B) prepares and serves 500 or more meals per day.

326.17 (5) Other food and beverage service, including food carts, mobile food units,
326.18 seasonal temporary food stands, and seasonal permanent food stands, ~~\$50~~ \$60.

326.19 (6) Beer or wine table service, ~~\$50~~ \$60. "Beer or wine table service" means a fee
326.20 category where the only alcoholic beverage service is beer or wine, served to customers
326.21 seated at tables.

326.22 (7) Alcoholic beverage service, other than beer or wine table service, ~~\$135~~ \$165.

326.23 "Alcohol beverage service, other than beer or wine table service" means a fee
326.24 category where alcoholic mixed drinks are served or where beer or wine are served from
326.25 a bar.

326.26 (8) Lodging per sleeping accommodation unit, ~~\$8~~ \$10, including hotels, motels,
326.27 lodging establishments, and resorts, up to a maximum of ~~\$800~~ \$1,000. "Lodging per
326.28 sleeping accommodation unit" means a fee category including the number of guest rooms,
326.29 cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the
326.30 number of beds in a dormitory.

326.31 (9) First public pool, ~~\$180~~ \$325; each additional public pool, ~~\$100~~ \$175. "Public
326.32 pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

326.33 (10) First spa, ~~\$110~~ \$175; each additional spa, ~~\$50~~ \$100. "Spa pool" means a fee
326.34 category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

326.35 (11) Private sewer or water, ~~\$50~~ \$60. "Individual private water" means a fee
326.36 category with a water supply other than a community public water supply as defined in

327.1 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
 327.2 individual sewage treatment system which uses subsurface treatment and disposal.

327.3 (12) Additional food service, ~~\$130~~ \$150. "Additional food service" means a location
 327.4 at a food service establishment, other than the primary food preparation and service area,
 327.5 used to prepare or serve food to the public.

327.6 (13) Additional inspection fee, ~~\$300~~ \$360. "Additional inspection fee" means a
 327.7 fee to conduct the second inspection each year for elementary and secondary education
 327.8 facility school lunch programs when required by the Richard B. Russell National School
 327.9 Lunch Act.

327.10 (e) A fee of ~~\$350~~ for review of ~~the~~ construction plans must accompany the initial
 327.11 license application for restaurants, hotels, motels, lodging establishments, ~~or~~ resorts ~~with~~
 327.12 ~~five or more sleeping units~~, seasonal food stands, and mobile food units. The fee for
 327.13 this construction plan review is as follows:

327.14	<u>Service Area</u>	<u>Type</u>	<u>Fee</u>
327.15	<u>Food</u>	<u>limited food menu</u>	<u>\$275</u>
327.16		<u>small establishment</u>	<u>\$400</u>
327.17		<u>medium establishment</u>	<u>\$450</u>
327.18		<u>large food establishment</u>	<u>\$500</u>
327.19		<u>additional food service</u>	<u>\$150</u>
327.20	<u>Transient food service</u>	<u>food cart</u>	<u>\$250</u>
327.21		<u>seasonal permanent food stand</u>	<u>\$250</u>
327.22		<u>seasonal temporary food stand</u>	<u>\$250</u>
327.23		<u>mobile food unit</u>	<u>\$350</u>
327.24	<u>Alcohol</u>	<u>beer or wine table service</u>	<u>\$150</u>
327.25		<u>alcohol service from bar</u>	<u>\$250</u>
327.26	<u>Lodging</u>	<u>less than 25 rooms</u>	<u>\$375</u>
327.27		<u>25 to less than 100 rooms</u>	<u>\$400</u>
327.28		<u>100 rooms or more</u>	<u>\$500</u>
327.29		<u>less than five cabins</u>	<u>\$350</u>
327.30		<u>five to less than ten cabins</u>	<u>\$400</u>
327.31		<u>ten cabins or more</u>	<u>\$450</u>

328.1 (f) When existing food and beverage service establishments, hotels, motels, lodging
 328.2 establishments, ~~or resorts, seasonal food stands, and mobile food units~~ are extensively
 328.3 remodeled, a fee of ~~\$250~~ must be submitted with the remodeling plans. ~~A fee of \$250~~
 328.4 ~~must be submitted for new construction or remodeling for a restaurant with a limited food~~
 328.5 ~~menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for~~
 328.6 ~~a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.~~
 328.7 The fee for this construction plan review is as follows:

328.8	<u>Service Area</u>	<u>Type</u>	<u>Fee</u>
328.9	<u>Food</u>	<u>limited food menu</u>	<u>\$250</u>
328.10		<u>small establishment</u>	<u>\$300</u>
328.11		<u>medium establishment</u>	<u>\$350</u>
328.12		<u>large food establishment</u>	<u>\$400</u>
328.13		<u>additional food service</u>	<u>\$150</u>
328.14	<u>Transient food service</u>	<u>food cart</u>	<u>\$250</u>
328.15		<u>seasonal permanent food stand</u>	<u>\$250</u>
328.16		<u>seasonal temporary food stand</u>	<u>\$250</u>
328.17		<u>mobile food unit</u>	<u>\$250</u>
328.18	<u>Alcohol</u>	<u>beer or wine table service</u>	<u>\$150</u>
328.19		<u>alcohol service from bar</u>	<u>\$250</u>
328.20	<u>Lodging</u>	<u>less than 25 rooms</u>	<u>\$250</u>
328.21		<u>25 to less than 100 rooms</u>	<u>\$300</u>
328.22		<u>100 rooms or more</u>	<u>\$450</u>
328.23		<u>less than five cabins</u>	<u>\$250</u>
328.24		<u>five to less than ten cabins</u>	<u>\$350</u>
328.25		<u>ten cabins or more</u>	<u>\$400</u>

328.26 (g) ~~Seasonal temporary food stands and~~ Special event food stands are not required to
 328.27 submit construction or remodeling plans for review.

328.28 (h) Youth camps shall pay an annual single fee for food and lodging as follows:

- 328.29 (1) camps with up to 99 campers, \$325;
- 328.30 (2) camps with 100 to 199 campers, \$550; and
- 328.31 (3) camps with 200 or more campers; \$750.

329.1 Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that
329.2 operates a licensed boarding establishment, food and beverage service establishment,
329.3 seasonal temporary or permanent food stand, special event food stand, mobile food unit,
329.4 food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the
329.5 commissioner a \$35 annual statewide hospitality fee for each licensed activity. The fee
329.6 for establishments licensed by the Department of Health is required at the same time the
329.7 licensure fee is due. For establishments licensed by local governments, the fee is due by
329.8 July 1 of each year.

329.9 Subd. 4. **Posting requirements.** Every food and beverage service establishment,
329.10 for-profit youth camp, hotel, motel, lodging establishment, public pool, or resort must have
329.11 the license posted in a conspicuous place at the establishment. Mobile food units, food
329.12 carts, and seasonal temporary food stands shall be issued decals with the initial license and
329.13 each calendar year with license renewals. The current license year decal must be placed on
329.14 the unit or stand in a location determined by the commissioner. Decals are not transferable.

329.15 Sec. 38. Minnesota Statutes 2008, section 157.22, is amended to read:

329.16 **157.22 EXEMPTIONS.**

329.17 This chapter ~~shall not be construed to~~ does not apply to:

329.18 (1) interstate carriers under the supervision of the United States Department of
329.19 Health and Human Services;

329.20 (2) any building constructed and primarily used for religious worship;

329.21 (3) any building owned, operated, and used by a college or university in accordance
329.22 with health regulations promulgated by the college or university under chapter 14;

329.23 (4) any person, firm, or corporation whose principal mode of business is licensed
329.24 under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food
329.25 or beverage establishment; provided that the holding of any license pursuant to sections
329.26 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable
329.27 provisions of this chapter or the rules of the state commissioner of health relating to
329.28 food and beverage service establishments;

329.29 (5) family day care homes and group family day care homes governed by sections
329.30 245A.01 to 245A.16;

329.31 (6) nonprofit senior citizen centers for the sale of home-baked goods;

329.32 (7) fraternal or patriotic organizations that are tax exempt under section 501(c)(3),
329.33 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of
329.34 1986, or organizations related to or affiliated with such fraternal or patriotic organizations.

330.1 Such organizations may organize events at which home-prepared food is donated by
330.2 organization members for sale at the events, provided:

330.3 (i) the event is not a circus, carnival, or fair;

330.4 (ii) the organization controls the admission of persons to the event, the event agenda,
330.5 or both; and

330.6 (iii) the organization's licensed kitchen is not used in any manner for the event;

330.7 (8) food not prepared at an establishment and brought in by individuals attending a
330.8 potluck event for consumption at the potluck event. An organization sponsoring a potluck
330.9 event under this clause may advertise the potluck event to the public through any means.
330.10 Individuals who are not members of an organization sponsoring a potluck event under this
330.11 clause may attend the potluck event and consume the food at the event. Licensed food
330.12 establishments other than schools cannot be sponsors of potluck events. A school may
330.13 sponsor and hold potluck events in areas of the school other than the school's kitchen,
330.14 provided that the school's kitchen is not used in any manner for the potluck event. For
330.15 purposes of this clause, "school" means a public school as defined in section 120A.05,
330.16 subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization
330.17 at which a child is provided with instruction in compliance with sections 120A.22 and
330.18 120A.24. Potluck event food shall not be brought into a licensed food establishment
330.19 kitchen; ~~and~~

330.20 (9) a home school in which a child is provided instruction at home; and

330.21 (10) concession stands operated in conjunction with school-sponsored events on
330.22 school property are exempt from the 21-day restriction.

330.23 Sec. 39. Minnesota Statutes 2008, section 327.14, is amended by adding a subdivision
330.24 to read:

330.25 Subd. 9. **Special event recreational camping area.** "Special event recreational
330.26 camping area" means a recreational camping area which operates no more than two times
330.27 annually and for no more than 14 consecutive days.

330.28 Sec. 40. Minnesota Statutes 2008, section 327.15, is amended to read:

330.29 **327.15 LICENSE REQUIRED; RENEWAL; ~~PLANS FOR EXPANSION~~ FEES.**

330.30 Subdivision 1. **License required; plan review.** No person, firm or corporation shall
330.31 establish, maintain, conduct or operate a manufactured home park or recreational camping
330.32 area within this state without first obtaining ~~a~~ an annual license ~~therefor~~ from the state
330.33 Department of Health. Any person wishing to obtain a license shall submit an application,
330.34 pay the required fee specified in this section, and receive approval for operation, including

331.1 plan review approval. Application shall be made on forms provided by the commissioner
 331.2 and shall require the applicant to state the full name and address of the owner of the
 331.3 manufactured home park or recreational camping area, the name under which the business
 331.4 is to be conducted, and any other information as may be required by the commissioner
 331.5 to complete the application for license. Any person, firm, or corporation desiring to
 331.6 operate either a manufactured home park or a recreational camping area on the same site
 331.7 in connection with the other, need only obtain one license. ~~A license shall expire and be~~
 331.8 ~~renewed as prescribed by the commissioner pursuant to section 144.122.~~ The license shall
 331.9 state the number of manufactured home sites and recreational camping sites allowed
 331.10 according to state commissioner of health approval. ~~No renewal license shall be issued if~~
 331.11 ~~the number of sites specified in the application exceeds those of the original application~~
 331.12 ~~The number of licensed sites shall not be increased unless the plans for expansion or~~
 331.13 ~~the construction for expansion are first submitted and the expansion is approved by~~
 331.14 ~~the Department of Health. Any manufactured home park or recreational camping area~~
 331.15 ~~located in more than one municipality shall be dealt with as two separate manufactured~~
 331.16 ~~home parks or camping areas.~~ The license shall be conspicuously displayed in the office
 331.17 of the manufactured home park or camping area. The license is not transferable ~~as to~~ to
 331.18 another person or place.

331.19 Subd. 2. **License renewal.** Initial and renewal licenses for all manufactured home
 331.20 parks and recreational camping areas shall be issued annually and shall have an expiration
 331.21 date included on the license. Any person who operates a manufactured home park or
 331.22 recreational camping area after the expiration date of a license or without having submitted
 331.23 an application and paid the fee shall be deemed to have violated the provisions of this
 331.24 chapter and shall be subject to enforcement action, as provided in the Health Enforcement
 331.25 Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of \$120 shall
 331.26 be added to the total of the license fee for any manufactured home park or recreational
 331.27 camping area operating without a license for a period of up to 30 days. A late fee of \$360
 331.28 shall be added to the license fee for any manufactured home park or recreational camping
 331.29 area operating more than 30 days without a license.

331.30 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)
 331.31 The following fees are required for manufactured home parks and recreational camping
 331.32 areas licensed under this chapter. Recreational camping areas and manufactured home
 331.33 parks shall pay the highest applicable fee under paragraph (c). The license fee for new
 331.34 operators of a manufactured home park or recreational camping area previously licensed
 331.35 under this chapter for the same calendar year is one-half of the appropriate annual license
 331.36 fee, plus any penalty that may be required. The license fee for operators opening on

332.1 or after October 1 is one-half of the appropriate annual license fee, plus any penalty
332.2 that may be required.

332.3 (b) All manufactured home parks and recreational camping areas shall pay the
332.4 following annual base fee:

332.5 (1) a manufactured home park, \$150; and

332.6 (2) a recreational camping area with:

332.7 (i) 24 or less sites, \$50;

332.8 (ii) 25-99 sites, \$212; and

332.9 (iii) 100 or more sites, \$300.

332.10 In addition to the base fee, manufactured home parks and recreational camping areas shall
332.11 pay \$4 for each licensed site. This paragraph does not apply to special event recreational
332.12 camping areas or to operators of a manufactured home park or a recreational camping area
332.13 licensed under section 157.16 for the same location.

332.14 (c) In addition to the fee in paragraph (b), each manufactured home park or
332.15 recreational camping area shall pay an additional annual fee for each fee category
332.16 specified in this paragraph:

332.17 (1) Manufactured home parks and recreational camping areas with public swimming
332.18 pools and spas shall pay the appropriate fees specified in section 157.16.

332.19 (2) Individual private sewer or water, \$60. "Individual private water" means a fee
332.20 category with a water supply other than a community public water supply as defined in
332.21 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an
332.22 individual sewage treatment system which uses subsurface treatment and disposal.

332.23 (d) The following fees must accompany a plan review application for initial
332.24 construction of a manufactured home park or recreational camping area:

332.25 (1) for initial construction of less than 25 sites, \$375;

332.26 (2) for initial construction of 25 to less than 100 sites, \$400; and

332.27 (3) for initial construction of 100 or more sites, \$500.

332.28 (e) The following fees must accompany a plan review application when an existing
332.29 manufactured home park or recreational camping area is expanded:

332.30 (1) for expansion of less than 25 sites, \$250;

332.31 (2) for expansion of 25 and less than 100 sites, \$300; and

332.32 (3) for expansion of 100 or more sites, \$450.

332.33 Subd. 4. Fees, special event recreational camping areas. (a) The following fees
332.34 are required for special event recreational camping areas licensed under this chapter.

332.35 (b) All special event recreational camping areas shall pay an annual fee of \$150 plus
332.36 \$1 for each licensed site.

333.1 (c) A special event recreational camping area shall pay a late fee of \$360 for failing
333.2 to obtain a license prior to operating.

333.3 (d) The following fees must accompany a plan review application for initial
333.4 construction of a special event recreational camping area:

333.5 (1) for initial construction of less than 25 special event recreational camping sites,
333.6 \$375;

333.7 (2) for initial construction of 25 to less than 100 sites, \$400; and

333.8 (3) for initial construction of 100 or more sites, \$500.

333.9 (e) The following fees must accompany a plan review application for expansion of a
333.10 special event recreational camping area:

333.11 (1) for expansion of less than 25 sites, \$250;

333.12 (2) for expansion of 25 and less than 100 sites, \$300; and

333.13 (3) for expansion of 100 or more sites, \$450.

333.14 Sec. 41. Minnesota Statutes 2008, section 327.16, is amended to read:

333.15 **327.16 LICENSE PLAN REVIEW APPLICATION.**

333.16 Subdivision 1. **Made to state Department of Health.** The plan review application
333.17 for license to operate and maintain a manufactured home park or recreational camping
333.18 area shall be made to the state Department of Health, at such office and in such manner
333.19 as may be prescribed by that department.

333.20 Subd. 2. **Contents.** The ~~applicant for a primary license or annual license shall make~~
333.21 ~~application in writing~~ plan review application shall be made upon a form provided by the
333.22 state Department of Health setting forth:

333.23 (1) The full name and address of the applicant or applicants, or names and addresses
333.24 of the partners if the applicant is a partnership, or the names and addresses of the officers
333.25 if the applicant is a corporation.

333.26 (2) A legal description of the site, lot, field, or tract of land upon which the applicant
333.27 proposes to operate and maintain a manufactured home park or recreational camping area.

333.28 (3) The proposed and existing facilities on and about the site, lot, field, or tract of
333.29 land for the proposed construction or alteration and maintaining of a sanitary community
333.30 building for toilets, urinals, sinks, wash basins, slop-sinks, showers, drains, laundry
333.31 facilities, source of water supply, sewage, garbage and waste disposal; except that no
333.32 toilet facilities shall be required in any manufactured home park which permits only
333.33 manufactured homes equipped with toilet facilities discharging to water carried sewage
333.34 disposal systems; and method of fire and storm protection.

334.1 (4) The proposed method of lighting the structures and site, lot, field, or tract of land
334.2 upon which the manufactured home park or recreational camping area is to be located.

334.3 (5) The calendar months of the year which the applicant will operate the
334.4 manufactured home park or recreational camping area.

334.5 (6) Plans and drawings for new construction or alteration, including buildings, wells,
334.6 plumbing and sewage disposal systems.

334.7 Subd. 3. **Fees; Approval.** The application for ~~the primary license~~ plan review shall
334.8 be submitted with all plans and specifications enumerated in subdivision 2, ~~and payment~~
334.9 ~~of a fee in an amount prescribed by the state commissioner of health pursuant to section~~
334.10 ~~144.122~~ and shall be accompanied by an approved zoning permit from the municipality or
334.11 county wherein the park is to be located, or a statement from the municipality or county
334.12 that it does not require an approved zoning permit. ~~The fee for the annual license shall be~~
334.13 ~~in an amount prescribed by the state commissioner of health pursuant to section 144.122.~~
334.14 ~~All license fees paid to the commissioner of health shall be turned over to the state~~
334.15 ~~treasury.~~ The fee submitted for the primary license plan review shall be retained by the
334.16 state even though the proposed project is not approved and a license is denied.

334.17 When construction has been completed in accordance with approved plans and
334.18 specifications the state commissioner of health shall promptly cause the manufactured
334.19 home park or recreational camping area and appurtenances thereto to be inspected. When
334.20 the inspection and report has been made and the state commissioner of health finds that
334.21 all requirements of sections 327.10, 327.11, 327.14 to 327.28, and such conditions of
334.22 health and safety as the state commissioner of health may require, have been met by
334.23 the applicant, the state commissioner of health shall forthwith issue the primary license
334.24 in the name of the state.

334.25 Subd. 4. **Sanitary facilities** Compliance with current state law. ~~During the~~
334.26 ~~pendency of the application for such primary license any change in the sanitary or safety~~
334.27 ~~facilities of the intended manufactured home park or recreational camping area shall be~~
334.28 ~~immediately reported in writing to the state Department of Health through the office~~
334.29 ~~through which the application was made. If no objection is made by the state Department~~
334.30 ~~of Health to such change in such sanitary or safety facilities within 60 days of the date~~
334.31 ~~such change is reported, it shall be deemed to have the approval of the state Department of~~
334.32 ~~Health.~~ Any manufactured home park or recreational camping area must be constructed
334.33 and operated according to all applicable state electrical, fire, plumbing, and building codes.

334.34 Subd. 5. **Permit.** When the plans and specifications have been approved, the state
334.35 Department of Health shall issue an approval report permitting the applicant to construct

335.1 or make alterations upon a manufactured home park or recreational camping area and the
335.2 appurtenances thereto according to the plans and specifications presented.

335.3 Such approval does not relieve the applicant from securing building permits in
335.4 municipalities that require permits or from complying with any other municipal ordinance
335.5 or ordinances, applicable thereto, not in conflict with this statute.

335.6 Subd. 6. **Denial of construction.** If the application to construct or make alterations
335.7 upon a manufactured home park or recreational camping area and the appurtenances
335.8 thereto or a ~~primary~~ license to operate and maintain the same is denied by the state
335.9 commissioner of health, the commissioner shall so state in writing giving the reason
335.10 or reasons for denying the application. If the objections can be corrected the applicant
335.11 may amend the application and resubmit it for approval, and if denied the applicant may
335.12 appeal from the decision of the state commissioner of health as provided in section
335.13 144.99, subdivision 10.

335.14 Sec. 42. Minnesota Statutes 2008, section 327.20, subdivision 1, is amended to read:

335.15 Subdivision 1. **Rules.** No domestic animals or house pets of occupants of
335.16 manufactured home parks or recreational camping areas shall be allowed to run at large,
335.17 or commit any nuisances within the limits of a manufactured home park or recreational
335.18 camping area. Each manufactured home park or recreational camping area licensed under
335.19 the provisions of sections 327.10, 327.11, and 327.14 to 327.28 shall, among other things,
335.20 provide for the following, ~~in the manner hereinafter specified:~~

335.21 (1) A responsible attendant or caretaker shall be in charge of every manufactured
335.22 home park or recreational camping area at all times, who shall maintain the park or
335.23 area, and its facilities and equipment in a clean, orderly and sanitary condition. In any
335.24 manufactured home park containing more than 50 lots, the attendant, caretaker, or other
335.25 responsible park employee, shall be readily available at all times in case of emergency.

335.26 (2) All manufactured home parks shall be well drained and be located so that the
335.27 drainage of the park area will not endanger any water supply. No wastewater from
335.28 manufactured homes or recreational camping vehicles shall be deposited on the surface of
335.29 the ground. All sewage and other water carried wastes shall be discharged into a municipal
335.30 sewage system whenever available. When a municipal sewage system is not available, a
335.31 sewage disposal system acceptable to the state commissioner of health shall be provided.

335.32 (3) No manufactured home shall be located closer than three feet to the side lot lines
335.33 of a manufactured home park, if the abutting property is improved property, or closer than
335.34 ten feet to a public street or alley. Each individual site shall abut or face on a driveway
335.35 or clear unoccupied space of not less than 16 feet in width, which space shall have

336.1 unobstructed access to a public highway or alley. There shall be an open space of at least
336.2 ten feet between the sides of adjacent manufactured homes including their attachments
336.3 and at least three feet between manufactured homes when parked end to end. The space
336.4 between manufactured homes may be used for the parking of motor vehicles and other
336.5 property, if the vehicle or other property is parked at least ten feet from the nearest
336.6 adjacent manufactured home position. The requirements of this paragraph shall not apply
336.7 to recreational camping areas and variances may be granted by the state commissioner
336.8 of health in manufactured home parks when the variance is applied for in writing and in
336.9 the opinion of the commissioner the variance will not endanger the health, safety, and
336.10 welfare of manufactured home park occupants.

336.11 (4) An adequate supply of water of safe, sanitary quality shall be furnished at each
336.12 manufactured home park or recreational camping area. The source of the water supply
336.13 shall first be approved by the state Department of Health.

336.14 (5) All plumbing shall be installed in accordance with the rules of the state
336.15 commissioner of labor and industry and the provisions of the Minnesota Plumbing Code.

336.16 (6) In the case of a manufactured home park with less than ten manufactured homes,
336.17 a plan for the sheltering or the safe evacuation to a safe place of shelter of the residents of
336.18 the park in times of severe weather conditions, such as tornadoes, high winds, and floods.
336.19 The shelter or evacuation plan shall be developed with the assistance and approval of
336.20 the municipality where the park is located and shall be posted at conspicuous locations
336.21 throughout the park. The park owner shall provide each resident with a copy of the
336.22 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.
336.23 Nothing in this paragraph requires the Department of Health to review or approve any
336.24 shelter or evacuation plan developed by a park. Failure of a municipality to approve a plan
336.25 submitted by a park shall not be grounds for action against the park by the Department of
336.26 Health if the park has made a good faith effort to develop the plan and obtain municipal
336.27 approval.

336.28 (7) A manufactured home park with ten or more manufactured homes, licensed prior
336.29 to March 1, 1988, shall provide a safe place of shelter for park residents or a plan for the
336.30 evacuation of park residents to a safe place of shelter within a reasonable distance of the
336.31 park for use by park residents in times of severe weather, including tornadoes and high
336.32 winds. The shelter or evacuation plan must be approved by the municipality by March 1,
336.33 1989. The municipality may require the park owner to construct a shelter if it determines
336.34 that a safe place of shelter is not available within a reasonable distance from the park. A
336.35 copy of the municipal approval and the plan shall be submitted by the park owner to the

337.1 Department of Health. The park owner shall provide each resident with a copy of the
337.2 approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.

337.3 (8) A manufactured home park with ten or more manufactured homes, receiving
337.4 ~~a primary~~ an initial license after March 1, 1988, must provide the type of shelter required
337.5 by section 327.205, except that for manufactured home parks established as temporary,
337.6 emergency housing in a disaster area declared by the President of the United States or
337.7 the governor, an approved evacuation plan may be provided in lieu of a shelter for a
337.8 period not exceeding 18 months.

337.9 (9) For the purposes of this subdivision, "park owner" and "resident" have the
337.10 ~~meaning~~ meanings given them in section 327C.01.

337.11 Sec. 43. Minnesota Statutes 2008, section 327.20, is amended by adding a subdivision
337.12 to read:

337.13 Subd. 4. Special event recreational camping areas. Each special event camping
337.14 area licensed under sections 327.10, 327.11, and 327.14 to 327.28 is subject to this section.

337.15 (1) Recreational camping vehicles and tents, including attachments, must be
337.16 separated from each other and other structures by at least seven feet.

337.17 (2) A minimum area of 300 square feet per site must be provided and the total
337.18 number of sites must not exceed one site for every 300 square feet of usable land area.

337.19 (3) Each site must abut or face a driveway or clear unoccupied space of at least 16
337.20 feet in width, which space must have unobstructed access to a public roadway.

337.21 (4) If no approved on-site water supply system is available, hauled water may be
337.22 used, provided that persons using hauled water comply with Minnesota Rules, parts
337.23 4720.4000 to 4720.4600.

337.24 (5) Nonburied sewer lines may be permitted provided they are of approved materials,
337.25 watertight, and properly maintained.

337.26 (6) If a sanitary dumping station is not provided on-site, arrangements must be
337.27 made with a licensed sewage pumper to service recreational camping vehicle holding
337.28 tanks as needed.

337.29 (7) Toilet facilities must be provided consisting of toilets connected to an approved
337.30 sewage disposal system, portable toilets, or approved, properly constructed privies.

337.31 (8) Toilets must be provided in the ratio of one toilet for each sex for each 150 sites.

337.32 (9) Toilets must be not more than 400 feet from any site.

337.33 (10) If a central building or buildings are provided with running water, then toilets
337.34 and handwashing lavatories must be provided in the building or buildings that meet the
337.35 requirements of this subdivision.

338.1 (11) Showers, if provided, must be provided in the ratio of one shower for each sex
338.2 for each 250 sites. Showerheads must be provided, where running water is available, for
338.3 each camping event exceeding two nights.

338.4 (12) Central toilet and shower buildings, if provided, must be constructed with
338.5 adequate heating, ventilation, and lighting, and floors of impervious material sloped
338.6 to drain. Walls must be of a washable material. Permanent facilities must meet the
338.7 requirements of the Americans with Disabilities Act.

338.8 (13) An adequate number of durable, covered, watertight containers must be
338.9 provided for all garbage and refuse. Garbage and refuse must be collected as often as
338.10 necessary to prevent nuisance conditions.

338.11 (14) Campgrounds must be located in areas free of poison ivy or other noxious
338.12 weeds considered detrimental to health. Sites must not be located in areas of tall grass or
338.13 weeds and sites must be adequately drained.

338.14 (15) Campsites for recreational vehicles may not be located on inclines of greater
338.15 than eight percent grade or one inch drop per lineal foot.

338.16 (16) A responsible attendant or caretaker must be available on-site at all times during
338.17 the operation of any special event recreational camping area that has 50 or more sites.

338.18 Sec. 44. **MINNESOTA COLORECTAL CANCER PREVENTION**
338.19 **DEMONSTRATION PROJECT.**

338.20 Subdivision 1. **Establishment.** The commissioner of health shall award grants
338.21 to Hennepin County Medical Center and MeritCare Bemidji for a colorectal screening
338.22 demonstration project to provide screening to uninsured and underinsured women and
338.23 men. The project shall expire December 31, 2010.

338.24 Subd. 2. **Eligibility.** To be eligible for colorectal screening under this demonstration
338.25 project, an applicant must:

338.26 (1) be at least 50 years of age, or under the age of 50 and at high risk for colon cancer;

338.27 (2) be uninsured, or if insured, have coverage that does not cover the full cost of
338.28 colorectal cancer screenings;

338.29 (3) not be eligible for medical assistance, general assistance medical care, or
338.30 MinnesotaCare programs; and

338.31 (4) have a gross family income at or below 250 percent of the federal poverty level.

338.32 Subd. 3. **Services.** Services provided under this project shall include:

338.33 (1) colorectal cancer screening, according to standard practices of medicine, or
338.34 guidelines provided by the Institute for Clinical Systems Improvement or the American
338.35 Cancer Society;

- 339.1 (2) follow-up services for abnormal tests; and
- 339.2 (3) diagnostic services to determine the extent and proper course of treatment.

339.3 Subd. 4. **Project evaluation.** The commissioner of health shall evaluate the
339.4 demonstration project and make recommendations for increasing the number of persons in
339.5 Minnesota who receive recommended colon cancer screening. The commissioner of health
339.6 shall submit the evaluation and recommendations to the legislature by January 15, 2011.

339.7 Sec. 45. **RESEARCH OF EXPOSURE PATHWAYS FOR**
339.8 **PERFLUOROCHEMICALS.**

339.9 The commissioner of health shall study and report to the legislature by January
339.10 15, 2011, on the exposure pathways for perfluorochemicals, focusing on food sources
339.11 that might be affected by contact with contaminated water or air. This research will be
339.12 performed to the extent that nonstate funds and environmental health tracking funds are
339.13 available and include garden vegetables produced or consumed by a representative sample
339.14 of the population from the east metropolitan area including indigenous people and people
339.15 of color. In developing and performing the research, the commissioner must convene and
339.16 consult with a citizen advisory group consisting of residents from the east metropolitan
339.17 area, including indigenous people and people of color.

339.18 Sec. 46. **FEASIBILITY PILOT PROJECT FOR CANCER SURVEILLANCE.**

339.19 The commissioner of health must provide a grant to the Hennepin County Medical
339.20 Center for a one-year feasibility pilot project to collect occupational, residential, and
339.21 military service history data from newly diagnosed cancer patients at the Hennepin
339.22 County Medical Center's Cancer Center. Funding for this grant shall come from the
339.23 Department of Health's current resources for the Chronic Disease and Environmental
339.24 Epidemiology Section.

339.25 Under this pilot project, Hennepin County Medical Center will design an expansion
339.26 of its existing cancer registry to include the collection of additional data, including the
339.27 cancer patient's occupational, residential, and military service history. Patient consent is
339.28 required for collection of these additional data. The consent must be in writing and must
339.29 contain notice informing the patient about private and confidential data concerning the
339.30 patient pursuant to Minnesota Statutes, section 13.04, subdivision 2. The patient is entitled
339.31 to opt out of the project at any time. The data collection expansion may also include the
339.32 cancer patient's possible toxic environmental exposure history, if known. The purpose of
339.33 this pilot project is to determine the following:

- 339.34 (1) the feasibility of collecting these data on a statewide scale;

340.1 (2) the potential design of a self-administered patient questionnaire template; and
340.2 (3) necessary qualifications for staff who will collect these data.
340.3 Hennepin County Medical Center must report the results of this pilot project to the
340.4 legislature by October 1, 2010.

340.5 Sec. 47. **SMOKING CESSATION.**

340.6 The commissioner of health must prioritize smoking prevention and smoking
340.7 cessation activities in low-income, indigenous, and minority communities in their
340.8 collaborations with the organization specifically described in Minnesota Statutes, section
340.9 144.396, subdivision 8.

340.10 Sec. 48. **MEDICAL RESPONSE UNIT REIMBURSEMENT PILOT PROGRAM.**

340.11 (a) The Department of Public Safety or its contract designee shall collaborate
340.12 with the Minnesota Ambulance Association to create the parameters of the medical
340.13 response unit reimbursement pilot program, including determining criteria for baseline
340.14 data reporting.

340.15 (b) In conducting the pilot program, the Department of Public Safety must consult
340.16 with the Minnesota Ambulance Association, Minnesota Fire Chiefs Association,
340.17 Emergency Services Regulatory Board, and the Minnesota Council of Health Plans to:

340.18 (1) identify no more than five medical response units registered as medical response
340.19 units with the Minnesota Emergency Medical Services Regulatory Board according to
340.20 Minnesota Statutes, chapter 144E, to participate in the program;

340.21 (2) outline and develop criteria for reimbursement;

340.22 (3) determine the amount of reimbursement for each unit response; and

340.23 (4) collect program data to be analyzed for a final report.

340.24 (c) Further criteria for the medical response unit reimbursement pilot program
340.25 shall include:

340.26 (1) the pilot program will expire on December 31, 2010, or when the appropriation
340.27 is extended, whichever occurs first;

340.28 (2) a report shall be made to the legislature by March 1, 2011, by the Department
340.29 of Public Safety or its contractor as to the effectiveness and value of this reimbursement
340.30 pilot program to the emergency medical services delivery system, any actual or potential
340.31 savings to the health care system, and impact on patient outcomes;

340.32 (3) participating medical response units must adhere to the requirements of this
340.33 pilot program outlined in an agreement between the Department of Public Safety and
340.34 the medical response unit, including but not limited to, requirements relating to data
340.35 collection, response criteria, and patient outcomes and disposition;

341.1 (4) individual entities licensed to provide ambulance care under Minnesota Statutes,
341.2 chapter 144E, are not eligible for participation in this pilot program;

341.3 (5) if a participating medical response unit withdraws from the pilot program, the
341.4 Department of Public Safety in consultation with the Minnesota Ambulance Association
341.5 may choose another pilot site if funding is available;

341.6 (6) medical response units must coordinate their operations under this pilot project
341.7 with the ambulance service or services licensed to provide care in their first response
341.8 geographic areas;

341.9 (7) licensed ambulance services that participate with the medical response unit in
341.10 the pilot program assume no financial or legal liability for the actions of the participating
341.11 medical response unit; and

341.12 (8) the Department of Public Safety and its pilot program partners have no ongoing
341.13 responsibility to reimburse medical response units beyond the parameters of the pilot
341.14 program.

341.15 Sec. 49. **REVIEW OF PROPOSED REGULATIONS FOR BODY ART**
341.16 **TECHNICIANS AND BODY ART ESTABLISHMENTS.**

341.17 The commissioner of health shall review proposed regulatory legislation for
341.18 body art technicians and body art establishments and develop recommendations on the
341.19 proper level of regulation needed for body art technicians and establishments in order
341.20 to protect public health. The recommendations must include a review of how other
341.21 states comply with the American Association of Blood Banks standards, how regulatory
341.22 requirements affect currently operating body art establishments, and the appropriate level
341.23 of coordination between the state and local jurisdictions that currently regulate body art
341.24 establishments. The commissioner shall submit the results of the review and possible
341.25 regulatory recommendations for body art technicians and establishments to the chairs and
341.26 ranking minority members of the legislative committees with jurisdiction over health
341.27 care by January 15, 2010.

341.28 Sec. 50. **HEARING AIDS; ENFORCEMENT.**

341.29 Costs incurred by the Minnesota Department of Health for conducting investigations
341.30 of unlicensed hearing aid dispensers shall be apportioned between all licensed or
341.31 credentialed professions that dispense hearing aids.

341.32 **EFFECTIVE DATE.** This section is effect July 1, 2011.

341.33 Sec. 51. **REPEALER.**

342.1 (a) Minnesota Statutes 2008, sections 103I.112; 144.9501, subdivision 17b; and
342.2 327.14, subdivisions 5 and 6, are repealed.

342.3 (b) Minnesota Rules, part 4626.2015, subpart 9, is repealed.

342.4 **ARTICLE 11**
342.5 **HEALTH-RELATED FEES**

342.6 Section 1. Minnesota Statutes 2008, section 148D.180, subdivision 1, is amended to
342.7 read:

342.8 Subdivision 1. **Application fees.** Application fees for licensure are as follows:

342.9 (1) for a licensed social worker, \$45;

342.10 (2) for a licensed graduate social worker, \$45;

342.11 (3) for a licensed independent social worker, ~~\$90~~ \$45;

342.12 (4) for a licensed independent clinical social worker, ~~\$90~~ \$45;

342.13 (5) for a temporary license, \$50; and

342.14 (6) for a licensure by endorsement, ~~\$150~~ \$85.

342.15 The fee for criminal background checks is the fee charged by the Bureau of Criminal
342.16 Apprehension. The criminal background check fee must be included with the application
342.17 fee as required pursuant to section 148D.055.

342.18 Sec. 2. Minnesota Statutes 2008, section 148D.180, subdivision 2, is amended to read:

342.19 Subd. 2. **License fees.** License fees are as follows:

342.20 (1) for a licensed social worker, ~~\$115.20~~ \$81;

342.21 (2) for a licensed graduate social worker, ~~\$201.60~~ \$144;

342.22 (3) for a licensed independent social worker, ~~\$302.40~~ \$216;

342.23 (4) for a licensed independent clinical social worker, ~~\$331.20~~ \$238.50;

342.24 (5) for an emeritus license, \$43.20; and

342.25 (6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

342.26 If the licensee's initial license term is less or more than 24 months, the required
342.27 license fees must be prorated proportionately.

342.28 Sec. 3. Minnesota Statutes 2008, section 148D.180, subdivision 3, is amended to read:

342.29 Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

342.30 (1) for a licensed social worker, ~~\$115.20~~ \$81;

342.31 (2) for a licensed graduate social worker, ~~\$201.60~~ \$144;

342.32 (3) for a licensed independent social worker, ~~\$302.40~~ \$216; and

342.33 (4) for a licensed independent clinical social worker, ~~\$331.20~~ \$238.50.

343.1 Sec. 4. Minnesota Statutes 2008, section 148D.180, subdivision 5, is amended to read:

343.2 Subd. 5. **Late fees.** Late fees are as follows:

343.3 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision
343.4 3; and

343.5 (2) supervision plan late fee, \$40.

343.6 Sec. 5. Minnesota Statutes 2008, section 148E.180, subdivision 1, is amended to read:

343.7 Subdivision 1. **Application fees.** Application fees for licensure are as follows:

343.8 (1) for a licensed social worker, \$45;

343.9 (2) for a licensed graduate social worker, \$45;

343.10 (3) for a licensed independent social worker, ~~\$90~~ \$45;

343.11 (4) for a licensed independent clinical social worker, ~~\$90~~ \$45;

343.12 (5) for a temporary license, \$50; and

343.13 (6) for a licensure by endorsement, ~~\$150~~ \$85.

343.14 The fee for criminal background checks is the fee charged by the Bureau of Criminal
343.15 Apprehension. The criminal background check fee must be included with the application
343.16 fee as required according to section 148E.055.

343.17 Sec. 6. Minnesota Statutes 2008, section 148E.180, subdivision 2, is amended to read:

343.18 Subd. 2. **License fees.** License fees are as follows:

343.19 (1) for a licensed social worker, ~~\$115.20~~ \$81;

343.20 (2) for a licensed graduate social worker, ~~\$201.60~~ \$144;

343.21 (3) for a licensed independent social worker, ~~\$302.40~~ \$216;

343.22 (4) for a licensed independent clinical social worker, ~~\$331.20~~ \$238.50;

343.23 (5) for an emeritus license, \$43.20; and

343.24 (6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

343.25 If the licensee's initial license term is less or more than 24 months, the required
343.26 license fees must be prorated proportionately.

343.27 Sec. 7. Minnesota Statutes 2008, section 148E.180, subdivision 3, is amended to read:

343.28 Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

343.29 (1) for a licensed social worker, ~~\$115.20~~ \$81;

343.30 (2) for a licensed graduate social worker, ~~\$201.60~~ \$144;

343.31 (3) for a licensed independent social worker, ~~\$302.40~~ \$216; and

343.32 (4) for a licensed independent clinical social worker, ~~\$331.20~~ \$238.50.

344.1 Sec. 8. Minnesota Statutes 2008, section 148E.180, subdivision 5, is amended to read:

344.2 Subd. 5. **Late fees.** Late fees are as follows:

344.3 (1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision

344.4 3; and

344.5 (2) supervision plan late fee, \$40.

344.6 Sec. 9. Minnesota Statutes 2008, section 152.126, subdivision 1, is amended to read:

344.7 Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this
344.8 subdivision have the meanings given.

344.9 (a) "Board" means the Minnesota State Board of Pharmacy established under
344.10 chapter 151.

344.11 (b) "Controlled substances" means those substances listed in section 152.02,
344.12 subdivisions 3 ~~and 4~~ to 5, and those substances defined by the board pursuant to section
344.13 152.02, subdivisions 7, 8, and 12.

344.14 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
344.15 30. Dispensing does not include the direct administering of a controlled substance to a
344.16 patient by a licensed health care professional.

344.17 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
344.18 pursuant to a valid prescription. For the purposes of this section, a dispenser does not
344.19 include a licensed hospital pharmacy that distributes controlled substances for inpatient
344.20 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

344.21 (e) "Prescriber" means a licensed health care professional who is authorized to
344.22 prescribe a controlled substance under section 152.12, subdivision 1.

344.23 (f) "Prescription" has the meaning given in section 151.01, subdivision 16.

344.24 Sec. 10. Minnesota Statutes 2008, section 152.126, subdivision 2, is amended to read:

344.25 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish
344.26 by January 1, 2010, an electronic system for reporting the information required under
344.27 subdivision 4 for all controlled substances dispensed within the state.

344.28 (b) The board may contract with a vendor for the purpose of obtaining technical
344.29 assistance in the design, implementation, operation, and maintenance of the electronic
344.30 reporting system. ~~The vendor's role shall be limited to providing technical support to the
344.31 board concerning the software, databases, and computer systems required to interface with
344.32 the existing systems currently used by pharmacies to dispense prescriptions and transmit
344.33 prescription data to other third parties.~~

345.1 Sec. 11. Minnesota Statutes 2008, section 152.126, subdivision 6, is amended to read:

345.2 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
345.3 subdivision, the data submitted to the board under subdivision 4 is private data on
345.4 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

345.5 (b) Except as specified in subdivision 5, the following persons shall be considered
345.6 permissible users and may access the data submitted under subdivision 4 in the same or
345.7 similar manner, and for the same or similar purposes, as those persons who are authorized
345.8 to access similar private data on individuals under federal and state law:

345.9 (1) a prescriber, to the extent the information relates specifically to a current patient,
345.10 to whom the prescriber is prescribing or considering prescribing any controlled substance;

345.11 (2) a dispenser, to the extent the information relates specifically to a current patient
345.12 to whom that dispenser is dispensing or considering dispensing any controlled substance;

345.13 (3) an individual who is the recipient of a controlled substance prescription for
345.14 which data was submitted under subdivision 4, or a guardian of the individual, parent or
345.15 guardian of a minor, or health care agent of the individual acting under a health care
345.16 directive under chapter 145C;

345.17 (4) personnel of the board specifically assigned to conduct a bona fide investigation
345.18 of a specific licensee;

345.19 (5) personnel of the board engaged in the collection of controlled substance
345.20 prescription information as part of the assigned duties and responsibilities under this
345.21 section;

345.22 (6) authorized personnel of a vendor under contract with the board who are engaged
345.23 in the design, implementation, operation, and maintenance of the electronic reporting
345.24 system as part of the assigned duties and responsibilities of their employment, provided
345.25 that access to data is limited to the minimum amount necessary to ~~test and maintain the~~
345.26 ~~system databases~~ carry out such duties and responsibilities;

345.27 (7) federal, state, and local law enforcement authorities acting pursuant to a valid
345.28 search warrant; and

345.29 (8) personnel of the medical assistance program assigned to use the data collected
345.30 under this section to identify recipients whose usage of controlled substances may warrant
345.31 restriction to a single primary care physician, a single outpatient pharmacy, or a single
345.32 hospital.

345.33 For purposes of clause (3), access by an individual includes persons in the definition
345.34 of an individual under section 13.02.

345.35 (c) Any permissible user identified in paragraph (b), who directly accesses
345.36 the data electronically, shall implement and maintain a comprehensive information

346.1 security program that contains administrative, technical, and physical safeguards that
346.2 are appropriate to the user's size and complexity, and the sensitivity of the personal
346.3 information obtained. The permissible user shall identify reasonably foreseeable internal
346.4 and external risks to the security, confidentiality, and integrity of personal information
346.5 that could result in the unauthorized disclosure, misuse, or other compromise of the
346.6 information and assess the sufficiency of any safeguards in place to control the risks.

346.7 (d) The board shall not release data submitted under this section unless it is provided
346.8 with evidence, satisfactory to the board, that the person requesting the information is
346.9 entitled to receive the data.

346.10 (e) The board shall not release the name of a prescriber without the written consent
346.11 of the prescriber or a valid search warrant or court order. The board shall provide a
346.12 mechanism for a prescriber to submit to the board a signed consent authorizing the release
346.13 of the prescriber's name when data containing the prescriber's name is requested.

346.14 (f) The board shall maintain a log of all persons who access the data and shall ensure
346.15 that any permissible user complies with paragraph (c) prior to attaining direct access to
346.16 the data.

346.17 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into
346.18 pursuant to subdivision 2. A vendor shall not use data collected under this section for
346.19 any purpose not specified in this section.

346.20 Sec. 12. **REPEALER.**

346.21 Minnesota Statutes 2008, section 148D.180, subdivision 8, is repealed.

346.22 **ARTICLE 12**

346.23 **HUMAN SERVICES FORECAST ADJUSTMENTS**

346.24 Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
346.25 **SERVICES FORECAST ADJUSTMENT.**

346.26 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
346.27 from the appropriations in Laws 2008, chapter 363, from the general fund, or any other
346.28 fund named, to the Department of Human Services for the purposes specified in this
346.29 article, to be available for the fiscal year indicated for each purpose. The figure "2009"
346.30 used in this article means that the appropriation or appropriations listed are available
346.31 for the fiscal year ending June 30, 2009.

346.32 Sec. 2. **COMMISSIONER OF HUMAN**
346.33 **SERVICES**

347.1	<u>Subdivision 1. Total Appropriation</u>	<u>\$ (478,994,000)</u>
347.2	<u>Appropriations by Fund</u>	
347.3	<u>2009</u>	
347.4	<u>General</u>	<u>(445,130,000)</u>
347.5	<u>Health Care Access</u>	<u>(19,460,000)</u>
347.6	<u>Federal TANF</u>	<u>(14,404,000)</u>
347.7	<u>Subd. 2. Revenue and Pass-Through</u>	
347.8	<u>Federal TANF</u>	<u>1,107,000</u>
347.9	<u>Subd. 3. Children and Economic Assistance</u>	
347.10	<u>Grants</u>	
347.11	<u>General</u>	<u>27,002,000</u>
347.12	<u>Federal TANF</u>	<u>(16,211,000)</u>
347.13	<u>The amounts that may be spent from this</u>	
347.14	<u>appropriation for each purpose are as follows:</u>	
347.15	<u>(a) MFIP/DWP Grants</u>	
347.16	<u>General</u>	<u>17,530,000</u>
347.17	<u>Federal TANF</u>	<u>(16,211,000)</u>
347.18	<u>(b) MFIP Child Care Assistance Grants</u>	<u>4,933,000</u>
347.19	<u>(c) General Assistance Grants</u>	<u>1,458,000</u>
347.20	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>513,000</u>
347.21	<u>(e) Group Residential Housing Grants</u>	<u>2,568,000</u>
347.22	<u>Subd. 4. Basic Health Care Grants</u>	
347.23	<u>General</u>	<u>(224,341,000)</u>
347.24	<u>Health Care Access</u>	<u>(19,460,000)</u>

348.1 The amounts that may be spent from this
 348.2 appropriation for each purpose are as follows:

348.3 **(a) MinnesotaCare**

348.4 Health Care Access (19,460,000)

348.5 **(b) MA Basic Health Care - Families and**

348.6 **Children** (100,055,000)

348.7 **(c) MA Basic Health Care - Elderly and**

348.8 **Disabled** (136,795,000)

348.9 **(d) General Assistance Medical Care** 12,539,000

348.10 **Subd. 5. Continuing Care Grants** (247,791,000)

348.11 The amounts that may be spent from this
 348.12 appropriation for each purpose are as follows:

348.13 **(a) MA Long-Term Care Facilities** (59,204,000)

348.14 **(b) MA Long-Term Care Waivers** (168,927,000)

348.15 **(c) Chemical Dependency Entitlement Grants** (19,660,000)

348.16 **Sec. 3. EFFECTIVE DATE.**

348.17 Sections 1 and 2 are effective the day following final enactment.

348.18 **ARTICLE 13**
 348.19 **APPROPRIATIONS**

348.20 **Section 1. SUMMARY OF APPROPRIATIONS.**

348.21 The amounts shown in this section summarize direct appropriations by fund made
 348.22 in this article.

348.23	<u>2010</u>	<u>2011</u>	<u>Total</u>
348.24 <u>General</u>	\$ <u>4,452,323,000</u>	\$ <u>5,280,470,000</u>	\$ <u>9,732,793,000</u>
348.25 <u>State Government Special</u>			
348.26 <u>Revenue</u>	<u>62,451,000</u>	<u>61,515,000</u>	<u>123,966,000</u>

349.1	<u>Health Care Access</u>	<u>489,995,000</u>	<u>568,298,000</u>	<u>1,058,293,000</u>
349.2	<u>Federal TANF</u>	<u>301,220,000</u>	<u>268,711,000</u>	<u>569,931,000</u>
349.3	<u>Lottery Prize</u>	<u>1,665,000</u>	<u>1,665,000</u>	<u>3,330,000</u>
349.4	<u>Federal Fund</u>	<u>110,000,000</u>	<u>0</u>	<u>110,000,000</u>
349.5	<u>Total</u>	<u>\$ 5,417,704,000</u>	<u>\$ 6,180,659,000</u>	<u>\$ 11,598,363,000</u>

349.6 **Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATION.**

349.7 The sums shown in the columns marked "Appropriations" are appropriated to the
 349.8 agencies and for the purposes specified in this article. The appropriations are from the
 349.9 general fund, or another named fund, and are available for the fiscal years indicated
 349.10 for each purpose. The figures "2010" and "2011" used in this article mean that the
 349.11 appropriations listed under them are available for the fiscal year ending June 30, 2010, or
 349.12 June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal
 349.13 year 2011. "The biennium" is fiscal years 2010 and 2011. Appropriations for the fiscal
 349.14 year ending June 30, 2009, are effective the day following final enactment.

349.15		<u>APPROPRIATIONS</u>	
349.16		<u>Available for the Year</u>	
349.17		<u>Ending June 30</u>	
349.18		<u>2010</u>	<u>2011</u>

349.19 **Sec. 3. HUMAN SERVICES**

349.20	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 5,230,100,000</u>	<u>\$ 5,997,715,000</u>
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349.21 Appropriations by Fund

349.22		<u>2010</u>	<u>2011</u>
349.23	<u>General</u>	<u>4,376,839,000</u>	<u>5,211,018,000</u>
349.24	<u>State Government</u>		
349.25	<u>Special Revenue</u>	<u>1,315,000</u>	<u>565,000</u>
349.26	<u>Health Care Access</u>	<u>450,792,000</u>	<u>527,489,000</u>
349.27	<u>Federal TANF</u>	<u>289,487,000</u>	<u>256,978,000</u>
349.28	<u>Lottery Prize</u>	<u>1,665,000</u>	<u>1,665,000</u>
349.29	<u>Federal Fund</u>	<u>110,000,000</u>	<u>0</u>

350.1 **Receipts for Systems Projects.**
350.2 Appropriations and federal receipts for
350.3 information systems projects for MAXIS,
350.4 PRISM, MMIS, and SSIS must be deposited
350.5 in the state system account authorized in
350.6 Minnesota Statutes, section 256.014. Money
350.7 appropriated for computer projects approved
350.8 by the Minnesota Office of Enterprise
350.9 Technology, funded by the legislature, and
350.10 approved by the commissioner of finance,
350.11 may be transferred from one project to
350.12 another and from development to operations
350.13 as the commissioner of human services
350.14 considers necessary, except that any transfers
350.15 to one project that exceed \$1,000,000 or
350.16 multiple transfers to one project that exceed
350.17 \$1,000,000 in total require the express
350.18 approval of the legislature. The preceding
350.19 requirement for legislative approval does not
350.20 apply to transfers made to establish a project's
350.21 initial operating budget each year; instead,
350.22 the requirements of section 11, subdivision 2,
350.23 of this article apply to those transfers. Any
350.24 unexpended balance in the appropriation
350.25 for these projects does not cancel but is
350.26 available for ongoing development and
350.27 operations. Any computer project with a
350.28 total cost exceeding \$1,000,000, including,
350.29 but not limited to, a replacement for the
350.30 proposed HealthMatch system, shall not be
350.31 commenced without the express approval of
350.32 the legislature.

350.33 **HealthMatch Systems Project.** In fiscal
350.34 year 2010, \$3,054,000 shall be transferred
350.35 from the HealthMatch account in the state

351.1 systems account in the special revenue fund
351.2 to the general fund.

351.3 **Nonfederal Share Transfers.** The
351.4 nonfederal share of activities for which
351.5 federal administrative reimbursement is
351.6 appropriated to the commissioner may be
351.7 transferred to the special revenue fund.

351.8 **TANF Maintenance of Effort.**

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

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

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

351.25 (3) state and county MFIP administrative
351.26 costs under Minnesota Statutes, chapters
351.27 256J and 256K;

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

351.31 (5) expenditures made on behalf of
351.32 noncitizen MFIP recipients who qualify
351.33 for the medical assistance without federal
351.34 financial participation program under

352.1 Minnesota Statutes, section 256B.06,
352.2 subdivision 4, paragraphs (d), (e), and (j);
352.3 and
352.4 (6) qualifying working family credit
352.5 expenditures under Minnesota Statutes,
352.6 section 290.0671.

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

352.16 (c) For fiscal years beginning with state
352.17 fiscal year 2003, the commissioner shall
352.18 ensure that the maintenance of effort used
352.19 by the commissioner of finance for the
352.20 February and November forecasts required
352.21 under Minnesota Statutes, section 16A.103,
352.22 contains expenditures under paragraph (a),
352.23 clause (1), equal to at least 16 percent of
352.24 the total required under Code of Federal
352.25 Regulations, title 45, section 263.1.

352.26 (d) For the federal fiscal years beginning on
352.27 or after October 1, 2007, the commissioner
352.28 may not claim an amount of TANF/MOE in
352.29 excess of the 75 percent standard in Code
352.30 of Federal Regulations, title 45, section
352.31 263.1(a)(2), except:

352.32 (1) to the extent necessary to meet the 80
352.33 percent standard under Code of Federal
352.34 Regulations, title 45, section 263.1(a)(1),
352.35 if it is determined by the commissioner

353.1 that the state will not meet the TANF work
353.2 participation target rate for the current year;

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

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

353.14 For the purposes of clauses (1) to (3),
353.15 the commissioner may supplement the
353.16 MOE claim with working family credit
353.17 expenditures to the extent such expenditures
353.18 or other qualified expenditures are otherwise
353.19 available after considering the expenditures
353.20 allowed in this section.

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

353.27 (f) Notwithstanding any contrary provision
353.28 in this article, this provision expires June 30,
353.29 2013.

353.30 **Working Family Credit Expenditures as**
353.31 **TANF/MOE.** The commissioner may claim
353.32 as TANF/MOE up to \$6,707,000 per year of
353.33 working family credit expenditures for fiscal
353.34 year 2010 through fiscal year 2011.

- 354.1 **Working Family Credit Expenditures**
354.2 **to be Claimed for TANF/MOE.** The
354.3 commissioner may count the following
354.4 amounts of working family credit expenditure
354.5 as TANF/MOE:
- 354.6 (1) fiscal year 2010, \$30,217,000;
354.7 (2) fiscal year 2011, \$55,596,000;
354.8 (3) fiscal year 2012, \$28,519,000; and
354.9 (4) fiscal year 2013, \$22,138,000.
- 354.10 Notwithstanding any contrary provision in
354.11 this article, this rider expires June 30, 2013.
- 354.12 **TANF Transfer to Federal Child Care**
354.13 **and Development Fund.** The following
354.14 TANF fund amounts are appropriated to the
354.15 commissioner for the purposes of MFIP and
354.16 transition year child care under Minnesota
354.17 Statutes, section 119B.05:
- 354.18 (1) fiscal year 2010, \$5,909,000;
354.19 (2) fiscal year 2011, \$9,808,000;
354.20 (3) fiscal year 2012, \$10,826,000; and
354.21 (4) fiscal year 2013, \$4,026,000.
- 354.22 The commissioner shall authorize the
354.23 transfer of sufficient TANF funds to the
354.24 federal child care and development fund to
354.25 meet this appropriation and shall ensure that
354.26 all transferred funds are expended according
354.27 to federal child care and development fund
354.28 regulations.
- 354.29 **Food Stamps Employment and Training.**
354.30 (a) The commissioner shall apply for and
354.31 claim the maximum allowable federal
354.32 matching funds under United States Code,

355.1 title 7, section 2025, paragraph (h), for
355.2 state expenditures made on behalf of family
355.3 stabilization services participants voluntarily
355.4 engaged in food stamp employment and
355.5 training activities, where appropriate.

355.6 (b) Notwithstanding Minnesota Statutes,
355.7 sections 256D.051, subdivisions 1a, 6b,
355.8 and 6c, and 256J.626, federal food stamps
355.9 employment and training funds received
355.10 as reimbursement of MFIP consolidated
355.11 fund grant expenditures for diversionary
355.12 work program participants and child
355.13 care assistance program expenditures for
355.14 two-parent families must be deposited in the
355.15 general fund. The amount of funds must be
355.16 limited to \$3,350,000 in fiscal year 2010
355.17 and \$4,440,000 in fiscal years 2011 through
355.18 2013, contingent on approval by the federal
355.19 Food and Nutrition Service.

355.20 (c) Consistent with the receipt of these federal
355.21 funds, the commissioner may adjust the
355.22 level of working family credit expenditures
355.23 claimed as TANF maintenance of effort.
355.24 Notwithstanding any contrary provision in
355.25 this article, this rider expires June 30, 2013.

355.26 **ARRA Food Support Administration.**
355.27 The funds available for food support
355.28 administration under the American Recovery
355.29 and Reinvestment Act (ARRA) of 2009
355.30 are appropriated to the commissioner
355.31 to pay actual costs of implementing the
355.32 food support benefit increases, increased
355.33 eligibility determinations, and outreach. Of
355.34 these funds, 20 percent shall be allocated
355.35 to the commissioner and 80 percent shall

356.1 be allocated to counties. The commissioner
356.2 shall allocate the county portion based on
356.3 caseload. Reimbursement shall be based on
356.4 actual costs reported by counties through
356.5 existing processes. Tribal reimbursement
356.6 must be made from the state portion based
356.7 on a caseload factor equivalent to that of a
356.8 county.

356.9 **ARRA Food Support Benefit Increases.**
356.10 The funds provided for food support benefit
356.11 increases under the Supplemental Nutrition
356.12 Assistance Program provisions of the
356.13 American Recovery and Reinvestment Act
356.14 (ARRA) of 2009 must be used for benefit
356.15 increases beginning July 1, 2009.

356.16 **Emergency Fund for the TANF Program.**
356.17 TANF Emergency Contingency funds
356.18 available under the American Recovery
356.19 and Reinvestment Act of 2009 (Public Law
356.20 111-5) are appropriated to the commissioner.
356.21 The commissioner must request TANF
356.22 Emergency Contingency funds from the
356.23 Secretary of the Department of Health
356.24 and Human Services to the extent the
356.25 commissioner meets or expects to meet the
356.26 requirements of section 403(c) of the Social
356.27 Security Act. The commissioner must seek
356.28 to maximize such grants. The funds received
356.29 must be used as appropriated. Each county
356.30 must maintain the county's current level of
356.31 emergency assistance funding under the
356.32 MFIP consolidated fund and use the funds
356.33 under this paragraph to supplement existing
356.34 emergency assistance funding levels.

356.35 **Subd. 2. Agency Management**

357.1 The amounts that may be spent from the
 357.2 appropriation for each purpose are as follows:

357.3 **(a) Financial Operations**

357.4	<u>Appropriations by Fund</u>		
357.5	<u>General</u>	<u>3,380,000</u>	<u>3,908,000</u>
357.6	<u>Health Care Access</u>	<u>1,281,000</u>	<u>1,016,000</u>
357.7	<u>Federal TANF</u>	<u>122,000</u>	<u>122,000</u>

357.8 **(b) Legal and Regulatory Operations**

357.9	<u>Appropriations by Fund</u>		
357.10	<u>General</u>	<u>13,749,000</u>	<u>13,534,000</u>
357.11	<u>State Government</u>		
357.12	<u>Special Revenue</u>	<u>440,000</u>	<u>440,000</u>
357.13	<u>Health Care Access</u>	<u>943,000</u>	<u>943,000</u>
357.14	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

357.15 **(c) Management Operations**

357.16	<u>Appropriations by Fund</u>		
357.17	<u>General</u>	<u>4,334,000</u>	<u>4,562,000</u>
357.18	<u>Health Care Access</u>	<u>242,000</u>	<u>242,000</u>

357.19 **Lease Cost Reduction.** Base level funding
 357.20 to the commissioner shall be reduced by
 357.21 \$381,000 in fiscal year 2010, and \$153,000
 357.22 in fiscal year 2011, to reflect a reduction in
 357.23 lease costs related to the Minnehaha Avenue
 357.24 building.

357.25 **Base Adjustment.** The general fund base is
 357.26 increased by \$153,000 in each of fiscal years
 357.27 2012 and 2013.

357.28 **(d) Information Technology Operations**

358.1	<u>Appropriations by Fund</u>		
358.2	<u>General</u>	<u>28,077,000</u>	<u>28,077,000</u>
358.3	<u>Health Care Access</u>	<u>4,856,000</u>	<u>4,868,000</u>
358.4	<u>Subd. 3. Revenue and Pass-Through Revenue</u>		
358.5	<u>Expenditures</u>	<u>65,746,000</u>	<u>67,068,000</u>

358.6 This appropriation is from the federal TANF
 358.7 fund.

358.8 **Subd. 4. Children and Economic Assistance**
 358.9 **Grants**

358.10 The amounts that may be spent from this
 358.11 appropriation for each purpose are as follows:

358.12 **(a) MFIP/DWP Grants**

358.13	<u>Appropriations by Fund</u>		
358.14	<u>General</u>	<u>63,205,000</u>	<u>89,033,000</u>
358.15	<u>Federal TANF</u>	<u>100,404,000</u>	<u>85,789,000</u>

358.16 **(b) Support Services Grants**

358.17	<u>Appropriations by Fund</u>		
358.18	<u>General</u>	<u>8,715,000</u>	<u>12,498,000</u>
358.19	<u>Federal TANF</u>	<u>121,257,000</u>	<u>102,757,000</u>

358.20 **MFIP Consolidated Fund.** The MFIP
 358.21 consolidated fund TANF appropriation is
 358.22 reduced by \$1,854,000 in fiscal year 2011
 358.23 and fiscal year 2012.

358.24 Notwithstanding Minnesota Statutes, section
 358.25 256J.626, subdivision 8, paragraph (b), the
 358.26 commissioner shall reduce proportionately
 358.27 the reimbursement to counties for
 358.28 administrative expenses.

359.1 **Subsidized Employment Funding Through**

359.2 **ARRA.** The commissioner is authorized to
359.3 apply for TANF emergency fund grants for
359.4 subsidized employment activities. Growth
359.5 in expenditures for subsidized employment
359.6 within the supported work program and the
359.7 MFIP consolidated fund over the amount
359.8 expended in the calendar quarters in the
359.9 TANF emergency fund base year shall be
359.10 used to leverage the TANF emergency fund
359.11 grants for subsidized employment and to
359.12 fund supported work. The commissioner
359.13 shall develop procedures to maximize
359.14 reimbursement of these expenditures over the
359.15 TANF emergency fund base year quarters,
359.16 and may contract directly with employers
359.17 and providers to maximize these TANF
359.18 emergency fund grants.

359.19 **Supported Work.** Of the TANF
359.20 appropriation, \$6,400,000 in fiscal year
359.21 2011 is to the commissioner for supported
359.22 work for MFIP recipients and is available
359.23 until expended. Supported work includes
359.24 paid transitional work experience and
359.25 a continuum of employment assistance,
359.26 including outreach and recruitment,
359.27 program orientation and intake, testing and
359.28 assessment, job development and marketing,
359.29 preworksite training, supported worksite
359.30 experience, job coaching, and postplacement
359.31 follow-up, in addition to extensive case
359.32 management and referral services.

359.33 **Base Adjustment.** The general fund base
359.34 is reduced by \$3,783,000 in each of fiscal
359.35 years 2012 and 2013. The TANF fund base

360.1 is increased by \$9,704,000 in each of fiscal
 360.2 years 2012 and 2013.

360.3 **Integrated Services Program Funding.**

360.4 The TANF appropriation for integrated
 360.5 services program funding is \$1,250,000 in
 360.6 fiscal year 2010 and \$2,500,000 in fiscal year
 360.7 2011.

360.8 **TANF Emergency Fund; Nonrecurrent**

360.9 **Short-Term Benefits.** TANF emergency
 360.10 contingency fund grants received due to
 360.11 increases in expenditures for nonrecurrent
 360.12 short-term benefits must be used to offset the
 360.13 increase in these expenditures for counties
 360.14 under the MFIP consolidated fund, under
 360.15 Minnesota Statutes, section 256J.626,
 360.16 and the diversionary work program. The
 360.17 commissioner shall develop procedures
 360.18 to maximize reimbursement of these
 360.19 expenditures over the TANF emergency fund
 360.20 base year quarters. Growth in expenditures
 360.21 for the diversionary work program over the
 360.22 amount expended in the calendar quarters in
 360.23 the TANF emergency fund base year shall be
 360.24 used to leverage these funds.

360.25 **(c) MFIP Child Care Assistance Grants**

360.26	<u>Appropriations by Fund</u>		
360.27	<u>General</u>	<u>61,171,000</u>	<u>65,214,000</u>
360.28	<u>Federal TANF</u>	<u>1,022,000</u>	<u>406,000</u>

360.29 **ARRA Child Care Development Block**

360.30 **Grant Funds.** The funds available from the
 360.31 child care development block grant under
 360.32 ARRA must be used for MFIP child care to
 360.33 the extent that those funds are not earmarked

361.1 for quality expansion or to improve the
 361.2 quality of infant and toddler care.

361.3 **Acceleration of ARRA Child Care and**
 361.4 **Development Fund Expenditure.** The
 361.5 commissioner must liquidate all child care
 361.6 and development money available under
 361.7 the American Recovery and Reinvestment
 361.8 Act (ARRA) of 2009, Public Law 111-5,
 361.9 by September 30, 2010. In order to expend
 361.10 those funds by September 30, 2010, the
 361.11 commissioner may redesignate and expend
 361.12 the ARRA child care and development funds
 361.13 appropriated in fiscal year 2011 for purposes
 361.14 under this section for related purposes that
 361.15 will allow liquidation by September 30,
 361.16 2010. Child care and development funds
 361.17 otherwise available to the commissioner
 361.18 for those related purposes shall be used to
 361.19 fund the purposes from which the ARRA
 361.20 child care and development funds had been
 361.21 redesignated.

361.22 **(d) Basic Sliding Fee Child Care Assistance**

361.23	<u>Grants</u>	<u>40,104,000</u>	<u>45,096,000</u>
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361.24 **Base Adjustment.** The general fund base is
 361.25 decreased by \$260,000 in each of fiscal years
 361.26 2012 and 2013.

361.27 **School Readiness Service Agreements.**
 361.28 \$261,000 in fiscal year 2010 and \$261,000
 361.29 in fiscal year 2011 are from the federal
 361.30 child care development funds received from
 361.31 the American Recovery and Reinvestment
 361.32 Act of 2009, Public Law 111-5, to the
 361.33 commissioner of human services consistent
 361.34 with federal regulations for the purpose of

362.1 school readiness service agreements under
362.2 Minnesota Statutes, section 119B.231. This
362.3 is a onetime appropriation. Any unexpended
362.4 balance the first year is available in the
362.5 second year.

362.6 **Child Care Development Fund**

362.7 **Unexpended Balance.** In addition to
362.8 the amount provided in this section, the
362.9 commissioner shall expend \$5,244,000 in
362.10 fiscal year 2010 from the federal child care
362.11 development fund unexpended balance
362.12 for basic sliding fee child care under
362.13 Minnesota Statutes, section 119B.03. The
362.14 commissioner shall ensure that all child
362.15 care and development funds are expended
362.16 according to the federal child care and
362.17 development fund regulations.

362.18 **Basic Sliding Fee.** \$7,045,000 in fiscal year
362.19 2010 and \$6,974,000 in fiscal year 2011 are
362.20 from the federal child care development
362.21 funds received from the American Recovery
362.22 and Reinvestment Act of 2009, Public
362.23 Law 111-5, to the commissioner of human
362.24 services consistent with federal regulations
362.25 for the purpose of basic sliding fee child care
362.26 assistance under Minnesota Statutes, section
362.27 119B.03. This is a onetime appropriation.
362.28 Any unexpended balance the first year is
362.29 available in the second year.

362.30 **Basic Sliding Fee Allocation for Calendar**

362.31 **Year 2010.** Notwithstanding Minnesota
362.32 Statutes, section 119B.03, subdivision 6,
362.33 in calendar year 2010, basic sliding fee
362.34 funds shall be distributed according to
362.35 this provision. Funds shall be allocated

363.1 first in amounts equal to each county's
363.2 guaranteed floor, according to Minnesota
363.3 Statutes, section 119B.03, subdivision 8,
363.4 with any remaining available funds allocated
363.5 according to the following formula:

363.6 (a) Up to one-fourth of the funds shall be
363.7 allocated in proportion to the number of
363.8 families participating in the transition year
363.9 child care program as reported during and
363.10 averaged over the most recent six months
363.11 completed at the time of the notice of
363.12 allocation. Funds in excess of the amount
363.13 necessary to serve all families in this category
363.14 shall be allocated according to paragraph (d).

363.15 (b) Up to three-fourths of the funds shall
363.16 be allocated in proportion to the average
363.17 of each county's most recent six months of
363.18 reported waiting list as defined in Minnesota
363.19 Statutes, section 119B.03, subdivision 2, and
363.20 the reinstatement list of those families whose
363.21 assistance was terminated with the approval
363.22 of the commissioner under Minnesota Rules,
363.23 part 3400.0183, subpart 1. Funds in excess
363.24 of the amount necessary to serve all families
363.25 in this category shall be allocated according
363.26 to paragraph (d).

363.27 (c) The amount necessary to serve all families
363.28 in paragraphs (a) and (b) shall be calculated
363.29 based on the basic sliding fee average cost of
363.30 care per family in the county with the highest
363.31 cost in the most recently completed calendar
363.32 year.

363.33 (d) Funds in excess of the amount necessary
363.34 to serve all families in paragraphs (a) and
363.35 (b) shall be allocated in proportion to each

364.1 county's total expenditures for the basic
 364.2 sliding fee child care program reported
 364.3 during the most recent fiscal year completed
 364.4 at the time of the notice of allocation. To
 364.5 the extent that funds are available, and
 364.6 notwithstanding Minnesota Statutes, section
 364.7 119B.03, subdivision 8, for the period
 364.8 January 1, 2011, to December 31, 2011, each
 364.9 county's guaranteed floor must be equal to its
 364.10 original calendar year 2010 allocation.

364.11	<u>(e) Child Care Development Grants</u>	<u>1,487,000</u>	<u>1,487,000</u>
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364.12 **Family, friends, and neighbor grants.**
 364.13 \$375,000 in fiscal year 2010 and \$375,000
 364.14 in fiscal year 2011 are from the child
 364.15 care development fund required targeted
 364.16 quality funds for quality expansion and
 364.17 infant/toddler from the American Recovery
 364.18 and Reinvestment Act of 2009, Public
 364.19 Law 111-5, to the commissioner of human
 364.20 services for family, friends, and neighbor
 364.21 grants under Minnesota Statutes, section
 364.22 119B.232. This appropriation may be used
 364.23 on programs receiving family, friends, and
 364.24 neighbor grant funds as of June 30, 2009,
 364.25 or on new programs or projects. This is a
 364.26 onetime appropriation. Any unexpended
 364.27 balance the first year is available in the
 364.28 second year.

364.29 **Voluntary quality rating system training,**
 364.30 **coaching, consultation, and supports.**
 364.31 \$633,000 in fiscal year 2010 and \$633,000
 364.32 in fiscal year 2011 are from the federal child
 364.33 care development fund required targeted
 364.34 quality funds for quality expansion and
 364.35 infant/toddler from the American Recovery

365.1 and Reinvestment Act of 2009, Public
 365.2 Law 111-5, to the commissioner of human
 365.3 services consistent with federal regulations
 365.4 for the purpose of providing grants to provide
 365.5 statewide child-care provider training,
 365.6 coaching, consultation, and supports to
 365.7 prepare for the voluntary Minnesota quality
 365.8 rating system rating tool. This is a onetime
 365.9 appropriation. Any unexpended balance the
 365.10 first year is available in the second year.

365.11 **Voluntary quality rating system. \$184,000**
 365.12 in fiscal year 2010 and \$1,200,000 in fiscal
 365.13 year 2011 are from the federal child care
 365.14 development fund required targeted funds for
 365.15 quality expansion and infant/toddler from the
 365.16 American Recovery and Reinvestment Act of
 365.17 2009, Public Law 111-5, to the commissioner
 365.18 of human services consistent with federal
 365.19 regulations for the purpose of implementing
 365.20 the voluntary Parent Aware quality star
 365.21 rating system pilot in coordination with the
 365.22 Minnesota Early Learning Foundation. The
 365.23 appropriation for the first year is to complete
 365.24 and promote the voluntary Parent Aware
 365.25 quality rating system pilot program through
 365.26 June 30, 2010, and the appropriation for the
 365.27 second year is to continue the voluntary
 365.28 Minnesota quality rating system pilot
 365.29 through June 30, 2011. This is a onetime
 365.30 appropriation. Any unexpended balance the
 365.31 first year is available in the second year.

365.32 **(f) Child Support Enforcement Grants** 3,705,000 3,705,000

365.33 **(g) Children's Services Grants**

366.1	<u>Appropriations by Fund</u>		
366.2	<u>General</u>	<u>48,333,000</u>	<u>50,498,000</u>
366.3	<u>Federal TANF</u>	<u>340,000</u>	<u>240,000</u>
366.4	<u>Base Adjustment.</u> The general fund base is		
366.5	<u>decreased by \$5,371,000 in fiscal year 2012</u>		
366.6	<u>and increased \$8,737,000 in fiscal year 2013.</u>		
366.7	<u>Privatized Adoption Grants.</u> Federal		
366.8	<u>reimbursement for privatized adoption grant</u>		
366.9	<u>and foster care recruitment grant expenditures</u>		
366.10	<u>is appropriated to the commissioner for</u>		
366.11	<u>adoption grants and foster care and adoption</u>		
366.12	<u>administrative purposes.</u>		
366.13	<u>Adoption Assistance Incentive Grants.</u>		
366.14	<u>Federal funds available during fiscal year</u>		
366.15	<u>2010 and fiscal year 2011 for the adoption</u>		
366.16	<u>incentive grants are appropriated to the</u>		
366.17	<u>commissioner for these purposes.</u>		
366.18	<u>Adoption Assistance and Relative Custody</u>		
366.19	<u>Assistance.</u> The commissioner may transfer		
366.20	<u>unencumbered appropriation balances for</u>		
366.21	<u>adoption assistance and relative custody</u>		
366.22	<u>assistance between fiscal years and between</u>		
366.23	<u>programs.</u>		
366.24	<u>(h) Children and Community Services Grants</u>	<u>67,663,000</u>	<u>67,542,000</u>
366.25	<u>Targeted Case Management Temporary</u>		
366.26	<u>Funding Adjustment.</u> The commissioner		
366.27	<u>shall recover from each county and tribe</u>		
366.28	<u>receiving a targeted case management</u>		
366.29	<u>temporary funding payment in fiscal year</u>		
366.30	<u>2008 an amount equal to that payment. The</u>		
366.31	<u>commissioner shall recover one-half of the</u>		
366.32	<u>funds by February 1, 2010, and the remainder</u>		
366.33	<u>by February 1, 2011. At the commissioner's</u>		

367.1 discretion and at the request of a county
 367.2 or tribe, the commissioner may revise
 367.3 the payment schedule, but full payment
 367.4 must not be delayed beyond May 1, 2011.
 367.5 The commissioner may use the recovery
 367.6 procedure under Minnesota Statutes, section
 367.7 256.017, to recover the funds. Recovered
 367.8 funds must be deposited into the general
 367.9 fund.

367.10 <u>(i) General Assistance Grants</u>	<u>48,215,000</u>	<u>48,608,000</u>
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367.11 **General Assistance Standard.** The
 367.12 commissioner shall set the monthly standard
 367.13 of assistance for general assistance units
 367.14 consisting of an adult recipient who is
 367.15 childless and unmarried or living apart
 367.16 from parents or a legal guardian at \$203.
 367.17 The commissioner may reduce this amount
 367.18 according to Laws 1997, chapter 85, article
 367.19 3, section 54.

367.20 **Emergency General Assistance.** The
 367.21 amount appropriated for emergency general
 367.22 assistance funds is limited to no more
 367.23 than \$7,889,812 in fiscal year 2010 and
 367.24 \$7,889,812 in fiscal year 2011. Funds
 367.25 to counties must be allocated by the
 367.26 commissioner using the allocation method
 367.27 specified in Minnesota Statutes, section
 367.28 256D.06.

367.29 <u>(j) Minnesota Supplemental Aid Grants</u>	<u>33,930,000</u>	<u>35,191,000</u>
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367.30 **Emergency Minnesota Supplemental**
 367.31 **Aid Funds.** The amount appropriated for
 367.32 emergency Minnesota supplemental aid
 367.33 funds is limited to no more than \$1,100,000
 367.34 in fiscal year 2010 and \$1,100,000 in fiscal

368.1 year 2011. Funds to counties must be
 368.2 allocated by the commissioner using the
 368.3 allocation method specified in Minnesota
 368.4 Statutes, section 256D.46.

368.5 <u>(k) Group Residential Housing Grants</u>	<u>111,778,000</u>	<u>114,034,000</u>
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368.6 **Group Residential Housing Costs**

368.7 **Refinanced.** (a) Effective July 1, 2011, the
 368.8 commissioner shall increase the home and
 368.9 community-based service rates and county
 368.10 allocations provided to programs for persons
 368.11 with disabilities established under section
 368.12 1915(c) of the Social Security Act to the
 368.13 extent that these programs will be paying
 368.14 for the costs above the rate established
 368.15 in Minnesota Statutes, section 256I.05,
 368.16 subdivision 1.

368.17 (b) For persons receiving services under
 368.18 Minnesota Statutes, section 245A.02, who
 368.19 reside in licensed adult foster care beds
 368.20 for which a difficulty of care payment
 368.21 was being made under Minnesota Statutes,
 368.22 section 256I.05, subdivision 1c, paragraph
 368.23 (b), counties may request an exception to
 368.24 the individual's service authorization not to
 368.25 exceed the difference between the client's
 368.26 monthly service expenditures plus the
 368.27 amount of the difficulty of care payment.

368.28 <u>(l) Children's Mental Health Grants</u>	<u>16,885,000</u>	<u>16,882,000</u>
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368.29 **Funding Usage.** Up to 75 percent of a fiscal
 368.30 year's appropriation for children's mental
 368.31 health grants may be used to fund allocations
 368.32 in that portion of the fiscal year ending
 368.33 December 31.

369.1 **(m) Other Children and Economic Assistance**

369.2	<u>Grants</u>	<u>16,047,000</u>	<u>15,339,000</u>
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369.3 **Fraud Prevention Grants.** Of this
 369.4 appropriation, \$379,000 in fiscal year 2010
 369.5 and \$379,000 in fiscal year 2011 is to the
 369.6 commissioner for fraud prevention grants to
 369.7 counties.

369.8 **Homeless and Runaway Youth.** \$218,000
 369.9 in fiscal year 2010 is for the Runaway
 369.10 and Homeless Youth Act under Minnesota
 369.11 Statutes, section 256K.45. Funds shall be
 369.12 spent in each area of the continuum of care
 369.13 to ensure that programs are meeting the
 369.14 greatest need. Any unexpended balance in
 369.15 the first year is available in the second year.
 369.16 Beginning July 1, 2011, the base is increased
 369.17 by \$119,000 each year.

369.18 **ARRA Homeless Youth Funds.** To the
 369.19 extent permitted under federal law, the
 369.20 commissioner shall designate \$2,500,000
 369.21 of the Homeless Prevention and Rapid
 369.22 Re-Housing Program funds provided under
 369.23 the American Recovery and Reinvestment
 369.24 Act of 2009, Public Law 111-5, for agencies
 369.25 providing homelessness prevention and rapid
 369.26 rehousing services to youth.

369.27 **Supportive Housing Services.** \$1,500,000
 369.28 each year is for supportive services under
 369.29 Minnesota Statutes, section 256K.26. This is
 369.30 a onetime appropriation. Beginning in fiscal
 369.31 year 2012, the base is increased by \$68,000
 369.32 per year.

369.33 **Community Action Grants.** Community
 369.34 action grants are reduced one time by

370.1 \$1,764,000 each year. This reduction is due
370.2 to the availability of federal funds under the
370.3 American Recovery and Reinvestment Act.

370.4 **Base Adjustment.** The general fund base
370.5 is increased by \$773,000 in fiscal year 2012
370.6 and \$773,000 in fiscal year 2013.

370.7 **Federal ARRA Funds for Existing**
370.8 **Programs.** (a) Federal funds received by the
370.9 commissioner for the emergency food and
370.10 shelter program from the American Recovery
370.11 and Reinvestment Act of 2009, Public
370.12 Law 111-5, but not previously approved
370.13 by the legislature are appropriated to the
370.14 commissioner for the purposes of the grant
370.15 program.

370.16 (b) Federal funds received by the
370.17 commissioner for the emergency shelter
370.18 grant program including the Homelessness
370.19 Prevention and Rapid Re-Housing
370.20 Program from the American Recovery and
370.21 Reinvestment Act of 2009, Public Law
370.22 111-5, are appropriated to the commissioner
370.23 for the purposes of the grant programs.

370.24 (c) Federal funds received by the
370.25 commissioner for the emergency food
370.26 assistance program from the American
370.27 Recovery and Reinvestment Act of 2009,
370.28 Public Law 111-5, are appropriated to the
370.29 commissioner for the purposes of the grant
370.30 program.

370.31 (d) Federal funds received by the
370.32 commissioner for senior congregate meals
370.33 and senior home-delivered meals from the
370.34 American Recovery and Reinvestment Act
370.35 of 2009, Public Law 111-5, are appropriated

371.1 to the commissioner for the Minnesota Board
 371.2 on Aging, for purposes of the grant programs.

371.3 (e) Federal funds received by the
 371.4 commissioner for the community services
 371.5 block grant program from the American
 371.6 Recovery and Reinvestment Act of 2009,
 371.7 Public Law 111-5, are appropriated to the
 371.8 commissioner for the purposes of the grant
 371.9 program.

371.10 **Long-Term Homeless Supportive**
 371.11 **Service Fund Appropriation.** To the
 371.12 extent permitted under federal law, the
 371.13 commissioner shall designate \$3,000,000
 371.14 of the Homelessness Prevention and Rapid
 371.15 Re-Housing Program funds provided under
 371.16 the American Recovery and Reinvestment
 371.17 Act of 2009, Public Law, 111-5, to the
 371.18 long-term homeless service fund under
 371.19 Minnesota Statutes, section 256K.26. This
 371.20 appropriation shall become available by July
 371.21 1, 2009. This paragraph is effective the day
 371.22 following final enactment.

371.23 **Subd. 5. Children and Economic Assistance**
 371.24 **Management**

371.25 The amounts that may be spent from the
 371.26 appropriation for each purpose are as follows:

371.27 **(a) Children and Economic Assistance**
 371.28 **Administration**

371.29	<u>Appropriations by Fund</u>		
371.30	<u>General</u>	<u>10,318,000</u>	<u>10,308,000</u>
371.31	<u>Federal TANF</u>	<u>496,000</u>	<u>496,000</u>

372.1 **Base Adjustment.** The federal TANF base
 372.2 is increased by \$700,000 in each of fiscal
 372.3 years 2012 and 2013.

372.4 **School Readiness Service Agreements.**
 372.5 \$406,000 in fiscal year 2010 and \$406,000
 372.6 in fiscal year 2011 are from the federal
 372.7 child care development funds received from
 372.8 the American Recovery and Reinvestment
 372.9 Act of 2009, Public Law 111-5, to the
 372.10 commissioner of human services consistent
 372.11 with federal regulations for the purpose of
 372.12 school readiness service agreements under
 372.13 Minnesota Statutes, section 119B.231. This
 372.14 is a onetime appropriation. Any unexpended
 372.15 balance the first year is available in the
 372.16 second year.

372.17 **(b) Children and Economic Assistance**
 372.18 **Operations**

372.19	<u>Appropriations by Fund</u>		
372.20	<u>General</u>	<u>33,590,000</u>	<u>33,423,000</u>
372.21	<u>Health Care Access</u>	<u>361,000</u>	<u>361,000</u>

372.22 **Financial Institution Data Match and**
 372.23 **Payment of Fees.** The commissioner is
 372.24 authorized to allocate up to \$310,000 each
 372.25 year in fiscal years 2010 and 2011 from the
 372.26 PRISM special revenue account to make
 372.27 payments to financial institutions in exchange
 372.28 for performing data matches between account
 372.29 information held by financial institutions
 372.30 and the public authority's database of child
 372.31 support obligors as authorized by Minnesota
 372.32 Statutes, section 13B.06, subdivision 7.

373.1 **School Readiness Service Agreements.**
 373.2 \$106,000 in fiscal year 2010 and \$241,000
 373.3 in fiscal year 2011 are from the federal
 373.4 child care development funds received from
 373.5 the American Recovery and Reinvestment
 373.6 Act of 2009, Public Law 111-5, to the
 373.7 commissioner of human services consistent
 373.8 with federal regulations for the purpose of
 373.9 school readiness service agreements under
 373.10 Minnesota Statutes, section 119B.231. This
 373.11 is a onetime appropriation.

373.12 **Use of Federal Stabilization Funds.**
 373.13 \$33,000,000 in fiscal year 2010 is
 373.14 appropriated from the fiscal stabilization
 373.15 account in the federal fund to the
 373.16 commissioner. This appropriation must not
 373.17 be used for any activity or service for which
 373.18 federal reimbursement is claimed. This is a
 373.19 onetime appropriation.

373.20 **Subd. 6. Basic Health Care Grants**

373.21 The amounts that may be spent from this
 373.22 appropriation for each purpose are as follows:

373.23 <u>(a) MinnesotaCare Grants</u>	<u>391,915,000</u>	<u>485,448,000</u>
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373.24 This appropriation is from the health care
 373.25 access fund.

373.26 <u>(b) MA Basic Health Care Grants - Families</u>		
373.27 <u>and Children</u>	<u>751,988,000</u>	<u>973,088,000</u>

373.28 **Medical Education Research Costs**
 373.29 **(MERC).** Of these funds, the commissioner
 373.30 of human services shall transfer \$38,000,000
 373.31 in fiscal year 2010 to the medical education
 373.32 research fund. These funds must restore the
 373.33 fiscal year 2009 unallotment of the transfers

374.1 under Minnesota Statutes, section 256B.69,
374.2 subdivision 5c, paragraph (a), for the July 1,
374.3 2008, through June 30, 2009, period.

374.4 **Newborn Screening Fee.** Of the general
374.5 fund appropriation, \$34,000 in fiscal
374.6 year 2011 is to the commissioner for the
374.7 hospital reimbursement increase described
374.8 under Minnesota Statutes, section 256.969,
374.9 subdivision 28.

374.10 **Local Share Payment Modification**
374.11 **Required for ARRA Compliance.**
374.12 Effective from July 1, 2009, to December
374.13 31, 2010, Hennepin County's monthly
374.14 contribution to the nonfederal share of
374.15 medical assistance costs must be reduced
374.16 to the percentage required on September
374.17 1, 2008, to meet federal requirements for
374.18 enhanced federal match under the American
374.19 Reinvestment and Recovery Act (ARRA)
374.20 of 2009. Notwithstanding the requirements
374.21 of Minnesota Statutes, section 256B.19,
374.22 subdivision 1c, paragraph (d), for the period
374.23 beginning July 1, 2009, to December 31,
374.24 2010, Hennepin County's monthly payment
374.25 under that provision is reduced to \$434,688.

374.26 **Capitation Payments.** Effective from
374.27 July 1, 2009, to December 31, 2010,
374.28 notwithstanding the provisions of Minnesota
374.29 Statutes 2008, section 256B.19, subdivision
374.30 1c, paragraph (c), the commissioner shall
374.31 increase capitation payments made to the
374.32 Metropolitan Health Plan under Minnesota
374.33 Statutes 2008, section 256B.69, by
374.34 \$6,800,000 to recognize higher than average

375.1 medical education costs. The increased
375.2 amount includes federal matching funds.

375.3 **Use of Savings.** Any savings derived
375.4 from implementation of the prohibition in
375.5 Minnesota Statutes, section 256B.032, on the
375.6 enrollment of low-quality, high-cost health
375.7 care providers as vendors of state health care
375.8 program services shall be used to offset on a
375.9 pro rata basis the reimbursement reductions
375.10 for basic care services in Minnesota Statutes,
375.11 section 256B.766.

375.12 **(c) MA Basic Health Care Grants - Elderly and**

375.13 **Disabled** 970,183,000 1,142,310,000

375.14 **Minnesota Disability Health Options.**

375.15 Notwithstanding Minnesota Statutes, section
375.16 256B.69, subdivision 5a, paragraph (b), for
375.17 the period beginning July 1, 2009, to June
375.18 30, 2011, the monthly enrollment of persons
375.19 receiving home and community-based
375.20 waivered services under Minnesota
375.21 Disability Health Options shall not exceed
375.22 1,000. If the budget neutrality provision
375.23 in Minnesota Statutes, section 256B.69,
375.24 subdivision 23, paragraph (f), is reached
375.25 prior to June 30, 2013, the commissioner may
375.26 waive this monthly enrollment requirement.

375.27 **Hospital Fee-for-Service Payment Delay.**

375.28 Payments from the Medicaid Management
375.29 Information System that would otherwise
375.30 have been made for inpatient hospital
375.31 services for Minnesota health care program
375.32 enrollees must be delayed as follows: for
375.33 fiscal year 2011, payments in the month of
375.34 June equal to \$15,937,000 must be included

376.1 in the first payment of fiscal year 2012 and
 376.2 for fiscal year 2013, payments in the month
 376.3 of June equal to \$6,666,000 must be included
 376.4 in the first payment of fiscal year 2014. The
 376.5 provisions of Minnesota Statutes, section
 376.6 16A.124, do not apply to these delayed
 376.7 payments. Notwithstanding any contrary
 376.8 provision in this article, this paragraph
 376.9 expires December 31, 2014.

376.10 **Nonhospital Fee-for-Service Payment**

376.11 **Delay. Payments from the Medicaid**
 376.12 **Management Information System that would**
 376.13 **otherwise have been made for nonhospital**
 376.14 **acute care services for Minnesota health**
 376.15 **care program enrollees must be delayed as**
 376.16 **follows: payments in the month of June equal**
 376.17 **to \$23,438,000 for fiscal year 2011 must be**
 376.18 **included in the first payment for fiscal year**
 376.19 **2012, and payments in the month of June**
 376.20 **equal to \$27,156,000 for fiscal year 2013**
 376.21 **must be included in the first payment for**
 376.22 **fiscal year 2014. This payment delay must**
 376.23 **not include nursing facilities, intermediate**
 376.24 **care facilities for persons with developmental**
 376.25 **disabilities, home and community-based**
 376.26 **services, prepaid health plans, personal care**
 376.27 **provider organizations, and home health**
 376.28 **agencies. The provisions of Minnesota**
 376.29 **Statutes, section 16A.124, do not apply to**
 376.30 **these delayed payments. Notwithstanding**
 376.31 **any contrary provision in this article, this**
 376.32 **paragraph expires December 31, 2014.**

376.33 <u>(d) General Assistance Medical Care Grants</u>	<u>345,223,000</u>	<u>381,081,000</u>
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376.34 **(e) Other Health Care Grants**

377.1 Appropriations by Fund

377.2	<u>General</u>	<u>295,000</u>	<u>295,000</u>
377.3	<u>Health Care Access</u>	<u>23,533,000</u>	<u>7,080,000</u>

377.4 **Base Adjustment.** The health care access
 377.5 fund base is reduced to \$190,000 in each of
 377.6 fiscal years 2012 and 2013.

377.7 **Subd. 7. Health Care Management**

377.8 The amounts that may be spent from the
 377.9 appropriation for each purpose are as follows:

377.10 **(a) Health Care Administration**

377.11 Appropriations by Fund

377.12	<u>General</u>	<u>7,831,000</u>	<u>7,742,000</u>
377.13	<u>Health Care Access</u>	<u>1,812,000</u>	<u>906,000</u>

377.14 **(b) Health Care Operations**

377.15 Appropriations by Fund

377.16	<u>General</u>	<u>19,914,000</u>	<u>18,949,000</u>
377.17	<u>Health Care Access</u>	<u>25,099,000</u>	<u>25,875,000</u>

377.18 **Base Adjustment.** The health care access
 377.19 fund base is increased by \$1,006,000 in
 377.20 fiscal year 2012 and \$1,781,000 in fiscal year
 377.21 2013. The general fund base is decreased by
 377.22 \$237,000 in fiscal year 2012 and \$237,000 in
 377.23 fiscal year 2013.

377.24 **Subd. 8. Continuing Care Grants**

377.25 The amounts that may be spent from the
 377.26 appropriation for each purpose are as follows:

377.27 **(a) Aging and Adult Services Grants**

378.1	<u>Appropriations by Fund</u>		
378.2	<u>General</u>	<u>13,488,000</u>	<u>15,779,000</u>
378.3	<u>Federal</u>	<u>500,000</u>	<u>0</u>
378.4	<u>Base Adjustment.</u> The general fund base is		
378.5	<u>increased by \$5,751,000 in fiscal year 2012</u>		
378.6	<u>and \$6,705,000 in fiscal year 2013.</u>		
378.7	<u>Information and Assistance</u>		
378.8	<u>Reimbursement.</u> Federal administrative		
378.9	<u>reimbursement obtained from information</u>		
378.10	<u>and assistance services provided by the</u>		
378.11	<u>Senior LinkAge or Disability Linkage lines</u>		
378.12	<u>to people who are identified as eligible for</u>		
378.13	<u>medical assistance shall be appropriated to</u>		
378.14	<u>the commissioner for this activity.</u>		
378.15	<u>Community Service Development Grant</u>		
378.16	<u>Reduction.</u> Funding for community service		
378.17	<u>development grants must be reduced by</u>		
378.18	<u>\$251,000 for fiscal year 2010; \$266,000 in</u>		
378.19	<u>fiscal year 2011; \$25,000 in fiscal year 2012;</u>		
378.20	<u>and \$25,000 in fiscal year 2013. Base level</u>		
378.21	<u>funding shall be restored in fiscal year 2014.</u>		
378.22	<u>Senior Nutrition Use of Federal Funds.</u>		
378.23	<u>For fiscal year 2010, general fund grants</u>		
378.24	<u>for home-delivered meals and congregate</u>		
378.25	<u>dining shall be reduced by \$500,000. The</u>		
378.26	<u>commissioner must replace these general</u>		
378.27	<u>fund reductions with equal amounts from</u>		
378.28	<u>federal funding for senior nutrition from the</u>		
378.29	<u>American Recovery and Reinvestment Act</u>		
378.30	<u>of 2009.</u>		
378.31	<u>(b) Alternative Care Grants</u>	<u>50,234,000</u>	<u>48,576,000</u>

379.1 **Base Adjustment.** The general fund base is
 379.2 decreased by \$3,598,000 in fiscal year 2012
 379.3 and \$3,470,000 in fiscal year 2013.

379.4 **Alternative Care Transfer.** Any money
 379.5 allocated to the alternative care program that
 379.6 is not spent for the purposes indicated does
 379.7 not cancel but must be transferred to the
 379.8 medical assistance account.

379.9 **(c) Medical Assistance Grants; Long-Term**

379.10 <u>Care Facilities.</u>	<u>367,444,000</u>	<u>419,749,000</u>
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379.11 **(d) Medical Assistance Long-Term Care**

379.12 <u>Waivers and Home Care Grants</u>	<u>854,373,000</u>	<u>1,043,411,000</u>
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379.13 **Manage Growth in TBI and CADI**

379.14 **Waivers.** During the fiscal years beginning
 379.15 on July 1, 2009, and July 1, 2010, the
 379.16 commissioner shall allocate money for home
 379.17 and community-based waiver programs
 379.18 under Minnesota Statutes, section 256B.49,
 379.19 to ensure a reduction in state spending that is
 379.20 equivalent to limiting the caseload growth of
 379.21 the TBI waiver to 12.5 allocations per month
 379.22 each year of the biennium and the CADI
 379.23 waiver to 95 allocations per month each year
 379.24 of the biennium. Limits do not apply: (1)
 379.25 when there is an approved plan for nursing
 379.26 facility bed closures for individuals under
 379.27 age 65 who require relocation due to the
 379.28 bed closure; (2) to fiscal year 2009 waiver
 379.29 allocations delayed due to unallotment; or (3)
 379.30 to transfers authorized by the commissioner
 379.31 from the personal care assistance program
 379.32 of individuals having a home care rating
 379.33 of "CS," "MT," or "HL." Priorities for the
 379.34 allocation of funds must be for individuals

380.1 anticipated to be discharged from institutional
380.2 settings or who are at imminent risk of a
380.3 placement in an institutional setting.

380.4 **Manage Growth in DD Waiver.** The
380.5 commissioner shall manage the growth in
380.6 the DD waiver by limiting the allocations
380.7 included in the February 2009 forecast to 15
380.8 additional diversion allocations each month
380.9 for the calendar years that begin on January
380.10 1, 2010, and January 1, 2011. Additional
380.11 allocations must be made available for
380.12 transfers authorized by the commissioner
380.13 from the personal care program of individuals
380.14 having a home care rating of "CS," "MT,"
380.15 or "HL."

380.16 **Adjustment to Lead Agency Waiver**
380.17 **Allocations.** Prior to the availability of the
380.18 alternative license defined in Minnesota
380.19 Statutes, section 245A.11, subdivision 8,
380.20 the commissioner shall reduce lead agency
380.21 waiver allocations for the purposes of
380.22 implementing a moratorium on corporate
380.23 foster care.

380.24 **Alternatives to Personal Care Assistance**
380.25 **Services.** Base level funding of \$3,237,000
380.26 in fiscal year 2012 and \$4,856,000 in
380.27 fiscal year 2013 is to implement alternative
380.28 services to personal care assistance services
380.29 for persons with mental health and other
380.30 behavioral challenges who can benefit
380.31 from other services that more appropriately
380.32 meet their needs and assist them in living
380.33 independently in the community. These
380.34 services may include, but not be limited to, a
380.35 1915(i) state plan option.

381.1 **(e) Mental Health Grants**

381.2 Appropriations by Fund

381.3 General 77,739,000 77,739,000

381.4 Health Care Access 750,000 750,000

381.5 Lottery Prize 1,508,000 1,508,000

381.6 **Funding Usage.** Up to 75 percent of a fiscal
 381.7 year's appropriation for adult mental health
 381.8 grants may be used to fund allocations in that
 381.9 portion of the fiscal year ending December
 381.10 31.

381.11 **(f) Deaf and Hard-of-Hearing Grants** 1,930,000 1,917,000

381.12 **(g) Chemical Dependency Entitlement Grants** 111,303,000 122,822,000

381.13 **Payments for Substance Abuse Treatment.**

381.14 For services provided during fiscal years
 381.15 2010 and 2011, county-negotiated rates and
 381.16 provider claims to the consolidated chemical
 381.17 dependency fund must not exceed rates
 381.18 charged for these services on January 1, 2009.

381.19 For services provided in fiscal years 2012
 381.20 and 2013, statewide average rates under the
 381.21 new rate methodology to be developed under
 381.22 Minnesota Statutes, section 254B.12, must
 381.23 not exceed the average rates charged for these
 381.24 services on January 1, 2009, plus \$3,787,000
 381.25 for fiscal year 2012 and \$5,023,000 for fiscal
 381.26 year 2013. Notwithstanding any provision
 381.27 to the contrary in this article, this provision
 381.28 expires on June 30, 2013.

381.29 **Chemical Dependency Special Revenue**

381.30 **Account.** For fiscal year 2010, \$750,000
 381.31 must be transferred from the consolidated

382.1 chemical dependency treatment fund
 382.2 administrative account and deposited into the
 382.3 general fund.

382.4 **County CD Share of MA Costs for**
 382.5 **ARRA Compliance.** Notwithstanding the
 382.6 provisions of Minnesota Statutes, chapter
 382.7 254B, for chemical dependency services
 382.8 provided during the period July 1, 2009,
 382.9 to December 31, 2010, and reimbursed by
 382.10 medical assistance at the enhanced federal
 382.11 matching rate provided under the American
 382.12 Recovery and Reinvestment Act of 2009, the
 382.13 county share is 30 percent of the nonfederal
 382.14 share.

382.15 **(h) Chemical Dependency Nonentitlement**

382.16 **Grants** 1,729,000 1,729,000

382.17 **Base Adjustment.** The general fund base is
 382.18 decreased by \$3,000 in each of fiscal years
 382.19 2012 and 2013.

382.20 **(i) Other Continuing Care Grants** 18,272,000 13,139,000

382.21 **Base Adjustment.** The general fund base is
 382.22 increased by \$7,028,000 in fiscal year 2012
 382.23 and increased by \$8,243,000 in fiscal year
 382.24 2013.

382.25 **Technology Grants.** \$650,000 in fiscal
 382.26 year 2010 and \$1,000,000 in fiscal year
 382.27 2011 are for technology grants, case
 382.28 consultation, evaluation, and consumer
 382.29 information grants related to developing and
 382.30 supporting alternatives to shift-staff foster
 382.31 care residential service models.

382.32 **Other Continuing Care Grants; HIV**
 382.33 **Grants.** Money appropriated for the HIV

383.1 drug and insurance grant program in fiscal
 383.2 year 2010 may be used in either year of the
 383.3 biennium.

383.4 **Subd. 9. Continuing Care Management**

383.5 Appropriations by Fund

383.6	<u>General</u>	<u>24,927,000</u>	<u>25,314,000</u>
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383.7 State Government

383.8	<u>Special Revenue</u>	<u>875,000</u>	<u>125,000</u>
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383.9	<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>
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383.10 **Quality Assurance Commission.** Effective
 383.11 July 1, 2009, state funding for the quality
 383.12 assurance commission under Minnesota
 383.13 Statutes, section 256B.0951, is canceled.

383.14 **County Maintenance of Effort.** \$350,000 in
 383.15 fiscal year 2010 is from the general fund for
 383.16 the State-County Results Accountability and
 383.17 Service Delivery Reform under Minnesota
 383.18 Statutes, chapter 402A.

383.19 **Base Adjustment.** The general fund base is
 383.20 decreased \$2,697,000 in fiscal year 2012 and
 383.21 \$2,791,000 in fiscal year 2013.

383.22	<u>Subd. 10. State-Operated Services</u>	<u>258,794,000</u>	<u>266,191,000</u>
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383.23 The amounts that may be spent from the
 383.24 appropriation for each purpose are as follows:

383.25 **Transfer Authority Related to**
 383.26 **State-Operated Services.** Money
 383.27 appropriated to finance state-operated
 383.28 services may be transferred between the
 383.29 fiscal years of the biennium with the approval
 383.30 of the commissioner of finance.

383.31 **County Past Due Receivables.** The
 383.32 commissioner is authorized to withhold

384.1 county federal administrative reimbursement
384.2 when the county of financial responsibility
384.3 for cost-of-care payments due the state
384.4 under Minnesota Statutes, section 246.54
384.5 or 253B.045, is 90 days past due. The
384.6 commissioner shall deposit the withheld
384.7 federal administrative earnings for the county
384.8 into the general fund to settle the claims with
384.9 the county of financial responsibility. The
384.10 process for withholding funds is governed by
384.11 Minnesota Statutes, section 256.017.

384.12 **Forecast and Census Data.** The
384.13 commissioner shall include census data and
384.14 fiscal projections for state-operated services
384.15 and Minnesota sex offender services with the
384.16 November and February budget forecasts.
384.17 Notwithstanding any contrary provision in
384.18 this article, this paragraph shall not expire.

384.19 **(a) Adult Mental Health Services** 107,702,000 107,201,000

384.20 **Appropriation Limitation.** No part of
384.21 the appropriation in this article to the
384.22 commissioner for mental health treatment
384.23 services provided by state-operated services
384.24 shall be used for the Minnesota sex offender
384.25 program.

384.26 **Community Behavioral Health Hospitals.**
384.27 Under Minnesota Statutes, section 246.51,
384.28 subdivision 1, a determination order for the
384.29 clients served in a community behavioral
384.30 health hospital operated by the commissioner
384.31 of human services is only required when
384.32 a client's third-party coverage has been
384.33 exhausted.

385.1 **Base Adjustment.** The general fund base is
 385.2 decreased by \$500,000 for fiscal year 2012
 385.3 and by \$500,000 for fiscal year 2013.

385.4 **(b) Minnesota Sex Offender Services**

385.5	<u>Appropriations by Fund</u>		
385.6	<u>General</u>	<u>38,348,000</u>	<u>67,503,000</u>
385.7	<u>Federal Fund</u>	<u>26,495,000</u>	<u>0</u>

385.8 **Use of Federal Stabilization Funds.** Of
 385.9 this appropriation, \$26,495,000 in fiscal year
 385.10 2010 is from the fiscal stabilization account
 385.11 in the federal fund to the commissioner.
 385.12 This appropriation must not be used for
 385.13 any activity or service for which federal
 385.14 reimbursement is claimed. This is a onetime
 385.15 appropriation.

385.16 **(c) Minnesota Security Hospital and METO**
 385.17 **Services**

385.18	<u>Appropriations by Fund</u>		
385.19	<u>General</u>	<u>230,000,000</u>	<u>83,735,000</u>
385.20	<u>Federal Fund</u>	<u>83,504,000</u>	<u>0</u>

385.21 **Minnesota Security Hospital.** For the
 385.22 purposes of enhancing the safety of
 385.23 the public, improving supervision, and
 385.24 enhancing community-based mental health
 385.25 treatment, state-operated services may
 385.26 establish additional community capacity
 385.27 for providing treatment and supervision
 385.28 of clients who have been ordered into a
 385.29 less restrictive alternative of care from the
 385.30 state-operated services transitional services

387.1 of providing support services to families as
387.2 required under Minnesota Statutes, section
387.3 144.966, subdivision 3a. \$74,000 of this
387.4 appropriation in fiscal year 2011 and \$51,000
387.5 of this appropriation in subsequent fiscal
387.6 years may be used by the commissioner
387.7 for administrative costs associated with
387.8 increasing the fee, contract administration,
387.9 program oversight, and provide follow-up to
387.10 families who need assistance beyond those
387.11 available through the contractor.

387.12 **Support Services for Families With**
387.13 **Children Who are Deaf or Have Hearing**
387.14 **Loss.** Of the general fund amount, \$16,000
387.15 in fiscal year 2010 and \$284,000 in fiscal
387.16 year 2011 is for support services to families
387.17 with children who are deaf or have hearing
387.18 loss. Of this amount, in fiscal year 2011,
387.19 \$223,000 is for grants and the balance is for
387.20 administrative costs. Base funding in fiscal
387.21 years 2012 and 2013 is \$300,000 each year.
387.22 Of this amount, \$241,000 each year is for
387.23 grants and the balance is for administrative
387.24 costs.

387.25 **Funding Usage.** Up to 75 percent of the
387.26 fiscal year 2012 appropriation for local public
387.27 health grants may be used to fund calendar
387.28 year 2011 allocations for this program. The
387.29 general fund reduction of \$5,193,000 in
387.30 fiscal year 2011 for local public health grants
387.31 is onetime and the base funding for local
387.32 public health grants for fiscal year 2012 is
387.33 increased by \$5,193,000.

387.34 **Colorectal Screening.** \$88,000 in fiscal year
387.35 2010 and \$62,000 in fiscal year 2011 are

388.1 for grants to the Hennepin County Medical
388.2 Center and MeritCare Bemidji for colorectal
388.3 screening demonstration projects.

388.4 **Feasibility Pilot Project for Cancer**
388.5 **Surveillance.** Of the general fund
388.6 appropriation for fiscal year 2010, \$100,000
388.7 is to the commissioner to provide grant
388.8 funding to cover the cost of one full-time
388.9 equivalent position at the Hennepin County
388.10 Medical Center to carry out the feasibility
388.11 pilot project.

388.12 **American Recovery and Reinvestment**
388.13 **Act Funds.** Federal funds received by the
388.14 commissioner for WIC program management
388.15 information systems from the American
388.16 Recovery and Reinvestment Act of 2009,
388.17 Public Law 111-5, are appropriated to the
388.18 commissioner for the purpose of the grant.

388.19 **TANF Appropriations.** (1) \$1,156,000 of
388.20 the TANF funds are appropriated each year to
388.21 the commissioner for family planning grants
388.22 under Minnesota Statutes, section 145.925.

388.23 (2) \$3,579,000 of the TANF funds are
388.24 appropriated each year to the commissioner
388.25 for home visiting and nutritional services
388.26 listed under Minnesota Statutes, section
388.27 145.882, subdivision 7, clauses (6) and (7).
388.28 Funds must be distributed to community
388.29 health boards according to Minnesota
388.30 Statutes, section 145A.131, subdivision 1.

388.31 (3) \$2,000,000 of the TANF funds are
388.32 appropriated each year to the commissioner
388.33 for decreasing racial and ethnic disparities
388.34 in infant mortality rates under Minnesota
388.35 Statutes, section 145.928, subdivision 7.

389.1 (4) \$4,998,000 of the TANF funds are
 389.2 appropriated each year to the commissioner
 389.3 for the family home visiting grant program
 389.4 according to Minnesota Statutes, section
 389.5 145A.17. \$4,000,000 of the funding must
 389.6 be distributed to community health boards
 389.7 according to Minnesota Statutes, section
 389.8 145A.131, subdivision 1. \$998,000 of
 389.9 the funding must be distributed to tribal
 389.10 governments based on Minnesota Statutes,
 389.11 section 145A.14, subdivision 2a. The
 389.12 commissioner may use five percent of
 389.13 the funds appropriated each fiscal year to
 389.14 conduct the ongoing evaluations required
 389.15 under Minnesota Statutes, section 145A.17,
 389.16 subdivision 7, and may use ten percent of
 389.17 the funds appropriated each fiscal year to
 389.18 provide training and technical assistance as
 389.19 required under Minnesota Statutes, section
 389.20 145A.17, subdivisions 4 and 5.

389.21 **Base Adjustment.** The general fund base
 389.22 is increased by \$10,302,000 for fiscal year
 389.23 2012 and increased by \$5,109,000 for fiscal
 389.24 year 2013. The health care access fund base
 389.25 is reduced to \$1,719,000 for both fiscal years
 389.26 2012 and 2013.

389.27 **TANF Carryforward.** Any unexpended
 389.28 balance of the TANF appropriation in the
 389.29 first year of the biennium does not cancel but
 389.30 is available for the second year.

389.31 **Subd. 3. Policy Quality and Compliance**

389.32	<u>Appropriations by Fund</u>		
389.33	<u>General</u>	<u>7,491,000</u>	<u>7,242,000</u>

390.1	<u>State Government</u>		
390.2	<u>Special Revenue</u>	<u>14,173,000</u>	<u>14,173,000</u>
390.3	<u>Health Care Access</u>	<u>17,561,000</u>	<u>12,090,000</u>

390.4 **Community-Based Health Care**

390.5 **Demonstration Project.** Notwithstanding
390.6 the provisions of Laws 2007, chapter 147,
390.7 article 19, section 3, subdivision 6, paragraph
390.8 (e), base level funding to the commissioner
390.9 for the demonstration project grant described
390.10 in Minnesota Statutes, section 62Q.80,
390.11 subdivision 1a, shall be zero for fiscal years
390.12 2011 and 2012.

390.13 **Medical Education and Research Cost**

390.14 **Federal Compliance.** Notwithstanding
390.15 Laws 2008, chapter 363, article 18, section
390.16 4, subdivision 3, the base level funding
390.17 for the commissioner to distribute to the
390.18 Mayo Clinic for transitional funding while
390.19 federal compliance changes are made to the
390.20 medical education and research cost funding
390.21 distribution formula shall be \$0 for fiscal
390.22 years 2010 and 2011.

390.23 **Autism Clinical Research.** The
390.24 commissioner, in partnership with a
390.25 Minnesota research institution, shall apply
390.26 for funds available for research grants under
390.27 the American Recovery and Reinvestment
390.28 Act (ARRA) of 2009 in order to expand
390.29 research and treatment of autism spectrum
390.30 disorders.

390.31 **Health Information Technology.** (a) Of
390.32 the health care access fund appropriation,
390.33 \$4,000,000 is to fund the revolving loan
390.34 account under Minnesota Statutes, section

391.1 62J.496. This appropriation must not be
 391.2 expended unless it is matched with federal
 391.3 funding under the federal Health Information
 391.4 Technology for Economic and Clinical
 391.5 Health (HITECH) Act. This appropriation
 391.6 must not be included in the agency's base
 391.7 budget for the fiscal year beginning July 1,
 391.8 2012.

391.9 (b) On or before June 30, 2013, \$1,200,000
 391.10 shall be transferred from the revolving loan
 391.11 account under Minnesota Statutes, section
 391.12 62J.496, to the health care access fund.
 391.13 This is a onetime transfer and must not be
 391.14 included in the agency's base budget for the
 391.15 fiscal year beginning July 1, 2014.

391.16 **Base Adjustment.** The general fund
 391.17 base is \$8,243,000 in fiscal year 2012 and
 391.18 \$8,243,000 in fiscal year 2013. The health
 391.19 care access fund base is \$10,950,000 in fiscal
 391.20 year 2012 and \$6,816,000 in fiscal year 2013.

391.21 **Subd. 4. Health Protection**

391.22 Appropriations by Fund

391.23	<u>General</u>	<u>9,871,000</u>	<u>9,780,000</u>
391.24	<u>State Government</u>		
391.25	<u>Special Revenue</u>	<u>30,209,000</u>	<u>30,209,000</u>

391.26 **Base Adjustment.** The general fund base is
 391.27 reduced by \$50,000 in each of fiscal years
 391.28 2012 and 2013.

391.29 **Health Protection Appropriations. (a)**
 391.30 \$163,000 each year is for the lead abatement
 391.31 grant program.

391.32 (b) \$100,000 each year is for emergency
 391.33 preparedness and response activities.

392.1 (c) \$50,000 each year is for tuberculosis
 392.2 prevention and control. This is a onetime
 392.3 appropriation.

392.4 **American Recovery and Reinvestment**
 392.5 **Act Funds.** Federal funds received
 392.6 by the commissioner for immunization
 392.7 operations from the American Recovery
 392.8 and Reinvestment Act of 2009, Public Law
 392.9 111-5, are appropriated to the commissioner
 392.10 for the purposes of the grant.

392.11	<u>Subd. 5. Administrative Support Services</u>	<u>7,190,000</u>		<u>7,190,000</u>
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392.12 Sec. 5. **HEALTH-RELATED BOARDS**

392.13	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>15,017,000</u>	<u>\$</u>	<u>14,831,000</u>
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392.14 This appropriation is from the state
 392.15 government special revenue fund.

392.16 **Transfer.** In fiscal year 2010, \$6,000,000
 392.17 shall be transferred from the state government
 392.18 special revenue fund to the general fund.

392.19 The amounts that may be spent for each
 392.20 purpose are specified in the following
 392.21 subdivisions.

392.22	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>447,000</u>		<u>447,000</u>
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392.23	<u>Subd. 3. Board of Dentistry</u>	<u>1,009,000</u>		<u>1,009,000</u>
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392.24	<u>Subd. 4. Board of Dietetic and Nutrition</u>			
392.25	<u>Practice</u>	<u>105,000</u>		<u>105,000</u>

392.26	<u>Subd. 5. Board of Marriage and Family</u>			
392.27	<u>Therapy</u>	<u>137,000</u>		<u>137,000</u>

392.28	<u>Subd. 6. Board of Medical Practice</u>	<u>3,674,000</u>		<u>3,674,000</u>
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392.29	<u>Subd. 7. Board of Nursing</u>	<u>4,217,000</u>		<u>4,219,000</u>
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393.1 Subd. 8. Board of Nursing Home

393.2 Administrators 1,146,000 958,000

393.3 Administrative Services Unit - Operating

393.4 Costs. Of this appropriation, \$524,000

393.5 in fiscal year 2010 and \$526,000 in

393.6 fiscal year 2011 are for operating costs

393.7 of the administrative services unit. The

393.8 administrative services unit may receive

393.9 and expend reimbursements for services

393.10 performed by other agencies.

393.11 Administrative Services Unit - Retirement

393.12 Costs. Of this appropriation in fiscal year

393.13 2010, \$201,000 is for onetime retirement

393.14 costs in the health-related boards. This

393.15 funding may be transferred to the health

393.16 boards incurring those costs for their

393.17 payment. These funds are available either

393.18 year of the biennium.

393.19 Administrative Services Unit - Volunteer

393.20 Health Care Provider Program. Of this

393.21 appropriation, \$79,000 in fiscal year 2010

393.22 and \$89,000 in fiscal year 2011 are to pay

393.23 for medical professional liability coverage

393.24 required under Minnesota Statutes, section

393.25 214.40.

393.26 Administrative Services Unit - Contested

393.27 Cases and Other Legal Proceedings. Of

393.28 this appropriation, \$200,000 in fiscal year

393.29 2010 and \$200,000 in fiscal year 2011

393.30 are for costs of contested case hearings

393.31 and other unanticipated costs of legal

393.32 proceedings involving health-related

393.33 boards funded under this section. Upon

393.34 certification of a health-related board to the

394.1 administrative services unit that the costs
 394.2 will be incurred and that there is insufficient
 394.3 money available to pay for the costs out of
 394.4 money currently available to that board, the
 394.5 administrative services unit is authorized
 394.6 to transfer money from this appropriation
 394.7 to the board for payment of those costs
 394.8 with the approval of the commissioner of
 394.9 finance. This appropriation does not cancel.
 394.10 Any unencumbered and unspent balances
 394.11 remain available for these expenditures in
 394.12 subsequent fiscal years.

394.13	<u>Subd. 9. Board of Optometry</u>	<u>101,000</u>	<u>101,000</u>
394.14	<u>Subd. 10. Board of Pharmacy</u>	<u>1,413,000</u>	<u>1,413,000</u>
394.15	<u>Subd. 11. Board of Physical Therapy</u>	<u>295,000</u>	<u>295,000</u>
394.16	<u>Subd. 12. Board of Podiatry</u>	<u>56,000</u>	<u>56,000</u>
394.17	<u>Subd. 13. Board of Psychology</u>	<u>806,000</u>	<u>806,000</u>
394.18	<u>Subd. 14. Board of Social Work</u>	<u>1,022,000</u>	<u>1,022,000</u>
394.19	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>195,000</u>	<u>195,000</u>
394.20	<u>Subd. 16. Board of Behavioral Health and</u>		
394.21	<u>Therapy</u>	<u>394,000</u>	<u>394,000</u>

394.22	Sec. 6. <u>EMERGENCY MEDICAL SERVICES</u>		
394.23	<u>BOARD</u>	<u>\$ 4,378,000</u>	<u>\$ 3,828,000</u>

394.24	<u>Appropriations by Fund</u>		
394.25		<u>2010</u>	<u>2011</u>
394.26	<u>General</u>	<u>3,674,000</u>	<u>3,124,000</u>
394.27	<u>State Government</u>		
394.28	<u>Special Revenue</u>	<u>704,000</u>	<u>704,000</u>

394.29 Longevity Award and Incentive Program.
 394.30 Of the general fund appropriation, \$700,000

395.1 in fiscal year 2010 and \$700,000 in fiscal year
 395.2 2011 are to the board for the Cooper/Sams
 395.3 volunteer ambulance program, under
 395.4 Minnesota Statutes, section 144E.40.

395.5 **Transfer.** In fiscal year 2010, \$6,182,000
 395.6 is transferred from the Cooper/Sams
 395.7 volunteer ambulance trust, established under
 395.8 Minnesota Statutes, section 144E.42, to the
 395.9 general fund.

395.10 **Health Professional Services Program.**
 395.11 \$704,000 in fiscal year 2010 and \$704,000 in
 395.12 fiscal year 2011 from the state government
 395.13 special revenue fund are for the health
 395.14 professional services program.

395.15 **Comprehensive Advanced Life-Support**
 395.16 **Educational (CALs) Program.** \$100,000 in
 395.17 the first year from the Cooper/Sams volunteer
 395.18 ambulance trust is for the comprehensive
 395.19 advanced life-support educational (CALs)
 395.20 program established under Minnesota
 395.21 Statutes, section 144E.37. This appropriation
 395.22 is to extend availability and affordability
 395.23 of the CALs program for rural emergency
 395.24 medical personnel and to assist hospital staff
 395.25 in attaining the credentialing levels necessary
 395.26 for implementation of the statewide trauma
 395.27 system.

395.28 **Sec. 7. DEPARTMENT OF VETERANS**

395.29 **AFFAIRS** \$ 200,000 \$ 0

395.30 **Veterans Paramedic Apprenticeship**
 395.31 **Program.** Of this appropriation, \$200,000
 395.32 in the first year is from the Cooper/Sams
 395.33 volunteer ambulance trust for transfer
 395.34 to the commissioner of veterans affairs

396.1 for a grant to the Minnesota Ambulance
 396.2 Association to implement a veterans
 396.3 paramedic apprenticeship program to
 396.4 reintegrate returning military medics into
 396.5 Minnesota's workforce in the field of
 396.6 paramedic and emergency services, thereby
 396.7 guaranteeing returning military medics
 396.8 gainful employment with livable wages and
 396.9 benefits. This appropriation is available until
 396.10 expended.

396.11 Sec. 8. **DEPARTMENT OF PUBLIC SAFETY** \$ **250,000** \$ **0**

396.12 **Medical Response Unit Reimbursement**

396.13 **Pilot Program.** (a) \$250,000 in the first
 396.14 year is from the Cooper/Sams volunteer
 396.15 ambulance trust for a transfer to the
 396.16 Department of Public Safety for a medical
 396.17 response unit reimbursement pilot program.
 396.18 Of this appropriation, \$75,000 is for
 396.19 administrative costs to the Department of
 396.20 Public Safety, including providing contract
 396.21 staff support and technical assistance to the
 396.22 pilot program partners if necessary.

396.23 (b) Of the amount in paragraph (a), \$175,000
 396.24 is to be used to provide a predetermined
 396.25 reimbursement amount to the participating
 396.26 medical response units. The Department
 396.27 of Public Safety or its contract designee
 396.28 will develop an agreement with the medical
 396.29 response units outlining reimbursement and
 396.30 program requirements to include HIPAA
 396.31 compliance while participating in the pilot
 396.32 program.

396.33 Sec. 9. **COUNCIL ON DISABILITY** \$ **524,000** \$ **524,000**

397.1 Sec. 10. OMBUDSMAN FOR MENTAL
 397.2 HEALTH AND DEVELOPMENTAL
 397.3 DISABILITIES \$ 1,655,000 \$ 1,655,000

397.4 Sec. 11. OMBUDSPERSON FOR FAMILIES \$ 265,000 \$ 265,000

397.5 Sec. 12. Laws 2007, chapter 147, article 19, section 3, subdivision 4, as amended
 397.6 by Laws 2008, chapter 277, article 5, section 1; and Laws 2008, chapter 363, article
 397.7 18, section 7, is amended to read:

397.8 Subd. 4. **Children and Economic Assistance**
 397.9 **Grants**

397.10 The amounts that may be spent from this
 397.11 appropriation for each purpose are as follows:

397.12 (a) **MFIP/DWP Grants**

397.13	Appropriations by Fund		
397.14	General	62,069,000	62,405,000
397.15	Federal TANF	75,904,000	80,841,000

397.16 (b) **Support Services Grants**

397.17	Appropriations by Fund		
397.18	General	8,715,000	8,715,000
397.19	Federal TANF	113,429,000	115,902,000

397.20 **TANF Prior Appropriation Cancellation.**

397.21 Notwithstanding Laws 2001, First Special
 397.22 Session chapter 9, article 17, section
 397.23 2, subdivision 11, paragraph (b), any
 397.24 unexpended TANF funds appropriated to the
 397.25 commissioner to contract with the Board of
 397.26 Trustees of Minnesota State Colleges and
 397.27 Universities, to provide tuition waivers to
 397.28 employees of health care and human service

398.1 providers that are members of qualifying
398.2 consortia operating under Minnesota
398.3 Statutes, sections 116L.10 to 116L.15, must
398.4 cancel at the end of fiscal year 2007.

398.5 **MFIP Pilot Program.** Of the TANF
398.6 appropriation, \$100,000 in fiscal year 2008
398.7 and \$750,000 in fiscal year 2009 are for a
398.8 grant to the Stearns-Benton Employment and
398.9 Training Council for the Workforce U pilot
398.10 program. Base level funding for this program
398.11 shall be \$750,000 in 2010 and \$0 in 2011.

398.12 **Supported Work.** (1) Of the TANF
398.13 appropriation, \$5,468,000 in fiscal year 2008
398.14 is for supported work for MFIP participants,
398.15 to be allocated to counties and tribes based
398.16 on the criteria under clauses (2) and (3), and
398.17 is available until expended. Paid transitional
398.18 work experience and other supported
398.19 employment under this rider provides
398.20 a continuum of employment assistance,
398.21 including outreach and recruitment,
398.22 program orientation and intake, testing and
398.23 assessment, job development and marketing,
398.24 preworksite training, supported worksite
398.25 experience, job coaching, and postplacement
398.26 follow-up, in addition to extensive case
398.27 management and referral services. * **(The**
398.28 **preceding text "and \$7,291,000 in fiscal**
398.29 **year 2009" was indicated as vetoed by the**
398.30 **governor.)**

398.31 (2) A county or tribe is eligible to receive an
398.32 allocation under this rider if:

398.33 (i) the county or tribe is not meeting the
398.34 federal work participation rate;

399.1 (ii) the county or tribe has participants who
399.2 are required to perform work activities under
399.3 Minnesota Statutes, chapter 256J, but are not
399.4 meeting hourly work requirements; and

399.5 (iii) the county or tribe has assessed
399.6 participants who have completed six weeks
399.7 of job search or are required to perform
399.8 work activities and are not meeting the
399.9 hourly requirements, and the county or tribe
399.10 has determined that the participant would
399.11 benefit from working in a supported work
399.12 environment.

399.13 (3) A county or tribe may also be eligible for
399.14 funds in order to contract for supplemental
399.15 hours of paid work at the participant's child's
399.16 place of education, child care location, or the
399.17 child's physical or mental health treatment
399.18 facility or office. This grant to counties and
399.19 tribes is specifically for MFIP participants
399.20 who need to work up to five hours more
399.21 per week in order to meet the hourly work
399.22 requirement, and the participant's employer
399.23 cannot or will not offer more hours to the
399.24 participant.

399.25 **Work Study.** Of the TANF appropriation,
399.26 \$750,000 each year are to the commissioner
399.27 to contract with the Minnesota Office of
399.28 Higher Education for the biennium beginning
399.29 July 1, 2007, for work study grants under
399.30 Minnesota Statutes, section 136A.233,
399.31 specifically for low-income individuals who
399.32 receive assistance under Minnesota Statutes,
399.33 chapter 256J, and for grants to opportunities
399.34 industrialization centers. * **(The preceding**
399.35 **text beginning "Work Study. Of the TANF**

400.1 **appropriation," was indicated as vetoed**
400.2 **by the governor.)**

400.3 **Integrated Service Projects.** \$2,500,000
400.4 in fiscal year 2008 and \$2,500,000 in fiscal
400.5 year 2009 are appropriated from the TANF
400.6 fund to the commissioner to continue to
400.7 fund the existing integrated services projects
400.8 for MFIP families, and if funding allows,
400.9 additional similar projects.

400.10 **Base Adjustment.** The TANF base for fiscal
400.11 year 2010 is \$115,902,000 and for fiscal year
400.12 2011 is \$115,152,000.

400.13 **(c) MFIP Child Care Assistance Grants**

400.14	General	74,654,000	71,951,000
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400.15 **(d) Basic Sliding Fee Child Care Assistance**
400.16 **Grants**

400.17	General	42,995,000	45,008,000
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400.18 **Base Adjustment.** The general fund base
400.19 is \$44,881,000 for fiscal year 2010 and
400.20 \$44,852,000 for fiscal year 2011.

400.21 **At-Home Infant Care Program.** No
400.22 funding shall be allocated to or spent on
400.23 the at-home infant care program under
400.24 Minnesota Statutes, section 119B.035.

400.25 **(e) Child Care Development Grants**

400.26	General	4,390,000	6,390,000
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400.27 **Prekindergarten Exploratory Projects.** Of
400.28 the general fund appropriation, \$2,000,000
400.29 the first year and \$4,000,000 the second

401.1 year are for grants to the city of St. Paul,
401.2 Hennepin County, and Blue Earth County to
401.3 establish scholarship demonstration projects
401.4 to be conducted in partnership with the
401.5 Minnesota Early Learning Foundation to
401.6 promote children's school readiness. This
401.7 appropriation is available until June 30, 2009.

401.8 **Child Care Services Grants.** Of this
401.9 appropriation, \$250,000 each year are for
401.10 the purpose of providing child care services
401.11 grants under Minnesota Statutes, section
401.12 119B.21, subdivision 5. This appropriation
401.13 is for the 2008-2009 biennium only, and does
401.14 not increase the base funding.

401.15 **Early Childhood Professional**
401.16 **Development System.** Of this appropriation,
401.17 \$250,000 each year are for purposes of the
401.18 early childhood professional development
401.19 system, which increases the quality and
401.20 continuum of professional development
401.21 opportunities for child care practitioners.
401.22 This appropriation is for the 2008-2009
401.23 biennium only, and does not increase the
401.24 base funding.

401.25 **Base Adjustment.** The general fund base
401.26 is \$1,515,000 for each of fiscal years 2010
401.27 and 2011.

401.28 **(f) Child Support Enforcement Grants**

401.29 General 11,038,000 3,705,000

401.30 **Child Support Enforcement.** \$7,333,000
401.31 for fiscal year 2008 is to make grants to
401.32 counties for child support enforcement
401.33 programs to make up for the loss under the

402.1 2005 federal Deficit Reduction Act of federal
 402.2 matching funds for federal incentive funds
 402.3 passed on to the counties by the state.

402.4 This appropriation is available until June 30,
 402.5 2009.

402.6 **(g) Children's Services Grants**

402.7	Appropriations by Fund		
402.8	General	63,647,000	71,147,000
402.9	Health Care Access	250,000	-0-
402.10	TANF	240,000	340,000

402.11 **Grants for Programs Serving Young**
 402.12 **Parents.** Of the TANF fund appropriation,
 402.13 \$140,000 each year is for a grant to a program
 402.14 or programs that provide comprehensive
 402.15 services through a private, nonprofit agency
 402.16 to young parents in Hennepin County who
 402.17 have dropped out of school and are receiving
 402.18 public assistance. The program administrator
 402.19 shall report annually to the commissioner on
 402.20 skills development, education, job training,
 402.21 and job placement outcomes for program
 402.22 participants.

402.23 **County Allocations for Rate Increases.**
 402.24 County Children and Community Services
 402.25 Act allocations shall be increased by
 402.26 \$197,000 effective October 1, 2007, and
 402.27 \$696,000 effective October 1, 2008, to help
 402.28 counties pay for the rate adjustments to
 402.29 day training and habilitation providers for
 402.30 participants paid by county social service
 402.31 funds. Notwithstanding the provisions of
 402.32 Minnesota Statutes, section 256M.40, the
 402.33 allocation to a county shall be based on

403.1 the county's proportion of social services
403.2 spending for day training and habilitation
403.3 services as determined in the most recent
403.4 social services expenditure and grant
403.5 reconciliation report.

403.6 **Privatized Adoption Grants.** Federal
403.7 reimbursement for privatized adoption grant
403.8 and foster care recruitment grant expenditures
403.9 is appropriated to the commissioner for
403.10 adoption grants and foster care and adoption
403.11 administrative purposes.

403.12 **Adoption Assistance Incentive Grants.**
403.13 Federal funds available during fiscal year
403.14 2008 and fiscal year 2009 for the adoption
403.15 incentive grants are appropriated to the
403.16 commissioner for these purposes.

403.17 **Adoption Assistance and Relative Custody**
403.18 **Assistance.** The commissioner may transfer
403.19 unencumbered appropriation balances for
403.20 adoption assistance and relative custody
403.21 assistance between fiscal years and between
403.22 programs.

403.23 **Children's Mental Health Grants.** Of the
403.24 general fund appropriation, \$5,913,000 in
403.25 fiscal year 2008 and \$6,825,000 in fiscal year
403.26 2009 are for children's mental health grants.
403.27 The purpose of these grants is to increase and
403.28 maintain the state's children's mental health
403.29 service capacity, especially for school-based
403.30 mental health services. The commissioner
403.31 shall require grantees to utilize all available
403.32 third party reimbursement sources as a
403.33 condition of using state grant funds. At
403.34 least 15 percent of these funds shall be
403.35 used to encourage efficiencies through early

404.1 intervention services. At least another 15
404.2 percent shall be used to provide respite care
404.3 services for children with severe emotional
404.4 disturbance at risk of out-of-home placement.

404.5 **Mental Health Crisis Services.** Of the
404.6 general fund appropriation, \$2,528,000 in
404.7 fiscal year 2008 and \$2,850,000 in fiscal year
404.8 2009 are for statewide funding of children's
404.9 mental health crisis services. Providers must
404.10 utilize all available funding streams.

404.11 **Children's Mental Health Evidence-Based**
404.12 **and Best Practices.** Of the general fund
404.13 appropriation, \$375,000 in fiscal year 2008
404.14 and \$750,000 in fiscal year 2009 are for
404.15 children's mental health evidence-based and
404.16 best practices including, but not limited
404.17 to: Adolescent Integrated Dual Diagnosis
404.18 Treatment services; school-based mental
404.19 health services; co-location of mental
404.20 health and physical health care, and; the
404.21 use of technological resources to better
404.22 inform diagnosis and development of
404.23 treatment plan development by mental
404.24 health professionals. The commissioner
404.25 shall require grantees to utilize all available
404.26 third-party reimbursement sources as a
404.27 condition of using state grant funds.

404.28 **Culturally Specific Mental Health**
404.29 **Treatment Grants.** Of the general fund
404.30 appropriation, \$75,000 in fiscal year 2008
404.31 and \$300,000 in fiscal year 2009 are for
404.32 children's mental health grants to support
404.33 increased availability of mental health
404.34 services for persons from cultural and
404.35 ethnic minorities within the state. The

405.1 commissioner shall use at least 20 percent
405.2 of these funds to help members of cultural
405.3 and ethnic minority communities to become
405.4 qualified mental health professionals and
405.5 practitioners. The commissioner shall assist
405.6 grantees to meet third-party credentialing
405.7 requirements and require them to utilize all
405.8 available third-party reimbursement sources
405.9 as a condition of using state grant funds.

405.10 **Mental Health Services for Children with**
405.11 **Special Treatment Needs.** Of the general
405.12 fund appropriation, \$50,000 in fiscal year
405.13 2008 and \$200,000 in fiscal year 2009 are
405.14 for children's mental health grants to support
405.15 increased availability of mental health
405.16 services for children with special treatment
405.17 needs. These shall include, but not be limited
405.18 to: victims of trauma, including children
405.19 subjected to abuse or neglect, veterans and
405.20 their families, and refugee populations;
405.21 persons with complex treatment needs, such
405.22 as eating disorders; and those with low
405.23 incidence disorders.

405.24 **MFIP and Children's Mental Health**
405.25 **Pilot Project.** Of the TANF appropriation,
405.26 \$100,000 in fiscal year 2008 and \$200,000
405.27 in fiscal year 2009 are to fund the MFIP
405.28 and children's mental health pilot project.
405.29 Of these amounts, up to \$100,000 may be
405.30 expended on evaluation of this pilot.

405.31 **Prenatal Alcohol or Drug Use.** Of the
405.32 general fund appropriation, \$75,000 ~~each~~
405.33 ~~year is to award grants beginning July 1,~~
405.34 ~~2007, to programs that provide services~~
405.35 ~~under Minnesota Statutes, section 254A.171,~~

406.1 ~~in Pine, Kanabec, and Carlton Counties.~~
406.2 the second year is for a grant to A Circle
406.3 of Women for program services. This
406.4 appropriation shall become part of the base
406.5 appropriation.

406.6 **Base Adjustment.** The general fund base
406.7 is \$62,572,000 in fiscal year 2010 and
406.8 \$62,575,000 in fiscal year 2011.

406.9 **(h) Children and Community Services Grants**

406.10 General 101,369,000 69,208,000

406.11 **Base Adjustment.** The general fund base
406.12 is \$69,274,000 in each of fiscal years 2010
406.13 and 2011.

406.14 **Targeted Case Management Temporary**
406.15 **Funding.** (a) Of the general fund
406.16 appropriation, \$32,667,000 in fiscal year
406.17 2008 is transferred to the targeted case
406.18 management contingency reserve account in
406.19 the general fund to be allocated to counties
406.20 and tribes affected by reductions in targeted
406.21 case management federal Medicaid revenue
406.22 as a result of the provisions in the federal
406.23 Deficit Reduction Act of 2005, Public Law
406.24 109-171.

406.25 (b) Contingent upon (1) publication by the
406.26 federal Centers for Medicare and Medicaid
406.27 Services of final regulations implementing
406.28 the targeted case management provisions
406.29 of the federal Deficit Reduction Act of
406.30 2005, Public Law 109-171, or (2) the
406.31 issuance of a finding by the Centers for
406.32 Medicare and Medicaid Services of federal
406.33 Medicaid overpayments for targeted case

408.1 childless and unmarried or living apart
408.2 from parents or a legal guardian at \$203.
408.3 The commissioner may reduce this amount
408.4 according to Laws 1997, chapter 85, article
408.5 3, section 54.

408.6 **Emergency General Assistance.** The
408.7 amount appropriated for emergency general
408.8 assistance funds is limited to no more
408.9 than \$7,889,812 in fiscal year 2008 and
408.10 \$7,889,812 in fiscal year 2009. Funds
408.11 to counties must be allocated by the
408.12 commissioner using the allocation method
408.13 specified in Minnesota Statutes, section
408.14 256D.06.

408.15 **(j) Minnesota Supplemental Aid Grants**

408.16	General	30,505,000	30,812,000
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408.17 **Emergency Minnesota Supplemental**
408.18 **Aid Funds.** The amount appropriated for
408.19 emergency Minnesota supplemental aid
408.20 funds is limited to no more than \$1,100,000
408.21 in fiscal year 2008 and \$1,100,000 in fiscal
408.22 year 2009. Funds to counties must be
408.23 allocated by the commissioner using the
408.24 allocation method specified in Minnesota
408.25 Statutes, section 256D.46.

408.26 **(k) Group Residential Housing Grants**

408.27	General	91,069,000	98,671,000
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408.28 **People Incorporated.** Of the general fund
408.29 appropriation, \$460,000 each year is to
408.30 augment community support and mental
408.31 health services provided to individuals

409.1 residing in facilities under Minnesota
 409.2 Statutes, section 256I.05, subdivision 1m.

409.3 **(l) Other Children and Economic Assistance**

409.4 **Grants**

409.5	General	20,183,000	16,333,000
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409.6	Federal TANF	1,500,000	1,500,000
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409.7 **Base Adjustment.** The general fund base
 409.8 shall be \$16,033,000 in fiscal year 2010 and
 409.9 \$15,533,000 in fiscal year 2011. The TANF
 409.10 base shall be \$1,500,000 in fiscal year 2010
 409.11 and \$1,181,000 in fiscal year 2011.

409.12 **Homeless and Runaway Youth.** Of the
 409.13 general fund appropriation, \$500,000 each
 409.14 year are for the Runaway and Homeless
 409.15 Youth Act under Minnesota Statutes, section
 409.16 256K.45. Funds shall be spent in each area
 409.17 of the continuum of care to ensure that
 409.18 programs are meeting the greatest need. This
 409.19 is a onetime appropriation.

409.20 **Long-Term Homelessness.** Of the general
 409.21 fund appropriation, \$2,000,000 in fiscal year
 409.22 2008 is for implementation of programs
 409.23 to address long-term homelessness and is
 409.24 available in either year of the biennium. This
 409.25 is a onetime appropriation.

409.26 **Minnesota Community Action Grants.** (a)
 409.27 Of the general fund appropriation, \$250,000
 409.28 each year is for the purposes of Minnesota
 409.29 community action grants under Minnesota
 409.30 Statutes, sections 256E.30 to 256E.32. This
 409.31 is a onetime appropriation.

409.32 (b) Of the TANF appropriation, \$1,500,000
 409.33 each year is for community action agencies

410.1 for auto repairs, auto loans, and auto
410.2 purchase grants to individuals who are
410.3 eligible to receive benefits under Minnesota
410.4 Statutes, chapter 256J, or who have lost
410.5 eligibility for benefits under Minnesota
410.6 Statutes, chapter 256J, due to earnings in the
410.7 prior 12 months. Base level funding for this
410.8 activity shall be \$1,500,000 in fiscal year
410.9 2010 and \$1,181,000 in fiscal year 2011. *

410.10 **(The preceding text beginning "(b) Of the**
410.11 **TANF appropriation," was indicated as**
410.12 **vetoed by the governor.)**

410.13 (c) Money appropriated under paragraphs (a)
410.14 and (b) that is not spent in the first year does
410.15 not cancel but is available for the second
410.16 year.

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

410.18 Sec. 13. **EMERGENCY SERVICES SHELTER GRANTS FROM AMERICAN**
410.19 **RECOVERY AND REINVESTMENT ACT.**

410.20 (a) To the extent permitted under federal law, the commissioner of human services,
410.21 when determining the uses of the emergency services shelter grants provided under the
410.22 American Recovery and Reinvestment Act, shall give priority to programs that serve
410.23 the following:

410.24 (1) homeless youth;

410.25 (2) American Indian women who are victims of trafficking;

410.26 (3) high-risk adult males considered to be very likely to enter or reenter state or
410.27 county correctional programs, or chemical and mental health programs;

410.28 (4) battered women; and

410.29 (5) families affected by foreclosure.

410.30 (b) Paragraph (a) does not supersede use of ARRA funds as otherwise provided
410.31 in this act.

410.32 Sec. 14. **TRANSFERS.**

410.33 Subdivision 1. **Grants.** The commissioner of human services, with the approval
410.34 of the commissioner of finance, and after notification of the chairs of the relevant senate

411.1 budget division and house of representatives finance division committee, may transfer
411.2 unencumbered appropriation balances for the biennium ending June 30, 2011, within
411.3 fiscal years among the MFIP, general assistance, general assistance medical care, medical
411.4 assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section
411.5 119B.05, Minnesota supplemental aid, and group residential housing programs, and the
411.6 entitlement portion of the chemical dependency consolidated treatment fund, and between
411.7 fiscal years of the biennium.

411.8 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
411.9 money may be transferred within the Departments of Human Services and Health as the
411.10 commissioners consider necessary, with the advance approval of the commissioner of
411.11 finance. The commissioner shall inform the chairs of the relevant house and senate health
411.12 committees quarterly about transfers made under this provision.

411.13 Sec. 15. **2007 AND 2008 APPROPRIATION AMENDMENTS.**

411.14 (a) Notwithstanding Laws 2007, chapter 147, article 19, section 3, subdivision 4,
411.15 paragraph (g), as amended by Laws 2008, chapter 363, article 18, section 7, the TANF
411.16 fund base for the Children's Mental Health Pilots is \$0 in fiscal year 2011. This paragraph
411.17 is effective retroactively from July 1, 2008.

411.18 (b) The appropriation for patient incentive programs under Laws 2007, chapter 147,
411.19 article 19, section 3, subdivision 6, paragraph (e), is canceled. This paragraph is effective
411.20 retroactively from July 1, 2007.

411.21 (c) The onetime general fund base reduction for Child Care Development Grants
411.22 under Laws 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (d), is
411.23 increased by \$4,000. This paragraph is effective retroactively from July 1, 2008.

411.24 (d) The base for Children Services Grants under Laws 2008, chapter 363, article 18,
411.25 section 3, subdivision 4, paragraph (e), is decreased \$1,000 in each year of the fiscal year
411.26 2010 and 2011 biennium. This paragraph is effective retroactively from July 1, 2008.

411.27 (e) Notwithstanding Laws 2008, chapter 363, article 18, section 3, subdivision 4, the
411.28 general fund base adjustment for Children and Community Services Grants under Laws
411.29 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (f), is increased by
411.30 \$98,000 each year of fiscal years 2010 and 2011. This paragraph is effective retroactively
411.31 from July 1, 2008.

411.32 (f) The base for Other Continuing Care Grants under Laws 2008, chapter 363, article
411.33 18, section 3, subdivision 6, paragraph (h), is decreased by \$10,000 in fiscal year 2010.
411.34 This paragraph is effective retroactively from July 1, 2008.

412.1 Sec. 16. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

412.2 The commissioners of health and human services shall not use indirect cost
412.3 allocations to pay for the operational costs of any program for which they are responsible.

412.4 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

412.5 All uncodified language contained in this article expires on June 30, 2011, unless a
412.6 different expiration date is explicit.

412.7 Sec. 18. **EFFECTIVE DATE.**

412.8 The provisions in this article are effective July 1, 2009, unless a different effective
412.9 date is specified."

412.10 Delete the title and insert:

412.11 "A bill for an act

412.12 relating to state government; making changes to health and human services;
412.13 amending provisions related to licensing, the Minnesota family investment
412.14 program, child care, adult supports; fraud prevention, state-operated services,
412.15 the Minnesota sex offender program, the Department of Health, health care
412.16 programs, chemical and mental health; continuing care programs, and public
412.17 health; establishing the State-County Results, Accountability, and Service
412.18 Delivery Redesign; making technical changes; making forecast adjustments;
412.19 requiring reports; establishing and increasing fees; appropriating money;
412.20 amending Minnesota Statutes 2008, sections 60A.092, subdivision 2; 62D.03,
412.21 subdivision 4; 62D.05, subdivision 3; 62J.495; 62J.496; 62J.497, subdivisions
412.22 1, 2, by adding subdivisions; 62J.692, subdivision 7; 103I.208, subdivision
412.23 2; 119B.09, subdivision 7; 119B.13, subdivision 6; 119B.21, subdivisions 5,
412.24 10; 119B.231, subdivisions 2, 3, 4; 144.0724, subdivisions 2, 4, 8, by adding
412.25 subdivisions; 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision
412.26 1a; 144.125, subdivision 1; 144.226, subdivision 4; 144.72, subdivisions 1, 3;
412.27 144.9501, subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions
412.28 1g, 4; 144.9508, subdivisions 2, 3, 4; 144.9512, subdivision 2; 144.966, by
412.29 adding a subdivision; 144.97, subdivisions 2, 4, 6, by adding subdivisions;
412.30 144.98, subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision
412.31 1; 144A.073, by adding a subdivision; 144A.44, subdivision 2; 144A.46,
412.32 subdivision 1; 145A.17, by adding a subdivision; 148.6445, by adding a
412.33 subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180, subdivisions 1, 2, 3, 5;
412.34 152.126, subdivisions 1, 2, 6; 153A.17; 157.15, by adding a subdivision; 157.16;
412.35 157.22; 176.011, subdivision 9; 245.462, subdivision 18; 245.470, subdivision
412.36 1; 245.4871, subdivision 27; 245.488, subdivision 1; 245A.03, by adding a
412.37 subdivision; 245A.10, subdivisions 2, 3; 245A.11, subdivision 2a, by adding
412.38 subdivisions; 245A.16, subdivisions 1, 3; 245C.03, subdivision 2; 245C.04,
412.39 subdivisions 1, 3; 245C.05, subdivision 4, by adding a subdivision; 245C.08,
412.40 subdivision 2; 245C.10, subdivision 3, by adding subdivisions; 245C.17, by
412.41 adding a subdivision; 245C.20; 245C.21, subdivision 1a; 245C.23, subdivision 2;
412.42 246.50, subdivision 5, by adding subdivisions; 246.51, by adding subdivisions;
412.43 246.511; 246.52; 246.54, subdivision 2; 246B.01, by adding subdivisions;
412.44 252.025, subdivision 7; 252.46, by adding a subdivision; 252.50, subdivision 1;
412.45 254A.02, by adding a subdivision; 254A.16, by adding a subdivision; 254B.03,
412.46 subdivisions 1, 3, by adding a subdivision; 254B.05, subdivision 1; 254B.09,
412.47 subdivision 2; 256.01, subdivision 2b, by adding subdivisions; 256.045,
412.48 subdivision 3; 256.476, subdivisions 5, 11; 256.962, subdivisions 2, 6; 256.969,
412.49 subdivisions 2b, 3a, by adding subdivisions; 256.975, subdivision 7; 256.983,

413.1 subdivision 1; 256B.04, subdivision 16; 256B.055, subdivisions 7, 12; 256B.056,
 413.2 subdivisions 3c, 3d; 256B.057, by adding a subdivision; 256B.0575; 256B.0595,
 413.3 subdivisions 1, 2; 256B.06, subdivisions 4, 5; 256B.0621, subdivision 2;
 413.4 256B.0622, subdivision 2; 256B.0623, subdivision 5; 256B.0624, subdivisions
 413.5 5, 8; 256B.0625, subdivisions 3, 3c, 6a, 7, 9, 11, 13, 13e, 13h, 17, 17a, 19a,
 413.6 19c, 26, 42, 47, by adding subdivisions; 256B.0641, subdivision 3; 256B.0651;
 413.7 256B.0652; 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657,
 413.8 subdivisions 2, 6, 8, by adding a subdivision; 256B.08, by adding a subdivision;
 413.9 256B.0911, subdivisions 1, 1a, 3, 3a, 3b, 3c, 4a, 5, 6, 7, by adding subdivisions;
 413.10 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3e, 3h, 5, by adding a
 413.11 subdivision; 256B.0916, subdivision 2; 256B.0917, by adding a subdivision;
 413.12 256B.092, subdivision 8a, by adding subdivisions; 256B.0943, subdivisions 1,
 413.13 12; 256B.0944, by adding a subdivision; 256B.0947, subdivision 1; 256B.15,
 413.14 subdivisions 1, 1a, 1h, 2, by adding subdivisions; 256B.199; 256B.37,
 413.15 subdivisions 1, 5; 256B.434, subdivision 4, by adding a subdivision; 256B.437,
 413.16 subdivision 6; 256B.441, subdivisions 55, 58, by adding a subdivision; 256B.49,
 413.17 subdivisions 12, 13, 14, 17, by adding subdivisions; 256B.501, subdivision
 413.18 4a; 256B.5011, subdivision 2; 256B.5012, by adding a subdivision; 256B.69,
 413.19 subdivisions 5a, 5c, 5f, 23; 256B.76, subdivision 1; 256D.03, subdivision 4;
 413.20 256D.44, subdivision 5; 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05,
 413.21 subdivisions 1a, 7c; 256J.08, subdivision 73a; 256J.24, subdivision 5; 256J.425,
 413.22 subdivisions 2, 3; 256J.45, subdivision 3; 256J.49, subdivisions 1, 4; 256J.521,
 413.23 subdivision 2; 256J.545; 256J.561, subdivisions 2, 3; 256J.57, subdivision
 413.24 1; 256J.575, subdivisions 3, 4, 6, 7; 256J.621; 256J.626, subdivision 7;
 413.25 256J.95, subdivisions 3, 11, 12, 13; 256L.03, by adding a subdivision; 256L.04,
 413.26 subdivisions 1, 7a, 10a, by adding a subdivision; 256L.05, subdivisions 1, 3, 3a,
 413.27 by adding a subdivision; 256L.07, subdivisions 1, 2, 3, by adding a subdivision;
 413.28 256L.11, subdivision 1; 256L.15, subdivisions 2, 3; 256L.17, subdivisions 3, 5;
 413.29 259.67, by adding a subdivision; 270A.09, by adding a subdivision; 327.14,
 413.30 by adding a subdivision; 327.15; 327.16; 327.20, subdivision 1, by adding a
 413.31 subdivision; 501B.89, by adding a subdivision; 519.05; 604A.33, subdivision
 413.32 1; 609.232, subdivision 11; 626.556, subdivision 3c; 626.5572, subdivisions
 413.33 6, 13, 21; Laws 2003, First Special Session chapter 14, article 13C, section
 413.34 2, subdivision 1, as amended; Laws 2007, chapter 147, article 19, section 3,
 413.35 subdivision 4, as amended; proposing coding for new law in Minnesota Statutes,
 413.36 chapters 62Q; 246B; 254B; 256; 256B; proposing coding for new law as
 413.37 Minnesota Statutes, chapter 402A; repealing Minnesota Statutes 2008, sections
 413.38 103I.112; 144.9501, subdivision 17b; 148D.180, subdivision 8; 245C.11,
 413.39 subdivisions 1, 2; 246.51, subdivision 1; 246.53, subdivision 3; 256.962,
 413.40 subdivision 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6,
 413.41 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092, subdivision
 413.42 5a; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256I.06, subdivision
 413.43 9; 256L.17, subdivision 6; 327.14, subdivisions 5, 6; Minnesota Rules, parts
 413.44 4626.2015, subpart 9; 9555.6125, subpart 4, item B."

414.1 We request the adoption of this report and repassage of the bill.

414.2 House Conferees: (Signed)

414.3
414.4 Thomas Huntley Paul Thissen

414.5
414.6 Larry Hosch Karen Clark

414.7
414.8 Jim Abeler

414.9 Senate Conferees: (Signed)

414.10
414.11 Linda Berglin Tony Lourey

414.12
414.13 Kathy Sheran Julie Rosen

414.14
414.15 Yvonne Prettner Solon