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HOUSE FILE NO. 1362

FIRST COMMITTEE ENGROSSMENT

March 5, 2009

Authored by Huntley

The bill was read for the first time and referred to the Committee on Finance

Referred by Chair to Health Care and Human Services Finance Division.

April 21, 2009

Returned to the Committee on Finance as Amended.

A bill for an act

1.1 relating to state government; establishing the health and human services budget;
1.2 making changes to licensing; Minnesota family investment program, children,
1.3 and adult supports; child support; the Department of Health; health care
1.4 programs; making technical changes; chemical and mental health; continuing
1.5 care programs; establishing the State-County Results, Accountability, and
1.6 Service Delivery Redesign; making forecast adjustments; requiring reports;
1.7 increasing fees; appropriating money; amending Minnesota Statutes 2008,
1.8 sections 13.465, subdivision 8; 62J.495; 62J.496; 62J.497, subdivisions 1, 2, by
1.9 adding a subdivision; 62J.692, subdivision 7; 125A.744, subdivision 3; 144.0724,
1.10 subdivisions 2, 4, 8, by adding subdivisions; 144.122; 144.218, subdivision
1.11 1; 144.225, subdivision 2; 144.2252; 144.226, subdivisions 1, 4; 144A.073,
1.12 by adding a subdivision; 144A.44, subdivision 2; 144A.46, subdivision
1.13 1; 148.6445, by adding a subdivision; 176.011, subdivision 9; 245.4885,
1.14 subdivision 1; 245A.03, by adding a subdivision; 245A.10, subdivisions 2, 3,
1.15 4, 5, by adding subdivisions; 245A.11, subdivision 2a, by adding a subdivision;
1.16 245A.16, subdivisions 1, 3; 245C.03, subdivision 2; 245C.04, subdivisions 1,
1.17 3; 245C.05, subdivision 4; 245C.08, subdivision 2; 245C.10, subdivision 3,
1.18 by adding subdivisions; 245C.17, by adding a subdivision; 245C.20; 245C.21,
1.19 subdivision 1a; 245C.23, subdivision 2; 246.50, subdivision 5, by adding
1.20 subdivisions; 246.51, by adding subdivisions; 246.511; 246.52; 246B.01, by
1.21 adding subdivisions; 252.43; 252.46, by adding a subdivision; 254A.02, by
1.22 adding a subdivision; 254A.16, by adding a subdivision; 254B.03, subdivisions
1.23 1, 3, by adding a subdivision; 254B.05, subdivision 1; 254B.09, subdivision
1.24 2; 256.01, subdivision 2b, by adding subdivisions; 256.962, subdivisions
1.25 2, 6; 256.963, by adding a subdivision; 256.969, subdivision 3a; 256.975,
1.26 subdivision 7; 256B.04, subdivision 16; 256B.055, subdivisions 7, 12; 256B.056,
1.27 subdivisions 3, 3b, 3c, by adding a subdivision; 256B.057, subdivisions 3,
1.28 9, by adding a subdivision; 256B.0575; 256B.0595, subdivision 1; 256B.06,
1.29 subdivisions 4, 5; 256B.0621, subdivision 2; 256B.0625, subdivisions 3c, 6a, 7,
1.30 8, 8a, 9, 13e, 17, 19a, 19c, 26, 41, 47; 256B.0631, subdivision 1; 256B.0651;
1.31 256B.0652; 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657,
1.32 subdivisions 2, 6, 8; 256B.0911, subdivisions 1, 1a, 3, 3a, 4a, 5, 6, 7, by adding
1.33 subdivisions; 256B.0913, subdivision 4; 256B.0915, subdivisions 3e, 3h, 5,
1.34 by adding a subdivision; 256B.0917, by adding a subdivision; 256B.092,
1.35 subdivision 8a, by adding subdivisions; 256B.0944, by adding a subdivision;
1.36 256B.0945, subdivision 4; 256B.0947, subdivision 1; 256B.15, subdivisions 1a,
1.37 1h, 2, by adding subdivisions; 256B.437, subdivision 6; 256B.441, subdivisions
1.38 48, 55, by adding subdivisions; 256B.49, subdivisions 12, 14, 17, by adding
1.39

2.1 subdivisions; 256B.501, subdivision 4a; 256B.5011, subdivision 2; 256B.5012,
 2.2 by adding a subdivision; 256B.5013, subdivision 1; 256B.69, subdivisions 5a,
 2.3 5c, 5f; 256B.76, subdivisions 1, 4, by adding a subdivision; 256B.761; 256D.03,
 2.4 subdivision 4; 256D.051, subdivision 2a; 256D.0515; 256D.06, subdivision 2;
 2.5 256D.09, subdivision 6; 256D.44, subdivision 5; 256D.46; 256D.49, subdivision
 2.6 3; 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivision 1a;
 2.7 256J.20, subdivision 3; 256J.24, subdivisions 5a, 10; 256J.37, subdivision 3a, by
 2.8 adding a subdivision; 256J.38, subdivision 1; 256J.45, subdivision 3; 256J.575,
 2.9 subdivisions 3, 6, 7; 256J.621; 256J.626, subdivision 6; 256J.751, by adding
 2.10 a subdivision; 256J.95, subdivision 12; 256L.04, subdivision 10a; 256L.05,
 2.11 subdivision 1, by adding subdivisions; 256L.11, subdivisions 1, 7; 256L.12,
 2.12 subdivision 9; 256L.17, subdivision 3; 259.89, subdivision 1; 260C.317,
 2.13 subdivision 4; 393.07, subdivision 10; 501B.89, by adding a subdivision;
 2.14 518A.53, subdivisions 1, 4, 10; 519.05; 604A.33, subdivision 1; 609.232,
 2.15 subdivision 11; 626.556, subdivision 3c, by adding a subdivision; 626.5572,
 2.16 subdivisions 6, 21; Laws 2003, First Special Session chapter 14, article 13C,
 2.17 section 2, subdivision 1, as amended; Laws 2007, chapter 147, article 19, section
 2.18 3, subdivision 4, as amended; proposing coding for new law in Minnesota
 2.19 Statutes, chapters 62Q; 144; 246B; 254A; 254B; 256; 256B; proposing coding
 2.20 for new law as Minnesota Statutes, chapter 402A; repealing Minnesota Statutes
 2.21 2008, sections 62U.08; 246.51, subdivision 1; 246.53, subdivision 3; 256.962,
 2.22 subdivision 7; 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6,
 2.23 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.092, subdivision
 2.24 5a; 256I.06, subdivision 9; 256J.626, subdivision 7; 259.83, subdivision 3;
 2.25 259.89, subdivisions 2, 3, 4; Minnesota Rules, parts 9500.1243, subpart 3;
 2.26 9500.1261, subparts 3, 4, 5, 6; 9555.6125, subpart 4, item B.

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

2.28 **ARTICLE 1**

2.29 **LICENSING**

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

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

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

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

2.42 (1) in cases of financial hardship;

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

2.44 (3) for new providers; or

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

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

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

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

3.15 (1) in cases of financial hardship;

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

3.17 (3) for new providers.

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

3.19 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
3.20 under subdivision 1, an applicant for an initial license or certification issued by the
3.21 commissioner shall submit a ~~\$500~~ \$750 application fee with each new application required
3.22 under this subdivision. The application fee shall not be prorated, is nonrefundable, and
3.23 is in lieu of the annual license or certification fee that expires on December 31. The
3.24 commissioner shall not process an application until the application fee is paid.

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

3.27 (1) For a license to provide ~~waivered~~ residential-based habilitation services to
3.28 persons with developmental disabilities ~~or related conditions~~ under chapter 245B, an
3.29 applicant shall submit an application for each county in which the ~~waivered~~ services
3.30 will be provided.

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

4.1 (3) For a license to provide independent living assistance for youth under section
 4.2 245A.22, an applicant shall submit a single application to provide services statewide.

4.3 Sec. 3. Minnesota Statutes 2008, section 245A.10, subdivision 4, is amended to read:

4.4 Subd. 4. **License ~~or certification~~ fee for ~~certain programs~~ a child care center.**

4.5 ~~(a) A child care centers and programs with a licensed capacity center~~ shall pay an annual
 4.6 nonrefundable license ~~or certification~~ fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee <u>Fiscal Year</u> <u>2010</u>	Other Program License Fee <u>Fiscal</u> <u>Year 2011 and</u> <u>thereafter</u>
1 to 24 persons	\$225 <u>\$295</u>	\$400 <u>\$360</u>
25 to 49 persons	\$340 <u>\$410</u>	\$600 <u>\$475</u>
50 to 74 persons	\$450 <u>\$520</u>	\$800 <u>\$585</u>
75 to 99 persons	\$565 <u>\$635</u>	\$1,000 <u>\$700</u>
100 to 124 persons	\$675 <u>\$745</u>	\$1,200 <u>\$810</u>
125 to 149 persons	\$900 <u>\$970</u>	\$1,400 <u>\$1,035</u>
	\$1,050	
150 to 174 persons	\$1,120	\$1,600 <u>\$1,185</u>
	\$1,200	
175 to 199 persons	\$1,270	\$1,800 <u>\$1,335</u>
	\$1,350	
200 to 224 persons	\$1,420	\$2,000 <u>\$1,485</u>
	\$1,500	
225 or more persons	\$1,570	\$2,500 <u>\$1,635</u>

4.25 ~~(b) A day training and habilitation program serving persons with developmental~~
 4.26 ~~disabilities or related conditions shall be assessed a license fee based on the schedule in~~
 4.27 ~~paragraph (a) unless the license holder serves more than 50 percent of the same persons~~
 4.28 ~~at two or more locations in the community. Except as provided in paragraph (c), when a~~
 4.29 ~~day training and habilitation program serves more than 50 percent of the same persons in~~
 4.30 ~~two or more locations in a community, the day training and habilitation program shall pay~~
 4.31 ~~a license fee based on the licensed capacity of the largest facility and the other facility~~
 4.32 ~~or facilities shall be charged a license fee based on a licensed capacity of a residential~~
 4.33 ~~program serving one to 24 persons.~~

4.34 ~~(c) When a day training and habilitation program serving persons with developmental~~
 4.35 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
 4.36 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
 4.37 ~~capacity for each location.~~

5.1 Sec. 4. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 5.2 to read:

5.3 Subd. 4a. License fee for an adult day care center. An adult day care center
 5.4 licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual
 5.5 nonrefundable license fee based on the following schedule:

	<u>Licensed Capacity</u>	<u>License Fee Fiscal</u> <u>Year 2010</u>	<u>License Fee Fiscal</u> <u>Year 2011 and thereafter</u>
5.8	<u>1 to 24 persons</u>	<u>\$930</u>	<u>\$1,460</u>
5.9	<u>25 to 49 persons</u>	<u>\$1,130</u>	<u>\$1,660</u>
5.10	<u>50 to 74 persons</u>	<u>\$1,330</u>	<u>\$1,860</u>
5.11	<u>75 to 99 persons</u>	<u>\$1,530</u>	<u>\$2,060</u>
5.12	<u>100 or more persons</u>	<u>\$1,730</u>	<u>\$2,260</u>

5.13 Sec. 5. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 5.14 to read:

5.15 Subd. 4b. License fee for day training and habilitation program. (a) A day
 5.16 training and habilitation program licensed under chapter 245B to provide services to
 5.17 persons with developmental disabilities shall pay an annual nonrefundable license fee
 5.18 based on the following schedule:

	<u>Licensed Capacity</u>	<u>License Fee Fiscal</u> <u>Year 2010</u>	<u>License Fee Fiscal</u> <u>Year 2011 and thereafter</u>
5.21	<u>1 to 24 persons</u>	<u>\$925</u>	<u>\$1,430</u>
5.22	<u>25 to 49 persons</u>	<u>\$1,125</u>	<u>\$1,630</u>
5.23	<u>50 to 74 persons</u>	<u>\$1,325</u>	<u>\$1,830</u>
5.24	<u>75 to 99 persons</u>	<u>\$1,525</u>	<u>\$2,030</u>
5.25	<u>100 to 124 persons</u>	<u>\$1,725</u>	<u>\$2,230</u>
5.26	<u>125 to 149 persons</u>	<u>\$1,925</u>	<u>\$2,430</u>
5.27	<u>150 to 174 persons</u>	<u>\$2,125</u>	<u>\$2,630</u>
5.28	<u>175 to 199 persons</u>	<u>\$2,325</u>	<u>\$2,830</u>
5.29	<u>200 to 224 persons</u>	<u>\$2,525</u>	<u>\$3,030</u>
5.30	<u>225 or more persons</u>	<u>\$3,025</u>	<u>\$3,530</u>

5.31 (b) A day training and habilitation program licensed under chapter 245B must
 5.32 be assessed a license fee based on the schedule in paragraph (a) unless the license
 5.33 holder serves more than 50 percent of the same persons at two or more locations in the
 5.34 community. Except as provided in paragraph (c), when a day training and habilitation
 5.35 program serves more than 50 percent of the same persons in two or more locations in a
 5.36 community, the day training and habilitation program shall pay a license fee based on the

6.1 licensed capacity of the largest facility and the other facility or facilities must be charged a
 6.2 license fee based on a licensed capacity of a residential program serving one to 24 persons.

6.3 (c) When a day training and habilitation program serving persons with developmental
 6.4 disabilities seeks a single license allowed under section 245B.07, subdivision 12, clause (2)
 6.5 or (3), the licensing fee must be based on the combined licensed capacity for each location.

6.6 Sec. 6. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 6.7 to read:

6.8 Subd. 4c. **License fee for residential program serving persons with**
 6.9 **developmental disabilities.** A residential program licensed under chapter 245B whether
 6.10 certified as an intermediate care facility for persons with developmental disabilities or not
 6.11 shall pay an annual nonrefundable license fee based on the following schedule:

	<u>Licensed Capacity</u>	<u>License Fee Fiscal</u>	<u>License Fee Fiscal Year</u>
		<u>Year 2010</u>	<u>2011 and thereafter</u>
6.14	<u>1 to 24 persons</u>	<u>\$1,000</u>	<u>\$1,600</u>
6.15	<u>25 to 49 persons</u>	<u>\$1,200</u>	<u>\$1,800</u>
6.16	<u>50 to 74 persons</u>	<u>\$1,400</u>	<u>\$2,000</u>
6.17	<u>75 or more persons</u>	<u>\$1,600</u>	<u>\$2,200</u>

6.18 Sec. 7. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 6.19 to read:

6.20 Subd. 4d. **License fee for program providing crisis respite.** (a) In fiscal year
 6.21 2010, a program licensed to provide crisis respite services for persons with developmental
 6.22 disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$1,600.

6.23 (b) In fiscal year 2011 and thereafter, a program licensed to provide crisis respite
 6.24 services for persons with developmental disabilities under chapter 245B shall pay an
 6.25 annual nonrefundable license fee of \$2,000.

6.26 Sec. 8. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 6.27 to read:

6.28 Subd. 4e. **License fee for program providing residential-based habilitation**
 6.29 **services.** (a) In fiscal year 2010, a program licensed to provide residential-based
 6.30 habilitation services for persons with developmental disabilities under chapter 245B
 6.31 shall pay an annual nonrefundable license fee that is based on a base rate of \$715 plus
 6.32 \$50 times the number of clients served on the first day of August of the current license
 6.33 year. State-operated programs are exempt from the license fee under this paragraph and
 6.34 paragraph (b).

7.1 (b) In fiscal year 2011 and thereafter, a program licensed to provide residential-based
 7.2 habilitation services for persons with developmental disabilities under chapter 245B shall
 7.3 pay an annual nonrefundable license fee that is based on a base rate of \$1,000 plus \$70
 7.4 times the number of clients served on the first day of August of the current license year.

7.5 Sec. 9. Minnesota Statutes 2008, section 245A.10, is amended by adding a subdivision
 7.6 to read:

7.7 Subd. 4f. **License fee for program providing semi-independent living services**
 7.8 **or supported employment services.** (a) In fiscal year 2010, a program licensed to
 7.9 provide semi-independent living services for persons with developmental disabilities
 7.10 under chapter 245B or supported employment services for persons with developmental
 7.11 disabilities under chapter 245B shall pay an annual nonrefundable license fee of \$1,250.

7.12 (b) In fiscal year 2011 and thereafter, a program licensed to provide semi-independent
 7.13 living services for persons with developmental disabilities under chapter 245B or
 7.14 supported employment services for persons with developmental disabilities under chapter
 7.15 245B shall pay an annual nonrefundable license fee of \$2,000.

7.16 Sec. 10. Minnesota Statutes 2008, section 245A.10, is amended by adding a
 7.17 subdivision to read:

7.18 Subd. 4g. **License fee for residential program serving persons with physical**
 7.19 **disabilities.** A residential program licensed under Minnesota Rules, parts 9570.2000 to
 7.20 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
 7.21 license fee based on the following schedule:

	<u>Licensed Capacity</u>	<u>License Fee Fiscal</u> <u>Year 2010</u>	<u>License Fee Fiscal</u> <u>Year 2011 and thereafter</u>
7.24	<u>1 to 24 persons</u>	<u>\$713</u>	<u>\$1,025</u>
7.25	<u>25 to 49 persons</u>	<u>\$913</u>	<u>\$1,225</u>
7.26	<u>50 to 74 persons</u>	<u>\$1,113</u>	<u>\$1,425</u>
7.27	<u>75 to 99 persons</u>	<u>\$1,313</u>	<u>\$1,625</u>
7.28	<u>100 to 124 persons</u>	<u>\$1,513</u>	<u>\$1,825</u>
7.29	<u>125 or more persons</u>	<u>\$1,713</u>	<u>\$2,025</u>

7.30 Sec. 11. Minnesota Statutes 2008, section 245A.10, is amended by adding a
 7.31 subdivision to read:

7.32 Subd. 4h. **License fee for residential programs serving adults with mental**
 7.33 **illness.** (a) In fiscal year 2010, a residential program licensed under Minnesota Rules,

8.1 parts 9520.0500 to 9520.0670, to serve adults with mental illness shall pay an annual
 8.2 nonrefundable license fee of \$2,450.

8.3 (b) In fiscal year 2011 and thereafter, a residential program licensed under Minnesota
 8.4 Rules, parts 9520.0500 to 9520.0670, to serve adults with mental illness shall pay an
 8.5 annual nonrefundable license fee of \$4,400.

8.6 Sec. 12. Minnesota Statutes 2008, section 245A.10, is amended by adding a
 8.7 subdivision to read:

8.8 Subd. 4i. **License fee for a children's residential program.** (a) In fiscal year 2010,
 8.9 a children's residential program licensed under Minnesota Rules, chapter 2960, shall pay
 8.10 an annual nonrefundable license fee of \$2,450.

8.11 (b) In fiscal year 2011 and thereafter, a children's residential program licensed under
 8.12 Minnesota Rules, chapter 2960, shall pay an annual nonrefundable license fee of \$4,400.

8.13 Sec. 13. Minnesota Statutes 2008, section 245A.10, is amended by adding a
 8.14 subdivision to read:

8.15 Subd. 4j. **License fee for programs licensed to provide drug or chemical**
 8.16 **dependency treatment.** (a) A program licensed under Minnesota Rules, parts 9530.6405
 8.17 to 9530.6505 or 9530.6510 to 9530.6590, to provide drug or chemical dependency
 8.18 treatment shall pay an annual nonrefundable license fee based on the following schedule:

	<u>Licensed Capacity</u>	<u>License Fee Fiscal</u>	<u>License Fee Fiscal</u>
		<u>Year 2010</u>	<u>2011 and thereafter</u>
8.21	<u>1 to 24 persons</u>	<u>\$755</u>	<u>\$1,035</u>
8.22	<u>25 to 49 persons</u>	<u>\$955</u>	<u>\$1,235</u>
8.23	<u>50 to 74 persons</u>	<u>\$1,155</u>	<u>\$1,435</u>
8.24	<u>75 to 99 persons</u>	<u>\$1,355</u>	<u>\$1,635</u>
8.25	<u>100 to 124 persons</u>	<u>\$1,555</u>	<u>\$1,835</u>
8.26	<u>125 or more persons</u>	<u>\$1,755</u>	<u>\$2,035</u>

8.27 (b) In fiscal year 2010, if a license issued to a program under Minnesota Rules, parts
 8.28 9530.6405 to 9530.6505, does not have a stated licensed capacity, the drug or chemical
 8.29 dependency treatment program shall pay an annual nonrefundable license fee based on a
 8.30 licensed capacity of one to 24 persons for fiscal year 2010.

8.31 (c) In fiscal year 2011 and thereafter, if a license issued to a program under Minnesota
 8.32 Rules, parts 9530.6405 to 9530.6505, does not have a stated licensed capacity, the drug or
 8.33 chemical dependency treatment program shall pay an annual nonrefundable license fee
 8.34 based on a licensed capacity of one to 24 persons for fiscal year 2011 and thereafter.

9.1 Sec. 14. Minnesota Statutes 2008, section 245A.10, is amended by adding a
9.2 subdivision to read:

9.3 Subd. 4k. License fee for independent living assistance for youth. A program
9.4 licensed to provide independent living assistance for youth under section 245A.22, shall
9.5 pay an annual nonrefundable license fee of \$2,000.

9.6 Sec. 15. Minnesota Statutes 2008, section 245A.10, is amended by adding a
9.7 subdivision to read:

9.8 Subd. 4l. License fee for private agencies that provide child foster care or
9.9 adoption services. A private agency licensed under Minnesota Rules, parts 9545.0755
9.10 to 9545.0845, to provide child foster care or adoption services shall pay an annual
9.11 nonrefundable license fee of \$400.

9.12 Sec. 16. Minnesota Statutes 2008, section 245A.10, subdivision 5, is amended to read:

9.13 ~~Subd. 5. License or Mental health center or mental health clinic certification fee~~
9.14 ~~for other programs. (a) Except as provided in paragraphs (b) and (c), a program without~~
9.15 ~~a stated licensed capacity shall pay a license or certification fee of \$400.~~

9.16 ~~(b)~~ A mental health center or mental health clinic requesting certification for
9.17 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
9.18 parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,000 per year. If the
9.19 mental health center or mental health clinic provides services at a primary location with
9.20 satellite facilities, the satellite facilities shall be certified with the primary location without
9.21 an additional charge.

9.22 ~~(c) A program licensed to provide residential-based habilitation services under the~~
9.23 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
9.24 ~~an annual license fee that includes a base rate of \$250 plus \$38 times the number of clients~~
9.25 ~~served on the first day of August of the current license year. State-operated programs are~~
9.26 ~~exempt from the license fee under this paragraph.~~

9.27 Sec. 17. Minnesota Statutes 2008, section 245A.10, is amended by adding a
9.28 subdivision to read:

9.29 Subd. 7. Human services licensing revenue and appropriations. Effective July
9.30 1, 2011:

9.31 (1) departmental earnings collected under subdivisions 3, 4 to 4l, and 5 shall be
9.32 deposited in the state government special revenue fund; and

10.1 (2) the direct appropriation to the department for licensing activities in subdivisions
10.2 3, 4 to 4l, and 5 shall be transferred from the general fund to the state government special
10.3 revenue fund.

10.4 Sec. 18. Minnesota Statutes 2008, section 245A.11, subdivision 2a, is amended to read:

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

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

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

10.16 (c) The commissioner may grant variances to paragraph (a) to allow the use of a fifth
10.17 bed for emergency crisis services for a person with serious and persistent mental illness
10.18 or a developmental disability, regardless of age, if the variance complies with section
10.19 245A.04, subdivision 9, and approval of the variance is recommended by the county in
10.20 which the licensed foster care provider is located.

10.21 (d) ~~Notwithstanding paragraph (a),~~ If the 2009 legislature adopts a rate reduction
10.22 that impacts providers of adult foster care services, the commissioner may issue an adult
10.23 foster care license with a capacity of five adults if the fifth bed does not increase the
10.24 overall statewide capacity of licensed adult foster care beds in homes that are not the
10.25 primary residence of the license holder, over the licensed capacity in such homes on July
10.26 1, 2009, as identified in a plan submitted to the commissioner by the county, when the
10.27 capacity is recommended by the county licensing agency of the county in which the
10.28 facility is located and if the recommendation verifies that:

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

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

10.32 (i) individualized plan of care;

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

10.34 (iii) individual resident placement agreement under Minnesota Rules, part

10.35 9555.5105, subpart 19, if required;

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

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

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

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

11.12 Sec. 19. Minnesota Statutes 2008, section 245A.11, is amended by adding a
11.13 subdivision to read:

11.14 **Subd. 8. Alternate overnight supervision technology; adult foster care license.**

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

11.23 (1) that staff are not present on-site overnight; and

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

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

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

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

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

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

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

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

12.13 (i) a description of the triggering incident;

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

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

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

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

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

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

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

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

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

12.34 (2) response alternative (2) requires the electronic notification and alert system
12.35 under alternative (1), but more than ten minutes may pass before the license holder is

13.1 present on-site to respond to the situation. Under alternative (2), all of the following
13.2 conditions are met:

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

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

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

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

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

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

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

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

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

13.35 (5) how the license holder protects the foster care recipient's privacy related to
13.36 electronic monitoring and related to any electronically recorded data generated by the

14.1 monitoring system. The consent form must explain where and how the electronically
14.2 recorded data is stored, with whom it will be shared, and how long it is retained; and
14.3 (6) the risks and benefits of the alternative overnight supervision system.

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

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

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

14.13 (i) For the purposes of paragraphs (c) to (h), "license holder" has the meaning
14.14 under section 245A.02, subdivision 9, and additionally includes all staff, volunteers, and
14.15 contractors affiliated with the license holder.

14.16 Sec. 20. Minnesota Statutes 2008, section 245A.16, subdivision 1, is amended to read:

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

14.27 (1) dual licensure of family child care and child foster care, dual licensure of child
14.28 and adult foster care, and adult foster care and family child care;

14.29 (2) adult foster care maximum capacity;

14.30 (3) adult foster care minimum age requirement;

14.31 (4) child foster care maximum age requirement;

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

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

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

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

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

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

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

15.14 Sec. 21. Minnesota Statutes 2008, section 245A.16, subdivision 3, is amended to read:

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

15.21 Sec. 22. Minnesota Statutes 2008, section 245C.04, subdivision 1, is amended to read:

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

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

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

15.31 (1) registered under chapter 144D; or

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

16.1 (3) the following conditions are met:

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

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

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

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

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

16.22 (f) From January 1, 2010, to December 31, 2012, unless otherwise specified in
16.23 paragraph (c), the commissioner shall conduct a study of an individual required to be
16.24 studied under section 245C.03 at the time of reapplication for an adult foster care license.
16.25 The county shall collect and forward to the commissioner the information required under
16.26 section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a)
16.27 and (b). The background study conducted by the commissioner under this paragraph
16.28 must include a review of the information required under section 245C.08, subdivision 1,
16.29 paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.

16.30 (g) The commissioner shall conduct a background study of an individual specified
16.31 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
16.32 affiliated with an adult foster care license holder. The county shall collect and forward
16.33 to the commissioner the information required under section 245C.05, subdivision 1,
16.34 paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b). The background
16.35 study conducted by the commissioner under this paragraph must include a review of

17.1 the information required under section 245C.08, subdivision 1, paragraph (a), and
17.2 subdivisions 3 and 4.

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

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

17.10 Sec. 23. Minnesota Statutes 2008, section 245C.05, subdivision 4, is amended to read:

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

17.14 (1) background study information to the commissioner;

17.15 (2) background study results to the license holder; ~~and~~

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

17.18 (4) background study results to county agencies for background studies conducted
17.19 by the commissioner for adult foster care.

17.20 Sec. 24. Minnesota Statutes 2008, section 245C.08, subdivision 2, is amended to read:

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

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

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

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

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

17.32 (c) Notwithstanding expungement by a court, the county agency may consider
17.33 information obtained under paragraph (a), clause (3), unless the commissioner received

18.1 notice of the petition for expungement and the court order for expungement is directed
18.2 specifically to the commissioner.

18.3 Sec. 25. Minnesota Statutes 2008, section 245C.10, is amended by adding a
18.4 subdivision to read:

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

18.10 Sec. 26. Minnesota Statutes 2008, section 245C.10, is amended by adding a
18.11 subdivision to read:

18.12 Subd. 8. **Private agencies.** The commissioner shall recover the cost of conducting
18.13 background studies under section 245C.33 for studies initiated by private agencies for the
18.14 purpose of adoption through a fee of no more than \$70 per study charged to the private
18.15 agency. The fees collected under this subdivision are appropriated to the commissioner for
18.16 the purpose of conducting background studies.

18.17 Sec. 27. Minnesota Statutes 2008, section 245C.17, is amended by adding a
18.18 subdivision to read:

18.19 Subd. 6. **Notice to county agency.** For studies on individuals related to a license to
18.20 provide adult foster care, the commissioner shall also provide a notice of the background
18.21 study results to the county agency that initiated the background study.

18.22 Sec. 28. Minnesota Statutes 2008, section 245C.20, is amended to read:

18.23 **245C.20 LICENSE HOLDER RECORD KEEPING.**

18.24 A licensed program shall document the date the program initiates a background
18.25 study under this chapter in the program's personnel files. When a background study is
18.26 completed under this chapter, a licensed program shall maintain a notice that the study
18.27 was undertaken and completed in the program's personnel files. Except when background
18.28 studies are initiated through the commissioner's online system, if a licensed program
18.29 has not received a response from the commissioner under section 245C.17 within 45
18.30 days of initiation of the background study request, the licensed program must contact the
18.31 commissioner human services licensing division to inquire about the status of the study. If
18.32 a license holder initiates a background study under the commissioner's online system, but

19.1 the background study subject's name does not appear in the list of active or recent studies
19.2 initiated by that license holder, the license holder must either contact the human services
19.3 licensing division or resubmit the background study information online for that individual.

19.4 Sec. 29. Minnesota Statutes 2008, section 245C.21, subdivision 1a, is amended to read:

19.5 Subd. 1a. **Submission of reconsideration request to county or private agency.**

19.6 (a) For disqualifications related to studies conducted by county agencies for family child
19.7 care and family adult day services, and for disqualifications related to studies conducted
19.8 by the commissioner for child foster care and adult foster care, the individual shall
19.9 submit the request for reconsideration to the county ~~or private~~ agency that initiated the
19.10 background study.

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

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

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

19.20 Sec. 30. Minnesota Statutes 2008, section 245C.23, subdivision 2, is amended to read:

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

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

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

19.29 (3) an individual who has a right to request a hearing under sections 245C.27 and
19.30 256.045, or 245C.28 and chapter 14 for a disqualification that has not been set aside, does
19.31 not request a hearing within the specified time; or

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

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

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

20.10 (d) For background studies related to adult foster care, the commissioner shall also
20.11 notify the county that initiated the study of the results of the reconsideration.

20.12 Sec. 31. Minnesota Statutes 2008, section 256B.092, is amended by adding a
20.13 subdivision to read:

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

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

20.26 Sec. 32. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

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

20.32 (b) The commissioner shall implement on January 1, 2002, one or more aggregate,
20.33 need-based methods for allocating to local agencies the home and community-based
20.34 waived service resources available to support recipients with disabilities in need of

21.1 the level of care provided in a nursing facility or a hospital. The commissioner shall
21.2 allocate resources to single counties and county partnerships in a manner that reflects
21.3 consideration of:

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

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

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

21.14 (2) an amount approved by the commissioner based on the recipient's extraordinary
21.15 needs that cannot be met within the current allowable reimbursement level. The
21.16 increased reimbursement level must be necessary to allow the recipient to be discharged
21.17 from an institution or to prevent imminent placement in an institution. The additional
21.18 reimbursement may be used to secure environmental modifications; assistive technology
21.19 and equipment; and increased costs for supervision, training, and support services
21.20 necessary to address the recipient's extraordinary needs. The commissioner may approve
21.21 an increased reimbursement level for up to one year of the recipient's relocation from an
21.22 institution or up to six months of a determination that a current waiver recipient is at
21.23 imminent risk of being placed in an institution.

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

21.29 (e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
21.30 legislature adopts a rate reduction that impacts payment to providers of adult foster care
21.31 services, the commissioner may issue adult foster care licenses that permit a capacity of
21.32 five adults. The application for a five-bed license must meet the requirements of section
21.33 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care
21.34 services, the county must negotiate a revised per diem rate for room and board and waiver
21.35 services that reflects the legislated rate reduction and results in an overall average per
21.36 diem reduction for all foster care recipients in that home. The revised per diem must allow

22.1 the provider to maintain, as much as possible, the level of services or enhanced services
22.2 provided in the residence, while mitigating the losses of the legislated rate reduction.

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

22.4 Sec. 33. **WAIVER.**

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

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

22.9 Sec. 34. **REPEALER.**

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

22.12 (b) Minnesota Rules, part 9555.6125, subpart 4, item B, is repealed.

22.13 **ARTICLE 2**

22.14 **MFIP, CHILDREN, AND ADULT SUPPORTS**

22.15 Section 1. Minnesota Statutes 2008, section 256D.051, subdivision 2a, is amended to
22.16 read:

22.17 Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law,
22.18 the commissioner shall:

22.19 (1) based on this section and section 256D.052 and Code of Federal Regulations,
22.20 title 7, section 273.7, supervise the administration of food stamp employment and training
22.21 services to county agencies;

22.22 (2) disburse money appropriated for food stamp employment and training services
22.23 to county agencies based upon the county's costs as specified in section 256D.051,
22.24 subdivision 6c;

22.25 (3) accept and supervise the disbursement of any funds that may be provided by the
22.26 federal government or from other sources for use in this state for food stamp employment
22.27 and training services;

22.28 (4) apply for the maximum allowable federal matching funds under United States
22.29 Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family
22.30 stabilization services participants voluntarily engaged in food stamp employment and
22.31 training activities, where appropriate;

23.1 (5) cooperate with other agencies including any agency of the United States or of
23.2 another state in all matters concerning the powers and duties of the commissioner under
23.3 this section and section 256D.052; and

23.4 ~~(5)~~ (6) in cooperation with the commissioner of employment and economic
23.5 development, ensure that each component of an employment and training program carried
23.6 out under this section is delivered through a statewide workforce development system,
23.7 unless the component is not available locally through such a system.

23.8 Sec. 2. Minnesota Statutes 2008, section 256D.0515, is amended to read:

23.9 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

23.10 All food stamp households must be determined eligible for the benefit discussed
23.11 under section 256.029. Food stamp households must demonstrate that:

23.12 ~~(1)~~ their gross income meets the federal Food Stamp requirements under United
23.13 States Code, title 7, section 2014(c); ~~and~~

23.14 ~~(2) they have financial resources, excluding vehicles, of less than \$7,000.~~

23.15 Sec. 3. Minnesota Statutes 2008, section 256D.06, subdivision 2, is amended to read:

23.16 Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a
23.17 grant of emergency general assistance shall, to the extent funds are available, be made to
23.18 an eligible single adult, married couple, or family for an emergency need, ~~as defined in~~
23.19 ~~rules promulgated by the commissioner,~~ where the recipient requests temporary assistance
23.20 not exceeding 30 days if an emergency situation appears to exist under criteria adopted by
23.21 the county agency and the individual or family is ineligible for MFIP or DWP or is not a
23.22 participant of MFIP or DWP and whose annual net income is no greater than 200 percent
23.23 of the federal poverty level for the previous calendar year. If an applicant or recipient
23.24 relates facts to the county agency which may be sufficient to constitute an emergency
23.25 situation, the county agency shall, to the extent funds are available, advise the person of the
23.26 procedure for applying for assistance according to this subdivision. An emergency general
23.27 assistance grant is available to a recipient not more than once in any 12-month period.

23.28 (b) Funding for an emergency general assistance program is limited to the
23.29 appropriation. Each fiscal year, the commissioner shall allocate to counties the money
23.30 appropriated for emergency general assistance grants based on each county agency's
23.31 average share of state's emergency general expenditures for the immediate past three fiscal
23.32 years as determined by the commissioner, and may reallocate any unspent amounts to
23.33 other counties.

23.34 (c) No county shall be allocated less than \$1,000 for the fiscal year.

24.1 (d) Should an emergency be declared as provided in section 12.31, the commissioner
24.2 may immediately reallocate unspent funds without regard to the other provisions of this
24.3 section to meet the emergency needs. The emergency reallocation must be excluded from
24.4 calculations for subsequent allocations as provided in paragraphs (b) and (c).

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

24.7 Sec. 4. Minnesota Statutes 2008, section 256D.09, subdivision 6, is amended to read:

24.8 Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or
24.9 family general assistance is paid to a recipient in excess of the payment due, it shall be
24.10 recoverable by the county agency. The agency shall give written notice to the recipient of
24.11 its intention to recover the overpayment.

24.12 (b) Except as provided for interim assistance in section 256D.06, subdivision
24.13 5, when an overpayment occurs, the county agency shall recover the overpayment
24.14 from a current recipient by reducing the amount of aid payable to the assistance unit of
24.15 which the recipient is a member, for one or more monthly assistance payments, until
24.16 the overpayment is repaid. All county agencies in the state shall reduce the assistance
24.17 payment by three percent of the assistance unit's standard of need in nonfraud cases and
24.18 ten percent where fraud has occurred, or the amount of the monthly payment, whichever is
24.19 less, for all overpayments.

24.20 (c) In cases when there is both an overpayment and underpayment, the county
24.21 agency shall offset one against the other in correcting the payment.

24.22 (d) Overpayments may also be voluntarily repaid, in part or in full, by the individual,
24.23 in addition to the aid reductions provided in this subdivision, to include further voluntary
24.24 reductions in the grant level agreed to in writing by the individual, until the total amount
24.25 of the overpayment is repaid.

24.26 (e) The county agency shall make reasonable efforts to recover overpayments to
24.27 persons no longer on assistance under standards adopted in rule by the commissioner
24.28 of human services. The county agency need not attempt to recover overpayments of
24.29 less than \$35 paid to an individual no longer on assistance if the individual does not
24.30 receive assistance again within three years, unless the individual has been convicted of
24.31 violating section 256.98.

24.32 (f) Establishment of an overpayment is limited to 12 months prior to the month of
24.33 discovery due to an agency error and six years prior to the month of discovery due to a
24.34 client error or an intentional program violation determined under section 256.046.

25.1 Sec. 5. Minnesota Statutes 2008, section 256D.46, is amended to read:

25.2 **256D.46 EMERGENCY MINNESOTA SUPPLEMENTAL AID.**

25.3 Subdivision 1. **Eligibility.** ~~A county agency must grant emergency Minnesota~~
25.4 ~~supplemental aid, to the extent funds are available, if the recipient is without adequate~~
25.5 ~~resources to resolve an emergency that, if unresolved, will threaten the health or safety~~
25.6 ~~of the recipient. For the purposes of this section, the term "recipient" includes persons~~
25.7 ~~for whom a group residential housing benefit is being paid under sections 256I.01 to~~
25.8 ~~256I.06. Recipients of Minnesota supplemental aid who have emergent need may apply~~
25.9 ~~for emergency general assistance medical care under section 256D.06, subdivision 2.~~

25.10 **Subd. 2. Income and resource test.** ~~All income and resources available to the~~
25.11 ~~recipient must be considered in determining the recipient's ability to meet the emergency~~
25.12 ~~need. Property that can be liquidated in time to resolve the emergency and income,~~
25.13 ~~excluding an amount equal to the Minnesota supplemental aid standard of assistance, that~~
25.14 ~~is normally disregarded or excluded under the Minnesota supplemental aid program must~~
25.15 ~~be considered available to meet the emergency need.~~

25.16 **Subd. 3. Payment amount.** ~~The amount of assistance granted under emergency~~
25.17 ~~Minnesota supplemental aid is limited to the amount necessary to resolve the emergency.~~
25.18 ~~An emergency Minnesota supplemental aid grant is available to a recipient no more~~
25.19 ~~than once in any 12-month period. Funding for emergency Minnesota supplemental~~
25.20 ~~aid is limited to the appropriation. Each fiscal year, the commissioner shall allocate to~~
25.21 ~~counties the money appropriated for emergency Minnesota supplemental aid grants based~~
25.22 ~~on each county agency's average share of state's emergency Minnesota supplemental aid~~
25.23 ~~expenditures for the immediate past three fiscal years as determined by the commissioner,~~
25.24 ~~and may reallocate any unspent amounts to other counties. Any emergency Minnesota~~
25.25 ~~supplemental aid expenditures by a county above the amount of the commissioner's~~
25.26 ~~allocation to the county must be made from county funds.~~

25.27 Sec. 6. Minnesota Statutes 2008, section 256D.49, subdivision 3, is amended to read:

25.28 **Subd. 3. Overpayment of monthly grants and recovery of ATM errors.** (a) When
25.29 the county agency determines that an overpayment of the recipient's monthly payment
25.30 of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment
25.31 to the recipient. If the person is no longer receiving Minnesota supplemental aid, the
25.32 county agency may request voluntary repayment or pursue civil recovery. If the person is
25.33 receiving Minnesota supplemental aid, the county agency shall recover the overpayment
25.34 by withholding an amount equal to three percent of the standard of assistance for the
25.35 recipient or the total amount of the monthly grant, whichever is less.

26.1 (b) Establishment of an overpayment is limited to 12 months prior to the month of
26.2 discovery due to an agency error and six years prior to the month of discovery due to a
26.3 client error or an intentional program violation determined under section 256.046.

26.4 (c) For recipients receiving benefits via electronic benefit transfer, if the overpayment
26.5 is a result of an automated teller machine (ATM) dispensing funds in error to the recipient,
26.6 the agency may recover the ATM error by immediately withdrawing funds from the
26.7 recipient's electronic benefit transfer account, up to the amount of the error.

26.8 (d) Residents of nursing homes, regional treatment centers, and licensed residential
26.9 facilities with negotiated rates shall not have overpayments recovered from their personal
26.10 needs allowance.

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

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

26.19 Sec. 8. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

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

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

27.1 The county agency shall count the loan value of all other vehicles and apply this
27.2 amount as if it were equity value to the asset limit described in this section. To establish the
27.3 loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide,
27.4 Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook,
27.5 or when the applicant or participant disputes the loan value listed in the guidebook as
27.6 unreasonable given the condition of the particular vehicle, the county agency may require
27.7 the applicant or participant document the loan value by securing a written statement from
27.8 a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer
27.9 would pay to purchase the vehicle. The county agency shall reimburse the applicant or
27.10 participant for the cost of a written statement that documents a lower loan value;
27.11 (2) the value of life insurance policies for members of the assistance unit;
27.12 (3) one burial plot per member of an assistance unit;
27.13 (4) the value of personal property needed to produce earned income, including
27.14 tools, implements, farm animals, inventory, business loans, business checking and
27.15 savings accounts used at least annually and used exclusively for the operation of a
27.16 self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use
27.17 is to produce income and if the vehicles are essential for the self-employment business;
27.18 (5) the value of personal property not otherwise specified which is commonly
27.19 used by household members in day-to-day living such as clothing, necessary household
27.20 furniture, equipment, and other basic maintenance items essential for daily living;
27.21 (6) the value of real and personal property owned by a recipient of Supplemental
27.22 Security Income or Minnesota supplemental aid;
27.23 (7) the value of corrective payments, but only for the month in which the payment
27.24 is received and for the following month;
27.25 (8) a mobile home or other vehicle used by an applicant or participant as the
27.26 applicant's or participant's home;
27.27 (9) money in a separate escrow account that is needed to pay real estate taxes or
27.28 insurance and that is used for this purpose;
27.29 (10) money held in escrow to cover employee FICA, employee tax withholding,
27.30 sales tax withholding, employee worker compensation, business insurance, property rental,
27.31 property taxes, and other costs that are paid at least annually, but less often than monthly;
27.32 (11) monthly assistance payments for the current month's or short-term emergency
27.33 needs under section 256J.626, subdivision 2;
27.34 (12) the value of school loans, grants, or scholarships for the period they are
27.35 intended to cover;

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

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

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

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

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

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

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

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

28.18 Sec. 9. Minnesota Statutes 2008, section 256J.24, subdivision 5a, is amended to read:

28.19 Subd. 5a. **Food portion of MFIP transitional standard.** The commissioner
28.20 shall adjust the food portion of the MFIP transitional standard ~~by October 1 each year~~
28.21 ~~beginning October 1998~~ as needed to reflect the ~~cost-of-living~~ adjustments to the food
28.22 ~~Stamp support~~ program. The commissioner shall ~~annually~~ publish ~~in the State Register~~
28.23 the transitional standard for an assistance unit of sizes one to ten in the State Register
28.24 whenever an adjustment is made.

28.25 Sec. 10. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

28.26 Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income
28.27 disregard to ensure that most participants do not lose eligibility for MFIP until their
28.28 income reaches at least ~~115~~ 110 percent of the federal poverty guidelines in effect ~~in~~
28.29 ~~October of each fiscal year~~ at the time of the adjustment. The adjustment to the disregard
28.30 shall be based on a household size of three, and the resulting earned income disregard
28.31 percentage must be applied to all household sizes. The adjustment under this subdivision
28.32 must be implemented ~~at the same time as the October food stamp~~ or whenever there is a
28.33 food support ~~cost-of-living~~ adjustment is reflected in the food portion of MFIP transitional
28.34 standard as required under subdivision 5a.

29.1 Sec. 11. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

29.2 Subd. 3a. **Rental subsidies; unearned income.** (a) ~~Effective July 1, 2003,~~ The
29.3 county agency shall count ~~\$50~~ \$100 of the value of public and assisted rental subsidies
29.4 provided through the Department of Housing and Urban Development (HUD) as unearned
29.5 income to the cash portion of the MFIP grant. The full amount of the subsidy must be
29.6 counted as unearned income when the subsidy is less than ~~\$50~~ \$100. The income from
29.7 this subsidy shall be budgeted according to section 256J.34.

29.8 (b) The provisions of this subdivision shall not apply to an MFIP assistance unit
29.9 which includes a participant who is:

29.10 (1) age 60 or older;

29.11 (2) a caregiver who is suffering from an illness, injury, or incapacity that has been
29.12 certified by a qualified professional when the illness, injury, or incapacity is expected
29.13 to continue for more than 30 days and prevents the person from obtaining or retaining
29.14 employment; or

29.15 (3) a caregiver whose presence in the home is required due to the illness or
29.16 incapacity of another member in the assistance unit, a relative in the household, or a foster
29.17 child in the household when the illness or incapacity and the need for the participant's
29.18 presence in the home has been certified by a qualified professional and is expected to
29.19 continue for more than 30 days.

29.20 (c) The provisions of this subdivision shall not apply to an MFIP assistance unit
29.21 where the parental caregiver is an SSI recipient.

29.22 (d) Prior to implementing this provision, the commissioner must identify the MFIP
29.23 participants subject to this provision and provide written notice to these participants at
29.24 least 30 days before the first grant reduction. The notice must inform the participant of the
29.25 basis for the potential grant reduction, the exceptions to the provision, if any, and inform
29.26 the participant of the steps necessary to claim an exception. A person who is found not to
29.27 meet one of the exceptions to the provision must be notified and informed of the right to a
29.28 fair hearing under section 256J.40. The notice must also inform the participant that the
29.29 participant may be eligible for a rent reduction resulting from a reduction in the MFIP
29.30 grant and encourage the participant to contact the local housing authority.

29.31 **EFFECTIVE DATE.** This section is effective February 1, 2010.

29.32 Sec. 12. Minnesota Statutes 2008, section 256J.37, is amended by adding a subdivision
29.33 to read:

29.34 **Subd. 11. Treatment of Supplemental Security Income.** Effective March 1,
29.35 2010, the county shall reduce the cash portion of the MFIP grant by up to \$125 for an

30.1 MFIP assistance unit that includes one or more Supplemental Security Income (SSI)
30.2 recipients who reside in the household, and who would otherwise be included in the MFIP
30.3 assistance unit under section 256J.24, subdivision 2, but are excluded solely due to the
30.4 SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If
30.5 the SSI recipient or recipients receive less than \$125 of SSI, only the amount received
30.6 must be used in calculating the MFIP cash assistance payment. This provision does not
30.7 apply to relative caregivers who could elect to be included in the MFIP assistance unit
30.8 under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are
30.9 included in the MFIP assistance unit.

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

30.11 Sec. 13. Minnesota Statutes 2008, section 256J.38, subdivision 1, is amended to read:

30.12 Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant
30.13 receives an overpayment due to agency, client, or ATM error, or due to assistance received
30.14 while an appeal is pending and the participant or former participant is determined
30.15 ineligible for assistance or for less assistance than was received, the county agency must
30.16 recoup or recover the overpayment using the following methods:

30.17 (1) reconstruct each affected budget month and corresponding payment month;

30.18 (2) use the policies and procedures that were in effect for the payment month; and

30.19 (3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the
30.20 calculation of the overpayment when the unit has not reported within two calendar months
30.21 following the end of the month in which the income was received.

30.22 (b) Establishment of an overpayment is limited to 12 months prior to the month of
30.23 discovery due to agency error and six years prior to the month of discovery due to client
30.24 error or an intentional program violation determined under section 256.046.

30.25 Sec. 14. Minnesota Statutes 2008, section 256J.575, subdivision 3, is amended to read:

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

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

30.32 (2) a participant who is applying for Supplemental Security Income or Social
30.33 Security disability insurance; and

31.1 (3) a participant who is a noncitizen who has been in the United States for 12 or
31.2 fewer months.

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

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

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

31.12 Sec. 15. Minnesota Statutes 2008, section 256J.621, is amended to read:

31.13 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

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

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

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

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

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

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

31.31 (c) Expenditures on the program are maintenance of effort state funds under
31.32 a separate state program for participants under paragraph (b), clauses (1) and (2).

31.33 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort

32.1 funds. Months in which a participant receives work participation cash benefits under this
32.2 section do not count toward the participant's MFIP 60-month time limit.

32.3 Sec. 16. Minnesota Statutes 2008, section 256J.626, subdivision 6, is amended to read:

32.4 Subd. 6. **Base allocation to counties and tribes; definitions.** (a) For purposes of
32.5 this section, the following terms have the meanings given.

32.6 (1) "2002 historic spending base" means the commissioner's determination of
32.7 the sum of the reimbursement related to fiscal year 2002 of county or tribal agency
32.8 expenditures for the base programs listed in clause ~~(6)~~ (5), items (i) through (iv), and
32.9 earnings related to calendar year 2002 in the base program listed in clause ~~(6)~~ (5), item
32.10 (v), and the amount of spending in fiscal year 2002 in the base program listed in clause
32.11 ~~(6)~~ (5), item (vi), issued to or on behalf of persons residing in the county or tribal service
32.12 delivery area.

32.13 (2) "Adjusted caseload factor" means a factor weighted:

32.14 (i) 47 percent on the MFIP cases in each county at four points in time in the most
32.15 recent 12-month period for which data is available multiplied by the county's caseload
32.16 difficulty factor; and

32.17 (ii) 53 percent on the count of adults on MFIP in each county and tribe at four points
32.18 in time in the most recent 12-month period for which data is available multiplied by the
32.19 county or tribe's caseload difficulty factor.

32.20 (3) "Caseload difficulty factor" means a factor determined by the commissioner for
32.21 each county and tribe based upon the self-support index described in section 256J.751,
32.22 subdivision 2, clause (6).

32.23 ~~(4) "Initial allocation" means the amount potentially available to each county or tribe~~
32.24 ~~based on the formula in paragraphs (b) through (d).~~

32.25 ~~(5)~~ (4) "Final allocation" means the amount available to each county or tribe based
32.26 on the formula in paragraphs (b) through (d), after adjustment by subdivision 7 and (c).

32.27 ~~(6)~~ (5) "Base programs" means the:

32.28 (i) MFIP employment and training services under Minnesota Statutes 2002, section
32.29 256J.62, subdivision 1, in effect June 30, 2002;

32.30 (ii) bilingual employment and training services to refugees under Minnesota Statutes
32.31 2002, section 256J.62, subdivision 6, in effect June 30, 2002;

32.32 (iii) work literacy language programs under Minnesota Statutes 2002, section
32.33 256J.62, subdivision 7, in effect June 30, 2002;

32.34 (iv) supported work program authorized in Laws 2001, First Special Session chapter
32.35 9, article 17, section 2, in effect June 30, 2002;

33.1 (v) administrative aid program under section 256J.76 in effect December 31, 2002;
33.2 and

33.3 (vi) emergency assistance program under Minnesota Statutes 2002, section 256J.48,
33.4 in effect June 30, 2002.

33.5 (b) The commissioner shall:

33.6 ~~(1) beginning July 1, 2003, determine the initial allocation of funds available under~~
33.7 ~~this section according to clause (2);~~

33.8 ~~(2) allocate all of the funds available for the period beginning July 1, 2003, and~~
33.9 ~~ending December 31, 2004, to each county or tribe in proportion to the county's or tribe's~~
33.10 ~~share of the statewide 2002 historic spending base;~~

33.11 ~~(3) determine for calendar year 2005 the initial allocation of funds to be made~~
33.12 ~~available under this section in proportion to the county or tribe's initial allocation for the~~
33.13 ~~period of July 1, 2003, to December 31, 2004;~~

33.14 ~~(4) determine for calendar year 2006 the initial allocation of funds to be made~~
33.15 ~~available under this section based 90 percent on the proportion of the county or tribe's~~
33.16 ~~share of the statewide 2002 historic spending base and ten percent on the proportion of~~
33.17 ~~the county or tribe's share of the adjusted caseload factor;~~

33.18 ~~(5) determine for calendar year 2007 the initial allocation of funds to be made~~
33.19 ~~available under this section based 70 percent on the proportion of the county or tribe's~~
33.20 ~~share of the statewide 2002 historic spending base and 30 percent on the proportion of the~~
33.21 ~~county or tribe's share of the adjusted caseload factor; and~~

33.22 ~~(6) determine for calendar year 2008 and subsequent years the initial allocation of~~
33.23 ~~allocate funds to be made available under this section based 50 percent on the proportion~~
33.24 ~~of the county or tribe's share of the statewide 2002 historic spending base and 50 percent~~
33.25 ~~on the proportion of the county or tribe's share of the adjusted caseload factor.~~

33.26 (c) With the commencement of a new or expanded tribal TANF program or an
33.27 agreement under section 256.01, subdivision 2, paragraph (g), in which some or all of
33.28 the responsibilities of particular counties under this section are transferred to a tribe,
33.29 the commissioner shall:

33.30 (1) in the case where all responsibilities under this section are transferred to a tribal
33.31 program, determine the percentage of the county's current caseload that is transferring to a
33.32 tribal program and adjust the affected county's allocation accordingly; and

33.33 (2) in the case where a portion of the responsibilities under this section are
33.34 transferred to a tribal program, the commissioner shall consult with the affected county or
33.35 counties to determine an appropriate adjustment to the allocation.

34.1 ~~(d) Effective January 1, 2005, counties and tribes will have their final allocations~~
34.2 ~~adjusted based on the performance provisions of subdivision 7.~~

34.3 **EFFECTIVE DATE.** This section is effective January 1, 2010.

34.4 Sec. 17. Minnesota Statutes 2008, section 256J.751, is amended by adding a
34.5 subdivision to read:

34.6 **Subd. 2a. County performance standards.** (a) For the purpose of this section, the
34.7 following terms have the meanings given:

34.8 (1) "Caseload reduction credit" (CRC) means the measure of how much the
34.9 Minnesota TANF caseload, including the separate state program caseload, has fallen
34.10 relative to the federal fiscal year 2005 caseload based on caseload data from October
34.11 1 to September 30.

34.12 (2) "TANF participation rate target" means a 50 percent participation rate reduced by
34.13 the CRC as calculated by the Department of Human Services.

34.14 (b) A county or tribe shall negotiate a multiyear improvement plan with the
34.15 commissioner if the county or tribe does not:

34.16 (1) achieve the TANF participation rate target or a five percentage point improvement
34.17 over the county or tribe's previous year's TANF participation rate under subdivision 2,
34.18 clause (7), as averaged across 12 consecutive months for the most recent year for which
34.19 the measurements are available; or

34.20 (2) perform within or above its range of expected performance on the annualized
34.21 three-year self-support index under subdivision 2, clause (6).

34.22 (c) A county or tribe that has successfully negotiated an improvement plan must
34.23 provide a semiannual report indicating that the plan has been implemented, the impact of
34.24 the plan, and any anticipated changes to the plan.

34.25 Sec. 18. Minnesota Statutes 2008, section 256J.95, subdivision 12, is amended to read:

34.26 **Subd. 12. Conversion or referral to MFIP.** (a) If at any time during the DWP
34.27 application process or during the four-month DWP eligibility period, it is determined that
34.28 a participant is unlikely to benefit from the diversionary work program, the county shall
34.29 convert or refer the participant to MFIP as specified in paragraph (d). Participants who are
34.30 determined to be unlikely to benefit from the diversionary work program must develop
34.31 and sign an employment plan. ~~Participants who meet any one of the criteria in paragraph~~
34.32 ~~(b) shall be considered to be unlikely to benefit from DWP, provided the necessary~~
34.33 ~~documentation is available to support the determination.~~

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

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

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

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

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

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

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

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

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

35.31 (e) The county shall not request a combined application form for a participant who
35.32 has exhausted the four months of the diversionary work program, has continued need for
35.33 cash and food assistance, and has completed, signed, and submitted a program change
35.34 request form within 30 days of the fourth month of the diversionary work program. The
35.35 county must process the program change request according to section 256J.32, subdivision
35.36 1, except that the county agency shall not require additional verification of information

36.1 in the case file unless the information is inaccurate, questionable, or no longer current.
36.2 When a participant does not request MFIP within 30 days of the diversionary work
36.3 program benefits being exhausted, a new combined application form must be completed
36.4 for any subsequent request for MFIP.

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

36.6 Sec. 19. Minnesota Statutes 2008, section 393.07, subdivision 10, is amended to read:

36.7 Subd. 10. **Food stamp program; Maternal and Child Nutrition Act.** (a) The local
36.8 social services agency shall establish and administer the food stamp program according
36.9 to rules of the commissioner of human services, the supervision of the commissioner as
36.10 specified in section 256.01, and all federal laws and regulations. The commissioner of
36.11 human services shall monitor food stamp program delivery on an ongoing basis to ensure
36.12 that each county complies with federal laws and regulations. Program requirements to be
36.13 monitored include, but are not limited to, number of applications, number of approvals,
36.14 number of cases pending, length of time required to process each application and deliver
36.15 benefits, number of applicants eligible for expedited issuance, length of time required
36.16 to process and deliver expedited issuance, number of terminations and reasons for
36.17 terminations, client profiles by age, household composition and income level and sources,
36.18 and the use of phone certification and home visits. The commissioner shall determine the
36.19 county-by-county and statewide participation rate.

36.20 (b) On July 1 of each year, the commissioner of human services shall determine a
36.21 statewide and county-by-county food stamp program participation rate. The commissioner
36.22 may designate a different agency to administer the food stamp program in a county if the
36.23 agency administering the program fails to increase the food stamp program participation
36.24 rate among families or eligible individuals, or comply with all federal laws and regulations
36.25 governing the food stamp program. The commissioner shall review agency performance
36.26 annually to determine compliance with this paragraph.

36.27 (c) A person who commits any of the following acts has violated section 256.98 or
36.28 609.821, or both, and is subject to both the criminal and civil penalties provided under
36.29 those sections:

36.30 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
36.31 willful statement or misrepresentation, or intentional concealment of a material fact, food
36.32 stamps or vouchers issued according to sections 145.891 to 145.897 to which the person
36.33 is not entitled or in an amount greater than that to which that person is entitled or which
36.34 specify nutritional supplements to which that person is not entitled; or

37.1 (2) presents or causes to be presented, coupons or vouchers issued according to
37.2 sections 145.891 to 145.897 for payment or redemption knowing them to have been
37.3 received, transferred or used in a manner contrary to existing state or federal law; or

37.4 (3) willfully uses, possesses, or transfers food stamp coupons, authorization to
37.5 purchase cards or vouchers issued according to sections 145.891 to 145.897 in any manner
37.6 contrary to existing state or federal law, rules, or regulations; or

37.7 (4) buys or sells food stamp coupons, authorization to purchase cards, other
37.8 assistance transaction devices, vouchers issued according to sections 145.891 to 145.897,
37.9 or any food obtained through the redemption of vouchers issued according to sections
37.10 145.891 to 145.897 for cash or consideration other than eligible food.

37.11 (d) A peace officer or welfare fraud investigator may confiscate food stamps,
37.12 authorization to purchase cards, or other assistance transaction devices found in the
37.13 possession of any person who is neither a recipient of the food stamp program nor
37.14 otherwise authorized to possess and use such materials. Confiscated property shall be
37.15 disposed of as the commissioner may direct and consistent with state and federal food
37.16 stamp law. The confiscated property must be retained for a period of not less than 30 days
37.17 to allow any affected person to appeal the confiscation under section 256.045.

37.18 (e) ~~Food stamp overpayment claims which are due in whole or in part to client~~
37.19 ~~error shall be established by the county agency for a period of six years from the date of~~
37.20 ~~any resultant overpayment. Establishment of a food stamp overpayment is limited to 12~~
37.21 months prior to the month of discovery due to an agency error and six years prior to the
37.22 month of discovery due to a client error or an intentional program violation determined
37.23 under section 256.046.

37.24 (f) With regard to the federal tax revenue offset program only, recovery incentives
37.25 authorized by the federal food and consumer service shall be retained at the rate of 50
37.26 percent by the state agency and 50 percent by the certifying county agency.

37.27 (g) A peace officer, welfare fraud investigator, federal law enforcement official,
37.28 or the commissioner of health may confiscate vouchers found in the possession of any
37.29 person who is neither issued vouchers under sections 145.891 to 145.897, nor otherwise
37.30 authorized to possess and use such vouchers. Confiscated property shall be disposed of
37.31 as the commissioner of health may direct and consistent with state and federal law. The
37.32 confiscated property must be retained for a period of not less than 30 days.

37.33 (h) The commissioner of human services may seek a waiver from the United States
37.34 Department of Agriculture to allow the state to specify foods that may and may not be
37.35 purchased in Minnesota with benefits funded by the federal Food Stamp Program. The
37.36 commissioner shall consult with the members of the house of representatives and senate

38.1 policy committees having jurisdiction over food support issues in developing the waiver.
38.2 The commissioner, in consultation with the commissioners of health and education, shall
38.3 develop a broad public health policy related to improved nutrition and health status. The
38.4 commissioner must seek legislative approval prior to implementing the waiver.

38.5 **Sec. 20. AMERICAN INDIAN CHILD WELFARE PROJECTS.**

38.6 Notwithstanding Minnesota Statutes, section 16A.28, the commissioner of human
38.7 services shall extend payment of state fiscal year 2009 funds in state fiscal year 2010
38.8 to tribes participating in the American Indian child welfare projects under Minnesota
38.9 Statutes, section 256.01, subdivision 14b. Future extensions of payment for a tribe
38.10 participating in the Indian child welfare projects under Minnesota Statutes, section 256.01,
38.11 subdivision 14b, must be granted according to the commissioner's authority under
38.12 Minnesota Statutes, section 16A.28.

38.13 **Sec. 21. REPEALER.**

38.14 (a) Minnesota Statutes 2008, sections 256I.06, subdivision 9; and 256J.626,
38.15 subdivision 7, are repealed.

38.16 (b) Minnesota Rules, parts 9500.1243, subpart 3; and 9500.1261, subparts 3, 4, 5,
38.17 and 6, are repealed.

38.18 **ARTICLE 3**
38.19 **CHILD SUPPORT**

38.20 Section 1. Minnesota Statutes 2008, section 518A.53, subdivision 1, is amended to
38.21 read:

38.22 Subdivision 1. **Definitions.** (a) For the purpose of this section, the following terms
38.23 have the meanings provided in this subdivision unless otherwise stated.

38.24 (b) "Payor of funds" means any person or entity that provides funds to an obligor,
38.25 including an employer as defined under chapter 24 of the Internal Revenue Code,
38.26 section 3401(d), an independent contractor, payor of worker's compensation benefits or
38.27 unemployment benefits, or a financial institution as defined in section 13B.06.

38.28 (c) "Business day" means a day on which state offices are open for regular business.

38.29 (d) The term "arrear" means amounts owed under a support order that are past due
38.30 as used in this section has the meaning provided in section 518A.26.

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

39.1 Sec. 2. Minnesota Statutes 2008, section 518A.53, subdivision 4, is amended to read:

39.2 Subd. 4. **Collection services.** (a) The commissioner of human services shall prepare
39.3 and make available to the courts a notice of services that explains child support and
39.4 maintenance collection services available through the public authority, including income
39.5 withholding, and the fees for such services. Upon receiving a petition for dissolution of
39.6 marriage or legal separation, the court administrator shall promptly send the notice of
39.7 services to the petitioner and respondent at the addresses stated in the petition.

39.8 (b) Either the obligee or obligor may at any time apply to the public authority for
39.9 either full IV-D services or for income withholding only services.

39.10 (c) For those persons applying for income withholding only services, a monthly
39.11 service fee of \$15 must be charged to the obligor. This fee is in addition to the amount of
39.12 the support order and shall be withheld through income withholding. The public authority
39.13 shall explain the service options in this section to the affected parties and encourage the
39.14 application for full child support collection services.

39.15 (d) If the obligee is not a current recipient of public assistance as defined in section
39.16 256.741, the person who applied for services may at any time choose to terminate either
39.17 full IV-D services or income withholding only services regardless of whether income
39.18 withholding is currently in place. The obligee or obligor may reapply for either full IV-D
39.19 services or income withholding only services at any time. Unless the applicant is a
39.20 recipient of public assistance as defined in section 256.741, a \$25 application fee shall be
39.21 charged at the time of each application.

39.22 (e) When a person terminates IV-D services, if an arrearage for public assistance as
39.23 defined in section 256.741 exists, the public authority may continue income withholding,
39.24 as well as use any other enforcement remedy for the collection of child support, until all
39.25 public assistance arrears are paid in full. Income withholding shall be in an amount equal
39.26 to 20 percent of the support order in effect at the time the services terminated; unless the
39.27 support order includes a specific monthly payback amount. If the support order includes a
39.28 specific monthly payback amount, income withholding shall be in the specific amount
39.29 ordered. The provisions of this paragraph apply to all support orders in effect on or before
39.30 January 1, 2010, and to all support orders in effect after January 1, 2010.

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

39.32 Sec. 3. Minnesota Statutes 2008, section 518A.53, subdivision 10, is amended to read:

39.33 Subd. 10. **Arrearage order.** (a) This section does not prevent the court from
39.34 ordering the payor of funds to withhold amounts to satisfy the obligor's previous arrearage
39.35 in support order payments. This remedy shall not operate to exclude availability of other

40.1 remedies to enforce judgments. The employer or payor of funds shall withhold from
40.2 the obligor's income an additional amount equal to 20 percent of the monthly child
40.3 support or maintenance obligation until the arrearage is paid; unless the support order
40.4 includes a specific monthly payback amount. If the support order includes a specific
40.5 monthly payback amount, income withholding shall be in the specific amount ordered.
40.6 The provisions of this paragraph apply to all support orders in effect on or before January
40.7 1, 2010, and to all support orders in effect after January 1, 2010.

40.8 (b) Notwithstanding any law to the contrary, funds from income sources included
40.9 in section 518A.26, subdivision 8, whether periodic or lump sum, are not exempt from
40.10 attachment or execution upon a judgment for child support arrearage.

40.11 (c) Absent an order to the contrary, if an arrearage exists at the time a support
40.12 order would otherwise terminate, income withholding shall continue in effect or may be
40.13 implemented in an amount equal to the support order plus an additional 20 percent of the
40.14 monthly child support obligation, until all arrears have been paid in full.

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

40.16 **ARTICLE 4**

40.17 **STATE-OPERATED SERVICES**

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

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

40.21 For purposes of this subdivision, "charge for services" means the ~~cost of services,~~
40.22 ~~treatment, maintenance, bonds issued for capital improvements, depreciation of buildings~~
40.23 ~~and equipment, and indirect costs related to the operation of state facilities. The~~
40.24 ~~commissioner may determine the charge for services on an anticipated average per diem~~
40.25 ~~basis as an all-inclusive charge per facility, per disability group, or per treatment program.~~
40.26 ~~The commissioner may determine a charge per service, using a method that includes direct~~
40.27 ~~and indirect costs.~~ usual and customary fee charged for services provided to clients. The
40.28 usual and customary fee shall be established in a manner required to appropriately bill
40.29 services to all payers and shall include the costs related to the operations of any program
40.30 offered by the state.

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

41.1 **Subd. 10. State-operated community-based program.** "State-operated
41.2 community-based program" means any program operated in the community including
41.3 community behavioral health hospitals, crisis centers, residential facilities, outpatient
41.4 services, and other community-based services developed and operated by the state and
41.5 under the commissioner's control.

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

41.8 **Subd. 11. Health plan company.** "Health plan company" has the meaning given it
41.9 in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in
41.10 section 256B.69, subdivision 2, paragraph (b), a county or group of counties participating
41.11 in county-based purchasing according to section 256B.692, and a children's mental health
41.12 collaborative under contract to provide medical assistance for individuals enrolled in
41.13 the prepaid medical assistance and MinnesotaCare programs under sections 245.493 to
41.14 245.495.

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

41.17 **Subd. 1a. Clients in state-operated community-based programs; determination.**
41.18 For clients admitted to a state-operated community-based program, the commissioner shall
41.19 make an investigation to determine the available health plan coverage for services being
41.20 provided. If the health plan coverage requires a co-pay or deductible, or if there is no
41.21 available health plan coverage, the commission shall make an investigation as necessary
41.22 to determine, and as circumstances require redetermine, what part of the noncovered
41.23 cost of care, if any, the client is able to pay. If the client is unable to pay the uncovered
41.24 cost of care, the commissioner shall make a determination as to the ability of the client's
41.25 relatives to pay. The client and relatives shall provide the commissioner documents and
41.26 proof necessary to determine their ability to pay. Failure to provide the commissioner with
41.27 sufficient information to determine ability to pay may make the client or relatives liable
41.28 for the full cost of care until the time when sufficient information is provided. If it is
41.29 determined that the responsible party does not have the ability to pay, the commissioner
41.30 shall waive payment of the portion that exceeds ability to pay under the determination.

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

42.1 Subd. 1b. **Clients served by regional treatment centers or nursing homes;**
42.2 **determination.** For clients served in regional treatment centers or nursing homes operated
42.3 by state-operated services, the commissioner shall make investigation as necessary to
42.4 determine, and as circumstances require redetermine, what part of the cost of care, if any,
42.5 the client is able to pay. If the client is unable to pay the full cost of care, the commissioner
42.6 shall determine whether the client's relatives have the ability to pay. The client and
42.7 relatives shall provide the commissioner documents and proof necessary to determine their
42.8 ability to pay. Failure to provide the commissioner with sufficient information to determine
42.9 ability to pay may make the client or relatives liable for the full cost of care until the time
42.10 when sufficient information is provided. No parent shall be liable for the cost of care given
42.11 a client at a regional treatment center after the client has reached the age of 18 years.

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

42.13 **246.511 RELATIVE RESPONSIBILITY.**

42.14 Except for chemical dependency services paid for with funds provided under chapter
42.15 254B, a client's relatives shall not, pursuant to the commissioner's authority under section
42.16 246.51, be ordered to pay more than ~~ten percent of the cost of~~ the following: (1) for
42.17 services provided in a community-based service, the noncovered cost of care as determined
42.18 under the ability to pay determination; and (2) for services provided at a regional treatment
42.19 center operated by state-operated services, 20 percent of the cost of care, unless they
42.20 reside outside the state. Parents of children in state facilities shall have their responsibility
42.21 to pay determined according to section 252.27, subdivision 2, or in rules adopted under
42.22 chapter 254B if the cost of care is paid under chapter 254B. The commissioner may
42.23 accept voluntary payments in excess of ~~ten~~ 20 percent. The commissioner may require
42.24 full payment of the full per capita cost of care in state facilities for clients whose parent,
42.25 parents, spouse, guardian, or conservator do not reside in Minnesota.

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

42.27 **246.52 PAYMENT FOR CARE; ORDER; ACTION.**

42.28 The commissioner shall issue an order to the client or the guardian of the estate, if
42.29 there be one, and relatives determined able to pay requiring them to pay ~~monthly~~ to the
42.30 state of Minnesota the amounts so determined the total of which shall not exceed the full
42.31 cost of care. Such order shall specifically state the commissioner's determination and shall
42.32 be conclusive unless appealed from as herein provided. When a client or relative fails to
42.33 pay the amount due hereunder the attorney general, upon request of the commissioner,

43.1 may institute, or direct the appropriate county attorney to institute, civil action to recover
43.2 such amount.

43.3 Sec. 8. Minnesota Statutes 2008, section 246B.01, is amended by adding a subdivision
43.4 to read:

43.5 Subd. 1a. **Client.** "Client" means a person who is admitted to the Minnesota sex
43.6 offender program or subject to a court hold order under section 253B.185 for the purpose
43.7 of assessment, diagnosis, care, treatment, supervision, or other services provided by the
43.8 Minnesota sex offender program.

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

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

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

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

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

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

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

44.1 Sec. 12. **[246B.07] PAYMENT FOR CARE AND TREATMENT:**
44.2 **DETERMINATION.**

44.3 Subdivision 1. **Procedures.** The commissioner shall make investigation as
44.4 necessary to determine, and as circumstances require redetermine, what part of the cost of
44.5 care, if any, the client is able to pay. The client shall provide the commissioner documents
44.6 and proof necessary to determine the ability to pay. Failure to provide the commissioner
44.7 with sufficient information to determine ability to pay may make the client liable for the
44.8 full cost of care until the time when sufficient information is provided.

44.9 Subd. 2. **Rules.** The commissioner shall adopt, pursuant to the Administrative
44.10 Procedure Act, rules establishing uniform standards for determination of client liability
44.11 for care provided by the Minnesota sex offender program. These rules shall have the
44.12 force and effect of law.

44.13 Subd. 3. **Applicability.** The commissioner may recover, under sections 246B.07 to
44.14 246B.10, the cost of any care provided by the Minnesota sex offender program.

44.15 Sec. 13. **[246B.08] PAYMENT FOR CARE; ORDER; ACTION.**

44.16 The commissioner shall issue an order to the client or the guardian of the estate, if
44.17 there is one, requiring them to pay to the state the amounts so determined, the total of which
44.18 shall not exceed the full cost of care. The order shall specifically state the commissioner's
44.19 determination and must be conclusive, unless appealed. When a client fails to pay the
44.20 amount due, the attorney general, upon request of the commissioner, may institute, or
44.21 direct the appropriate county attorney to institute, civil action to recover the amount.

44.22 Sec. 14. **[246B.09] CLAIM AGAINST ESTATE OF DECEASED CLIENT.**

44.23 Subdivision 1. **Client's estate.** Upon the death of a client, or a former client, the
44.24 total cost of care given the client, less the amount actually paid toward the cost of care by
44.25 the client, shall be filed by the commissioner as a claim against the estate of the client
44.26 with the court having jurisdiction to probate the estate and all proceeds collected by the
44.27 state in the case shall be divided between the state and county in proportion to the cost
44.28 of care each has borne.

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

44.31 If the commissioner of human services determines that the property or estate of a
44.32 client is not more than needed to care for and maintain the spouse and minor or dependent
44.33 children of a deceased client, the commissioner has the power to compromise the claim of
44.34 the state in a manner deemed just and proper.

46.1 shall develop a statewide plan to meet this goal, including uniform standards to be used
46.2 for the interoperable system for sharing and synchronizing patient data across systems.
46.3 The standards must be compatible with federal efforts. The uniform standards must be
46.4 developed by January 1, 2009, ~~with a status report on the development of these standards~~
46.5 ~~submitted to the legislature by January 15, 2008~~ and updated on an ongoing basis. The
46.6 commissioner shall include an update on standards development as part of an annual
46.7 report to the legislature.

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

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

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

46.19 (d) "HITECH Act" means the Health Information Technology for Economic and
46.20 Clinical Health Act in division A, title XIII and division B, title IV of the American
46.21 Recovery and Reinvestment Act of 2009, including federal regulations adopted under
46.22 that act.

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

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

46.29 (1) provide clinical decision support;

46.30 (2) support physician order entry;

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

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

46.34 Subd. 2. **E-Health Information Technology and Infrastructure Advisory**
46.35 **Committee.** (a) The commissioner shall establish a an e-Health Information Technology

47.1 ~~and Infrastructure~~ Advisory Committee governed by section 15.059 to advise the
47.2 commissioner on the following matters:

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

47.5 (2) recommendations for implementing a statewide interoperable health information
47.6 infrastructure, to include estimates of necessary resources, and for determining standards
47.7 for ~~administrative~~ clinical data exchange, clinical support programs, patient privacy
47.8 requirements, and maintenance of the security and confidentiality of individual patient
47.9 data;

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

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

47.16 (b) The members of the ~~e-Health Information Technology and Infrastructure~~
47.17 Advisory Committee shall include the commissioners, or commissioners' designees, of
47.18 health, human services, administration, and commerce and additional members to be
47.19 appointed by the commissioner to include persons representing Minnesota's local public
47.20 health agencies, licensed hospitals and other licensed facilities and providers, private
47.21 purchasers, the medical and nursing professions, health insurers and health plans, the
47.22 state quality improvement organization, academic and research institutions, consumer
47.23 advisory organizations with an interest and expertise in health information technology, and
47.24 other stakeholders as identified by the ~~Health Information Technology and Infrastructure~~
47.25 ~~Advisory Committee~~ commissioner to fulfill the requirements of section 3013, paragraph
47.26 (g) of the HITECH Act.

47.27 (c) The commissioner shall prepare and issue an annual report not later than January
47.28 30 of each year outlining progress to date in implementing a statewide health information
47.29 infrastructure and recommending ~~future projects~~ action on policy and necessary resources
47.30 to continue the promotion of adoption and effective use of health information technology.

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

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

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

48.1 (b) The electronic health record must be certified by the ~~Certification Commission~~
48.2 ~~for Healthcare Information Technology, or its successor~~ Office of the National Coordinator
48.3 pursuant to the HITECH Act. This criterion only applies to hospitals and health care
48.4 providers ~~whose practice setting is a practice setting covered by the Certification~~
48.5 ~~Commission for Healthcare Information Technology certifications~~ only if a certified
48.6 electronic health record product for the provider's particular practice setting is available.
48.7 This criterion shall be considered met if a hospital or health care provider is using an
48.8 electronic health records system that has been certified within the last three years, even if a
48.9 more current version of the system has been certified within the three-year period.

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

48.12 (d) The electronic health record must have the ability to generate information on
48.13 clinical quality measures and other measures reported under sections 4101, 4102, and
48.14 4201 of the HITECH Act.

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

48.18 **Subd. 4. Coordination with national HIT activities.** (a) The commissioner,
48.19 in consultation with the e-Health Advisory Committee, shall update the statewide
48.20 implementation plan required under subdivision 2 and released June 2008, to be consistent
48.21 with the updated Federal HIT Strategic Plan released by the Office of the National
48.22 Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan
48.23 shall meet the requirements for a plan required under section 3013 of the HITECH Act.

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

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

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

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

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

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

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

49.16 (4) monitoring and responding to national activity related to privacy, security, and
49.17 data stewardship of electronic health information and individually identifiable health
49.18 information.

49.19 (d) To the extent that the state is either required or allowed to apply, or designate an
49.20 entity to apply for or carry out activities and programs under section 3013 of the HITECH
49.21 Act, the commissioner of health, in consultation with the e-Health Advisory Committee
49.22 and the commissioner of human services, shall be the lead applicant or sole designating
49.23 authority. The commissioner shall make such designations consistent with the goals and
49.24 objectives of sections 62J.495 to 62J.497, and sections 62J.50 to 62J.61.

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

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

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

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

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

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

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

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

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

50.17 (1) avoid duplicative reporting requirements;

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

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

50.22 Subd. 6. **Data classification.** (a) Data collected on providers, dispensers, group
 50.23 purchasers, and electronic data intermediaries under this section are private data on
 50.24 individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition
 50.25 of summary data in section 13.02, subdivision 19, summary data prepared under this
 50.26 subdivision may be derived from nonpublic data.

50.27 (b) Nothing in this section authorizes the collection of individual patient data.

50.28 Sec. 3. Minnesota Statutes 2008, section 62J.496, is amended to read:

50.29 **62J.496 ELECTRONIC HEALTH RECORD SYSTEM REVOLVING**
 50.30 **ACCOUNT AND LOAN PROGRAM.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

51.33 (1) federally qualified health centers;

51.34 ~~(1)~~ (2) community clinics, as defined under section 145.9268;

51.35 ~~(2)~~ (3) hospitals eligible for rural hospital capital improvement grants, as defined
 51.36 in section 144.148;

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

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

52.6 ~~(4)~~ (5) nursing facilities licensed under sections 144A.01 to 144A.27; and

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

52.8 ~~(5)~~ (7) other providers of health or health care services approved by the
 52.9 commissioner for which interoperable electronic health record capability would improve
 52.10 quality of care, patient safety, or community health.

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

52.13 (1) critical access hospitals;

52.14 (2) federally qualified health centers;

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

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

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

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

52.23 (2) a quote from a vendor;

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

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

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

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

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

52.34 Subd. 3. **Loans.** (a) The commissioner of health may make a no interest, or low
 52.35 interest, loan to a provider or provider group who is eligible under subdivision 2 ~~on a~~
 52.36 ~~first-come, first-served basis provided that the applicant is able to comply with this section~~

53.1 consistent with the priorities established in subdivision 2. The total accumulative loan
53.2 principal must not exceed ~~\$1,500,000~~ \$3,000,000 per loan. The interest rate for each
53.3 loan, if imposed, shall not exceed the current market interest rate. The commissioner of
53.4 health has discretion over the size, interest rate, and number of loans made. Nothing in
53.5 this section shall require the commissioner to make a loan to an eligible borrower under
53.6 subdivision 2.

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

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

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

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

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

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

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

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

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

54.1 Subd. 4. **Data classification.** Data collected by the commissioner of health on the
54.2 application to determine eligibility under subdivision 2 and to monitor borrowers' default
54.3 risk or collect payments owed under subdivision 3 are (1) private data on individuals as
54.4 defined in section 13.02, subdivision 12; and (2) nonpublic data as defined in section
54.5 13.02, subdivision 9. The names of borrowers and the amounts of the loans granted
54.6 are public data.

54.7 Sec. 4. Minnesota Statutes 2008, section 62J.497, subdivision 1, is amended to read:

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

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

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

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

54.19 ~~(c)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
54.20 title 45, part 160.103.

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

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

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

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

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

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

55.1 (+) (k) "NCPDP Formulary and Benefits Standard" means the National Council for
55.2 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
55.3 Version 1, Release 0, October 2005.

55.4 (+) (l) "NCPDP SCRIPT Standard" means the National Council for Prescription
55.5 Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation
55.6 Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard
55.7 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
55.8 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and
55.9 regulations adopted under it. The standards shall be implemented according to the Centers
55.10 for Medicare and Medicaid Services schedule for compliance. Subsequently released
55.11 versions of the NCPDP SCRIPT Standard may be used, provided that the new version
55.12 of the standard is backward compatible to the current version adopted by the Centers for
55.13 Medicare and Medicaid Services.

55.14 (+) (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

55.15 (+) (n) "Prescriber" means a licensed health care professional who is authorized to
55.16 prescribe a controlled substance under section 152.12, subdivision 1.

55.17 (+) (o) "Prescription-related information" means information regarding eligibility for
55.18 drug benefits, medication history, or related health or drug information.

55.19 (+) (p) "Provider" or "health care provider" has the meaning given in section 62J.03,
55.20 subdivision 8.

55.21 Sec. 5. Minnesota Statutes 2008, section 62J.497, subdivision 2, is amended to read:

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

55.27 (b) ~~Nothing in this section requires providers, group purchasers, prescribers, or~~
55.28 ~~dispensers to conduct the transactions described in this section.~~ If transactions described in
55.29 this section are conducted, they must be done electronically using the standards described
55.30 in this section. Nothing in this section requires providers, group purchasers, prescribers,
55.31 or dispensers to electronically conduct transactions that are expressly prohibited by other
55.32 sections or federal law.

55.33 (c) Providers, group purchasers, prescribers, and dispensers must use either HL7
55.34 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related
55.35 information internally when the sender and the recipient are part of the same legal entity. If

56.1 an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard
56.2 or other applicable standards required by this section. Any pharmacy within an entity
56.3 must be able to receive electronic prescription transmittals from outside the entity using
56.4 the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health
56.5 Insurance Portability and Accountability Act (HIPAA) requirement that may require the
56.6 use of a HIPAA transaction standard within an organization.

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

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

56.14 Subd. 4. **Development and use of prior authorization and uniform formulary**
56.15 **exception form.** (a) The commissioner of health, in consultation with the Minnesota
56.16 Administrative Uniformity Committee, shall develop, by six weeks after enactment of
56.17 this subdivision, a uniform prior authorization and formulary exception form that allows
56.18 health care providers to request exceptions from group purchaser formularies, including
56.19 Medicare Part D plans, using a uniform form. Upon development of the form, all health
56.20 care providers must submit requests for prior authorization and formulary exceptions
56.21 using the uniform form, or by telephone if the group purchaser provides this option, and
56.22 all group purchasers must accept this form from health care providers.

56.23 (b) Effective January 1, 2011, the uniform prior authorization and formulary
56.24 exception form must be accessible by health care providers, and accepted and processed
56.25 by group purchasers, electronically through a secure Internet site.

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

56.27 A pharmacy benefit manager that provides prescription drug services must make
56.28 available medication therapy management services for enrollees taking four or more
56.29 prescriptions to treat or prevent two or more chronic medical conditions. For purposes
56.30 of this section, "medication therapy management" means the provision of the following
56.31 pharmaceutical care services by a licensed pharmacist to optimize the therapeutic
56.32 outcomes of the patient's medications:

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

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

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

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

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

57.8 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

57.9 (a) The state commissioner of health, by rule, may prescribe procedures and fees
57.10 for filing with the commissioner as prescribed by statute and for the issuance of original
57.11 and renewal permits, licenses, registrations, and certifications issued under authority of
57.12 the commissioner. The expiration dates of the various licenses, permits, registrations,
57.13 and certifications as prescribed by the rules shall be plainly marked thereon. Fees may
57.14 include application and examination fees and a penalty fee for renewal applications
57.15 submitted after the expiration date of the previously issued permit, license, registration,
57.16 and certification. The commissioner may also prescribe, by rule, reduced fees for permits,
57.17 licenses, registrations, and certifications when the application therefor is submitted
57.18 during the last three months of the permit, license, registration, or certification period.
57.19 Fees proposed to be prescribed in the rules shall be first approved by the Department of
57.20 Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
57.21 in an amount so that the total fees collected by the commissioner will, where practical,
57.22 approximate the cost to the commissioner in administering the program. All fees collected
57.23 shall be deposited in the state treasury and credited to the state government special revenue
57.24 fund unless otherwise specifically appropriated by law for specific purposes.

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

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

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

58.1	Joint Commission on Accreditation of	\$7,555 <u>\$7,655</u> plus \$13 <u>\$16</u> per bed
58.2	Healthcare Organizations (JCAHO) and	
58.3	American Osteopathic Association (AOA)	
58.4	hospitals	
58.5	Non-JCAHO and non-AOA hospitals	\$5,180 <u>\$5,280</u> plus \$247 <u>\$250</u> per bed
58.6	Nursing home	\$183 plus \$91 per bed

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

58.9	Outpatient surgical centers	\$3,349 <u>\$3,712</u>
58.10	Boarding care homes	\$183 plus \$91 per bed
58.11	Supervised living facilities	\$183 plus \$91 per bed.

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

58.15	Prospective payment surveys for hospitals	\$	900
58.16	Swing bed surveys for nursing homes	\$	1,200
58.17	Psychiatric hospitals	\$	1,400
58.18	Rural health facilities	\$	1,100
58.19	Portable x-ray providers	\$	500
58.20	Home health agencies	\$	1,800
58.21	Outpatient therapy agencies	\$	800
58.22	End stage renal dialysis providers	\$	2,100
58.23	Independent therapists	\$	800
58.24	Comprehensive rehabilitation outpatient facilities	\$	1,200
58.25	Hospice providers	\$	1,700
58.26	Ambulatory surgical providers	\$	1,800
58.27	Hospitals	\$	4,200

58.28 Other provider categories or additional Actual surveyor costs: average
 58.29 resurveys required to complete initial surveyor cost x number of hours
 58.30 certification for the survey process.

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

58.35 Sec. 9. Minnesota Statutes 2008, section 144.218, subdivision 1, is amended to read:

58.36 Subdivision 1. **Adoption.** (a) Upon receipt of a certified copy of an order, decree,
 58.37 or certificate of adoption, the state registrar shall register a replacement vital record in
 58.38 the new name of the adopted person. Except as provided in paragraph (b), the original
 58.39 record of birth is confidential pursuant to private data on individuals, as defined in section

59.1 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or
59.2 section 144.2252 or 144.2253.

59.3 (b) The information contained on the original birth record, except for the registration
59.4 number, shall be provided on request to: (1) a parent who is named on the original birth
59.5 record; or (2) the adopted person who is the subject of the record if the person is at least
59.6 19 years of age, unless there is an affidavit of nondisclosure on file with the state registrar.
59.7 Upon the receipt of a certified copy of a court order of annulment of adoption the state
59.8 registrar shall restore the original vital record to its original place in the file.

59.9 **EFFECTIVE DATE.** This section is effective August 1, 2010.

59.10 Sec. 10. Minnesota Statutes 2008, section 144.225, subdivision 2, is amended to read:

59.11 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision,
59.12 data pertaining to the birth of a child to a woman who was not married to the child's father
59.13 when the child was conceived nor when the child was born, including the original record
59.14 of birth and the certified vital record, are confidential data. At the time of the birth of a
59.15 child to a woman who was not married to the child's father when the child was conceived
59.16 nor when the child was born, the mother may designate demographic data pertaining to
59.17 the birth as public. Notwithstanding the designation of the data as confidential, it may
59.18 be disclosed:

59.19 (1) to a parent or guardian of the child;

59.20 (2) to the child when the child is 16 years of age or older;

59.21 (3) under paragraph (b) or (e); or

59.22 (4) pursuant to a court order. For purposes of this section, a subpoena does not
59.23 constitute a court order.

59.24 (b) Unless the child is adopted, data pertaining to the birth of a child that are not
59.25 accessible to the public become public data if 100 years have elapsed since the birth of
59.26 the child who is the subject of the data, or as provided under section 13.10, whichever
59.27 occurs first.

59.28 (c) If a child is adopted, data pertaining to the child's birth are governed by the
59.29 provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218,
59.30 subdivision 1; 144.2252; 144.2253; and 259.89.

59.31 (d) The name and address of a mother under paragraph (a) and the child's date of
59.32 birth may be disclosed to the county social services or public health member of a family
59.33 services collaborative for purposes of providing services under section 124D.23.

59.34 (e) The commissioner of human services shall have access to birth records for:

60.1 (1) the purposes of administering medical assistance, general assistance medical
60.2 care, and the MinnesotaCare program;

60.3 (2) child support enforcement purposes; and

60.4 (3) other public health purposes as determined by the commissioner of health.

60.5 **EFFECTIVE DATE.** This section is effective August 1, 2010.

60.6 Sec. 11. Minnesota Statutes 2008, section 144.2252, is amended to read:

60.7 **144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.**

60.8 (a) Whenever an adopted person requests the state registrar to disclose the
60.9 information on the adopted person's original birth record, the state registrar shall act
60.10 according to section ~~259.89~~ 144.2253.

60.11 (b) The state registrar shall provide a transcript of an adopted person's original birth
60.12 record to an authorized representative of a federally recognized American Indian tribe
60.13 for the sole purpose of determining the adopted person's eligibility for enrollment or
60.14 membership. Information contained in the birth record may not be used to provide the
60.15 adopted person information about the person's birth parents, except as provided in this
60.16 section or section ~~259.83~~ 144.2253.

60.17 **EFFECTIVE DATE.** This section is effective August 1, 2010.

60.18 Sec. 12. **[144.2253] ACCESS TO ORIGINAL BIRTH RECORDS BY ADOPTED**
60.19 **PERSON; DEPARTMENT DUTIES.**

60.20 Subdivision 1. Affidavits. The department shall prepare affidavit of disclosure and
60.21 nondisclosure forms under which a birth parent may agree to or object to the release of the
60.22 original birth record to the adopted person. The department shall make the forms readily
60.23 accessible to birth parents on the department's Web site.

60.24 Subd. 2. Disclosure. Upon request, the state registrar shall provide a noncertified
60.25 copy of the original birth record to an adopted person age 19 or older, unless there is
60.26 an affidavit of nondisclosure on file. The state registrar must comply with the terms of
60.27 affidavits of disclosure or affidavits of nondisclosure.

60.28 Subd. 3. Rescission of affidavit. A birth parent may rescind an affidavit of
60.29 disclosure or an affidavit of nondisclosure at any time.

60.30 Subd. 4. Affidavit of nondisclosure; access to birth record. If an affidavit of
60.31 nondisclosure is on file with the registrar, an adopted person age 19 or older may petition
60.32 the appropriate court for disclosure of the original birth record pursuant to section 259.61.
60.33 The court shall grant the petition if, after consideration of the interests of all known

61.1 persons affected by the petition, the court determines that the benefits of disclosure of the
61.2 information are greater than the benefits of nondisclosure.

61.3 Subd. 5. **Information provided.** (a) The department shall, in consultation with
61.4 adoption agencies and adoption advocates, provide information and educational materials
61.5 to adopted persons and birth parents about the changes in the law under this act affecting
61.6 accessibility to birth records. For purposes of this subdivision, an adoption advocate is a
61.7 nonprofit organization that works with adoption issues in Minnesota.

61.8 (b) The department shall include a notice on the department Web site about the
61.9 change in the law under this act and direct individuals to private agencies and advocates
61.10 for post-adoption resources.

61.11 (c) Adoption agencies may charge a fee for counseling and support services provided
61.12 to adopted persons and birth parents.

61.13 **EFFECTIVE DATE.** This section is effective August 1, 2010.

61.14 Sec. 13. Minnesota Statutes 2008, section 144.226, subdivision 1, is amended to read:

61.15 Subdivision 1. **Which services are for fee.** The fees for the following services shall
61.16 be the following or an amount prescribed by rule of the commissioner:

61.17 (a) The fee for the issuance of a certified vital record or a certification that the vital
61.18 record cannot be found is \$9. No fee shall be charged for a certified birth, stillbirth, or
61.19 death record that is reissued within one year of the original issue, if an amendment is
61.20 made to the vital record and if the previously issued vital record is surrendered. The
61.21 fee is nonrefundable.

61.22 (b) The fee for processing a request for the replacement of a birth record for
61.23 all events, except when filing a recognition of parentage pursuant to section 257.73,
61.24 subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

61.25 (c) The fee for processing a request for the filing of a delayed registration of
61.26 birth, stillbirth, or death is \$40. The fee is payable at the time of application and is
61.27 nonrefundable. This fee includes one subsequent review of the request if the request
61.28 is not acceptable upon the initial receipt.

61.29 (d) The fee for processing a request for the amendment of any vital record when
61.30 requested more than 45 days after the filing of the vital record is \$40. No fee shall be
61.31 charged for an amendment requested within 45 days after the filing of the vital record.
61.32 The fee is payable at the time of application and is nonrefundable. This fee includes one
61.33 subsequent review of the request if the request is not acceptable upon the initial receipt.

61.34 (e) The fee for processing a request for the verification of information from vital
61.35 records is \$9 when the applicant furnishes the specific information to locate the vital

62.1 record. When the applicant does not furnish specific information, the fee is \$20 per hour
62.2 for staff time expended. Specific information includes the correct date of the event and
62.3 the correct name of the registrant. Fees charged shall approximate the costs incurred in
62.4 searching and copying the vital records. The fee is payable at the time of application
62.5 and is nonrefundable.

62.6 (f) The fee for processing a request for the issuance of a copy of any document on
62.7 file pertaining to a vital record or statement that a related document cannot be found is \$9.
62.8 The fee is payable at the time of application and is nonrefundable.

62.9 (g) The department shall charge a fee of \$18 for noncertified copies of birth records
62.10 provided to adopted persons age 19 or older to cover the cost of providing the birth record
62.11 and any costs associated with the distribution of information to adopted persons and birth
62.12 parents required under section 144.2253, subdivision 5.

62.13 **EFFECTIVE DATE.** This section is effective August 1, 2010.

62.14 Sec. 14. Minnesota Statutes 2008, section 144.226, subdivision 4, is amended to read:

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

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

62.24 Sec. 15. Minnesota Statutes 2008, section 148.6445, is amended by adding a
62.25 subdivision to read:

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

62.27 Sec. 16. Minnesota Statutes 2008, section 259.89, subdivision 1, is amended to read:

62.28 Subdivision 1. **Request.** An adopted person who is 19 years of age or over may
62.29 request the commissioner of health to disclose the information on the adopted person's
62.30 original birth record. ~~The commissioner of health shall, within five days of receipt of~~
62.31 ~~the request, notify the commissioner of human services' agent or licensed child-placing~~
62.32 ~~agency when known, or the commissioner of human services when the agency is not~~
62.33 ~~known in writing of the request by the adopted person.~~

63.1 **EFFECTIVE DATE.** This section is effective August 1, 2010.

63.2 Sec. 17. Minnesota Statutes 2008, section 260C.317, subdivision 4, is amended to read:

63.3 Subd. 4. **Rights of terminated parent.** Upon entry of an order terminating the
63.4 parental rights of any person who is identified as a parent on the original birth record of
63.5 the child as to whom the parental rights are terminated, the court shall cause written
63.6 notice to be made to that person setting forth:

63.7 (1) the right of the person to file at any time with the state registrar of vital statistics
63.8 a consent to disclosure, as defined in section 144.212, subdivision 11; and

63.9 (2) the right of the person to file at any time with the state registrar of vital statistics
63.10 an affidavit stating that the information on the original birth record shall not be disclosed
63.11 as provided in section ~~144.2252~~ 144.2253; and.

63.12 ~~(3) the effect of a failure to file either a consent to disclosure, as defined in section~~
63.13 ~~144.212, subdivision 11, or an affidavit stating that the information on the original birth~~
63.14 ~~record shall not be disclosed.~~

63.15 **EFFECTIVE DATE.** This section is effective August 1, 2010.

63.16 Sec. 18. **REPEALER.**

63.17 (a) Minnesota Statutes 2008, sections 259.83, subdivision 3; and 259.89,
63.18 subdivisions 2, 3, and 4, are repealed effective retroactively from August 1, 2008.

63.19 (b) Minnesota Statutes 2008, section 62U.08, is repealed.

63.20 **ARTICLE 6**

63.21 **HEALTH CARE**

63.22 Section 1. Minnesota Statutes 2008, section 62J.692, subdivision 7, is amended to read:

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

63.29 (1) \$2,157,000 by the commissioner to the University of Minnesota Board of
63.30 Regents for the purposes described in sections 137.38 to 137.40;

63.31 (2) \$1,035,360 by the commissioner to the Hennepin County Medical Center for
63.32 clinical medical education;

64.1 (3) \$17,400,000 by the commissioner to the University of Minnesota Board of
64.2 Regents for purposes of medical education;

64.3 (4) \$1,121,640 by the commissioner to clinical medical education dental innovation
64.4 grants in accordance with subdivision 7a; and

64.5 (5) the remainder of the amount transferred according to section 256B.69,
64.6 subdivision 5c, paragraph (a), clauses (1) to (4), must be distributed by the commissioner
64.7 annually to clinical medical education programs that meet the qualifications of subdivision
64.8 3 based on the formula in subdivision 4, paragraph (a).

64.9 ~~(b) Fifty percent of the amount transferred according to section 256B.69, subdivision~~
64.10 ~~5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of~~
64.11 ~~Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40. Of~~
64.12 ~~the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph~~
64.13 ~~(a), clause (2), 24 percent of the amount shall be distributed by the commissioner to~~
64.14 ~~the Hennepin County Medical Center for clinical medical education. The remaining 26~~
64.15 ~~percent of the amount transferred shall be distributed by the commissioner in accordance~~
64.16 ~~with subdivision 7a. If the federal approval is not obtained for the matching funds under~~
64.17 ~~section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount~~
64.18 ~~transferred under this paragraph shall be distributed by the commissioner to the University~~
64.19 ~~of Minnesota Board of Regents for the purposes described in sections 137.38 to 137.40.~~

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

64.24 Sec. 2. Minnesota Statutes 2008, section 125A.744, subdivision 3, is amended to read:

64.25 Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26,
64.26 school districts may enroll as medical assistance providers or subcontractors and bill
64.27 the Department of Human Services under the medical assistance fee for service claims
64.28 processing system for special education services which are covered services under chapter
64.29 256B, which are provided in the school setting for a medical assistance recipient, and for
64.30 whom the district has secured informed consent consistent with section 13.05, subdivision
64.31 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type
64.32 of covered service. School districts shall be reimbursed by the commissioner of human
64.33 services for the federal share of individual education plan health-related services that
64.34 qualify for reimbursement by medical assistance, minus up to five percent retained by the
64.35 commissioner of human services for administrative costs, ~~not to exceed \$350,000 per~~

65.1 ~~fiscal year~~. The commissioner may withhold up to five percent of each payment to a
65.2 school district. Following the end of each fiscal year, the commissioner shall settle up with
65.3 each school district in order to ensure that collections from each district for departmental
65.4 administrative costs are made on a pro rata basis according to federal earnings for these
65.5 services in each district. A school district is not eligible to enroll as a home care provider
65.6 or a personal care provider organization for purposes of billing home care services under
65.7 sections 256B.0651 and 256B.0653 to 256B.0656 until the commissioner of human
65.8 services issues a bulletin instructing county public health nurses on how to assess for the
65.9 needs of eligible recipients during school hours. To use private duty nursing services or
65.10 personal care services at school, the recipient or responsible party must provide written
65.11 authorization in the care plan identifying the chosen provider and the daily amount
65.12 of services to be used at school.

65.13 Sec. 3. Minnesota Statutes 2008, section 256.01, subdivision 2b, is amended to read:

65.14 Subd. 2b. **Performance payments; performance measurement.** (a) The
65.15 commissioner shall develop and implement a pay-for-performance system to provide
65.16 performance payments to eligible medical groups and clinics that demonstrate optimum
65.17 care in serving individuals with chronic diseases who are enrolled in health care
65.18 programs administered by the commissioner under chapters 256B, 256D, and 256L.
65.19 The commissioner may receive any federal matching money that is made available
65.20 through the medical assistance program for managed care oversight contracted through
65.21 vendors, including consumer surveys, studies, and external quality reviews as required
65.22 by the federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part
65.23 438-managed care, subpart E-external quality review. Any federal money received
65.24 for managed care oversight is appropriated to the commissioner for this purpose. The
65.25 commissioner may expend the federal money received in either year of the biennium.

65.26 ~~(b) Effective July 1, 2008, or upon federal approval, whichever is later, the~~
65.27 ~~commissioner shall develop and implement a patient incentive health program to provide~~
65.28 ~~incentives and rewards to patients who are enrolled in health care programs administered~~
65.29 ~~by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and~~
65.30 ~~have met personal health goals established with the patients' primary care providers to~~
65.31 ~~manage a chronic disease or condition, including but not limited to diabetes, high blood~~
65.32 ~~pressure, and coronary artery disease. The commissioner, in consultation with the Health~~
65.33 ~~and Human Services Policy Committee, shall develop and provide to the legislature by~~
65.34 ~~December 15, 2009, a methodology and any draft legislation necessary to allow for the~~
65.35 ~~release, upon request, of summary data as defined in section 13.02, subdivision 19,~~

66.1 on claims and utilization for medical assistance, general assistance medical care, and
66.2 MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the
66.3 Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical
66.4 Systems Improvement, and other research institutions, to conduct analyses of health care
66.5 outcomes and treatment effectiveness, provided the research institutions do not release
66.6 private or nonpublic data, or data for which dissemination is prohibited by law.

66.7 Sec. 4. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
66.8 to read:

66.9 Subd. 18a. **Public Assistance Reporting Information System.** (a) Effective July
66.10 1, 2009, the commissioner shall comply with the federal requirements in Public Law
66.11 110-379 in implementing the Public Assistance Reporting Information System (PARIS) to
66.12 determine eligibility for all individuals applying for:

66.13 (1) health care benefits under chapters 256B, 256D, and 256L; and

66.14 (2) public benefits under chapters 119B, 256D, 256I, and the supplemental nutrition
66.15 assistance program.

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

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

66.20 Sec. 5. Minnesota Statutes 2008, section 256.962, subdivision 2, is amended to read:

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

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

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

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

67.1 (4) targeting families with incomes below 200 percent of the federal poverty
67.2 guidelines or who belong to underserved populations.

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

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

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

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

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

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

67.20 ~~(d)~~ (c) Each district shall designate an enrollment specialist to provide application
67.21 assistance and follow-up services with families who have indicated an interest in receiving
67.22 information or an application for the Minnesota health care program. A district is eligible
67.23 for the application assistance bonus described in subdivision 5.

67.24 ~~(e) Each~~ (d) If a school district or charter school maintains a district Web site, the
67.25 school district or charter school shall provide on ~~their~~ its Web site a link to information on
67.26 how to obtain an application and application assistance.

67.27 Sec. 7. Minnesota Statutes 2008, section 256.963, is amended by adding a subdivision
67.28 to read:

67.29 Subd. 3. **Urgent dental care services.** The commissioner of human services shall
67.30 authorize pilot projects to reduce the total costs to the state for dental services provided
67.31 to persons enrolled in Minnesota health care programs by reducing hospital emergency
67.32 room costs for preventable and nonemergency dental services. The commissioner may
67.33 provide start-up funding and establish special payment rates for urgent dental care services
67.34 provided as an alternative to emergency room services and may change or waive existing

68.1 payment policies in order to adequately reimburse providers for providing cost-effective
68.2 alternative services in outpatient or urgent care settings. The commissioner may establish
68.3 a project in conjunction with the initiative authorized under subdivisions 1 and 2, or
68.4 establish new initiatives, or may implement both approaches.

68.5 Sec. 8. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

68.6 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
68.7 assistance program must not be submitted until the recipient is discharged. However,
68.8 the commissioner shall establish monthly interim payments for inpatient hospitals that
68.9 have individual patient lengths of stay over 30 days regardless of diagnostic category.
68.10 Except as provided in section 256.9693, medical assistance reimbursement for treatment
68.11 of mental illness shall be reimbursed based on diagnostic classifications. Individual
68.12 hospital payments established under this section and sections 256.9685, 256.9686, and
68.13 256.9695, in addition to third party and recipient liability, for discharges occurring during
68.14 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
68.15 inpatient services paid for the same period of time to the hospital. This payment limitation
68.16 shall be calculated separately for medical assistance and general assistance medical
68.17 care services. The limitation on general assistance medical care shall be effective for
68.18 admissions occurring on or after July 1, 1991. Services that have rates established under
68.19 subdivision 11 or 12, must be limited separately from other services. After consulting with
68.20 the affected hospitals, the commissioner may consider related hospitals one entity and
68.21 may merge the payment rates while maintaining separate provider numbers. The operating
68.22 and property base rates per admission or per day shall be derived from the best Medicare
68.23 and claims data available when rates are established. The commissioner shall determine
68.24 the best Medicare and claims data, taking into consideration variables of recency of the
68.25 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
68.26 The commissioner shall notify hospitals of payment rates by December 1 of the year
68.27 preceding the rate year. The rate setting data must reflect the admissions data used to
68.28 establish relative values. Base year changes from 1981 to the base year established for the
68.29 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
68.30 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
68.31 1. The commissioner may adjust base year cost, relative value, and case mix index data
68.32 to exclude the costs of services that have been discontinued by the October 1 of the year
68.33 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
68.34 that encompass portions of two or more rate years shall have payments established based
68.35 on payment rates in effect at the time of admission unless the date of admission preceded

69.1 the rate year in effect by six months or more. In this case, operating payment rates for
69.2 services rendered during the rate year in effect and established based on the date of
69.3 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

69.12 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
69.13 fee-for-service admissions occurring on or after July 1, 2005, made to hospitals for
69.14 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
69.15 from the current statutory rates. Mental health services within diagnosis related groups
69.16 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
69.17 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
69.18 assistance does not include general assistance medical care. Payments made to managed
69.19 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
69.20 this reduction.

69.21 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
69.22 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
69.23 to hospitals for inpatient services before third-party liability and spenddown, is reduced
69.24 3.46 percent from the current statutory rates. Mental health services with diagnosis related
69.25 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
69.26 paragraph. Payments made to managed care plans shall be reduced for services provided
69.27 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

69.28 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
69.29 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
69.30 to hospitals for inpatient services before third-party liability and spenddown, is reduced
69.31 1.9 percent from the current statutory rates. Mental health services with diagnosis related
69.32 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
69.33 paragraph. Payments made to managed care plans shall be reduced for services provided
69.34 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

69.35 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
69.36 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for

70.1 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
70.2 from the current statutory rates. Mental health services with diagnosis related groups
70.3 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
70.4 Payments made to managed care plans shall be reduced for services provided on or after
70.5 July 1, 2010, to reflect this reduction.

70.6 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
70.7 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
70.8 hospitals for inpatient services before third-party liability and spenddown, is reduced
70.9 3.0 percent from the current statutory rates. Facilities defined under subdivision 16 are
70.10 excluded from this paragraph. Payments made to managed care plans shall be reduced for
70.11 services provided on or after January 1, 2010, to reflect this reduction.

70.12 (i) In addition to the reductions in paragraphs (b) and (h), the total payment for
70.13 fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for mental
70.14 health services within diagnosis-related groups 424 to 432 before third-party liability and
70.15 spenddown, is reduced 5.2 percent from the current statutory rates. Facilities defined under
70.16 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
70.17 shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

70.18 Sec. 9. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

70.19 Subd. 3. **Asset limitations for individuals and families.** To be eligible for medical
70.20 assistance, a person must not individually own more than \$3,000 in assets, or if a member
70.21 of a household with two family members, husband and wife, or parent and child, the
70.22 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
70.23 dependent. In addition to these maximum amounts, an eligible individual or family may
70.24 accrue interest on these amounts, but they must be reduced to the maximum at the time
70.25 of an eligibility redetermination. The accumulation of the clothing and personal needs
70.26 allowance according to section 256B.35 must also be reduced to the maximum at the
70.27 time of the eligibility redetermination. The value of assets that are not considered in
70.28 determining eligibility for medical assistance is the value of those assets excluded under
70.29 the supplemental security income program for aged, blind, and disabled persons, with
70.30 the following exceptions:

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

70.32 (2) capital and operating assets of a trade or business that the local agency determines
70.33 are necessary to the person's ability to earn an income are not considered. A bank account
70.34 that contains income or assets, or is used to pay personal expenses, is not considered a
70.35 capital or operating asset of a trade or business;

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

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

71.7 (5) effective upon federal approval, for a person who no longer qualifies as an
71.8 employed person with a disability due to loss of earnings, assets allowed while eligible
71.9 for medical assistance under section 256B.057, subdivision 9, are not considered for 12
71.10 months, beginning with the first month of ineligibility as an employed person with a
71.11 disability, to the extent that the person's total assets remain within the allowed limits of
71.12 section 256B.057, subdivision 9, paragraph (c).

71.13 The assets specified in clauses (1) to (4) must be disclosed to the local agency at the
71.14 time of application and at the time of an eligibility redetermination, and must be verified
71.15 upon request of the local agency.

71.16 Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 3b, is amended to
71.17 read:

71.18 Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a
71.19 revocable or irrevocable trust, or similar legal device, established on or before August
71.20 10, 1993, by a person or the person's spouse under the terms of which the person
71.21 receives or could receive payments from the trust principal or income and the trustee
71.22 has discretion in making payments to the person from the trust principal or income.
71.23 Notwithstanding that definition, a medical assistance qualifying trust does not include:
71.24 (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person
71.25 with a developmental disability living in an intermediate care facility for persons with
71.26 developmental disabilities; or (3) a trust set up by a person with payments made by the
71.27 Social Security Administration pursuant to the United States Supreme Court decision in
71.28 *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The maximum amount of payments that a
71.29 trustee of a medical assistance qualifying trust may make to a person under the terms of
71.30 the trust is considered to be available assets to the person, without regard to whether the
71.31 trustee actually makes the maximum payments to the person and without regard to the
71.32 purpose for which the medical assistance qualifying trust was established.

71.33 (b) Except as provided in paragraphs (c) and (d), trusts established after August 10,
71.34 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation
71.35 Act of 1993 (OBRA), Public Law 103-66.

72.1 (c) For purposes of paragraph (d), a pooled trust means a trust established under
72.2 United States Code, title 42, section 1396p(d)(4)(C).

72.3 (d) A beneficiary's interest in a pooled trust is considered an available asset unless
72.4 the trust provides that upon the death of the beneficiary or termination of the trust during
72.5 the beneficiary's lifetime, whichever is sooner, the department receives any amount in
72.6 excess of reasonable administrative fees remaining in the beneficiary's trust account up to
72.7 the amount of medical assistance benefits paid on behalf of the beneficiary.

72.8 **EFFECTIVE DATE.** This section is effective for pooled trust accounts established
72.9 on or after July 1, 2009.

72.10 Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to
72.11 read:

72.12 Subd. 3c. **Asset limitations for families and children.** A household of two or more
72.13 persons must not own more than \$20,000 in total net assets, and a household of one
72.14 person must not own more than \$10,000 in total net assets. In addition to these maximum
72.15 amounts, an eligible individual or family may accrue interest on these amounts, but they
72.16 must be reduced to the maximum at the time of an eligibility redetermination. The value of
72.17 assets that are not considered in determining eligibility for medical assistance for families
72.18 and children is the value of those assets excluded under the AFDC state plan as of July 16,
72.19 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
72.20 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

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

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

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

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

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

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

72.32 The assets specified in clauses (1) to (7) must be disclosed to the local agency at the
72.33 time of application and at the time of an eligibility redetermination, and must be verified
72.34 upon request of the local agency.

73.1 Sec. 12. Minnesota Statutes 2008, section 256B.056, is amended by adding a
73.2 subdivision to read:

73.3 Subd. 10a. **Delayed verification.** On the basis of information provided on the
73.4 completed application, a child whose family gross income is less than 90 percent of the
73.5 applicable income standard and who meets all other eligibility requirements, including
73.6 compliance at the time of application with citizenship or nationality documentation
73.7 requirements, shall be determined eligible beginning in the month of application. The
73.8 child must provide all required verifications within 60 days' notice of the eligibility
73.9 determination or eligibility shall be terminated. Applicants who are terminated for failure
73.10 to provide all required verifications are not eligible to apply for coverage using the delayed
73.11 verification procedures specified in this subdivision for 12 months.

73.12 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
73.13 approval, whichever is later.

73.14 Sec. 13. Minnesota Statutes 2008, section 256B.057, subdivision 3, is amended to read:

73.15 Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A
73.16 Medicare benefits, whose income is equal to or less than 100 percent of the federal
73.17 poverty guidelines, and whose assets are no more than ~~\$10,000 for a single individual~~
73.18 ~~and \$18,000 for a married couple or family of two or more~~ the maximum resource
73.19 level applied for the year for an individual or an individual and the individual's spouse
73.20 according to United States Code, title 42, section 1396d(p)(1)(C), is eligible for medical
73.21 assistance reimbursement of Part A and Part B premiums, Part A and Part B coinsurance
73.22 and deductibles, and cost-effective premiums for enrollment with a health maintenance
73.23 organization or a competitive medical plan under section 1876 of the Social Security Act.
73.24 Reimbursement of the Medicare coinsurance and deductibles, when added to the amount
73.25 paid by Medicare, must not exceed the total rate the provider would have received for the
73.26 same service or services if the person were a medical assistance recipient with Medicare
73.27 coverage. Increases in benefits under Title II of the Social Security Act shall not be
73.28 counted as income for purposes of this subdivision until July 1 of each year.

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

73.30 Sec. 14. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

73.31 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
73.32 for a person who is employed and who:

73.33 (1) meets the definition of disabled under the supplemental security income program;

74.1 (2) is at least 16 but less than 65 years of age;

74.2 (3) meets the asset limits in paragraph (c); and

74.3 (4) effective November 1, 2003, pays a premium and other obligations under
74.4 paragraph (e).

74.5 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
74.6 determinations.

74.7 (b) After the month of enrollment, a person enrolled in medical assistance under
74.8 this subdivision who:

74.9 (1) is temporarily unable to work and without receipt of earned income due to a
74.10 medical condition, as verified by a physician, may retain eligibility for up to four calendar
74.11 months; or

74.12 (2) effective January 1, 2004, loses employment for reasons not attributable to the
74.13 enrollee, may retain eligibility for up to four consecutive months after the month of job
74.14 loss. To receive a four-month extension, enrollees must verify the medical condition or
74.15 provide notification of job loss. All other eligibility requirements must be met and the
74.16 enrollee must pay all calculated premium costs for continued eligibility.

74.17 (c) For purposes of determining eligibility under this subdivision, a person's assets
74.18 must not exceed \$20,000, excluding:

74.19 (1) all assets excluded under section 256B.056;

74.20 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
74.21 Keogh plans, and pension plans; and

74.22 (3) medical expense accounts set up through the person's employer.

74.23 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65
74.24 earned income disregard. To be eligible, a person applying for medical assistance under
74.25 this subdivision must have earned income above the disregard level.

74.26 (2) Effective January 1, 2004, to be considered earned income, Medicare, Social
74.27 Security, and applicable state and federal income taxes must be withheld. To be eligible,
74.28 a person must document earned income tax withholding.

74.29 (e)(1) A person whose earned and unearned income is equal to or greater than 100
74.30 percent of federal poverty guidelines for the applicable family size must pay a premium
74.31 to be eligible for medical assistance under this subdivision. The premium shall be based
74.32 on the person's gross earned and unearned income and the applicable family size using a
74.33 sliding fee scale established by the commissioner, which begins at one percent of income
74.34 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
74.35 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual

75.1 adjustments in the premium schedule based upon changes in the federal poverty guidelines
75.2 shall be effective for premiums due in July of each year.

75.3 (2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for
75.4 medical assistance under this subdivision. An enrollee shall pay the greater of a ~~\$35~~ \$50
75.5 premium or the premium calculated in clause (1).

75.6 (3) Effective November 1, 2003, all enrollees who receive unearned income must
75.7 pay ~~one-half of one~~ 2.5 percent of unearned income in addition to the premium amount.

75.8 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
75.9 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
75.10 commissioner must reimburse the enrollee for Medicare Part B premiums under section
75.11 256B.0625, subdivision 15, paragraph (a).

75.12 (5) Increases in benefits under title II of the Social Security Act shall not be counted
75.13 as income for purposes of this subdivision until July 1 of each year.

75.14 (f) A person's eligibility and premium shall be determined by the local county
75.15 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
75.16 the commissioner.

75.17 (g) Any required premium shall be determined at application and redetermined at
75.18 the enrollee's six-month income review or when a change in income or household size is
75.19 reported. Enrollees must report any change in income or household size within ten days
75.20 of when the change occurs. A decreased premium resulting from a reported change in
75.21 income or household size shall be effective the first day of the next available billing month
75.22 after the change is reported. Except for changes occurring from annual cost-of-living
75.23 increases, a change resulting in an increased premium shall not affect the premium amount
75.24 until the next six-month review.

75.25 (h) Premium payment is due upon notification from the commissioner of the
75.26 premium amount required. Premiums may be paid in installments at the discretion of
75.27 the commissioner.

75.28 (i) Nonpayment of the premium shall result in denial or termination of medical
75.29 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
75.30 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
75.31 D, are met. Except when an installment agreement is accepted by the commissioner,
75.32 all persons disenrolled for nonpayment of a premium must pay any past due premiums
75.33 as well as current premiums due prior to being reenrolled. Nonpayment shall include
75.34 payment with a returned, refused, or dishonored instrument. The commissioner may
75.35 require a guaranteed form of payment as the only means to replace a returned, refused,
75.36 or dishonored instrument.

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

76.2 Sec. 15. Minnesota Statutes 2008, section 256B.057, is amended by adding a
76.3 subdivision to read:

76.4 **Subd. 11. Treatment for colorectal cancer.** (a) State-only funded medical
76.5 assistance may be paid for an individual who:

76.6 (1) has been screened for colorectal cancer by the colorectal cancer prevention
76.7 demonstration project;

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

76.10 (3) meets income eligibility guidelines for the colorectal cancer prevention
76.11 demonstration project;

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

76.13 (5) is not otherwise eligible for federally funded medical assistance or other
76.14 creditable coverage as defined under United States Code, title 42, section 1396a(aa).

76.15 (b) Medical assistance provided under this subdivision shall be limited to services
76.16 provided during the period that the individual receives treatment for colorectal cancer.

76.17 (c) An individual meeting the criteria in paragraph (a) is eligible for state-only
76.18 funded medical assistance without meeting the eligibility criteria relating to income and
76.19 assets in section 256B.056, subdivisions 1a to 5b.

76.20 Sec. 16. Minnesota Statutes 2008, section 256B.0575, is amended to read:

76.21 **256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED**
76.22 **PERSONS.**

76.23 Subdivision 1. Income deductions. When an institutionalized person is determined
76.24 eligible for medical assistance, the income that exceeds the deductions in paragraphs (a)
76.25 and (b) must be applied to the cost of institutional care.

76.26 (a) The following amounts must be deducted from the institutionalized person's
76.27 income in the following order:

76.28 (1) the personal needs allowance under section 256B.35 or, for a veteran who
76.29 does not have a spouse or child, or a surviving spouse of a veteran having no child, the
76.30 amount of an improved pension received from the veteran's administration not exceeding
76.31 \$90 per month;

76.32 (2) the personal allowance for disabled individuals under section 256B.36;

77.1 (3) if the institutionalized person has a legally appointed guardian or conservator,
77.2 five percent of the recipient's gross monthly income up to \$100 as reimbursement for
77.3 guardianship or conservatorship services;

77.4 (4) a monthly income allowance determined under section 256B.058, subdivision
77.5 2, but only to the extent income of the institutionalized spouse is made available to the
77.6 community spouse;

77.7 (5) a monthly allowance for children under age 18 which, together with the net
77.8 income of the children, would provide income equal to the medical assistance standard
77.9 for families and children according to section 256B.056, subdivision 4, for a family size
77.10 that includes only the minor children. This deduction applies only if the children do not
77.11 live with the community spouse and only to the extent that the deduction is not included
77.12 in the personal needs allowance under section 256B.35, subdivision 1, as child support
77.13 garnished under a court order;

77.14 (6) a monthly family allowance for other family members, equal to one-third of the
77.15 difference between 122 percent of the federal poverty guidelines and the monthly income
77.16 for that family member;

77.17 (7) reparations payments made by the Federal Republic of Germany and reparations
77.18 payments made by the Netherlands for victims of Nazi persecution between 1940 and
77.19 1945;

77.20 (8) all other exclusions from income for institutionalized persons as mandated by
77.21 federal law; and

77.22 (9) amounts for reasonable expenses, as specified in subdivision 2, incurred for
77.23 necessary medical or remedial care for the institutionalized person that are recognized
77.24 under state law, not medical assistance covered expenses, and ~~that are~~ not subject to
77.25 payment by a third party.

77.26 ~~Reasonable expenses are limited to expenses that have not been previously used as a~~
77.27 ~~deduction from income and are incurred during the enrollee's current period of eligibility,~~
77.28 ~~including retroactive months associated with the current period of eligibility, for medical~~
77.29 ~~assistance payment of long-term care services.~~

77.30 For purposes of clause (6), "other family member" means a person who resides
77.31 with the community spouse and who is a minor or dependent child, dependent parent, or
77.32 dependent sibling of either spouse. "Dependent" means a person who could be claimed as
77.33 a dependent for federal income tax purposes under the Internal Revenue Code.

77.34 (b) Income shall be allocated to an institutionalized person for a period of up to three
77.35 calendar months, in an amount equal to the medical assistance standard for a family
77.36 size of one if:

78.1 (1) a physician certifies that the person is expected to reside in the long-term care
78.2 facility for three calendar months or less;

78.3 (2) if the person has expenses of maintaining a residence in the community; and

78.4 (3) if one of the following circumstances apply:

78.5 (i) the person was not living together with a spouse or a family member as defined in
78.6 paragraph (a) when the person entered a long-term care facility; or

78.7 (ii) the person and the person's spouse become institutionalized on the same date, in
78.8 which case the allocation shall be applied to the income of one of the spouses.

78.9 For purposes of this paragraph, a person is determined to be residing in a licensed nursing
78.10 home, regional treatment center, or medical institution if the person is expected to remain
78.11 for a period of one full calendar month or more.

78.12 Subd. 2. Reasonable expenses. (a) For the purposes of subdivision 1, paragraph
78.13 (a), clause (9), reasonable expenses are limited to expenses that have not been previously
78.14 used as a deduction from income and were not:

78.15 (1) for long-term care expenses incurred during a period of ineligibility as defined in
78.16 section 256B.0595, subdivision 2;

78.17 (2) incurred more than three months before the month of application associated with
78.18 the current period of eligibility;

78.19 (3) for expenses incurred by a recipient that are duplicative of services that are
78.20 covered under chapter 256B; or

78.21 (4) nursing facility expenses incurred without a timely assessment as required under
78.22 section 256B.0911.

78.23 Sec. 17. Minnesota Statutes 2008, section 256B.0595, subdivision 1, is amended to
78.24 read:

78.25 Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before
78.26 August 10, 1993, if an institutionalized person or the institutionalized person's spouse has
78.27 given away, sold, or disposed of, for less than fair market value, any asset or interest
78.28 therein, except assets other than the homestead that are excluded under the supplemental
78.29 security program, within 30 months before or any time after the date of institutionalization
78.30 if the person has been determined eligible for medical assistance, or within 30 months
78.31 before or any time after the date of the first approved application for medical assistance
78.32 if the person has not yet been determined eligible for medical assistance, the person is
78.33 ineligible for long-term care services for the period of time determined under subdivision
78.34 2.

79.1 (b) Effective for transfers made after August 10, 1993, an institutionalized person, an
79.2 institutionalized person's spouse, or any person, court, or administrative body with legal
79.3 authority to act in place of, on behalf of, at the direction of, or upon the request of the
79.4 institutionalized person or institutionalized person's spouse, may not give away, sell, or
79.5 dispose of, for less than fair market value, any asset or interest therein, except assets other
79.6 than the homestead that are excluded under the Supplemental Security Income program,
79.7 for the purpose of establishing or maintaining medical assistance eligibility. This applies
79.8 to all transfers, including those made by a community spouse after the month in which
79.9 the institutionalized spouse is determined eligible for medical assistance. For purposes of
79.10 determining eligibility for long-term care services, any transfer of such assets within 36
79.11 months before or any time after an institutionalized person requests medical assistance
79.12 payment of long-term care services, or 36 months before or any time after a medical
79.13 assistance recipient becomes an institutionalized person, for less than fair market value
79.14 may be considered. Any such transfer is presumed to have been made for the purpose
79.15 of establishing or maintaining medical assistance eligibility and the institutionalized
79.16 person is ineligible for long-term care services for the period of time determined under
79.17 subdivision 2, unless the institutionalized person furnishes convincing evidence to
79.18 establish that the transaction was exclusively for another purpose, or unless the transfer is
79.19 permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a
79.20 trust that are considered transfers of assets under federal law, or in the case of any other
79.21 disposal of assets made on or after February 8, 2006, any transfers made within 60 months
79.22 before or any time after an institutionalized person requests medical assistance payment of
79.23 long-term care services and within 60 months before or any time after a medical assistance
79.24 recipient becomes an institutionalized person, may be considered.

79.25 (c) This section applies to transfers, for less than fair market value, of income
79.26 or assets, including assets that are considered income in the month received, such as
79.27 inheritances, court settlements, and retroactive benefit payments or income to which the
79.28 institutionalized person or the institutionalized person's spouse is entitled but does not
79.29 receive due to action by the institutionalized person, the institutionalized person's spouse,
79.30 or any person, court, or administrative body with legal authority to act in place of, on
79.31 behalf of, at the direction of, or upon the request of the institutionalized person or the
79.32 institutionalized person's spouse.

79.33 (d) This section applies to payments for care or personal services provided by a
79.34 relative, unless the compensation was stipulated in a notarized, written agreement which
79.35 was in existence when the service was performed, the care or services directly benefited
79.36 the person, and the payments made represented reasonable compensation for the care

80.1 or services provided. A notarized written agreement is not required if payment for the
80.2 services was made within 60 days after the service was provided.

80.3 (e) This section applies to the portion of any asset or interest that an institutionalized
80.4 person, an institutionalized person's spouse, or any person, court, or administrative body
80.5 with legal authority to act in place of, on behalf of, at the direction of, or upon the request
80.6 of the institutionalized person or the institutionalized person's spouse, transfers to any
80.7 annuity that exceeds the value of the benefit likely to be returned to the institutionalized
80.8 person or institutionalized person's spouse while alive, based on estimated life expectancy
80.9 as determined according to the current actuarial tables published by the Office of the
80.10 Chief Actuary of the Social Security Administration. The commissioner may adopt rules
80.11 reducing life expectancies based on the need for long-term care. This section applies to an
80.12 annuity purchased on or after March 1, 2002, that:

80.13 (1) is not purchased from an insurance company or financial institution that is
80.14 subject to licensing or regulation by the Minnesota Department of Commerce or a similar
80.15 regulatory agency of another state;

80.16 (2) does not pay out principal and interest in equal monthly installments; or

80.17 (3) does not begin payment at the earliest possible date after annuitization.

80.18 (f) Effective for transactions, including the purchase of an annuity, occurring on or
80.19 after February 8, 2006, by or on behalf of an institutionalized person who has applied for
80.20 or is receiving long-term care services or the institutionalized person's spouse shall be
80.21 treated as the disposal of an asset for less than fair market value unless the department is
80.22 named a preferred remainder beneficiary as described in section 256B.056, subdivision
80.23 11. Any subsequent change to the designation of the department as a preferred remainder
80.24 beneficiary shall result in the annuity being treated as a disposal of assets for less than
80.25 fair market value. The amount of such transfer shall be the maximum amount the
80.26 institutionalized person or the institutionalized person's spouse could receive from the
80.27 annuity or similar financial instrument. Any change in the amount of the income or
80.28 principal being withdrawn from the annuity or other similar financial instrument at the
80.29 time of the most recent disclosure shall be deemed to be a transfer of assets for less than
80.30 fair market value unless the institutionalized person or the institutionalized person's spouse
80.31 demonstrates that the transaction was for fair market value. In the event a distribution
80.32 of income or principal has been improperly distributed or disbursed from an annuity or
80.33 other retirement planning instrument of an institutionalized person or the institutionalized
80.34 person's spouse, a cause of action exists against the individual receiving the improper
80.35 distribution for the cost of medical assistance services provided or the amount of the
80.36 improper distribution, whichever is less.

81.1 (g) Effective for transactions, including the purchase of an annuity, occurring on
81.2 or after February 8, 2006, by or on behalf of an institutionalized person applying for or
81.3 receiving long-term care services shall be treated as a disposal of assets for less than fair
81.4 market value unless it is:

81.5 (i) an annuity described in subsection (b) or (q) of section 408 of the Internal
81.6 Revenue Code of 1986; or

81.7 (ii) purchased with proceeds from:

81.8 (A) an account or trust described in subsection (a), (c), or (p) of section 408 of the
81.9 Internal Revenue Code;

81.10 (B) a simplified employee pension within the meaning of section 408(k) of the
81.11 Internal Revenue Code; or

81.12 (C) a Roth IRA described in section 408A of the Internal Revenue Code; or

81.13 (iii) an annuity that is irrevocable and nonassignable; is actuarially sound as
81.14 determined in accordance with actuarial publications of the Office of the Chief Actuary of
81.15 the Social Security Administration; and provides for payments in equal amounts during
81.16 the term of the annuity, with no deferral and no balloon payments made.

81.17 (h) For purposes of this section, long-term care services include services in a nursing
81.18 facility, services that are eligible for payment according to section 256B.0625, subdivision
81.19 2, because they are provided in a swing bed, intermediate care facility for persons with
81.20 developmental disabilities, and home and community-based services provided pursuant
81.21 to sections 256B.0915, 256B.092, and 256B.49. For purposes of this subdivision and
81.22 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient
81.23 in a nursing facility or in a swing bed, or intermediate care facility for persons with
81.24 developmental disabilities or who is receiving home and community-based services under
81.25 sections 256B.0915, 256B.092, and 256B.49.

81.26 (i) This section applies to funds used to purchase a promissory note, loan, or
81.27 mortgage unless the note, loan, or mortgage:

81.28 (1) has a repayment term that is actuarially sound;

81.29 (2) provides for payments to be made in equal amounts during the term of the loan,
81.30 with no deferral and no balloon payments made; and

81.31 (3) prohibits the cancellation of the balance upon the death of the lender.

81.32 In the case of a promissory note, loan, or mortgage that does not meet an exception
81.33 in clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding
81.34 balance due as of the date of the institutionalized person's request for medical assistance
81.35 payment of long-term care services.

82.1 (j) This section applies to the purchase of a life estate interest in another person's
82.2 home unless the purchaser resides in the home for a period of at least one year after the
82.3 date of purchase.

82.4 (k) This section applies to transfers into a pooled trust that qualifies under United
82.5 States Code, title 42, section 1396p(d)(4)(C), by:

82.6 (1) a person age 65 or older or the person's spouse; or

82.7 (2) any person, court, or administrative body with legal authority to act in place
82.8 of, on behalf of, at the direction of, or upon the request of a person age 65 or older or
82.9 the person's spouse.

82.10 Sec. 18. Minnesota Statutes 2008, section 256B.06, subdivision 4, is amended to read:

82.11 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
82.12 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
82.13 other persons residing lawfully in the United States. Citizens or nationals of the United
82.14 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
82.15 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
82.16 Public Law 109-171.

82.17 (b) "Qualified noncitizen" means a person who meets one of the following
82.18 immigration criteria:

82.19 (1) admitted for lawful permanent residence according to United States Code, title 8;

82.20 (2) admitted to the United States as a refugee according to United States Code,
82.21 title 8, section 1157;

82.22 (3) granted asylum according to United States Code, title 8, section 1158;

82.23 (4) granted withholding of deportation according to United States Code, title 8,
82.24 section 1253(h);

82.25 (5) paroled for a period of at least one year according to United States Code, title 8,
82.26 section 1182(d)(5);

82.27 (6) granted conditional entrant status according to United States Code, title 8,
82.28 section 1153(a)(7);

82.29 (7) determined to be a battered noncitizen by the United States Attorney General
82.30 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
82.31 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

82.32 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
82.33 States Attorney General according to the Illegal Immigration Reform and Immigrant
82.34 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
82.35 Public Law 104-200; or

83.1 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
83.2 Law 96-422, the Refugee Education Assistance Act of 1980.

83.3 (c) All qualified noncitizens who were residing in the United States before August
83.4 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
83.5 medical assistance with federal financial participation.

83.6 (d) All qualified noncitizens who entered the United States on or after August 22,
83.7 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
83.8 medical assistance with federal financial participation through November 30, 1996.

83.9 Beginning December 1, 1996, qualified noncitizens who entered the United States
83.10 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
83.11 chapter are eligible for medical assistance with federal participation for five years if they
83.12 meet one of the following criteria:

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

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

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

83.18 (iv) veterans of the United States armed forces with an honorable discharge for
83.19 a reason other than noncitizen status, their spouses and unmarried minor dependent
83.20 children; or

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

83.23 Beginning December 1, 1996, qualified noncitizens who do not meet one of the
83.24 criteria in items (i) to (v) are eligible for medical assistance without federal financial
83.25 participation as described in paragraph (j).

83.26 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
83.27 women who are qualified noncitizens, as described in paragraph (b), are eligible for
83.28 medical assistance with federal financial participation as provided by the federal Children's
83.29 Health Insurance Program Reauthorization Act of 2009, Public Law 11-3.

83.30 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
83.31 are lawfully present in the United States, as defined in Code of Federal Regulations, title
83.32 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
83.33 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
83.34 with the United States Citizenship and Immigration Services to pursue any applicable
83.35 immigration status, including citizenship, that would qualify them for medical assistance
83.36 with federal financial participation.

84.1 (1) Persons who were medical assistance recipients on August 22, 1996, are eligible
84.2 for medical assistance with federal financial participation through December 31, 1996.

84.3 (2) Beginning January 1, 1997, persons described in clause (1) are eligible for
84.4 medical assistance without federal financial participation as described in paragraph (j).

84.5 (3) Beginning December 1, 1996, persons residing in the United States prior to
84.6 August 22, 1996, who were not receiving medical assistance and persons who arrived on
84.7 or after August 22, 1996, are eligible for medical assistance without federal financial
84.8 participation as described in paragraph (j).

84.9 (f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
84.10 are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this
84.11 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
84.12 Code, title 8, section 1101(a)(15).

84.13 (g) Payment shall also be made for care and services that are furnished to noncitizens,
84.14 regardless of immigration status, who otherwise meet the eligibility requirements of
84.15 this chapter, if such care and services are necessary for the treatment of an emergency
84.16 medical condition, except for organ transplants and related care and services and routine
84.17 prenatal care.

84.18 (h) For purposes of this subdivision, the term "emergency medical condition" means
84.19 a medical condition that meets the requirements of United States Code, title 42, section
84.20 1396b(v).

84.21 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
84.22 nonimmigrants, or eligible for medical assistance as described in paragraph (j), and who
84.23 are not covered by a group health plan or health insurance coverage according to Code of
84.24 Federal Regulations, title 42, section 457.310, lawfully present as designated in paragraph
84.25 (e), and who otherwise meet the eligibility requirements of this chapter, are eligible for
84.26 medical assistance through the period of pregnancy, including labor and delivery, and 60
84.27 days post partum, to the extent federal funds are available under title XXI of the Social
84.28 Security Act, and the state children's health insurance program, followed by 60 days
84.29 postpartum without federal financial participation.

84.30 (j) Qualified noncitizens as described in paragraph (d), and all other noncitizens
84.31 lawfully residing in the United States as described in paragraph (e), who are ineligible
84.32 for medical assistance with federal financial participation and who otherwise meet the
84.33 eligibility requirements of chapter 256B and of this paragraph, are eligible for medical
84.34 assistance without federal financial participation. Qualified noncitizens as described
84.35 in paragraph (d) are only eligible for medical assistance without federal financial
84.36 participation for five years from their date of entry into the United States.

85.1 (k) Beginning October 1, 2003, persons who are receiving care and rehabilitation
85.2 services from a nonprofit center established to serve victims of torture and are otherwise
85.3 ineligible for medical assistance under this chapter are eligible for medical assistance
85.4 without federal financial participation. These individuals are eligible only for the period
85.5 during which they are receiving services from the center. Individuals eligible under this
85.6 paragraph shall not be required to participate in prepaid medical assistance.

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

85.8 Sec. 19. Minnesota Statutes 2008, section 256B.06, subdivision 5, is amended to read:

85.9 Subd. 5. **Deeming of sponsor income and resources.** When determining eligibility
85.10 for any federal or state funded medical assistance under this section, the income
85.11 and resources of all noncitizens shall be deemed to include their sponsors' income
85.12 and resources as required under the Personal Responsibility and Work Opportunity
85.13 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
85.14 subsequently set out in federal rules. This section is effective May 1, 1997. Beginning
85.15 July 1, 2010, sponsor deeming does not apply to pregnant women and children who are
85.16 qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

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

85.18 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 3c, is amended to
85.19 read:

85.20 Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after
85.21 receiving recommendations from professional physician associations, professional
85.22 associations representing licensed nonphysician health care professionals, and consumer
85.23 groups, shall establish a 13-member Health Services Policy Committee, which consists of
85.24 12 voting members and one nonvoting member. The Health Services Policy Committee
85.25 shall advise the commissioner regarding health services pertaining to the administration
85.26 of health care benefits covered under the medical assistance, general assistance medical
85.27 care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at
85.28 least quarterly. The Health Services Policy Committee shall annually elect a physician
85.29 chair from among its members, who shall work directly with the commissioner's medical
85.30 director, to establish the agenda for each meeting. The Health Services Policy Committee
85.31 shall also recommend criteria for verifying centers of excellence for specific aspects of
85.32 medical care where a specific set of combined services, a volume of patients necessary to

86.1 maintain a high level of competency, or a specific level of technical capacity is associated
86.2 with improved health outcomes.

86.3 (b) The commissioner shall establish a dental subcommittee to operate under the
86.4 Health Services Policy Committee. The dental subcommittee consists of general dentists,
86.5 dental specialists, safety net providers, dental hygienists, health plan company and county
86.6 and public health representatives, health researchers, consumers, and the Minnesota
86.7 Department of Health oral health director. The dental subcommittee shall advise the
86.8 commissioner regarding:

86.9 (1) the critical access dental program under section 256B.76, subdivision 4;

86.10 (2) any changes to the critical access dental provider program necessary to comply
86.11 with program expenditure limits;

86.12 (3) dental coverage policy based on evidence, quality, continuity of care, and best
86.13 practices;

86.14 (4) the development of dental delivery models; and

86.15 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).

86.16 (c) The Health Services Policy Committee shall study approaches to making
86.17 provider reimbursement under the medical assistance, MinnesotaCare, and general
86.18 assistance medical care programs contingent on patient participation in a patient-centered
86.19 decision-making process, and shall evaluate the impact of these approaches on health
86.20 care quality, patient satisfaction, and health care costs. The committee shall present
86.21 findings and recommendations to the commissioner and the legislative committees with
86.22 jurisdiction over health care by January 15, 2010.

86.23 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 9, is amended to
86.24 read:

86.25 Subd. 9. **Dental services.** (a) Medical assistance covers dental services. Dental
86.26 services include, with prior authorization, fixed bridges that are cost-effective for persons
86.27 who cannot use removable dentures because of their medical condition.

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

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

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

86.32 (3) limited exams;

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

86.34 (5) periapical x-rays;

87.1 (6) panoramic x-rays, limited to one every five years, and only if provided in
87.2 conjunction with a posterior extraction or scheduled outpatient facility procedure, or as
87.3 medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology
87.4 and trauma. Panoramic x-rays may be taken once every two years for patients who cannot
87.5 cooperate for intraoral film due to a developmental disability or medical condition that
87.6 does not allow for intraoral film placement;

87.7 (7) prophylaxis, limited to one per year;

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

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

87.10 (10) anterior fillings;

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

87.12 (12) removable prostheses, each dental arch limited to one every six years;

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

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

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

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

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

87.22 (2) general anesthesia; and

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

87.24 (d) Medical assistance covers dental services for children that are medically
87.25 necessary. The following guidelines apply:

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

87.27 (2) application of sealants once every five years per permanent molar; and

87.28 (3) application of fluoride varnish once every six months.

87.29 **EFFECTIVE DATE.** This section is effective January 1, 2010.

87.30 Sec. 22. Minnesota Statutes 2008, section 256B.0625, subdivision 13e, is amended to
87.31 read:

87.32 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
87.33 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
87.34 the maximum allowable cost set by the federal government or by the commissioner plus
87.35 the fixed dispensing fee; or the usual and customary price charged to the public. The

88.1 amount of payment basis must be reduced to reflect all discount amounts applied to the
88.2 charge by any provider/insurer agreement or contract for submitted charges to medical
88.3 assistance programs. The net submitted charge may not be greater than the patient liability
88.4 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee
88.5 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per
88.6 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral
88.7 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral
88.8 nutritional products dispensed in quantities greater than one liter. Actual acquisition
88.9 cost includes quantity and other special discounts except time and cash discounts.
88.10 Effective July 1, 2008, the actual acquisition cost of a drug shall be estimated by the
88.11 commissioner, at average wholesale price minus ~~14~~ 15 percent. The actual acquisition
88.12 cost of antihemophilic factor drugs shall be estimated at the average wholesale price
88.13 minus 30 percent. The maximum allowable cost of a multisource drug may be set by the
88.14 commissioner and it shall be comparable to, but no higher than, the maximum amount
88.15 paid by other third-party payors in this state who have maximum allowable cost programs.
88.16 Establishment of the amount of payment for drugs shall not be subject to the requirements
88.17 of the Administrative Procedure Act.

88.18 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
88.19 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
88.20 facilities when a unit dose blister card system, approved by the department, is used. Under
88.21 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
88.22 The National Drug Code (NDC) from the drug container used to fill the blister card must
88.23 be identified on the claim to the department. The unit dose blister card containing the
88.24 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
88.25 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
88.26 will be required to credit the department for the actual acquisition cost of all unused
88.27 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
88.28 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
88.29 dispensed in a quantity that is less than a 30-day supply.

88.30 (c) Whenever a generically equivalent product is available, payment shall be on the
88.31 basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost
88.32 established by the commissioner.

88.33 (d) The basis for determining the amount of payment for drugs administered in an
88.34 outpatient setting shall be the lower of the usual and customary cost submitted by the
88.35 provider or the amount established for Medicare by the United States Department of

89.1 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
89.2 Security Act.

89.3 (e) The commissioner may negotiate lower reimbursement rates for specialty
89.4 pharmacy products than the rates specified in paragraph (a). The commissioner may
89.5 require individuals enrolled in the health care programs administered by the department
89.6 to obtain specialty pharmacy products from providers with whom the commissioner has
89.7 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
89.8 used by a small number of recipients or recipients with complex and chronic diseases
89.9 that require expensive and challenging drug regimens. Examples of these conditions
89.10 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
89.11 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
89.12 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
89.13 biotechnology drugs, high-cost therapies, and therapies that require complex care. The
89.14 commissioner shall consult with the formulary committee to develop a list of specialty
89.15 pharmacy products subject to this paragraph. In consulting with the formulary committee
89.16 in developing this list, the commissioner shall take into consideration the population
89.17 served by specialty pharmacy products, the current delivery system and standard of care in
89.18 the state, and access to care issues. The commissioner shall have the discretion to adjust
89.19 the reimbursement rate to prevent access to care issues.

89.20 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2008.

89.21 Sec. 23. Minnesota Statutes 2008, section 256B.0625, subdivision 17, is amended to
89.22 read:

89.23 Subd. 17. **Transportation costs.** (a) Medical assistance covers transportation costs
89.24 incurred solely for obtaining emergency medical care or transportation costs incurred
89.25 by eligible persons in obtaining emergency or nonemergency medical care when paid
89.26 directly to an ambulance company, common carrier, or other recognized providers of
89.27 transportation services.

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

89.32 The commissioner may use an order by the recipient's attending physician to certify that
89.33 the recipient requires special transportation services. Special transportation includes
89.34 driver-assisted service to eligible individuals. Driver-assisted service includes passenger

90.1 pickup at and return to the individual's residence or place of business, assistance with
90.2 admittance of the individual to the medical facility, and assistance in passenger securement
90.3 or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers
90.4 must obtain written documentation from the health care service provider who is serving
90.5 the recipient being transported, identifying the time that the recipient arrived. Special
90.6 transportation providers may not bill for separate base rates for the continuation of a trip
90.7 beyond the original destination. Special transportation providers must take recipients to
90.8 the nearest appropriate health care provider, using the most direct route available. The
90.9 maximum medical assistance reimbursement rates for special transportation services are:

90.10 (1) \$17 for the base rate and ~~\$1.35~~ \$1.65 per mile for services to eligible persons
90.11 who need a wheelchair-accessible van;

90.12 (2) ~~\$11.50~~ \$8.50 for the base rate and \$1.30 per mile for services to eligible persons
90.13 who do not need a wheelchair-accessible van; and

90.14 (3) \$60 for the base rate and \$2.40 per mile, and an attendant rate of \$9 per trip, for
90.15 services to eligible persons who need a stretcher-accessible vehicle.

90.16 Sec. 24. Minnesota Statutes 2008, section 256B.0625, subdivision 26, is amended to
90.17 read:

90.18 Subd. 26. **Special education services.** (a) Medical assistance covers medical
90.19 services identified in a recipient's individualized education plan and covered under the
90.20 medical assistance state plan. Covered services include occupational therapy, physical
90.21 therapy, speech-language therapy, clinical psychological services, nursing services,
90.22 school psychological services, school social work services, personal care assistants
90.23 serving as management aides, assistive technology devices, transportation services,
90.24 health assessments, and other services covered under the medical assistance state plan.
90.25 Mental health services eligible for medical assistance reimbursement must be provided or
90.26 coordinated through a children's mental health collaborative where a collaborative exists if
90.27 the child is included in the collaborative operational target population. The provision or
90.28 coordination of services does not require that the individual education plan be developed
90.29 by the collaborative.

90.30 The services may be provided by a Minnesota school district that is enrolled as a
90.31 medical assistance provider or its subcontractor, and only if the services meet all the
90.32 requirements otherwise applicable if the service had been provided by a provider other
90.33 than a school district, in the following areas: medical necessity, physician's orders,
90.34 documentation, personnel qualifications, and prior authorization requirements. The
90.35 nonfederal share of costs for services provided under this subdivision is the responsibility

91.1 of the local school district as provided in section 125A.74. Services listed in a child's
91.2 individual education plan are eligible for medical assistance reimbursement only if those
91.3 services meet criteria for federal financial participation under the Medicaid program.

91.4 (b) Approval of health-related services for inclusion in the individual education plan
91.5 does not require prior authorization for purposes of reimbursement under this chapter.
91.6 The commissioner may require physician review and approval of the plan not more than
91.7 once annually or upon any modification of the individual education plan that reflects a
91.8 change in health-related services.

91.9 (c) Services of a speech-language pathologist provided under this section are covered
91.10 notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

91.11 (1) holds a masters degree in speech-language pathology;

91.12 (2) is licensed by the Minnesota Board of Teaching as an educational
91.13 speech-language pathologist; and

91.14 (3) either has a certificate of clinical competence from the American Speech and
91.15 Hearing Association, has completed the equivalent educational requirements and work
91.16 experience necessary for the certificate or has completed the academic program and is
91.17 acquiring supervised work experience to qualify for the certificate.

91.18 (d) Medical assistance coverage for medically necessary services provided under
91.19 other subdivisions in this section may not be denied solely on the basis that the same or
91.20 similar services are covered under this subdivision.

91.21 (e) The commissioner shall develop and implement package rates, bundled rates, or
91.22 per diem rates for special education services under which separately covered services are
91.23 grouped together and billed as a unit in order to reduce administrative complexity.

91.24 (f) The commissioner shall develop a cost-based payment structure for payment
91.25 of these services. The commissioner shall reimburse claims submitted based on an
91.26 interim rate, and shall settle at a final rate once the department has determined it. The
91.27 commissioner shall notify the school district of the final rate. The school district has 60
91.28 days to appeal the final rate. To appeal the final rate, the school district shall file a written
91.29 appeal request to the commissioner within 60 days of the date the final rate determination
91.30 was mailed. The appeal request shall specify (1) the disputed items and (2) the name and
91.31 address of the person to contact regarding the appeal.

91.32 (g) Effective July 1, 2000, medical assistance services provided under an individual
91.33 education plan or an individual family service plan by local school districts shall not count
91.34 against medical assistance authorization thresholds for that child.

91.35 (h) Nursing services as defined in section 148.171, subdivision 15, and provided
91.36 as an individual education plan health-related service, are eligible for medical assistance

92.1 payment if they are otherwise a covered service under the medical assistance program.
 92.2 Medical assistance covers the administration of prescription medications by a licensed
 92.3 nurse who is employed by or under contract with a school district when the administration
 92.4 of medications is identified in the child's individualized education plan. The simple
 92.5 administration of medications alone is not covered under medical assistance when
 92.6 administered by a provider other than a school district or when it is not identified in the
 92.7 child's individualized education plan.

92.8 Sec. 25. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
 92.9 read:

92.10 Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical
 92.11 assistance benefit plan shall include the following co-payments for all recipients, effective
 92.12 for services provided on or after ~~October 1, 2003, and before January 1, 2009~~ July 1, 2009:

92.13 (1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an
 92.14 episode of service which is required because of a recipient's symptoms, diagnosis, or
 92.15 established illness, and which is delivered in an ambulatory setting by a physician or
 92.16 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
 92.17 audiologist, optician, or optometrist;

92.18 (2) \$3 for eyeglasses;

92.19 (3) \$6 for nonemergency visits to a hospital-based emergency room; ~~and~~

92.20 ~~(4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,~~
 92.21 ~~subject to a \$12 per month maximum for prescription drug co-payments. No co-payments~~
 92.22 ~~shall apply to antipsychotic drugs when used for the treatment of mental illness.~~

92.23 ~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall~~
 92.24 ~~include the following co-payments for all recipients, effective for services provided on~~
 92.25 ~~or after January 1, 2009:~~

92.26 ~~(1) \$6 for nonemergency visits to a hospital-based emergency room;~~

92.27 ~~(2)~~ (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
 92.28 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
 92.29 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

92.30 ~~(3)~~ (5) for individuals identified by the commissioner with income at or below 100
 92.31 percent of the federal poverty guidelines, total monthly co-payments must not exceed five
 92.32 percent of family income. For purposes of this paragraph, family income is the total
 92.33 earned and unearned income of the individual and the individual's spouse, if the spouse is
 92.34 enrolled in medical assistance and also subject to the five percent limit on co-payments.

93.1 ~~(e)~~ (b) Recipients of medical assistance are responsible for all co-payments in this
93.2 subdivision.

93.3 Sec. 26. **[256B.0755] PAYMENT REFORM DEMONSTRATION PROJECT FOR**
93.4 **SPECIAL PATIENT POPULATIONS.**

93.5 Subdivision 1. **Demonstration project.** (a) The commissioner of human services,
93.6 in consultation with the commissioner of health, shall establish a payment reform
93.7 demonstration project implementing an alternative payment system for health care
93.8 providers serving an identified group of patients who are enrolled in a state health
93.9 care program, and are either high utilizers of high-cost health care services or have
93.10 characteristics that put them at high risk of becoming high utilizers. The purpose of the
93.11 demonstration project is to implement and evaluate methods of reducing hospitalizations,
93.12 emergency room use, high-cost medications and specialty services, admissions to nursing
93.13 facilities, or use of long-term home and community-based services, in order to reduce the
93.14 total cost of care and services for the patients.

93.15 (b) The commissioner shall give the highest priority to projects that will serve
93.16 patients who have chronic medical conditions or complex medical needs that are
93.17 complicated by a physical disability, serious mental illness, or serious socioeconomic
93.18 factors such as poverty, homelessness, or language or cultural barriers. The commissioner
93.19 shall also give the highest priority to providers or groups of providers who have the
93.20 highest concentrations of patients with these characteristics.

93.21 (c) The commissioner must implement this payment reform demonstration project
93.22 in a manner consistent with the payment reform initiative provided in sections 62U.02
93.23 to 62U.04.

93.24 (d) For purposes of this section, "state health care program" means the medical
93.25 assistance, MinnesotaCare, and general assistance medical care programs.

93.26 Subd. 2. **Participation.** (a) The commissioner shall request eligible providers or
93.27 groups of providers to submit a proposal to participate in the demonstration project by
93.28 September 1, 2009. The providers who are interested in participating shall negotiate with
93.29 the commissioner to determine:

93.30 (1) the identified group of patients who are to be enrolled in the program;

93.31 (2) the services that are to be included in the total cost of care calculation;

93.32 (3) the methodology for calculating the total cost of care, which may take into
93.33 consideration the impact on costs to other state or local government programs including,
93.34 but not limited to, social services and income maintenance programs;

93.35 (4) the time period to be covered under the bid;

94.1 (5) the implementation of a risk adjustment mechanism to adjust for factors that are
94.2 beyond the control of the provider including nonclinical factors that will affect the cost
94.3 or outcomes of treatment;

94.4 (6) the payment reforms and payment methods to be used under the project, which
94.5 may include but are not limited to adjustments in fee-for-service payments, payment of
94.6 care coordination fees, payments for start-up and implementation costs to be recovered or
94.7 repaid later in the project, payments adjusted based on a provider's proportion of patients
94.8 who are enrolled in state health care programs; payments adjusted for the clinical or
94.9 socioeconomic complexity of the patients served, payment incentives tied to use of
94.10 inpatient and emergency room services, and periodic settle-up adjustments;

94.11 (7) methods of sharing financial risk and benefit between the commissioner and
94.12 the provider or groups of providers, which may include but are not limited to stop-loss
94.13 arrangements to cover high-cost outlier cases or costs that are beyond the control of the
94.14 provider, and risk-sharing and benefit-sharing corridors; and

94.15 (8) performance and outcome benchmarks to be used to measure performance,
94.16 achievement of cost-savings targets, and quality of care provided.

94.17 (b) A provider or group of providers may submit a proposal for a demonstration
94.18 project in partnership with a health maintenance organization or county-based purchasing
94.19 plan for the purposes of sharing risk, claims processing, or administration of the project,
94.20 or to extend participation in the project to persons who are enrolled in prepaid health
94.21 care programs.

94.22 Subd. 3. **Total cost of care agreement.** Based on negotiations, the commissioner
94.23 must enter into an agreement with interested and eligible providers or groups of providers
94.24 to implement projects that are designed to reduce the total cost of care for the identified
94.25 patients. To the extent possible, the projects shall begin implementation on January 1,
94.26 2010, or upon federal approval, whichever is later.

94.27 Subd. 4. **Eligibility.** To be eligible to participate, providers or groups of providers
94.28 must meet certification standards for health care homes established by the Department of
94.29 Health and the Department of Human Services under section 256B.0751.

94.30 Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers
94.31 and approvals necessary to implement this section and to obtain federal matching funds. To
94.32 the extent authorized by federal law, the commissioner may waive existing fee-for-service
94.33 payment rates, provider contract or performance requirements, consumer incentive
94.34 policies, or other requirements in statute or rule in order to allow the providers or groups
94.35 of providers to utilize alternative payment and financing methods that will appropriately
94.36 fund necessary and cost-effective primary care and care coordination services; establish

95.1 appropriate incentives for prevention, health promotion, and care coordination; and
95.2 mitigate financial harm to participating providers caused by the successful reduction in
95.3 preventable hospitalization, emergency room use, and other costly services.

95.4 Subd. 6. **Cost neutrality.** The total cost, including administrative costs, of this
95.5 demonstration project must not exceed the costs that would otherwise be incurred by
95.6 the state had services to the state health care program enrollees participating in the
95.7 demonstration project been provided, as applicable for the enrollee, under fee-for-service
95.8 or through managed care or county-based purchasing plans.

95.9 Sec. 27. Minnesota Statutes 2008, section 256B.15, subdivision 1a, is amended to read:

95.10 Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance
95.11 hereunder, on the person's death, if single, or on the death of the survivor of a married
95.12 couple, either or both of whom received medical assistance, or as otherwise provided
95.13 for in this section, the total amount paid for medical assistance rendered for the person
95.14 and spouse shall be filed as a claim against the estate of the person or the estate of the
95.15 surviving spouse in the court having jurisdiction to probate the estate or to issue a decree
95.16 of descent according to sections 525.31 to 525.313.

95.17 (b) For the purposes of this section, the person's estate must consist of:

95.18 (1) the person's probate estate;

95.19 (2) all of the person's interests or proceeds of those interests in real property the
95.20 person owned as a life tenant or as a joint tenant with a right of survivorship at the time of
95.21 the person's death;

95.22 (3) all of the person's interests or proceeds of those interests in securities the person
95.23 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time
95.24 of the person's death, to the extent the interests or proceeds of those interests become part
95.25 of the probate estate under section 524.6-307;

95.26 (4) all of the person's interests in joint accounts, multiple-party accounts, and
95.27 pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of
95.28 those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the
95.29 person's death to the extent the interests become part of the probate estate under section
95.30 524.6-207; and

95.31 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,
95.32 living trust, or other arrangements.

95.33 (c) For the purpose of this section and recovery in a surviving spouse's estate for
95.34 medical assistance paid for a predeceased spouse, the estate must consist of all of the legal
95.35 title and interests the deceased individual's predeceased spouse had in jointly owned or

96.1 marital property at the time of the spouse's death, as defined in subdivision 2b, and the
96.2 proceeds of those interests, that passed to the deceased individual or another individual, a
96.3 survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy
96.4 in common, survivorship, life estate, living trust, or other arrangement. A deceased
96.5 recipient who, at death, owned the property jointly with the surviving spouse shall have
96.6 an interest in the entire property.

96.7 (d) For the purpose of recovery in a single person's estate or the estate of a survivor
96.8 of a married couple, "other arrangement" includes any other means by which title to all or
96.9 any part of the jointly owned or marital property or interest passed from the predeceased
96.10 spouse to another including, but not limited to, transfers between spouses which are
96.11 permitted, prohibited, or penalized for purposes of medical assistance.

96.12 (e) A claim shall be filed if medical assistance was rendered for either or both
96.13 persons under one of the following circumstances:

96.14 ~~(a)~~ (1) the person was over 55 years of age, and received services under this chapter;

96.15 ~~(b)~~ (2) the person resided in a medical institution for six months or longer, received
96.16 services under this chapter, and, at the time of institutionalization or application for
96.17 medical assistance, whichever is later, the person could not have reasonably been expected
96.18 to be discharged and returned home, as certified in writing by the person's treating
96.19 physician. For purposes of this section only, a "medical institution" means a skilled
96.20 nursing facility, intermediate care facility, intermediate care facility for persons with
96.21 developmental disabilities, nursing facility, or inpatient hospital; or

96.22 ~~(c)~~ (3) the person received general assistance medical care services under chapter
96.23 256D.

96.24 (f) The claim shall be considered an expense of the last illness of the decedent for the
96.25 purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or
96.26 county agency with a claim under this section must be a creditor under section 524.6-307.

96.27 Any statute of limitations that purports to limit any county agency or the state agency,
96.28 or both, to recover for medical assistance granted hereunder shall not apply to any claim
96.29 made hereunder for reimbursement for any medical assistance granted hereunder. Notice
96.30 of the claim shall be given to all heirs and devisees of the decedent whose identity can be
96.31 ascertained with reasonable diligence. The notice must include procedures and instructions
96.32 for making an application for a hardship waiver under subdivision 5; time frames for
96.33 submitting an application and determination; and information regarding appeal rights and
96.34 procedures. Counties are entitled to one-half of the nonfederal share of medical assistance
96.35 collections from estates that are directly attributable to county effort. Counties are entitled
96.36 to ten percent of the collections for alternative care directly attributable to county effort.

97.1 Sec. 28. Minnesota Statutes 2008, section 256B.15, subdivision 1h, is amended to read:

97.2 Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For
97.3 purposes of this section, paragraphs (b) to ~~(k)~~ (j) apply if a person received medical
97.4 assistance for which a claim may be filed under this section and died single, or the
97.5 surviving spouse of the couple and was not survived by any of the persons described
97.6 in subdivisions 3 and 4.

97.7 ~~(b) For purposes of this section, the person's estate consists of: (1) the person's~~
97.8 ~~probate estate; (2) all of the person's interests or proceeds of those interests in real property~~
97.9 ~~the person owned as a life tenant or as a joint tenant with a right of survivorship at the~~
97.10 ~~time of the person's death; (3) all of the person's interests or proceeds of those interests in~~
97.11 ~~securities the person owned in beneficiary form as provided under sections 524.6-301 to~~
97.12 ~~524.6-311 at the time of the person's death, to the extent they become part of the probate~~
97.13 ~~estate under section 524.6-307; (4) all of the person's interests in joint accounts, multiple~~
97.14 ~~party accounts, and pay on death accounts, or the proceeds of those accounts, as provided~~
97.15 ~~under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent~~
97.16 ~~they become part of the probate estate under section 524.6-207; and (5) the person's~~
97.17 ~~legal title or interest at the time of the person's death in real property transferred under~~
97.18 ~~a transfer on death deed under section 507.071, or in the proceeds from the subsequent~~
97.19 ~~sale of the person's interest in the real property. Notwithstanding any law or rule to the~~
97.20 ~~contrary, a state or county agency with a claim under this section shall be a creditor under~~
97.21 ~~section 524.6-307.~~

97.22 ~~(e)~~ (b) Notwithstanding any law or rule to the contrary, the person's life estate or joint
97.23 tenancy interest in real property not subject to a medical assistance lien under sections
97.24 514.980 to 514.985 on the date of the person's death shall not end upon the person's death
97.25 and shall continue as provided in this subdivision. The life estate in the person's estate
97.26 shall be that portion of the interest in the real property subject to the life estate that is equal
97.27 to the life estate percentage factor for the life estate as listed in the Life Estate Mortality
97.28 Table of the health care program's manual for a person who was the age of the medical
97.29 assistance recipient on the date of the person's death. The joint tenancy interest in real
97.30 property in the estate shall be equal to the fractional interest the person would have owned
97.31 in the jointly held interest in the property had they and the other owners held title to the
97.32 property as tenants in common on the date the person died.

97.33 ~~(d)~~ (c) The court upon its own motion, or upon motion by the personal representative
97.34 or any interested party, may enter an order directing the remaindermen or surviving joint
97.35 tenants and their spouses, if any, to sign all documents, take all actions, and otherwise
97.36 fully cooperate with the personal representative and the court to liquidate the decedent's

98.1 life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of
98.2 those interests to the personal representative and provide for any legal and equitable
98.3 sanctions as the court deems appropriate to enforce and carry out the order, including an
98.4 award of reasonable attorney fees.

98.5 ~~(e)~~ (d) The personal representative may make, execute, and deliver any conveyances
98.6 or other documents necessary to convey the decedent's life estate or joint tenancy interest
98.7 in the estate that are necessary to liquidate and reduce to cash the decedent's interest or
98.8 for any other purposes.

98.9 ~~(f)~~ (e) Subject to administration, all costs, including reasonable attorney fees,
98.10 directly and immediately related to liquidating the decedent's life estate or joint tenancy
98.11 interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation
98.12 allocable to the decedent's interest and the net proceeds shall be turned over to the personal
98.13 representative and applied to payment of the claim presented under this section.

98.14 ~~(g)~~ (f) The personal representative shall bring a motion in the district court in which
98.15 the estate is being probated to compel the remaindermen or surviving joint tenants to
98.16 account for and deliver to the personal representative all or any part of the proceeds of any
98.17 sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the
98.18 decedent's life estate or joint tenancy interest in the decedent's estate, and do everything
98.19 necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of
98.20 the sale or other disposition over to the personal representative. The court may grant any
98.21 legal or equitable relief including, but not limited to, ordering a partition of real estate
98.22 under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy
98.23 interest available to the estate for payment of a claim under this section.

98.24 ~~(h)~~ (g) Subject to administration, the personal representative shall use all of the cash
98.25 or proceeds of interests to pay an allowable claim under this section. The remaindermen
98.26 or surviving joint tenants and their spouses, if any, may enter into a written agreement
98.27 with the personal representative or the claimant to settle and satisfy obligations imposed at
98.28 any time before or after a claim is filed.

98.29 ~~(i)~~ (h) The personal representative may, at their discretion, provide any or all of the
98.30 other owners, remaindermen, or surviving joint tenants with an affidavit terminating the
98.31 decedent's estate's interest in real property the decedent owned as a life tenant or as a joint
98.32 tenant with others, if the personal representative determines in good faith that neither the
98.33 decedent nor any of the decedent's predeceased spouses received any medical assistance
98.34 for which a claim could be filed under this section, or if the personal representative has
98.35 filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as
98.36 presented, or if there is a written agreement under paragraph ~~(h)~~ (g), or if the claim, as

99.1 allowed, has been paid in full or to the full extent of the assets the estate has available
99.2 to pay it. The affidavit may be recorded in the office of the county recorder or filed in
99.3 the Office of the Registrar of Titles for the county in which the real property is located.
99.4 Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit
99.5 shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a
99.6 joint tenant with others. The affidavit shall:

- 99.7 (1) be signed by the personal representative;
- 99.8 (2) identify the decedent and the interest being terminated;
- 99.9 (3) give recording information sufficient to identify the instrument that created the
99.10 interest in real property being terminated;
- 99.11 (4) legally describe the affected real property;
- 99.12 (5) state that the personal representative has determined that neither the decedent
99.13 nor any of the decedent's predeceased spouses received any medical assistance for which
99.14 a claim could be filed under this section;
- 99.15 (6) state that the decedent's estate has other assets sufficient to pay the claim, as
99.16 presented, or that there is a written agreement between the personal representative and
99.17 the claimant and the other owners or remaindermen or other joint tenants to satisfy the
99.18 obligations imposed under this subdivision; and
- 99.19 (7) state that the affidavit is being given to terminate the estate's interest under this
99.20 subdivision, and any other contents as may be appropriate.

99.21 The recorder or registrar of titles shall accept the affidavit for recording or filing. The
99.22 affidavit shall be effective as provided in this section and shall constitute notice even if it
99.23 does not include recording information sufficient to identify the instrument creating the
99.24 interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

99.25 ~~(h)~~ (i) The holder of a lien arising under subdivision 1c shall release the lien at
99.26 the holder's expense against an interest terminated under paragraph ~~(h)~~ (g) to the extent
99.27 of the termination.

99.28 ~~(i)~~ (j) If a lien arising under subdivision 1c is not released under paragraph ~~(h)~~ (i),
99.29 prior to closing the estate, the personal representative shall deed the interest subject to the
99.30 lien to the remaindermen or surviving joint tenants as their interests may appear. Upon
99.31 recording or filing, the deed shall work a merger of the recipient's life estate or joint
99.32 tenancy interest, subject to the lien, into the remainder interest or interest the decedent and
99.33 others owned jointly. The lien shall attach to and run with the property to the extent of
99.34 the decedent's interest at the time of the decedent's death.

99.35 Sec. 29. Minnesota Statutes 2008, section 256B.15, subdivision 2, is amended to read:

100.1 Subd. 2. **Limitations on claims.** The claim shall include only the total amount
100.2 of medical assistance rendered after age 55 or during a period of institutionalization
100.3 described in subdivision 1a, ~~clause (b)~~ paragraph (e), and the total amount of general
100.4 assistance medical care rendered, and shall not include interest. Claims that have been
100.5 allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A
100.6 claim against the estate of a surviving spouse who did not receive medical assistance, for
100.7 medical assistance rendered for the predeceased spouse, shall be payable from the full
100.8 value of all of the predeceased spouse's assets and interests which are part of the surviving
100.9 spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in
100.10 the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate
100.11 that were marital property or jointly owned property at any time during the marriage. The
100.12 claim is not payable from the value of assets or proceeds of assets in the estate attributable
100.13 to a predeceased spouse whom the individual married after the death of the predeceased
100.14 recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the
100.15 estate which the nonrecipient decedent spouse acquired with assets which were not marital
100.16 property or jointly owned property after the death of the predeceased recipient spouse.
100.17 Claims for alternative care shall be net of all premiums paid under section 256B.0913,
100.18 subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or
100.19 after July 1, 2003. Claims against marital property shall be limited to claims against
100.20 recipients who died on or after July 1, 2009.

100.21 Sec. 30. Minnesota Statutes 2008, section 256B.15, is amended by adding a
100.22 subdivision to read:

100.23 Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and
100.24 subdivisions 1a and 2, paragraphs (b) to (d) apply.

100.25 (b) At the time of death of a recipient spouse and solely for purpose of recovery of
100.26 medical assistance benefits received, a predeceased recipient spouse shall have a legal
100.27 title or interest in the undivided whole of all of the property which the recipient and the
100.28 recipient's surviving spouse owned jointly or which was marital property at any time
100.29 during their marriage regardless of the form of ownership and regardless of whether
100.30 it was owned or titled in the names of one or both the recipient and the recipient's
100.31 spouse. Title and interest in the property of a predeceased recipient spouse shall not end
100.32 or extinguish upon the person's death and shall continue for the purpose of allowing
100.33 recovery of medical assistance in the estate of the surviving spouse. Upon the death of
100.34 the predeceased recipient spouse, title and interest in the predeceased spouse's property
100.35 shall vest in the surviving spouse by operation of law and without the necessity for any

101.1 probate or decree of descent proceedings and shall continue to exist after the death of the
101.2 predeceased spouse and the surviving spouse to permit recovery of medical assistance.
101.3 The recipient spouse and the surviving spouse of a deceased recipient spouse shall not
101.4 encumber, disclaim, transfer, alienate, hypothecate, or otherwise divest themselves of
101.5 these interests before or upon death.

101.6 (c) For purposes of this section, "marital property" includes any and all real or
101.7 personal property of any kind or interests in such property the predeceased recipient
101.8 spouse and their spouse, or either of them, owned at the time of their marriage to each
101.9 other or acquired during their marriage regardless of whether it was owned or titled in
101.10 the names of one or both of them. If either or both spouses of a married couple received
101.11 medical assistance, all property owned during the marriage or which either or both spouses
101.12 acquired during their marriage shall be presumed to be marital property for purposes of
101.13 recovering medical assistance unless there is clear and convincing evidence to the contrary.

101.14 (d) The agency responsible for the claim for medical assistance for a recipient spouse
101.15 may, at its discretion, release specific real and personal property from the provisions of
101.16 this section. The release shall extinguish the interest created under paragraph (b) in the
101.17 land it describes upon filing or recording. The release need not be attested, certified, or
101.18 acknowledged as a condition of filing or recording and shall be filed or recorded in the
101.19 office of the county recorder or registrar of titles, as appropriate, in the county where the
101.20 real property is located. The party to whom the release is given shall be responsible for
101.21 paying all fees and costs necessary to record and file the release. If the property described
101.22 in the release is registered property, the registrar of titles shall accept it for recording and
101.23 shall record it on the certificate of title for each parcel of property described in the release.
101.24 If the property described in the release is abstract property, the recorder shall accept it
101.25 for filing and file it in the county's grantor-grantee indexes and any tract index the county
101.26 maintains for each parcel of property described in the release.

101.27 Sec. 31. Minnesota Statutes 2008, section 256B.15, is amended by adding a
101.28 subdivision to read:

101.29 Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to
101.30 intervene as a party in any proceeding involving recovery of medical assistance upon
101.31 filing a notice of intervention and serving such notice on the other parties.

101.32 Sec. 32. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

101.33 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
101.34 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year

102.1 basis beginning January 1, 1996. Managed care contracts which were in effect on June
102.2 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
102.3 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
102.4 commissioner may issue separate contracts with requirements specific to services to
102.5 medical assistance recipients age 65 and older.

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

102.11 (c) Effective for services rendered on or after January 1, 2003, the commissioner shall
102.12 withhold five percent of managed care plan payments under this section and county-based
102.13 purchasing plan's payment rate under section 256B.692 for the prepaid medical assistance
102.14 and general assistance medical care programs pending completion of performance targets.
102.15 Each performance target must be quantifiable, objective, measurable, and reasonably
102.16 attainable, except in the case of a performance target based on a federal or state law or rule.
102.17 Criteria for assessment of each performance target must be outlined in writing prior to the
102.18 contract effective date. The managed care plan must demonstrate, to the commissioner's
102.19 satisfaction, that the data submitted regarding attainment of the performance target is
102.20 accurate. The commissioner shall periodically change the administrative measures used
102.21 as performance targets in order to improve plan performance across a broader range of
102.22 administrative services. The performance targets must include measurement of plan
102.23 efforts to contain spending on health care services and administrative activities. The
102.24 commissioner may adopt plan-specific performance targets that take into account factors
102.25 affecting only one plan, including characteristics of the plan's enrollee population. The
102.26 withheld funds must be returned no sooner than July of the following year if performance
102.27 targets in the contract are achieved. The commissioner may exclude special demonstration
102.28 projects under subdivision 23. ~~A managed care plan or a county-based purchasing plan~~
102.29 ~~under section 256B.692 may include as admitted assets under section 62D.044 any amount~~
102.30 ~~withheld under this paragraph that is reasonably expected to be returned.~~

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

103.1 ~~(2) A managed care plan or a county-based purchasing plan under section 256B.692~~
103.2 ~~may include as admitted assets under section 62D.044 any amount withheld under~~
103.3 ~~this paragraph.~~ The return of the withhold under this paragraph is not subject to the
103.4 requirements of paragraph (c).

103.5 (e) Effective for services rendered on or after January 1, 2010, the commissioner
103.6 shall include as part of the performance targets described in paragraph (a) a reduction in
103.7 the health plan's emergency room utilization rate for state health care program enrollees
103.8 by a measurable rate of five percent from the plan's utilization rate for state health care
103.9 program enrollees for the previous calendar year.

103.10 The withheld funds must be returned no sooner than July 1 and no later than July
103.11 31 of the following calendar year if the managed care plan or county-based purchasing
103.12 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
103.13 rate was achieved.

103.14 The withhold described in this paragraph shall continue for each consecutive
103.15 contract period until the health plan's emergency room utilization rate for state health care
103.16 program enrollees is reduced by 25 percent of the health plan's emergency room utilization
103.17 rate for state health care program enrollees for calendar year 2008.

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

103.21 Sec. 33. Minnesota Statutes 2008, section 256B.69, subdivision 5c, is amended to read:

103.22 Subd. 5c. **Medical education and research fund.** (a) Except as provided in
103.23 paragraph (c), the commissioner of human services shall transfer each year to the medical
103.24 education and research fund established under section 62J.692, the following:

103.25 (1) an amount equal to the reduction in the prepaid medical assistance and prepaid
103.26 general assistance medical care payments as specified in this clause. Until January 1,
103.27 2002, the county medical assistance and general assistance medical care capitation base
103.28 rate prior to plan specific adjustments and after the regional rate adjustments under section
103.29 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin County, two percent for
103.30 the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota
103.31 counties; and after January 1, 2002, the county medical assistance and general assistance
103.32 medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent
103.33 for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent
103.34 for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments
103.35 and demonstration project payments operating under subdivision 23 are excluded from

104.1 this reduction. The amount calculated under this clause shall not be adjusted for periods
104.2 already paid due to subsequent changes to the capitation payments;

104.3 (2) beginning July 1, 2003, ~~\$2,157,000~~ \$4,314,000 from the capitation rates paid
104.4 under this section ~~plus any federal matching funds on this amount;~~

104.5 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
104.6 paid under this section; and

104.7 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
104.8 under this section.

104.9 (b) This subdivision shall be effective upon approval of a federal waiver which
104.10 allows federal financial participation in the medical education and research fund. Effective
104.11 July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4),
104.12 shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first
104.13 reduce the amounts otherwise required to be transferred under paragraph (a), clauses (2),
104.14 (3), and (4). Any excess following this reduction shall proportionally reduce the transfers
104.15 under paragraph (a), clause (1).

104.16 (c) Effective July 1, 2003, the amount reduced from the prepaid general assistance
104.17 medical care payments under paragraph (a), clause (1), shall be transferred to the general
104.18 fund.

104.19 (d) Beginning July 1, 2009, of the amounts in paragraph (a), the commissioner shall
104.20 transfer \$21,714,000 each fiscal year to the medical education and research fund. The
104.21 balance of the transfers under paragraph (a) shall be transferred to the medical education
104.22 and research fund no earlier than July 1 of the following fiscal year.

104.23 Sec. 34. Minnesota Statutes 2008, section 256B.69, subdivision 5f, is amended to read:

104.24 Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid
104.25 under this section are increased by \$12,700,000 per year. Beginning July 1, 2003, the
104.26 capitation rates paid under this section are increased by \$4,700,000 per year.

104.27 (b) Beginning July 1, 2009, the capitation rates paid under this section are increased
104.28 each year by the lesser of \$21,714,000 or an amount equal to the difference between the
104.29 estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1),
104.30 and the amount of the limit described in subdivision 5c, paragraph (b).

104.31 Sec. 35. **[256B.695] PAYMENT FOR BASIC CARE SERVICES.**

104.32 Effective service date July 1, 2009, total payments for basic care services, except
104.33 prescription drugs, medical supplies, prosthetics, lab, radiology, medical transportation,
104.34 and services subject to or specifically exempted from section 256B.76, subdivision 1,

105.1 paragraph (c), shall be reduced by 3.0 percent, prior to third-party liability and spenddown
105.2 calculation. Payments made to managed care and county-based purchasing plans shall be
105.3 reduced for services provided on or after January 1, 2010, to reflect this reduction.

105.4 Sec. 36. Minnesota Statutes 2008, section 256B.76, subdivision 1, is amended to read:

105.5 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
105.6 or after October 1, 1992, the commissioner shall make payments for physician services
105.7 as follows:

105.8 (1) payment for level one Centers for Medicare and Medicaid Services' common
105.9 procedural coding system codes titled "office and other outpatient services," "preventive
105.10 medicine new and established patient," "delivery, antepartum, and postpartum care,"
105.11 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
105.12 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
105.13 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
105.14 30, 1992. If the rate on any procedure code within these categories is different than the
105.15 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
105.16 then the larger rate shall be paid;

105.17 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
105.18 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

105.19 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
105.20 percentile of 1989, less the percent in aggregate necessary to equal the above increases
105.21 except that payment rates for home health agency services shall be the rates in effect
105.22 on September 30, 1992.

105.23 (b) Effective for services rendered on or after January 1, 2000, payment rates for
105.24 physician and professional services shall be increased by three percent over the rates
105.25 in effect on December 31, 1999, except for home health agency and family planning
105.26 agency services. The increases in this paragraph shall be implemented January 1, 2000,
105.27 for managed care.

105.28 (c) Effective for services rendered on or after July 1, 2009, payment rates for
105.29 physician and professional services shall be reduced by three percent over the rates in effect
105.30 on June 30, 2009, except for office or other outpatient services (procedure codes 99201
105.31 to 99215) and preventive medicine services (procedure codes 99381 to 99412) billed by
105.32 the following primary care specialties: general practitioner, internal medicine, pediatrics,
105.33 geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse practitioner,
105.34 adult nurse practitioner, geriatrics, and family practice. The commissioner, effective

106.1 January 1, 2010, shall reduce capitation rates paid to managed care and county-based
106.2 purchasing plans under sections 256B.69 and 256B.692 to reflect this payment reduction.

106.3 Sec. 37. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

106.4 Subd. 4. **Critical access dental providers.** Effective for dental services rendered
106.5 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
106.6 and dental clinics deemed by the commissioner to be critical access dental providers.
106.7 For dental services rendered on or after July 1, 2007, the commissioner shall increase
106.8 reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to
106.9 the critical access dental provider. The commissioner shall pay the health plan companies
106.10 in amounts sufficient to reflect increased reimbursements to critical access dental providers
106.11 as approved by the commissioner. In determining which dentists and dental clinics shall
106.12 be deemed critical access dental providers, the commissioner shall review:

106.13 (1) the utilization rate in the service area in which the dentist or dental clinic operates
106.14 for dental services to patients covered by medical assistance, general assistance medical
106.15 care, or MinnesotaCare as their primary source of coverage;

106.16 (2) the level of services provided by the dentist or dental clinic to patients covered
106.17 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
106.18 source of coverage; and

106.19 (3) whether the level of services provided by the dentist or dental clinic is critical to
106.20 maintaining adequate levels of patient access within the service area.

106.21 In the absence of a critical access dental provider in a service area, the commissioner may
106.22 designate a dentist or dental clinic as a critical access dental provider if the dentist or
106.23 dental clinic is willing to provide care to patients covered by medical assistance, general
106.24 assistance medical care, or MinnesotaCare at a level which significantly increases access
106.25 to dental care in the service area. The commissioner shall administer this subdivision
106.26 within the limits of available appropriations.

106.27 Sec. 38. Minnesota Statutes 2008, section 256B.76, is amended by adding a
106.28 subdivision to read:

106.29 Subd. 4a. **Designation and termination of critical access dental providers.** (a)
106.30 The commissioner shall not designate an individual dentist or clinic as a critical access
106.31 dental provider under subdivision 4 or section 256L.11, subdivision 7, when the owner or
106.32 any dentist employed by or under contract with the practice:

106.33 (1) has been subject to a corrective or disciplinary action by the Minnesota Board of
106.34 Dentistry within the past five years or is currently subject to a corrective or disciplinary

107.1 action by the board. Designation shall not be made until the provider is no longer subject
107.2 to a corrective or disciplinary action;

107.3 (2) does not bill on a clinic-specific location basis;

107.4 (3) has been subject, within the past five years, to a postinvestigation action by the
107.5 commissioner of human services or contracted health plan when investigating services
107.6 provided to Minnesota health care program enrollees, including administrative sanctions,
107.7 monetary recovery, referral to state regulatory agency, referral to the state attorney general
107.8 or county attorney general, or issuance of a warning as specified in Minnesota Rules, parts
107.9 9505.2160 to 9505.2245. Designation shall not be considered until the January of the
107.10 year following documentation that the activity that resulted in postinvestigative action
107.11 has stopped; or

107.12 (4) has not completed the application for critical access dental provider designation,
107.13 has submitted the application after the due date, provided incorrect information, or has
107.14 knowingly and willfully submitted a fraudulent designation form.

107.15 (b) The commissioner shall terminate a critical access designation of an individual
107.16 dentist or clinic, if the owner or any dentist employed by or under contract with the
107.17 practice:

107.18 (1) becomes subject to a disciplinary or corrective action by the Minnesota Board of
107.19 Dentistry. The provider shall not be considered for critical access designation until the
107.20 January following the year in which the action has ended; or

107.21 (2) becomes subject to a postinvestigation action by the commissioner of human
107.22 services or contracted health plan including administrative sanctions, monetary recovery,
107.23 referral to state regulatory agency, referral to the state attorney general or county attorney
107.24 general, or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to
107.25 9505.2245. Designation shall not be considered until the January of the year following
107.26 documentation that the activity that resulted in postinvestigative action has stopped.

107.27 (c) Any termination is retroactive to the date of the:

107.28 (1) postinvestigative action; or

107.29 (2) disciplinary or corrective action by the Minnesota Board of Dentistry.

107.30 (d) A provider who has been terminated or not designated may appeal only through
107.31 the contested hearing process as defined in section 14.02, subdivision 3, by filing with the
107.32 commissioner a written request of appeal. The appeal request must be received by the
107.33 commissioner no later than 30 days after notification of termination or nondesignation.

107.34 (e) The commissioner may make an exception to paragraph (a), clauses (1) and (3),
107.35 and paragraph (b), if an action taken by the Minnesota Board of Dentistry, commissioner

108.1 of human services, or contracted health plan is the result of a onetime event by an
108.2 individual employed or contracted by a group practice.

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

108.4 Sec. 39. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

108.5 Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is
108.6 eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical
108.7 care covers, except as provided in paragraph (c):

108.8 (1) inpatient hospital services;

108.9 (2) outpatient hospital services;

108.10 (3) services provided by Medicare certified rehabilitation agencies;

108.11 (4) prescription drugs and other products recommended through the process

108.12 established in section 256B.0625, subdivision 13;

108.13 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
108.14 for diabetics to monitor blood sugar level;

108.15 (6) eyeglasses and eye examinations provided by a physician or optometrist;

108.16 (7) hearing aids;

108.17 (8) prosthetic devices;

108.18 (9) laboratory and X-ray services;

108.19 (10) physician's services;

108.20 (11) medical transportation except special transportation;

108.21 (12) chiropractic services as covered under the medical assistance program;

108.22 (13) podiatric services;

108.23 (14) dental services as covered under the medical assistance program;

108.24 (15) mental health services covered under chapter 256B;

108.25 (16) prescribed medications for persons who have been diagnosed as mentally ill as
108.26 necessary to prevent more restrictive institutionalization;

108.27 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
108.28 deductible payments;

108.29 (18) medical equipment not specifically listed in this paragraph when the use of
108.30 the equipment will prevent the need for costlier services that are reimbursable under
108.31 this subdivision;

108.32 (19) services performed by a certified pediatric nurse practitioner, a certified family
108.33 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
108.34 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
108.35 practitioner in independent practice, if (1) the service is otherwise covered under this

109.1 chapter as a physician service, (2) the service provided on an inpatient basis is not included
109.2 as part of the cost for inpatient services included in the operating payment rate, and (3) the
109.3 service is within the scope of practice of the nurse practitioner's license as a registered
109.4 nurse, as defined in section 148.171;

109.5 (20) services of a certified public health nurse or a registered nurse practicing in
109.6 a public health nursing clinic that is a department of, or that operates under the direct
109.7 authority of, a unit of government, if the service is within the scope of practice of the
109.8 public health nurse's license as a registered nurse, as defined in section 148.171;

109.9 (21) telemedicine consultations, to the extent they are covered under section
109.10 256B.0625, subdivision 3b;

109.11 (22) care coordination and patient education services provided by a community
109.12 health worker according to section 256B.0625, subdivision 49; and

109.13 (23) regardless of the number of employees that an enrolled health care provider
109.14 may have, sign language interpreter services when provided by an enrolled health care
109.15 provider during the course of providing a direct, person-to-person covered health care
109.16 service to an enrolled recipient who has a hearing loss and uses interpreting services.

109.17 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
109.18 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited
109.19 to inpatient hospital services, including physician services provided during the inpatient
109.20 hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

109.21 (b) Effective August 1, 2005, sex reassignment surgery is not covered under this
109.22 subdivision.

109.23 (c) In order to contain costs, the commissioner of human services shall select
109.24 vendors of medical care who can provide the most economical care consistent with high
109.25 medical standards and shall where possible contract with organizations on a prepaid
109.26 capitation basis to provide these services. The commissioner shall consider proposals by
109.27 counties and vendors for prepaid health plans, competitive bidding programs, block grants,
109.28 or other vendor payment mechanisms designed to provide services in an economical
109.29 manner or to control utilization, with safeguards to ensure that necessary services are
109.30 provided. Before implementing prepaid programs in counties with a county operated or
109.31 affiliated public teaching hospital or a hospital or clinic operated by the University of
109.32 Minnesota, the commissioner shall consider the risks the prepaid program creates for the
109.33 hospital and allow the county or hospital the opportunity to participate in the program in a
109.34 manner that reflects the risk of adverse selection and the nature of the patients served by
109.35 the hospital, provided the terms of participation in the program are competitive with the
109.36 terms of other participants considering the nature of the population served. Payment for

110.1 services provided pursuant to this subdivision shall be as provided to medical assistance
110.2 vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For
110.3 payments made during fiscal year 1990 and later years, the commissioner shall consult
110.4 with an independent actuary in establishing prepayment rates, but shall retain final control
110.5 over the rate methodology.

110.6 (d) Effective January 1, 2008, drug coverage under general assistance medical
110.7 care is limited to prescription drugs that:

110.8 (i) are covered under the medical assistance program as described in section
110.9 256B.0625, subdivisions 13 and 13d; and

110.10 (ii) are provided by manufacturers that have fully executed general assistance
110.11 medical care rebate agreements with the commissioner and comply with the agreements.

110.12 Prescription drug coverage under general assistance medical care must conform to
110.13 coverage under the medical assistance program according to section 256B.0625,
110.14 subdivisions 13 to 13g.

110.15 (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
110.16 co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

110.17 (1) \$25 for eyeglasses;

110.18 (2) \$25 for nonemergency visits to a hospital-based emergency room;

110.19 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
110.20 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
110.21 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

110.22 (4) 50 percent coinsurance on restorative dental services.

110.23 (f) Recipients eligible under subdivision 3, paragraph (a), shall include the following
110.24 co-payments for services provided on or after January 1, 2009:

110.25 (1) \$25 for nonemergency visits to a hospital-based emergency room; and

110.26 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
110.27 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
110.28 shall apply to antipsychotic drugs when used for the treatment of mental illness.

110.29 (g) MS 2007 Supp [Expired]

110.30 (h) Effective January 1, 2009, co-payments shall be limited to one per day per
110.31 provider for nonemergency visits to a hospital-based emergency room. Recipients of
110.32 general assistance medical care are responsible for all co-payments in this subdivision.
110.33 The general assistance medical care reimbursement to the provider shall be reduced by the
110.34 amount of the co-payment, except that reimbursement for prescription drugs shall not be
110.35 reduced once a recipient has reached the \$7 per month maximum for prescription drug

111.1 co-payments. The provider collects the co-payment from the recipient. Providers may not
111.2 deny services to recipients who are unable to pay the co-payment.

111.3 (i) General assistance medical care reimbursement to fee-for-service providers
111.4 and payments to managed care plans shall not be increased as a result of the removal of
111.5 the co-payments effective January 1, 2009.

111.6 (j) Any county may, from its own resources, provide medical payments for which
111.7 state payments are not made.

111.8 (k) Chemical dependency services that are reimbursed under chapter 254B must not
111.9 be reimbursed under general assistance medical care.

111.10 (l) The maximum payment for new vendors enrolled in the general assistance
111.11 medical care program after the base year shall be determined from the average usual and
111.12 customary charge of the same vendor type enrolled in the base year.

111.13 (m) The conditions of payment for services under this subdivision are the same
111.14 as the conditions specified in rules adopted under chapter 256B governing the medical
111.15 assistance program, unless otherwise provided by statute or rule.

111.16 (n) Inpatient and outpatient payments shall be reduced by five percent, effective July
111.17 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
111.18 and incorporated by reference in paragraph (l).

111.19 (o) Payments for all other health services except inpatient, outpatient, and pharmacy
111.20 services shall be reduced by five percent, effective July 1, 2003.

111.21 (p) Payments to managed care plans shall be reduced by five percent for services
111.22 provided on or after October 1, 2003.

111.23 (q) A hospital receiving a reduced payment as a result of this section may apply the
111.24 unpaid balance toward satisfaction of the hospital's bad debts.

111.25 (r) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for
111.26 services provided on or after January 1, 2006. For purposes of this subdivision, a visit
111.27 means an episode of service which is required because of a recipient's symptoms,
111.28 diagnosis, or established illness, and which is delivered in an ambulatory setting by
111.29 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
111.30 audiologist, optician, or optometrist.

111.31 (s) Payments to managed care plans shall not be increased as a result of the removal
111.32 of the \$3 nonpreventive visit co-payment effective January 1, 2006.

111.33 (t) Payments for mental health services added as covered benefits after December
111.34 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

111.35 (u) In addition to the reductions in paragraphs (k) and (l), effective service date
111.36 July 1, 2009, total payments for basic care services, except prescription drugs, medical

112.1 supplies, prosthetics, lab, radiology, medical transportation, and services subject to or
112.2 specifically exempted from paragraph (v), shall be reduced by 3.0 percent, prior to
112.3 third-party liability and spenddown calculation. Payments made to managed care and
112.4 county-based purchasing plans shall be reduced for services provided on or after January
112.5 1, 2010, to reflect this reduction.

112.6 (v) Effective for services rendered on or after July 1, 2009, payment rates for
112.7 physician and professional services shall be reduced by three percent over the rates in
112.8 effect on June 30, 2009, except for office or other outpatient services (procedure codes
112.9 99201 to 99215) and preventive medicine services (procedure codes 99381 to 99412)
112.10 billed by the following primary care specialties: general practitioner, internal medicine,
112.11 pediatrics, geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse
112.12 practitioner, adult nurse practitioner, geriatrics, and family practice. The commissioner,
112.13 effective January 1, 2010, shall reduce capitation rates paid to managed care and
112.14 county-based purchasing plans under paragraph (c) to reflect this payment reduction.

112.15 Sec. 40. Minnesota Statutes 2008, section 256J.575, subdivision 6, is amended to read:

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

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

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

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

112.31 Sec. 41. Minnesota Statutes 2008, section 256J.575, subdivision 7, is amended to read:

112.32 Subd. 7. **Sanctions.** (a) The county agency or employment services provider must
112.33 follow the requirements of this subdivision at the time the county agency or employment

113.1 services provider has information that an MFIP recipient may meet the eligibility criteria
113.2 in subdivision 3.

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

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

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

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

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

113.23 (2) determine whether the participant qualifies for a good cause exception under
113.24 section 256J.57, or if the sanction is for noncooperation with child support requirements,
113.25 determine if the participant qualifies for a good cause exemption under section 256.741,
113.26 subdivision 10;

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

113.29 (4) explain the consequences of continuing noncompliance;

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

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

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

113.35 (d) If the participant fails to come to the face-to-face meeting, the case manager or a
113.36 designee shall attempt at least one home visit. If a face-to-face meeting is not conducted,

114.1 the county agency shall send the participant a written notice that includes the information
114.2 under paragraph (c).

114.3 (e) After the requirements of paragraphs (c) and (d) are met and prior to imposition
114.4 of a sanction, the county agency shall provide a notice of intent to sanction under section
114.5 256J.57, subdivision 2, and, when applicable, a notice of adverse action under section
114.6 256J.31.

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

114.9 Sec. 42. Minnesota Statutes 2008, section 256L.04, subdivision 10a, is amended to
114.10 read:

114.11 Subd. 10a. **Sponsor's income and resources deemed available; documentation.**
114.12 When determining eligibility for any federal or state benefits under sections 256L.01 to
114.13 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of
114.14 support as defined under United States Code, title 8, section 1183a, shall be deemed to
114.15 include their sponsors' income and resources as defined in the Personal Responsibility
114.16 and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections
114.17 421 and 422, and subsequently set out in federal rules. To be eligible for the program,
114.18 noncitizens must provide documentation of their immigration status. Beginning July
114.19 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply
114.20 to pregnant women and children who are qualified noncitizens, as described in section
114.21 256B.06, subdivision 4, paragraph (b).

114.22 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
114.23 approval, whichever is later. The commissioner shall notify the revisor of statutes when
114.24 federal approval has been obtained.

114.25 Sec. 43. Minnesota Statutes 2008, section 256L.05, subdivision 1, is amended to read:

114.26 Subdivision 1. **Application assistance and information availability.** (a)
114.27 Applications and application assistance must be made available at provider offices, local
114.28 human services agencies, school districts, public and private elementary schools in which
114.29 25 percent or more of the students receive free or reduced price lunches, community health
114.30 offices, Women, Infants and Children (WIC) program sites, Head Start program sites,
114.31 public housing councils, crisis nurseries, child care centers, early childhood education
114.32 and preschool program sites, legal aid offices, and libraries. These sites may accept
114.33 applications and forward the forms to the commissioner or local county human services

115.1 agencies ~~that choose to participate as an enrollment site~~. Otherwise, applicants may apply
115.2 directly to the commissioner or to participating local county human services agencies.

115.3 (b) Application assistance must be available for applicants choosing to file an
115.4 online application.

115.5 (c) The commissioner and local agencies shall assist enrollees in choosing a
115.6 managed care organization by:

115.7 (1) establishing a Web site to provide information about managed care organizations
115.8 and to allow online enrollment;

115.9 (2) making applications and information on managed care organizations available
115.10 to applicants and enrollees according to Title VI of the Civil Rights Act and federal
115.11 regulations adopted under that law, or any guidance from the United States Department of
115.12 Health and Human Services; and

115.13 (3) making benefit educators available to assist applicants in choosing a managed
115.14 care organization.

115.15 Sec. 44. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
115.16 to read:

115.17 Subd. 1c. **Open enrollment and streamlined application and enrollment**
115.18 **process.** (a) The commissioner and local agencies working in partnership must develop
115.19 a streamlined and efficient application and enrollment process that meets the criteria
115.20 specified in this subdivision.

115.21 (b) The commissioners of human services and education shall provide
115.22 recommendations to the legislature by January 15, 2010, on the creation of an open
115.23 enrollment process for MinnesotaCare that is tied to the public education system, including
115.24 prekindergarten programs. The recommendations must:

115.25 (1) be developed in consultation with MinnesotaCare enrollees and representatives
115.26 from organizations that advocate on behalf of children and families, low-income persons
115.27 and minority populations, counties, school administrators and nurses, health plans, and
115.28 health care providers;

115.29 (2) be based on enrollment and renewal procedures best practices, including express
115.30 lane eligibility as required under subdivision 1d;

115.31 (3) simplify the enrollment and renewal processes wherever possible; and

115.32 (4) establish a process to:

115.33 (i) disseminate information on MinnesotaCare to all children in the public education
115.34 system, including prekindergarten programs; and

115.35 (ii) enroll children and other household members who are eligible.

116.1 The commissioners of human services and education shall implement an open
116.2 enrollment process by August 1, 2010, to be effective beginning with the 2010-2011
116.3 school year.

116.4 (c) The commissioner and local agencies shall develop an online application process
116.5 for MinnesotaCare.

116.6 (d) The commissioner shall develop an application that is easily understandable
116.7 and does not exceed four pages in length.

116.8 (e) The commissioner of human services shall present to the legislature, by January
116.9 15, 2010, an implementation plan for the open enrollment period and online application
116.10 process.

116.11 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
116.12 approval, which must be requested by the commissioner, whichever is later.

116.13 Sec. 45. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
116.14 to read:

116.15 Subd. 1d. **Express lane eligibility.** (a) Children who complete an application
116.16 for educational benefits and indicate an interest in enrolling in MinnesotaCare on the
116.17 application form shall have the form considered an application for MinnesotaCare.

116.18 (b) The commissioner of education shall modify the application for educational
116.19 benefits to:

116.20 (1) include a separate section for MinnesotaCare;

116.21 (2) include a check box to allow all of the children included on the application for
116.22 educational benefits to apply for MinnesotaCare; and

116.23 (3) specify that if the MinnesotaCare application box is checked, the information on
116.24 the application will be shared with the commissioner of human services.

116.25 (c) The commissioner shall accept an applicant's declaration of citizenship and
116.26 provide the applicant a reasonable opportunity to provide acceptable documentation
116.27 without delaying eligibility.

116.28 (d) The commissioner of education shall forward electronically the information for
116.29 families who apply for MinnesotaCare to the commissioner of human services within five
116.30 business days of determining an applicant's eligibility for the free and reduced-price
116.31 school lunch program.

116.32 (e) The commissioner of human services shall accept the income determination
116.33 made by the commissioner of education in administering the free and reduced-price school
116.34 lunch program as proof of income for MinnesotaCare eligibility until renewal. Within 30

117.1 days of receipt of information provided by the commissioner of education under paragraph
117.2 (d), the commissioner of human services shall:

117.3 (1) enroll all eligible children in the MinnesotaCare program;

117.4 (2) notify children who are required to pay a premium under section 256L.15
117.5 that they may qualify for lower premiums if they complete the regular MinnesotaCare
117.6 application process, and provide instructions on how to apply and how to obtain
117.7 application assistance;

117.8 (3) notify children who are ineligible for MinnesotaCare based on the income
117.9 determination made by the commissioner of education that they may reapply for
117.10 MinnesotaCare, and provide instructions on how to apply and how to obtain application
117.11 assistance; and

117.12 (4) provide information about Minnesota health care programs for other household
117.13 members.

117.14 The date of application for the MinnesotaCare program is the date on the signed
117.15 application for educational benefits.

117.16 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
117.17 approval, which must be requested by the commissioner, whichever is later.

117.18 Sec. 46. Minnesota Statutes 2008, section 256L.11, subdivision 1, is amended to read:

117.19 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under
117.20 sections 256L.01 to 256L.11 shall be at the same rates and conditions established for
117.21 medical assistance, except as provided in subdivisions 2 to 6.

117.22 (b) Effective service date July 1, 2009, total payments for basic care services, except
117.23 prescription drugs, medical supplies, prosthetics, lab, radiology, medical transportation,
117.24 and services subject to or specifically exempted from paragraph (c), shall be reduced by
117.25 3.0 percent, prior to third-party liability and spenddown calculation. Payments made to
117.26 managed care and county-based purchasing plans shall be reduced for services provided
117.27 on or after January 1, 2010, to reflect this reduction.

117.28 (c) Effective for services rendered on or after July 1, 2009, payment rates for
117.29 physician and professional services shall be reduced by three percent over the rates in
117.30 effect on June 30, 2009, except for office or other outpatient services (procedure codes
117.31 99201 to 99215) and preventive medicine services (procedure codes 99381 to 99412)
117.32 billed by the following primary care specialties: general practitioner, internal medicine,
117.33 pediatrics, geriatric nurse practitioner, pediatric nurse practitioner, family practice nurse
117.34 practitioner, adult nurse practitioner, geriatrics, and family practice. The commissioner,

118.1 effective January 1, 2010, shall reduce capitation rates paid to managed care and
118.2 county-based purchasing plans under section 256L.12 to reflect this payment reduction.

118.3 Sec. 47. Minnesota Statutes 2008, section 256L.11, subdivision 7, is amended to read:

118.4 Subd. 7. **Critical access dental providers.** Effective for dental services provided
118.5 to MinnesotaCare enrollees on or after January 1, ~~2007~~ 2010, the commissioner shall
118.6 increase payment rates to dentists and dental clinics deemed by the commissioner to be
118.7 critical access providers under section 256B.76, ~~subdivision 4~~ subdivisions 4 and 4a, by
118.8 ~~50~~ 30 percent above the payment rate that would otherwise be paid to the provider. The
118.9 commissioner shall pay the prepaid health plans under contract with the commissioner
118.10 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
118.11 increase to providers who have been identified by the commissioner as critical access
118.12 dental providers under section 256B.76, subdivision 4. The commissioner shall administer
118.13 this subdivision within the limits of available appropriations.

118.14 Sec. 48. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

118.19 ~~(b) For services rendered on or after January 1, 2003, to December 31, 2003, the~~
118.20 ~~commissioner shall withhold .5 percent of managed care plan payments under this section~~
118.21 ~~pending completion of performance targets. The withheld funds must be returned no~~
118.22 ~~sooner than July 1 and no later than July 31 of the following year if performance targets~~
118.23 ~~in the contract are achieved. A managed care plan may include as admitted assets under~~
118.24 ~~section 62D.044 any amount withheld under this paragraph that is reasonably expected~~
118.25 ~~to be returned.~~

118.26 ~~(e)~~ (b) For services rendered on or after January 1, 2004, the commissioner shall
118.27 withhold five percent of managed care plan payments and county-based purchasing
118.28 plan payments under this section pending completion of performance targets. Each
118.29 performance target must be quantifiable, objective, measurable, and reasonably attainable,
118.30 except in the case of a performance target based on a federal or state law or rule. Criteria
118.31 for assessment of each performance target must be outlined in writing prior to the
118.32 contract effective date. The managed care plan must demonstrate, to the commissioner's
118.33 satisfaction, that the data submitted regarding attainment of the performance target is
118.34 accurate. The commissioner shall periodically change the administrative measures used

119.1 as performance targets in order to improve plan performance across a broader range of
119.2 administrative services. The performance targets must include measurement of plan
119.3 efforts to contain spending on health care services and administrative activities. The
119.4 commissioner may adopt plan-specific performance targets that take into account factors
119.5 affecting only one plan, such as characteristics of the plan's enrollee population. The
119.6 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
119.7 following calendar year if performance targets in the contract are achieved. ~~A managed
119.8 care plan or a county-based purchasing plan under section 256B.692 may include as
119.9 admitted assets under section 62D.044 any amount withheld under this paragraph that is
119.10 reasonably expected to be returned.~~

119.11 (c) Effective for services rendered on or after January 1, 2010, the commissioner
119.12 shall include as part of the performance targets described in paragraph (b) a reduction in
119.13 the plan's emergency room utilization rate for state health care program enrollees by a
119.14 measurable rate of five percent from the plan's utilization rate for the previous calendar
119.15 year.

119.16 The withheld funds must be returned no sooner than July 1 and no later than July
119.17 31 of the following calendar year if the managed care plan or county-based purchasing
119.18 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
119.19 rate was achieved.

119.20 The withhold described in this paragraph shall continue for each consecutive
119.21 contract period until the health plan's emergency room utilization rate for state health care
119.22 program enrollees is reduced by 25 percent of the health plan's emergency room utilization
119.23 rate for state health care program enrollees for calendar year 2008.

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

119.27 Sec. 49. Minnesota Statutes 2008, section 256L.17, subdivision 3, is amended to read:

119.28 Subd. 3. **Documentation.** (a) The commissioner of human services shall require
119.29 individuals and families, at the time of application or renewal, to indicate on a ~~checkoff~~
119.30 form developed by the commissioner whether they satisfy the MinnesotaCare asset
119.31 requirement.

119.32 (b) The commissioner may require individuals and families to provide any
119.33 information the commissioner determines necessary to verify compliance with the asset
119.34 requirement, if the commissioner determines that there is reason to believe that an
119.35 individual or family has assets that exceed the program limit.

120.1 Sec. 50. Minnesota Statutes 2008, section 501B.89, is amended by adding a
120.2 subdivision to read:

120.3 Subd. 4. **Annual filing requirement for supplemental needs trusts.** (a) A trustee
120.4 of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or
120.5 (C), shall submit to the commissioner of human services, at the time of a beneficiary's
120.6 request for medical assistance, the following information about the trust:

120.7 (1) a copy of the trust instrument; and

120.8 (2) an inventory of the beneficiary's trust account assets and the value of those assets.

120.9 (b) A trustee of a trust under subdivision 3 and United States Code, title 42, section
120.10 1396p(d)(4)(A) or (C), shall submit an accounting of the beneficiary's trust account to the
120.11 commissioner of human services at least annually until the trust, or the beneficiary's
120.12 interest in the trust, terminates. Accountings are due on the anniversary of the execution
120.13 date of the trust unless another annual date is established by the terms of the trust. The
120.14 accounting must include the following information for the accounting period:

120.15 (1) an inventory of trust assets and the value of those assets at the beginning of the
120.16 accounting period;

120.17 (2) additions to the trust during the accounting period and the source of those
120.18 additions;

120.19 (3) itemized distributions from the trust during the accounting period, including the
120.20 purpose of the distributions and to whom the distributions were made;

120.21 (4) an inventory of trust assets and the value of those assets at the end of the
120.22 accounting period; and

120.23 (5) changes to the trust instrument during the accounting period.

120.24 (c) For the purpose of paragraph (b), an accounting period is 12 months unless an
120.25 accounting period of a different length is permitted by the commissioner.

120.26 **EFFECTIVE DATE.** This section is effective for applications for medical
120.27 assistance and renewals of medical assistance submitted on or after July 1, 2009.

120.28 Sec. 51. Minnesota Statutes 2008, section 519.05, is amended to read:

120.29 **519.05 LIABILITY OF HUSBAND AND WIFE.**

120.30 (a) A spouse is not liable to a creditor for any debts of the other spouse. Where
120.31 husband and wife are living together, they shall be jointly and severally liable for
120.32 necessary medical services that have been furnished to either spouse, including any claims
120.33 arising under section 246.53, 256B.15, 256D.16, or 261.04, and necessary household

121.1 articles and supplies furnished to and used by the family. Notwithstanding this paragraph,
 121.2 in a proceeding under chapter 518 the court may apportion such debt between the spouses.

121.3 (b) Either spouse may close a credit card account or other unsecured consumer line
 121.4 of credit on which both spouses are contractually liable, by giving written notice to the
 121.5 creditor.

121.6 Sec. 52. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision
 121.7 1, as amended by Laws 2004, chapter 272, article 2, section 2, is amended to read:

121.8 Subdivision 1. **Total Appropriation** \$ 3,848,049,000 \$ 4,135,780,000

121.9	Summary by Fund		
121.10	General	3,301,811,000	3,561,055,000
121.11	State Government		
121.12	Special Revenue	534,000	534,000
121.13	Health Care Access	273,723,000	302,272,000
121.14	Federal TANF	270,425,000	270,363,000
121.15	Lottery Cash Flow	1,556,000	1,556,000

121.16 **Federal Contingency Appropriation.** (a)
 121.17 Federal Medicaid funds made available
 121.18 under title IV of the federal Jobs and Growth
 121.19 Tax Relief Reconciliation Act of 2003
 121.20 are appropriated to the commissioner of
 121.21 human services for use in the state's medical
 121.22 assistance and MinnesotaCare programs.
 121.23 The commissioners of human services and
 121.24 finance shall report to the legislative advisory
 121.25 committee on the additional federal Medicaid
 121.26 matching funds that will be available to the
 121.27 state.

121.28 (b) Because of the availability of these funds,
 121.29 the following policies shall become effective:
 121.30 (1) medical assistance and MinnesotaCare
 121.31 eligibility and local financial participation
 121.32 changes provided for in this act may be
 121.33 implemented prior to September 2, 2003, or
 121.34 may be delayed as necessary to maximize
 121.35 the use of federal funds received under

122.1 title IV of the Jobs and Growth Tax Relief
122.2 Reconciliation Act of 2003;
122.3 (2) the aggregate cap on the services
122.4 identified in Minnesota Statutes, section
122.5 256L.035, paragraph (a), clause (3), shall
122.6 be increased from \$2,000 to \$5,000. This
122.7 increase shall expire at the end of fiscal year
122.8 2007. Funds may be transferred from the
122.9 general fund to the health care access fund as
122.10 necessary to implement this provision; and
122.11 (3) the following payment shifts shall not be
122.12 implemented:
122.13 (i) MFIP payment shift found in subdivision
122.14 11;
122.15 (ii) the county payment shift found in
122.16 subdivision 1; and
122.17 (iii) the delay in medical assistance
122.18 and general assistance medical care
122.19 fee-for-service payments found in
122.20 subdivision 6.
122.21 (c) Notwithstanding section 14, paragraphs
122.22 (a) and (b) shall expire June 30, 2007.
122.23 **Receipts for Systems Projects.**
122.24 Appropriations and federal receipts for
122.25 information system projects for MAXIS,
122.26 PRISM, MMIS, and SSIS must be deposited
122.27 in the state system account authorized in
122.28 Minnesota Statutes, section 256.014. Money
122.29 appropriated for computer projects approved
122.30 by the Minnesota office of technology,
122.31 funded by the legislature, and approved
122.32 by the commissioner of finance may be
122.33 transferred from one project to another
122.34 and from development to operations as the

123.1 commissioner of human services considers
123.2 necessary. Any unexpended balance in
123.3 the appropriation for these projects does
123.4 not cancel but is available for ongoing
123.5 development and operations.

123.6 **Gifts.** Notwithstanding Minnesota Statutes,
123.7 chapter 7, the commissioner may accept
123.8 on behalf of the state additional funding
123.9 from sources other than state funds for the
123.10 purpose of financing the cost of assistance
123.11 program grants or nongrant administration.
123.12 All additional funding is appropriated to the
123.13 commissioner for use as designated by the
123.14 grantor of funding.

123.15 **Systems Continuity.** In the event of
123.16 disruption of technical systems or computer
123.17 operations, the commissioner may use
123.18 available grant appropriations to ensure
123.19 continuity of payments for maintaining the
123.20 health, safety, and well-being of clients
123.21 served by programs administered by the
123.22 department of human services. Grant funds
123.23 must be used in a manner consistent with the
123.24 original intent of the appropriation.

123.25 **Nonfederal Share Transfers.** The
123.26 nonfederal share of activities for which
123.27 federal administrative reimbursement is
123.28 appropriated to the commissioner may be
123.29 transferred to the special revenue fund.

123.30 **TANF Funds Appropriated to Other**
123.31 **Entities.** Any expenditures from the TANF
123.32 block grant shall be expended in accordance
123.33 with the requirements and limitations of part
123.34 A of title IV of the Social Security Act, as
123.35 amended, and any other applicable federal

124.1 requirement or limitation. Prior to any
124.2 expenditure of these funds, the commissioner
124.3 shall assure that funds are expended in
124.4 compliance with the requirements and
124.5 limitations of federal law and that any
124.6 reporting requirements of federal law are
124.7 met. It shall be the responsibility of any entity
124.8 to which these funds are appropriated to
124.9 implement a memorandum of understanding
124.10 with the commissioner that provides the
124.11 necessary assurance of compliance prior to
124.12 any expenditure of funds. The commissioner
124.13 shall receipt TANF funds appropriated
124.14 to other state agencies and coordinate all
124.15 related interagency accounting transactions
124.16 necessary to implement these appropriations.
124.17 Unexpended TANF funds appropriated to
124.18 any state, local, or nonprofit entity cancel
124.19 at the end of the state fiscal year unless
124.20 appropriating language permits otherwise.

124.21 **TANF Funds Transferred to Other Federal**
124.22 **Grants.** The commissioner must authorize
124.23 transfers from TANF to other federal block
124.24 grants so that funds are available to meet the
124.25 annual expenditure needs as appropriated.
124.26 Transfers may be authorized prior to the
124.27 expenditure year with the agreement of the
124.28 receiving entity. Transferred funds must be
124.29 expended in the year for which the funds
124.30 were appropriated unless appropriation
124.31 language permits otherwise. In accelerating
124.32 transfer authorizations, the commissioner
124.33 must aim to preserve the future potential
124.34 transfer capacity from TANF to other block
124.35 grants.

125.1 **TANF Maintenance of Effort.** (a) In
125.2 order to meet the basic maintenance of
125.3 effort (MOE) requirements of the TANF
125.4 block grant specified under Code of Federal
125.5 Regulations, title 45, section 263.1, the
125.6 commissioner may only report nonfederal
125.7 money expended for allowable activities
125.8 listed in the following clauses as TANF/MOE
125.9 expenditures:

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

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

125.18 (3) state and county MFIP administrative
125.19 costs under Minnesota Statutes, chapters
125.20 256J and 256K;

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

125.24 (5) expenditures made on behalf of
125.25 noncitizen MFIP recipients who qualify
125.26 for the medical assistance without federal
125.27 financial participation program under
125.28 Minnesota Statutes, section 256B.06,
125.29 subdivision 4, paragraphs (d), (e), and (j);
125.30 and

125.31 (6) qualifying working family credit
125.32 expenditures under Minnesota Statutes,
125.33 section 290.0671.

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

126.10 (c) By August 31 of each year, the
126.11 commissioner shall make a preliminary
126.12 calculation to determine the likelihood
126.13 that the state will meet its annual federal
126.14 work participation requirement under Code
126.15 of Federal Regulations, title 45, sections
126.16 261.21 and 261.23, after adjustment for any
126.17 caseload reduction credit under Code of
126.18 Federal Regulations, title 45, section 261.41.
126.19 If the commissioner determines that the
126.20 state will meet its federal work participation
126.21 rate for the federal fiscal year ending that
126.22 September, the commissioner may reduce the
126.23 expenditure under paragraph (a), clause (1),
126.24 to the extent allowed under Code of Federal
126.25 Regulations, title 45, section 263.1(a)(2).

126.26 (d) For fiscal years beginning with state
126.27 fiscal year 2003, the commissioner shall
126.28 assure that the maintenance of effort used
126.29 by the commissioner of finance for the
126.30 February and November forecasts required
126.31 under Minnesota Statutes, section 16A.103,
126.32 contains expenditures under paragraph (a),
126.33 clause (1), equal to at least 25 percent of
126.34 the total required under Code of Federal
126.35 Regulations, title 45, section 263.1.

127.1 (e) If nonfederal expenditures for the
127.2 programs and purposes listed in paragraph
127.3 (a) are insufficient to meet the state's
127.4 TANF/MOE requirements, the commissioner
127.5 shall recommend additional allowable
127.6 sources of nonfederal expenditures to the
127.7 legislature, if the legislature is or will be in
127.8 session to take action to specify additional
127.9 sources of nonfederal expenditures for
127.10 TANF/MOE before a federal penalty is
127.11 imposed. The commissioner shall otherwise
127.12 provide notice to the legislative commission
127.13 on planning and fiscal policy under paragraph
127.14 (g).

127.15 (f) If the commissioner uses authority
127.16 granted under section 11, or similar authority
127.17 granted by a subsequent legislature, to
127.18 meet the state's TANF/MOE requirement
127.19 in a reporting period, the commissioner
127.20 shall inform the chairs of the appropriate
127.21 legislative committees about all transfers
127.22 made under that authority for this purpose.

127.23 (g) If the commissioner determines that
127.24 nonfederal expenditures under paragraph
127.25 (a) are insufficient to meet TANF/MOE
127.26 expenditure requirements, and if the
127.27 legislature is not or will not be in
127.28 session to take timely action to avoid a
127.29 federal penalty, the commissioner may
127.30 report nonfederal expenditures from
127.31 other allowable sources as TANF/MOE
127.32 expenditures after the requirements of this
127.33 paragraph are met. The commissioner
127.34 may report nonfederal expenditures
127.35 in addition to those specified under
127.36 paragraph (a) as nonfederal TANF/MOE

128.1 expenditures, but only ten days after the
128.2 commissioner of finance has first submitted
128.3 the commissioner's recommendations for
128.4 additional allowable sources of nonfederal
128.5 TANF/MOE expenditures to the members of
128.6 the legislative commission on planning and
128.7 fiscal policy for their review.

128.8 (h) The commissioner of finance shall not
128.9 incorporate any changes in federal TANF
128.10 expenditures or nonfederal expenditures for
128.11 TANF/MOE that may result from reporting
128.12 additional allowable sources of nonfederal
128.13 TANF/MOE expenditures under the interim
128.14 procedures in paragraph (g) into the February
128.15 or November forecasts required under
128.16 Minnesota Statutes, section 16A.103, unless
128.17 the commissioner of finance has approved
128.18 the additional sources of expenditures under
128.19 paragraph (g).

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

128.26 (j) Notwithstanding section 14, paragraph
128.27 (a), clauses (1) to (6), and paragraphs (b) to
128.28 (j) expire June 30, 2007.

128.29 **Working Family Credit Expenditures as**
128.30 **TANF MOE.** The commissioner may claim
128.31 as TANF maintenance of effort up to the
128.32 following amounts of working family credit
128.33 expenditures for the following fiscal years:

128.34 (1) fiscal year 2004, \$7,013,000;

128.35 (2) fiscal year 2005, \$25,133,000;

129.1 (3) fiscal year 2006, \$6,942,000; and

129.2 (4) fiscal year 2007, \$6,707,000.

129.3 **Fiscal Year 2003 Appropriations**

129.4 **Carryforward.** Effective the day following
129.5 final enactment, notwithstanding Minnesota
129.6 Statutes, section 16A.28, or any other law to
129.7 the contrary, state agencies and constitutional
129.8 offices may carry forward unexpended
129.9 and unencumbered nongrant operating
129.10 balances from fiscal year 2003 general fund
129.11 appropriations into fiscal year 2004 to offset
129.12 general budget reductions.

129.13 **Transfer of Grant Balances.** Effective
129.14 the day following final enactment, the
129.15 commissioner of human services, with
129.16 the approval of the commissioner of
129.17 finance and after notification of the chair
129.18 of the senate health, human services and
129.19 corrections budget division and the chair
129.20 of the house of representatives health
129.21 and human services finance committee,
129.22 may transfer unencumbered appropriation
129.23 balances for the biennium ending June 30,
129.24 2003, in fiscal year 2003 among the MFIP,
129.25 MFIP child care assistance under Minnesota
129.26 Statutes, section 119B.05, general assistance,
129.27 general assistance medical care, medical
129.28 assistance, Minnesota supplemental aid,
129.29 and group residential housing programs,
129.30 and the entitlement portion of the chemical
129.31 dependency consolidated treatment fund, and
129.32 between fiscal years of the biennium.

129.33 **TANF Appropriation Cancellation.**

129.34 Notwithstanding the provisions of Laws
129.35 2000, chapter 488, article 1, section 16,

130.1 any prior appropriations of TANF funds
130.2 to the department of trade and economic
130.3 development or to the job skills partnership
130.4 board or any transfers of TANF funds from
130.5 another agency to the department of trade
130.6 and economic development or to the job
130.7 skills partnership board are not available
130.8 until expended, and if unobligated as of June
130.9 30, 2003, these appropriations or transfers
130.10 shall cancel to the TANF fund.

130.11 **Shift County Payment.** The commissioner
130.12 shall make up to 100 percent of the
130.13 calendar year 2005 payments to counties for
130.14 developmental disabilities semi-independent
130.15 living services grants, developmental
130.16 disabilities family support grants, and
130.17 adult mental health grants from fiscal year
130.18 2006 appropriations. This is a onetime
130.19 payment shift. Calendar year 2006 and future
130.20 payments for these grants are not affected by
130.21 this shift. This provision expires June 30,
130.22 2006.

130.23 **Capitation Rate Increase.** Of the health care
130.24 access fund appropriations to the University
130.25 of Minnesota in the higher education
130.26 omnibus appropriation bill, ~~\$2,157,000 in~~
130.27 ~~fiscal year 2004 and \$2,157,000 in fiscal year~~
130.28 ~~2005 are to be used to increase the capitation~~
130.29 ~~payments under~~ for fiscal years beginning
130.30 July 1, 2003, and thereafter, \$2,157,000 each
130.31 year shall be transferred to the commissioner
130.32 for purposes of Minnesota Statutes, section
130.33 256B.69. Notwithstanding the provisions of
130.34 section 14, this provision shall not expire.

130.35 Sec. 53. **INCOME METHODOLOGY.**

131.1 The commissioner of human services shall study approaches toward adopting a
131.2 uniform income methodology for families and children under medical assistance and
131.3 MinnesotaCare. The approaches to be examined by the commissioner must include, but
131.4 are not limited to: (1) replacing the MinnesotaCare gross income standard with a net
131.5 income standard based on the medical assistance families with children methodology; and
131.6 (2) replacing the medical assistance net income standard for families with children with
131.7 the MinnesotaCare gross income standard. The commissioner must evaluate the impact of
131.8 each approach on the number of potential MinnesotaCare and medical assistance enrollees
131.9 who are families and children and on administrative, health care, and other costs to the
131.10 state. The commissioner shall present findings and recommendations to the legislative
131.11 committees with jurisdiction over health care by January 15, 2010.

131.12 Sec. 54. **ADMINISTRATION OF MINNESOTACARE.**

131.13 The commissioner of human services, in cooperation with representatives of
131.14 county human services agencies, shall develop a plan to administer the MinnesotaCare
131.15 program. The plan must require county agencies to administer MinnesotaCare in their
131.16 respective counties under the supervision of the state agency and the commissioner
131.17 of human services. The plan, to the extent feasible, must incorporate procedures and
131.18 requirements that are identical to or consistent with those procedures and requirements
131.19 that apply to county administration of the medical assistance program. The commissioner
131.20 shall present recommendations to the legislative committees with jurisdiction over health
131.21 care by January 15, 2010.

131.22 Sec. 55. **EXPENDITURE LIMIT.**

131.23 For calendar years beginning on or after January 1, 2010, the commissioner of
131.24 human services shall limit annual expenditures for the critical access dental provider
131.25 program under Minnesota Statutes, sections 256B.76, subdivisions 4 and 4a, and 256L.11,
131.26 subdivision 7, to 75 percent of the expenditure level for the calendar year ending
131.27 December 31, 2008.

131.28 Sec. 56. **FEDERAL APPROVAL.**

131.29 The commissioner of human services shall resubmit for federal approval the
131.30 elimination of depreciation for self-employed farmers in determining income eligibility
131.31 for MinnesotaCare passed in Laws 2007, chapter 147, article 5, section 33.

132.1 Sec. 57. **APPROPRIATION; MEDICAL EDUCATION RESEARCH COSTS**
132.2 **(MERC).**

132.3 In fiscal year 2010, \$38,000,000 is appropriated from the general fund to the
132.4 commissioner of human services to restore the fiscal year 2009 unallotment of the transfers
132.5 under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), for the July 1,
132.6 2008, through June 30, 2009, period. The commissioner of human services shall transfer
132.7 \$38,000,000 in fiscal year 2010 to the medical education research fund.

132.8 Sec. 58. **REPEALER.**

132.9 Minnesota Statutes 2008, section 256.962, subdivision 7, is repealed.

132.10 **ARTICLE 7**
132.11 **TECHNICAL**

132.12 Section 1. Minnesota Statutes 2008, section 125A.744, subdivision 3, is amended to
132.13 read:

132.14 Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26,
132.15 school districts may enroll as medical assistance providers or subcontractors and bill
132.16 the Department of Human Services under the medical assistance fee for service claims
132.17 processing system for special education services which are covered services under chapter
132.18 256B, which are provided in the school setting for a medical assistance recipient, and for
132.19 whom the district has secured informed consent consistent with section 13.05, subdivision
132.20 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type
132.21 of covered service. School districts shall be reimbursed by the commissioner of human
132.22 services for the federal share of individual education plan health-related services that
132.23 qualify for reimbursement by medical assistance, minus up to five percent retained by the
132.24 commissioner of human services for administrative costs, not to exceed \$350,000 per
132.25 fiscal year. The commissioner may withhold up to five percent of each payment to a
132.26 school district. Following the end of each fiscal year, the commissioner shall settle up with
132.27 each school district in order to ensure that collections from each district for departmental
132.28 administrative costs are made on a pro rata basis according to federal earnings for these
132.29 services in each district. A school district is not eligible to enroll as a home care provider
132.30 or a personal care provider organization for purposes of billing home care services under
132.31 sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 until the commissioner
132.32 of human services issues a bulletin instructing county public health nurses on how to
132.33 assess for the needs of eligible recipients during school hours. To use private duty nursing
132.34 services or personal care services at school, the recipient or responsible party must provide

133.1 written authorization in the care plan identifying the chosen provider and the daily amount
133.2 of services to be used at school.

133.3 Sec. 2. Minnesota Statutes 2008, section 144A.46, subdivision 1, is amended to read:

133.4 Subdivision 1. **License required.** (a) A home care provider may not operate in the
133.5 state without a current license issued by the commissioner of health. A home care provider
133.6 may hold a separate license for each class of home care licensure.

133.7 (b) Within ten days after receiving an application for a license, the commissioner
133.8 shall acknowledge receipt of the application in writing. The acknowledgment must
133.9 indicate whether the application appears to be complete or whether additional information
133.10 is required before the application will be considered complete. Within 90 days after
133.11 receiving a complete application, the commissioner shall either grant or deny the license.
133.12 If an applicant is not granted or denied a license within 90 days after submitting a
133.13 complete application, the license must be deemed granted. An applicant whose license has
133.14 been deemed granted must provide written notice to the commissioner before providing a
133.15 home care service.

133.16 (c) Each application for a home care provider license, or for a renewal of a license,
133.17 shall be accompanied by a fee to be set by the commissioner under section 144.122.

133.18 (d) The commissioner of health, in consultation with the commissioner of human
133.19 services, shall provide recommendations to the legislature by February 15, 2009, for
133.20 provider standards for personal care assistant services as described in section ~~256B.0655~~
133.21 256B.0659.

133.22 Sec. 3. Minnesota Statutes 2008, section 176.011, subdivision 9, is amended to read:

133.23 Subd. 9. **Employee.** "Employee" means any person who performs services for
133.24 another for hire including the following:

133.25 (1) an alien;

133.26 (2) a minor;

133.27 (3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and
133.28 peace officer while engaged in the enforcement of peace or in the pursuit or capture of a
133.29 person charged with or suspected of crime;

133.30 (4) a person requested or commanded to aid an officer in arresting or retaking a
133.31 person who has escaped from lawful custody, or in executing legal process, in which
133.32 cases, for purposes of calculating compensation under this chapter, the daily wage of the
133.33 person shall be the prevailing wage for similar services performed by paid employees;

133.34 (5) a county assessor;

134.1 (6) an elected or appointed official of the state, or of a county, city, town, school
134.2 district, or governmental subdivision in the state. An officer of a political subdivision
134.3 elected or appointed for a regular term of office, or to complete the unexpired portion of a
134.4 regular term, shall be included only after the governing body of the political subdivision
134.5 has adopted an ordinance or resolution to that effect;

134.6 (7) an executive officer of a corporation, except those executive officers excluded
134.7 by section 176.041;

134.8 (8) a voluntary uncompensated worker, other than an inmate, rendering services in
134.9 state institutions under the commissioners of human services and corrections similar to
134.10 those of officers and employees of the institutions, and whose services have been accepted
134.11 or contracted for by the commissioner of human services or corrections as authorized by
134.12 law. In the event of injury or death of the worker, the daily wage of the worker, for the
134.13 purpose of calculating compensation under this chapter, shall be the usual wage paid at
134.14 the time of the injury or death for similar services in institutions where the services are
134.15 performed by paid employees;

134.16 (9) a voluntary uncompensated worker engaged in emergency management as
134.17 defined in section 12.03, subdivision 4, who is:

134.18 (i) registered with the state or any political subdivision of it, according to the
134.19 procedures set forth in the state or political subdivision emergency operations plan; and

134.20 (ii) acting under the direction and control of, and within the scope of duties approved
134.21 by, the state or political subdivision.

134.22 The daily wage of the worker, for the purpose of calculating compensation under this
134.23 chapter, shall be the usual wage paid at the time of the injury or death for similar services
134.24 performed by paid employees;

134.25 (10) a voluntary uncompensated worker participating in a program established by a
134.26 local social services agency. For purposes of this clause, "local social services agency"
134.27 means any agency established under section 393.01. In the event of injury or death of the
134.28 worker, the wage of the worker, for the purpose of calculating compensation under this
134.29 chapter, shall be the usual wage paid in the county at the time of the injury or death for
134.30 similar services performed by paid employees working a normal day and week;

134.31 (11) a voluntary uncompensated worker accepted by the commissioner of natural
134.32 resources who is rendering services as a volunteer pursuant to section 84.089. The daily
134.33 wage of the worker for the purpose of calculating compensation under this chapter, shall
134.34 be the usual wage paid at the time of injury or death for similar services performed by
134.35 paid employees;

135.1 (12) a voluntary uncompensated worker in the building and construction industry
135.2 who renders services for joint labor-management nonprofit community service projects.
135.3 The daily wage of the worker for the purpose of calculating compensation under this
135.4 chapter shall be the usual wage paid at the time of injury or death for similar services
135.5 performed by paid employees;

135.6 (13) a member of the military forces, as defined in section 190.05, while in state
135.7 active service, as defined in section 190.05, subdivision 5a. The daily wage of the member
135.8 for the purpose of calculating compensation under this chapter shall be based on the
135.9 member's usual earnings in civil life. If there is no evidence of previous occupation or
135.10 earning, the trier of fact shall consider the member's earnings as a member of the military
135.11 forces;

135.12 (14) a voluntary uncompensated worker, accepted by the director of the Minnesota
135.13 Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily
135.14 wage of the worker, for the purposes of calculating compensation under this chapter,
135.15 shall be the usual wage paid at the time of injury or death for similar services performed
135.16 by paid employees;

135.17 (15) a voluntary uncompensated worker, other than a student, who renders services
135.18 at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the
135.19 Blind, and whose services have been accepted or contracted for by the commissioner of
135.20 education, as authorized by law. In the event of injury or death of the worker, the daily
135.21 wage of the worker, for the purpose of calculating compensation under this chapter, shall
135.22 be the usual wage paid at the time of the injury or death for similar services performed in
135.23 institutions by paid employees;

135.24 (16) a voluntary uncompensated worker, other than a resident of the veterans home,
135.25 who renders services at a Minnesota veterans home, and whose services have been
135.26 accepted or contracted for by the commissioner of veterans affairs, as authorized by law.
135.27 In the event of injury or death of the worker, the daily wage of the worker, for the purpose
135.28 of calculating compensation under this chapter, shall be the usual wage paid at the time of
135.29 the injury or death for similar services performed in institutions by paid employees;

135.30 (17) a worker performing services under section ~~256B.0655~~ 256B.0659 for a
135.31 recipient in the home of the recipient or in the community under section 256B.0625,
135.32 subdivision 19a, who is paid from government funds through a fiscal intermediary under
135.33 section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33. For purposes of maintaining
135.34 workers' compensation insurance, the employer of the worker is as designated in law
135.35 by the commissioner of the Department of Human Services, notwithstanding any other
135.36 law to the contrary;

136.1 (18) students enrolled in and regularly attending the Medical School of the
136.2 University of Minnesota in the graduate school program or the postgraduate program. The
136.3 students shall not be considered employees for any other purpose. In the event of the
136.4 student's injury or death, the weekly wage of the student for the purpose of calculating
136.5 compensation under this chapter, shall be the annualized educational stipend awarded to
136.6 the student, divided by 52 weeks. The institution in which the student is enrolled shall
136.7 be considered the "employer" for the limited purpose of determining responsibility for
136.8 paying benefits under this chapter;

136.9 (19) a faculty member of the University of Minnesota employed for an academic
136.10 year is also an employee for the period between that academic year and the succeeding
136.11 academic year if:

136.12 (a) the member has a contract or reasonable assurance of a contract from the
136.13 University of Minnesota for the succeeding academic year; and

136.14 (b) the personal injury for which compensation is sought arises out of and in the
136.15 course of activities related to the faculty member's employment by the University of
136.16 Minnesota;

136.17 (20) a worker who performs volunteer ambulance driver or attendant services is an
136.18 employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other
136.19 entity for which the worker performs the services. The daily wage of the worker for the
136.20 purpose of calculating compensation under this chapter shall be the usual wage paid at the
136.21 time of injury or death for similar services performed by paid employees;

136.22 (21) a voluntary uncompensated worker, accepted by the commissioner of
136.23 administration, rendering services as a volunteer at the Department of Administration. In
136.24 the event of injury or death of the worker, the daily wage of the worker, for the purpose of
136.25 calculating compensation under this chapter, shall be the usual wage paid at the time of the
136.26 injury or death for similar services performed in institutions by paid employees;

136.27 (22) a voluntary uncompensated worker rendering service directly to the Pollution
136.28 Control Agency. The daily wage of the worker for the purpose of calculating compensation
136.29 payable under this chapter is the usual going wage paid at the time of injury or death for
136.30 similar services if the services are performed by paid employees;

136.31 (23) a voluntary uncompensated worker while volunteering services as a first
136.32 responder or as a member of a law enforcement assistance organization while acting
136.33 under the supervision and authority of a political subdivision. The daily wage of the
136.34 worker for the purpose of calculating compensation payable under this chapter is the
136.35 usual going wage paid at the time of injury or death for similar services if the services
136.36 are performed by paid employees;

137.1 (24) a voluntary uncompensated member of the civil air patrol rendering service on
137.2 the request and under the authority of the state or any of its political subdivisions. The
137.3 daily wage of the member for the purposes of calculating compensation payable under this
137.4 chapter is the usual going wage paid at the time of injury or death for similar services if
137.5 the services are performed by paid employees; and

137.6 (25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in
137.7 sections 145A.04 and 145A.06, responding at the request of or engaged in training
137.8 conducted by the commissioner of health. The daily wage of the volunteer for the purposes
137.9 of calculating compensation payable under this chapter is established in section 145A.06.
137.10 A person who qualifies under this clause and who may also qualify under another clause
137.11 of this subdivision shall receive benefits in accordance with this clause.

137.12 If it is difficult to determine the daily wage as provided in this subdivision, the trier
137.13 of fact may determine the wage upon which the compensation is payable.

137.14 Sec. 4. Minnesota Statutes 2008, section 245C.03, subdivision 2, is amended to read:

137.15 Subd. 2. **Personal care provider organizations.** The commissioner shall conduct
137.16 background studies on any individual required under sections 256B.0651 ~~and 256B.0653~~
137.17 to 256B.0656 and 256B.0659 to have a background study completed under this chapter.

137.18 Sec. 5. Minnesota Statutes 2008, section 245C.04, subdivision 3, is amended to read:

137.19 Subd. 3. **Personal care provider organizations.** (a) The commissioner shall
137.20 conduct a background study of an individual required to be studied under section 245C.03,
137.21 subdivision 2, at least upon application for initial enrollment under sections 256B.0651
137.22 ~~and 256B.0653~~ to 256B.0656 and 256B.0659.

137.23 (b) Organizations required to initiate background studies under sections 256B.0651
137.24 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 for individuals described in section 245C.03,
137.25 subdivision 2, must submit a completed background study form to the commissioner
137.26 before those individuals begin a position allowing direct contact with persons served
137.27 by the organization.

137.28 Sec. 6. Minnesota Statutes 2008, section 245C.10, subdivision 3, is amended to read:

137.29 Subd. 3. **Personal care provider organizations.** The commissioner shall recover
137.30 the cost of background studies initiated by a personal care provider organization under
137.31 sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 through a fee of no
137.32 more than \$20 per study charged to the organization responsible for submitting the

138.1 background study form. The fees collected under this subdivision are appropriated to the
138.2 commissioner for the purpose of conducting background studies.

138.3 Sec. 7. Minnesota Statutes 2008, section 256B.04, subdivision 16, is amended to read:

138.4 Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in
138.5 this paragraph, the commissioner of human services and the commissioner of health shall
138.6 jointly promulgate rules to be applied to the licensure of personal care services provided
138.7 under the medical assistance program. The rules shall consider standards for personal care
138.8 services that are based on the World Institute on Disability's recommendations regarding
138.9 personal care services. These rules shall at a minimum consider the standards and
138.10 requirements adopted by the commissioner of health under section 144A.45, which the
138.11 commissioner of human services determines are applicable to the provision of personal
138.12 care services, in addition to other standards or modifications which the commissioner of
138.13 human services determines are appropriate.

138.14 The commissioner of human services shall establish an advisory group including
138.15 personal care consumers and providers to provide advice regarding which standards or
138.16 modifications should be adopted. The advisory group membership must include not less
138.17 than 15 members, of which at least 60 percent must be consumers of personal care services
138.18 and representatives of recipients with various disabilities and diagnoses and ages. At least
138.19 51 percent of the members of the advisory group must be recipients of personal care.

138.20 The commissioner of human services may contract with the commissioner of health
138.21 to enforce the jointly promulgated licensure rules for personal care service providers.

138.22 Prior to final promulgation of the joint rule the commissioner of human services
138.23 shall report preliminary findings along with any comments of the advisory group and a
138.24 plan for monitoring and enforcement by the Department of Health to the legislature by
138.25 February 15, 1992.

138.26 Limits on the extent of personal care services that may be provided to an individual
138.27 must be based on the cost-effectiveness of the services in relation to the costs of inpatient
138.28 hospital care, nursing home care, and other available types of care. The rules must
138.29 provide, at a minimum:

138.30 (1) that agencies be selected to contract with or employ and train staff to provide and
138.31 supervise the provision of personal care services;

138.32 (2) that agencies employ or contract with a qualified applicant that a qualified
138.33 recipient proposes to the agency as the recipient's choice of assistant;

138.34 (3) that agencies bill the medical assistance program for a personal care service
138.35 by a personal care assistant and supervision by a qualified professional supervising the

139.1 personal care assistant unless the recipient selects the fiscal agent option under section
139.2 ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33;

139.3 (4) that agencies establish a grievance mechanism; and

139.4 (5) that agencies have a quality assurance program.

139.5 (b) The commissioner may waive the requirement for the provision of personal care
139.6 services through an agency in a particular county, when there are less than two agencies
139.7 providing services in that county and shall waive the requirement for personal care
139.8 assistants required to join an agency for the first time during 1993 when personal care
139.9 services are provided under a relative hardship waiver under Minnesota Statutes 1992,
139.10 section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies
139.11 providing personal care services have refused to employ or contract with the independent
139.12 personal care assistant.

139.13 Sec. 8. Minnesota Statutes 2008, section 256B.055, subdivision 12, is amended to read:

139.14 Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the
139.15 person is under age 19 and qualifies as a disabled individual under United States Code,
139.16 title 42, section 1382c(a), and would be eligible for medical assistance under the state
139.17 plan if residing in a medical institution, and the child requires a level of care provided in
139.18 a hospital, nursing facility, or intermediate care facility for persons with developmental
139.19 disabilities, for whom home care is appropriate, provided that the cost to medical
139.20 assistance under this section is not more than the amount that medical assistance would pay
139.21 for if the child resides in an institution. After the child is determined to be eligible under
139.22 this section, the commissioner shall review the child's disability under United States Code,
139.23 title 42, section 1382c(a) and level of care defined under this section no more often than
139.24 annually and may elect, based on the recommendation of health care professionals under
139.25 contract with the state medical review team, to extend the review of disability and level of
139.26 care up to a maximum of four years. The commissioner's decision on the frequency of
139.27 continuing review of disability and level of care is not subject to administrative appeal
139.28 under section 256.045. The county agency shall send a notice of disability review to the
139.29 enrollee six months prior to the date the recertification of disability is due. Nothing in this
139.30 subdivision shall be construed as affecting other redeterminations of medical assistance
139.31 eligibility under this chapter and annual cost-effective reviews under this section.

139.32 (b) For purposes of this subdivision, "hospital" means an institution as defined
139.33 in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part
139.34 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this
139.35 subdivision, a child requires a level of care provided in a hospital if the child is determined

140.1 by the commissioner to need an extensive array of health services, including mental health
140.2 services, for an undetermined period of time, whose health condition requires frequent
140.3 monitoring and treatment by a health care professional or by a person supervised by a
140.4 health care professional, who would reside in a hospital or require frequent hospitalization
140.5 if these services were not provided, and the daily care needs are more complex than
140.6 a nursing facility level of care.

140.7 A child with serious emotional disturbance requires a level of care provided in a
140.8 hospital if the commissioner determines that the individual requires 24-hour supervision
140.9 because the person exhibits recurrent or frequent suicidal or homicidal ideation or
140.10 behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that
140.11 may become life threatening, recurrent or frequent severe socially unacceptable behavior
140.12 associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing
140.13 and chronic developmental problems requiring continuous skilled observation, or severe
140.14 disabling symptoms for which office-centered outpatient treatment is not adequate, and
140.15 which overall severely impact the individual's ability to function.

140.16 (c) For purposes of this subdivision, "nursing facility" means a facility which
140.17 provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to
140.18 sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative
140.19 treatment; is in need of special treatments provided or supervised by a licensed nurse; or
140.20 has unpredictable episodes of active disease processes requiring immediate judgment
140.21 by a licensed nurse. For purposes of this subdivision, a child requires the level of care
140.22 provided in a nursing facility if the child is determined by the commissioner to meet
140.23 the requirements of the preadmission screening assessment document under section
140.24 256B.0911 and the home care independent rating document under section ~~256B.0655,~~
140.25 ~~subdivision 4, clause (3)~~ 256B.0659, adjusted to address age-appropriate standards for
140.26 children age 18 and under, pursuant to section ~~256B.0655, subdivision 3~~ 256B.0659.

140.27 (d) For purposes of this subdivision, "intermediate care facility for persons with
140.28 developmental disabilities" or "ICF/MR" means a program licensed to provide services to
140.29 persons with developmental disabilities under section 252.28, and chapter 245A, and a
140.30 physical plant licensed as a supervised living facility under chapter 144, which together
140.31 are certified by the Minnesota Department of Health as meeting the standards in Code of
140.32 Federal Regulations, title 42, part 483, for an intermediate care facility which provides
140.33 services for persons with developmental disabilities who require 24-hour supervision
140.34 and active treatment for medical, behavioral, or habilitation needs. For purposes of this
140.35 subdivision, a child requires a level of care provided in an ICF/MR if the commissioner
140.36 finds that the child has a developmental disability in accordance with section 256B.092,

141.1 is in need of a 24-hour plan of care and active treatment similar to persons with
141.2 developmental disabilities, and there is a reasonable indication that the child will need
141.3 ICF/MR services.

141.4 (e) For purposes of this subdivision, a person requires the level of care provided
141.5 in a nursing facility if the person requires 24-hour monitoring or supervision and a plan
141.6 of mental health treatment because of specific symptoms or functional impairments
141.7 associated with a serious mental illness or disorder diagnosis, which meet severity criteria
141.8 for mental health established by the commissioner and published in March 1997 as
141.9 the Minnesota Mental Health Level of Care for Children and Adolescents with Severe
141.10 Emotional Disorders.

141.11 (f) The determination of the level of care needed by the child shall be made by
141.12 the commissioner based on information supplied to the commissioner by the parent or
141.13 guardian, the child's physician or physicians, and other professionals as requested by the
141.14 commissioner. The commissioner shall establish a screening team to conduct the level of
141.15 care determinations according to this subdivision.

141.16 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner
141.17 must assess the case to determine whether:

141.18 (1) the child qualifies as a disabled individual under United States Code, title 42,
141.19 section 1382c(a), and would be eligible for medical assistance if residing in a medical
141.20 institution; and

141.21 (2) the cost of medical assistance services for the child, if eligible under this
141.22 subdivision, would not be more than the cost to medical assistance if the child resides in a
141.23 medical institution to be determined as follows:

141.24 (i) for a child who requires a level of care provided in an ICF/MR, the cost of
141.25 care for the child in an institution shall be determined using the average payment rate
141.26 established for the regional treatment centers that are certified as ICF's/MR;

141.27 (ii) for a child who requires a level of care provided in an inpatient hospital setting
141.28 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota
141.29 Rules, part 9505.3520, items F and G; and

141.30 (iii) for a child who requires a level of care provided in a nursing facility according
141.31 to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota
141.32 Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to
141.33 reflect rates which would be paid for children under age 16. The commissioner may
141.34 authorize an amount up to the amount medical assistance would pay for a child referred to
141.35 the commissioner by the preadmission screening team under section 256B.0911.

142.1 (h) Children eligible for medical assistance services under section 256B.055,
142.2 subdivision 12, as of June 30, 1995, must be screened according to the criteria in this
142.3 subdivision prior to January 1, 1996. Children found to be ineligible may not be removed
142.4 from the program until January 1, 1996.

142.5 Sec. 9. Minnesota Statutes 2008, section 256B.0621, subdivision 2, is amended to read:

142.6 Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3
142.7 to 10, the following terms have the meanings given them:

142.8 (1) "home care service recipients" means those individuals receiving the following
142.9 services under sections 256B.0651 to 256B.0656 and 256B.0659: skilled nursing visits,
142.10 home health aide visits, private duty nursing, personal care assistants, or therapies
142.11 provided through a home health agency;

142.12 (2) "home care targeted case management" means the provision of targeted case
142.13 management services for the purpose of assisting home care service recipients to gain
142.14 access to needed services and supports so that they may remain in the community;

142.15 (3) "institutions" means hospitals, consistent with Code of Federal Regulations, title
142.16 42, section 440.10; regional treatment center inpatient services, consistent with section
142.17 245.474; nursing facilities; and intermediate care facilities for persons with developmental
142.18 disabilities;

142.19 (4) "relocation targeted case management" includes the provision of both county
142.20 targeted case management and public or private vendor service coordination services
142.21 for the purpose of assisting recipients to gain access to needed services and supports if
142.22 they choose to move from an institution to the community. Relocation targeted case
142.23 management may be provided during the lesser of:

142.24 (i) the last 180 consecutive days of an eligible recipient's institutional stay; or

142.25 (ii) the limits and conditions which apply to federal Medicaid funding for this
142.26 service; and

142.27 (5) "targeted case management" means case management services provided to help
142.28 recipients gain access to needed medical, social, educational, and other services and
142.29 supports.

142.30 Sec. 10. Minnesota Statutes 2008, section 256B.0652, subdivision 3, is amended to
142.31 read:

142.32 Subd. 3. **Assessment and prior authorization process.** Effective January 1, 1996,
142.33 for purposes of providing informed choice, coordinating of local planning decisions, and
142.34 streamlining administrative requirements, the assessment and prior authorization process

143.1 for persons receiving both home care and home and community-based waived services
143.2 for persons with developmental disabilities shall meet the requirements of sections
143.3 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 with the following exceptions:

143.4 (a) Upon request for home care services and subsequent assessment by the public
143.5 health nurse under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659,
143.6 the public health nurse shall participate in the screening process, as appropriate, and,
143.7 if home care services are determined to be necessary, participate in the development
143.8 of a service plan coordinating the need for home care and home and community-based
143.9 waived services with the assigned county case manager, the recipient of services, and
143.10 the recipient's legal representative, if any.

143.11 (b) The public health nurse shall give prior authorization for home care services
143.12 to the extent that home care services are:

143.13 (1) medically necessary;

143.14 (2) chosen by the recipient and their legal representative, if any, from the array of
143.15 home care and home and community-based waived services available;

143.16 (3) coordinated with other services to be received by the recipient as described
143.17 in the service plan; and

143.18 (4) provided within the county's reimbursement limits for home care and home and
143.19 community-based waived services for persons with developmental disabilities.

143.20 (c) If the public health agency is or may be the provider of home care services to the
143.21 recipient, the public health agency shall provide the commissioner of human services with
143.22 a written plan that specifies how the assessment and prior authorization process will be
143.23 held separate and distinct from the provision of services.

143.24 Sec. 11. Minnesota Statutes 2008, section 256B.0657, subdivision 2, is amended to
143.25 read:

143.26 Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person
143.27 who:

143.28 (1) is a recipient of medical assistance as determined under sections 256B.055,
143.29 256B.056, and 256B.057, subdivision 9;

143.30 (2) is eligible for personal care assistant services under section ~~256B.0655~~
143.31 256B.0659;

143.32 (3) lives in the person's own apartment or home, which is not owned, operated, or
143.33 controlled by a provider of services not related by blood or marriage;

143.34 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
143.35 manage the individuals providing services, and to choose and obtain items, related

144.1 services, and supports as described in the participant's plan. If the recipient is not able to
144.2 carry out these functions but has a legal guardian or parent to carry them out, the guardian
144.3 or parent may fulfill these functions on behalf of the recipient; and

144.4 (5) has not been excluded or disenrolled by the commissioner.

144.5 (b) The commissioner may disenroll or exclude recipients, including guardians and
144.6 parents, under the following circumstances:

144.7 (1) recipients who have been restricted by the Primary Care Utilization Review
144.8 Committee may be excluded for a specified time period;

144.9 (2) recipients who exit the self-directed supports option during the recipient's
144.10 service plan year shall not access the self-directed supports option for the remainder of
144.11 that service plan year; and

144.12 (3) when the department determines that the recipient cannot manage recipient
144.13 responsibilities under the program.

144.14 Sec. 12. Minnesota Statutes 2008, section 256B.0657, subdivision 6, is amended to
144.15 read:

144.16 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
144.17 option include:

144.18 (1) personal care assistant services under section ~~256B.0655~~ 256B.0659; and

144.19 (2) items, related services, and supports, including assistive technology, that increase
144.20 independence or substitute for human assistance to the extent expenditures would
144.21 otherwise be used for human assistance.

144.22 (b) Items, supports, and related services purchased under this option shall not be
144.23 considered home care services for the purposes of section 144A.43.

144.24 Sec. 13. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to
144.25 read:

144.26 Subd. 8. **Self-directed budget requirements.** The budget for the provision of the
144.27 self-directed service option shall be equal to the greater of either:

144.28 (1) the annual amount of personal care assistant services under section ~~256B.0655~~
144.29 256B.0659 that the recipient has used in the most recent 12-month period; or

144.30 (2) the amount determined using the consumer support grant methodology under
144.31 section 256.476, subdivision 11, except that the budget amount shall include the federal
144.32 and nonfederal share of the average service costs.

144.33 Sec. 14. Minnesota Statutes 2008, section 256B.49, subdivision 17, is amended to read:

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

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

145.12 (1) an incentive-based payment process for achieving outcomes;

145.13 (2) the need for a state-level risk pool;

145.14 (3) the need for retention of management responsibility at the state agency level; and

145.15 (4) a phase-in strategy as appropriate.

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

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

145.22 (2) an amount approved by the commissioner based on the recipient's extraordinary
145.23 needs that cannot be met within the current allowable reimbursement level. The
145.24 increased reimbursement level must be necessary to allow the recipient to be discharged
145.25 from an institution or to prevent imminent placement in an institution. The additional
145.26 reimbursement may be used to secure environmental modifications; assistive technology
145.27 and equipment; and increased costs for supervision, training, and support services
145.28 necessary to address the recipient's extraordinary needs. The commissioner may approve
145.29 an increased reimbursement level for up to one year of the recipient's relocation from an
145.30 institution or up to six months of a determination that a current waiver recipient is at
145.31 imminent risk of being placed in an institution.

145.32 (d) Beginning July 1, 2001, medically necessary private duty nursing services
145.33 will be authorized under this section as complex and regular care according to sections
145.34 ~~256B.0651 and 256B.0653~~ to 256B.0656 and 256B.0659. The rate established by the
145.35 commissioner for registered nurse or licensed practical nurse services under any home and
145.36 community-based waiver as of January 1, 2001, shall not be reduced.

146.1 Sec. 15. Minnesota Statutes 2008, section 256B.501, subdivision 4a, is amended to
146.2 read:

146.3 Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner
146.4 shall adjust the limits of the established average daily reimbursement rates for waived
146.5 services to include the cost of home care services that may be provided to waived
146.6 services recipients. This adjustment must be used to maintain or increase services and
146.7 shall not be used by county agencies for inflation increases for waived services vendors.
146.8 Home care services referenced in this section are those listed in section 256B.0651,
146.9 subdivision 2. The average daily reimbursement rates established in accordance with
146.10 the provisions of this subdivision apply only to the combined average, daily costs of
146.11 waived and home care services and do not change home care limitations under sections
146.12 256B.0651 and ~~256B.0653~~ to 256B.0656 and 256B.0659. Waivered services recipients
146.13 receiving home care as of June 30, 1992, shall not have the amount of their services
146.14 reduced as a result of this section.

146.15 Sec. 16. Minnesota Statutes 2008, section 256G.02, subdivision 6, is amended to read:

146.16 Subd. 6. **Excluded time.** "Excluded time" means:

146.17 (a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter
146.18 other than an emergency shelter, halfway house, foster home, semi-independent living
146.19 domicile or services program, residential facility offering care, board and lodging facility
146.20 or other institution for the hospitalization or care of human beings, as defined in section
146.21 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
146.22 or correctional facility; or any facility based on an emergency hold under sections
146.23 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

146.24 (b) any period an applicant spends on a placement basis in a training and habilitation
146.25 program, including a rehabilitation facility or work or employment program as defined
146.26 in section 268A.01; or receiving personal care assistant services pursuant to section
146.27 ~~256B.0655, subdivision 2~~ 256B.0659; semi-independent living services provided under
146.28 section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and
146.29 habilitation programs and assisted living services; and

146.30 (c) any placement for a person with an indeterminate commitment, including
146.31 independent living.

146.32 Sec. 17. Minnesota Statutes 2008, section 256I.05, subdivision 1a, is amended to read:

146.33 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section
146.34 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed \$426.37

147.1 for other services necessary to provide room and board provided by the group residence
147.2 if the residence is licensed by or registered by the Department of Health, or licensed by
147.3 the Department of Human Services to provide services in addition to room and board,
147.4 and if the provider of services is not also concurrently receiving funding for services for
147.5 a recipient under a home and community-based waiver under title XIX of the Social
147.6 Security Act; or funding from the medical assistance program under section ~~256B.0655~~;
147.7 ~~subdivision 2~~ 256B.0659, for personal care services for residents in the setting; or residing
147.8 in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000.
147.9 If funding is available for other necessary services through a home and community-based
147.10 waiver, or personal care services under section ~~256B.0655~~, ~~subdivision 2~~ 256B.0659,
147.11 then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided
147.12 in law, in no case may the supplementary service rate exceed \$426.37. The registration
147.13 and licensure requirement does not apply to establishments which are exempt from state
147.14 licensure because they are located on Indian reservations and for which the tribe has
147.15 prescribed health and safety requirements. Service payments under this section may be
147.16 prohibited under rules to prevent the supplanting of federal funds with state funds. The
147.17 commissioner shall pursue the feasibility of obtaining the approval of the Secretary of
147.18 Health and Human Services to provide home and community-based waiver services under
147.19 title XIX of the Social Security Act for residents who are not eligible for an existing home
147.20 and community-based waiver due to a primary diagnosis of mental illness or chemical
147.21 dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

147.31 Sec. 18. Minnesota Statutes 2008, section 256J.45, subdivision 3, is amended to read:

147.32 Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county
147.33 agency shall not impose the sanction under section 256J.46 if it determines that the
147.34 participant has good cause for failing to attend orientation. Good cause exists when:

147.35 (1) appropriate child care is not available;

148.1 (2) the participant is ill or injured;

148.2 (3) a family member is ill and needs care by the participant that prevents the
148.3 participant from attending orientation. For a caregiver with a child or adult in the
148.4 household who meets the disability or medical criteria for home care services under
148.5 section ~~256B.0655, subdivision 1~~ 256B.0659, or a home and community-based waiver
148.6 services program under chapter 256B, or meets the criteria for severe emotional
148.7 disturbance under section 245.4871, subdivision 6, or for serious and persistent mental
148.8 illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when
148.9 an interruption in the provision of those services occurs which prevents the participant
148.10 from attending orientation;

148.11 (4) the caregiver is unable to secure necessary transportation;

148.12 (5) the caregiver is in an emergency situation that prevents orientation attendance;

148.13 (6) the orientation conflicts with the caregiver's work, training, or school schedule; or

148.14 (7) the caregiver documents other verifiable impediments to orientation attendance
148.15 beyond the caregiver's control.

148.16 (b) Counties must work with clients to provide child care and transportation
148.17 necessary to ensure a caregiver has every opportunity to attend orientation.

148.18 Sec. 19. Minnesota Statutes 2008, section 604A.33, subdivision 1, is amended to read:

148.19 Subdivision 1. **Application.** This section applies to residential treatment programs
148.20 for children or group homes for children licensed under chapter 245A, residential
148.21 services and programs for juveniles licensed under section 241.021, providers licensed
148.22 pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care
148.23 provider organizations under section ~~256B.0655, subdivision 1~~ 256B.0659, providers
148.24 of day training and habilitation services under sections 252.40 to 252.46, board and
148.25 lodging facilities licensed under chapter 157, intermediate care facilities for persons with
148.26 developmental disabilities, and other facilities licensed to provide residential services to
148.27 persons with developmental disabilities.

148.28 Sec. 20. Minnesota Statutes 2008, section 609.232, subdivision 11, is amended to read:

148.29 Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
148.30 age or older who:

148.31 (1) is a resident inpatient of a facility;

148.32 (2) receives services at or from a facility required to be licensed to serve adults
148.33 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
148.34 treatment of chemical dependency or mental illness, or one who is committed as a sexual

149.1 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
149.2 considered a vulnerable adult unless the person meets the requirements of clause (4);

149.3 (3) receives services from a home care provider required to be licensed under section
149.4 144A.46; or from a person or organization that exclusively offers, provides, or arranges
149.5 for personal care assistant services under the medical assistance program as authorized
149.6 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
149.7 ~~256B.0653~~ to 256B.0656 and 256B.0659; or

149.8 (4) regardless of residence or whether any type of service is received, possesses a
149.9 physical or mental infirmity or other physical, mental, or emotional dysfunction:

149.10 (i) that impairs the individual's ability to provide adequately for the individual's
149.11 own care without assistance, including the provision of food, shelter, clothing, health
149.12 care, or supervision; and

149.13 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
149.14 has an impaired ability to protect the individual from maltreatment.

149.15 Sec. 21. Minnesota Statutes 2008, section 626.5572, subdivision 6, is amended to read:

149.16 Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be
149.17 licensed under sections 144.50 to 144.58; a nursing home required to be licensed to
149.18 serve adults under section 144A.02; a residential or nonresidential facility required to
149.19 be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider
149.20 licensed or required to be licensed under section 144A.46; a hospice provider licensed
149.21 under sections 144A.75 to 144A.755; or a person or organization that exclusively offers,
149.22 provides, or arranges for personal care assistant services under the medical assistance
149.23 program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision
149.24 19a, 256B.0651, ~~and 256B.0653~~ to 256B.0656, and 256B.0659.

149.25 (b) For home care providers and personal care attendants, the term "facility" refers
149.26 to the provider or person or organization that exclusively offers, provides, or arranges for
149.27 personal care services, and does not refer to the client's home or other location at which
149.28 services are rendered.

149.29 Sec. 22. Minnesota Statutes 2008, section 626.5572, subdivision 21, is amended to
149.30 read:

149.31 Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of
149.32 age or older who:

149.33 (1) is a resident or inpatient of a facility;

150.1 (2) receives services at or from a facility required to be licensed to serve adults
150.2 under sections 245A.01 to 245A.15, except that a person receiving outpatient services for
150.3 treatment of chemical dependency or mental illness, or one who is served in the Minnesota
150.4 sex offender program on a court-hold order for commitment, or is committed as a sexual
150.5 psychopathic personality or as a sexually dangerous person under chapter 253B, is not
150.6 considered a vulnerable adult unless the person meets the requirements of clause (4);

150.7 (3) receives services from a home care provider required to be licensed under section
150.8 144A.46; or from a person or organization that exclusively offers, provides, or arranges
150.9 for personal care assistant services under the medical assistance program as authorized
150.10 under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~
150.11 256B.0653 to 256B.0656, and 256B.0659; or

150.12 (4) regardless of residence or whether any type of service is received, possesses a
150.13 physical or mental infirmity or other physical, mental, or emotional dysfunction:

150.14 (i) that impairs the individual's ability to provide adequately for the individual's
150.15 own care without assistance, including the provision of food, shelter, clothing, health
150.16 care, or supervision; and

150.17 (ii) because of the dysfunction or infirmity and the need for assistance, the individual
150.18 has an impaired ability to protect the individual from maltreatment.

150.19 ARTICLE 8

150.20 CHEMICAL AND MENTAL HEALTH

150.21 Section 1. Minnesota Statutes 2008, section 245.4885, subdivision 1, is amended to
150.22 read:

150.23 Subdivision 1. **Admission criteria.** ~~The county board shall, (a) Prior to admission,~~
150.24 ~~except in the case of emergency admission, determine the needed level of care for all~~
150.25 ~~children referred for treatment of severe emotional disturbance in a treatment foster care~~
150.26 ~~setting, residential treatment facility, or informally admitted to a regional treatment center~~
150.27 shall undergo an assessment to determine the appropriate level of care if public funds are
150.28 used to pay for the services. The county board shall also determine the needed level of
150.29 care for all children admitted to an acute care hospital for treatment of severe emotional
150.30 disturbance if public funds other than reimbursement under chapters 256B and 256D
150.31 are used to pay for the services.

150.32 (b) The county board shall determine the appropriate level of care when
150.33 county-controlled funds are used to pay for the services. When the child is enrolled in
150.34 a prepaid health program under section 256B.69, the enrolled child's contracted health
150.35 plan must determine the appropriate level of care. When the child is an Indian tribal

151.1 member seeking placement through the tribe in a tribally operated or contracted facility,
151.2 the tribe must determine the appropriate level of care. When more than one entity bears
151.3 responsibility for coverage, the entities shall coordinate level of care determination
151.4 activities to the extent possible.

151.5 (c) The level of care determination shall determine whether the proposed treatment:

151.6 (1) is necessary;

151.7 (2) is appropriate to the child's individual treatment needs;

151.8 (3) cannot be effectively provided in the child's home; and

151.9 (4) provides a length of stay as short as possible consistent with the individual

151.10 child's need.

151.11 (d) When a level of care determination is conducted, the ~~county board~~ responsible

151.12 entity may not determine that referral or admission to a treatment foster care setting; or

151.13 residential treatment facility; ~~or acute care hospital~~ is not appropriate solely because

151.14 services were not first provided to the child in a less restrictive setting and the child failed

151.15 to make progress toward or meet treatment goals in the less restrictive setting. The level

151.16 of care determination must be based on a diagnostic assessment that includes a functional

151.17 assessment which evaluates family, school, and community living situations; and an

151.18 assessment of the child's need for care out of the home using a validated tool which

151.19 assesses a child's functional status and assigns an appropriate level of care. The validated

151.20 tool must be approved by the commissioner of human services. If a diagnostic assessment

151.21 including a functional assessment has been completed by a mental health professional

151.22 within the past 180 days, a new diagnostic assessment need not be completed unless in the

151.23 opinion of the current treating mental health professional the child's mental health status

151.24 has changed markedly since the assessment was completed. The child's parent shall be

151.25 notified if an assessment will not be completed and of the reasons. A copy of the notice

151.26 shall be placed in the child's file. Recommendations developed as part of the level of care

151.27 determination process shall include specific community services needed by the child and,

151.28 if appropriate, the child's family, and shall indicate whether or not these services are

151.29 available and accessible to the child and family.

151.30 During the level of care determination process, the child, child's family, or child's

151.31 legal representative, as appropriate, must be informed of the child's eligibility for case

151.32 management services and family community support services and that an individual

151.33 family community support plan is being developed by the case manager, if assigned.

151.34 The level of care determination shall comply with section 260C.212. ~~Wherever~~

151.35 ~~possible~~, The parent shall be consulted in the process, unless clinically ~~inappropriate~~

151.36 detrimental to the child.

152.1 The level of care determination, and placement decision, and recommendations for
152.2 mental health services must be documented in the child's record.

152.3 ~~An alternate review process may be approved by the commissioner if the county~~
152.4 ~~board demonstrates that an alternate review process has been established by the county~~
152.5 ~~board and the times of review, persons responsible for the review, and review criteria are~~
152.6 ~~comparable to the standards in clauses (1) to (4).~~

152.7 Sec. 2. Minnesota Statutes 2008, section 254A.02, is amended by adding a subdivision
152.8 to read:

152.9 Subd. 8a. **Placing authority.** "Placing authority" means a county, prepaid health
152.10 plan, or tribal governing board governed by Minnesota Rules, parts 9530.6600 to
152.11 9530.6655.

152.12 Sec. 3. **[254A.081] GRANTS FOR DETOXIFICATION SERVICES.**

152.13 (a) Effective January 1, 2011, funds appropriated for alcohol and drug abuse services
152.14 from the children's and community services act grants under section 256M.40 must be
152.15 allocated to counties for detoxification services as defined in section 254A.08.

152.16 (b) Funds must be allocated in proportion to the percent of state population at or
152.17 below 100 percent of the federal poverty guideline residing in each county.

152.18 (c) Upon receipt of county expenditure reports for January to June of each year, the
152.19 commissioner shall pay each county based on the county's actual expenditures to date plus
152.20 projected expenditures for the remainder of the calendar year up to the total amount of
152.21 the allocation.

152.22 (d) By January 31, 2012, and each year thereafter, counties shall report actual
152.23 expenditures for detoxification services for the prior year. The commissioner shall
152.24 reallocate unexpended funds to counties that expended more than their allocation, based
152.25 on the percent of state population at or below 100 percent of the federal poverty guideline
152.26 residing in each eligible county.

152.27 Sec. 4. Minnesota Statutes 2008, section 254A.16, is amended by adding a subdivision
152.28 to read:

152.29 Subd. 6. **Monitoring.** The commissioner shall gather and placing authorities shall
152.30 provide information to measure compliance with Minnesota Rules, parts 9530.6600 to
152.31 9530.6655. The commissioner shall specify the format for data collection to facilitate
152.32 tracking, aggregating, and using the information.

153.1 Sec. 5. Minnesota Statutes 2008, section 254B.03, subdivision 1, is amended to read:

153.2 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
153.3 dependency services to persons residing within its jurisdiction who meet criteria
153.4 established by the commissioner for placement in a chemical dependency residential or
153.5 nonresidential treatment service. Chemical dependency money must be administered
153.6 by the local agencies according to law and rules adopted by the commissioner under
153.7 sections 14.001 to 14.69.

153.8 (b) In order to contain costs, ~~the county board shall, with the approval of the~~
153.9 commissioner of human services; shall select eligible vendors of chemical dependency
153.10 services who can provide economical and appropriate treatment. Unless the local agency
153.11 is a social services department directly administered by a county or human services board,
153.12 the local agency shall not be an eligible vendor under section 254B.05. The commissioner
153.13 may approve proposals from county boards to provide services in an economical manner
153.14 or to control utilization, with safeguards to ensure that necessary services are provided.
153.15 If a county implements a demonstration or experimental medical services funding plan,
153.16 the commissioner shall transfer the money as appropriate. ~~If a county selects a vendor~~
153.17 ~~located in another state, the county shall ensure that the vendor is in compliance with the~~
153.18 ~~rules governing licensure of programs located in the state.~~

153.19 (c) A culturally specific vendor that provides assessments under a variance under
153.20 Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to
153.21 persons not covered by the variance.

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

153.23 Sec. 6. Minnesota Statutes 2008, section 254B.03, subdivision 3, is amended to read:

153.24 Subd. 3. **Local agencies to pay state for county share.** Local agencies shall pay
153.25 the state for the county share of the services authorized by the local agency, except when
153.26 the payment is made according to section 254B.09, subdivision 8.

153.27 Sec. 7. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
153.28 to read:

153.29 **Subd. 9. Commissioner to select vendors and set rates.** (a) Effective July 1, 2011,
153.30 the commissioner shall:

153.31 (1) enter into agreements with eligible vendors that:

153.32 (i) meet the standards in section 254B.05, subdivision 1;

153.33 (ii) have good standing in all applicable licensure; and

- 154.1 (iii) have a current approved provider agreement as a Minnesota health care program
154.2 provider; and
- 154.3 (2) set rates for services reimbursed under this chapter.
- 154.4 (b) When setting rates, the commissioner shall consider the complexity and the
154.5 acuity of the problems presented by the client.
- 154.6 (c) When rates set under this section and rates set under section 254B.09, subdivision
154.7 8, apply to the same treatment placement, section 254B.09, subdivision 8, supersedes.

154.8 Sec. 8. Minnesota Statutes 2008, section 254B.05, subdivision 1, is amended to read:

154.9 Subdivision 1. **Licensure required.** Programs licensed by the commissioner are
154.10 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
154.11 notwithstanding the provisions of section 245A.03. American Indian programs located on
154.12 federally recognized tribal lands that provide chemical dependency primary treatment,
154.13 extended care, transitional residence, or outpatient treatment services, and are licensed by
154.14 tribal government are eligible vendors. Detoxification programs are not eligible vendors.
154.15 Programs that are not licensed as a chemical dependency residential or nonresidential
154.16 treatment program by the commissioner or by tribal government are not eligible vendors.
154.17 To be eligible for payment under the Consolidated Chemical Dependency Treatment Fund,
154.18 a vendor of a chemical dependency service must participate in the Drug and Alcohol
154.19 Abuse Normative Evaluation System and the treatment accountability plan.

154.20 Effective January 1, 2000, vendors of room and board are eligible for chemical
154.21 dependency fund payment if the vendor:

- 154.22 (1) ~~is certified by the county or tribal governing body as having~~ has rules prohibiting
154.23 residents bringing chemicals into the facility or using chemicals while residing in the
154.24 facility and provide consequences for infractions of those rules;
- 154.25 (2) has a current contract with a county or tribal governing body;
- 154.26 (3) is determined to meet applicable health and safety requirements;
- 154.27 (4) is not a jail or prison; and
- 154.28 (5) is not concurrently receiving funds under chapter 256I for the recipient.

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

154.30 Sec. 9. Minnesota Statutes 2008, section 254B.09, subdivision 2, is amended to read:

154.31 Subd. 2. **American Indian agreements.** The commissioner may enter into
154.32 agreements with federally recognized tribal units to pay for chemical dependency
154.33 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The

155.1 agreements must clarify how the governing body of the tribal unit fulfills local agency
155.2 responsibilities regarding:

155.3 ~~(1) selection of eligible vendors under section 254B.03, subdivision 1;~~

155.4 ~~(2) negotiation of agreements that establish vendor services and rates for programs
155.5 located on the tribal governing body's reservation;~~

155.6 ~~(3) (1) the form and manner of invoicing; and~~

155.7 ~~(4) (2) provide that only invoices for eligible vendors according to section 254B.05~~
155.8 will be included in invoices sent to the commissioner for payment, to the extent that
155.9 money allocated under subdivisions 4 and 5 is used.

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

155.11 Sec. 10. **[254B.11] MAXIMUM RATES.**

155.12 The commissioner shall publish maximum rates for vendors of the consolidated
155.13 chemical dependency treatment fund by July 1 of each year for implementation the
155.14 following January 1. Rates for calendar year 2010 must not exceed 185 percent of the
155.15 average rate on January 1, 2009, for each group of vendors with similar attributes. Unless
155.16 a new rate methodology is developed under section 254B.12, rates for services provided on
155.17 and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009,
155.18 for each group of vendors with similar attributes. Payment for services provided by Indian
155.19 Health Services or by agencies operated by Indian tribes for medical assistance-eligible
155.20 individuals must be governed by the applicable federal rate methodology.

155.21 Sec. 11. **[254B.12] RATE METHODOLOGY.**

155.22 (a) The commissioner shall, with broad-based stakeholder input, develop a
155.23 recommendation and present a report to the 2011 legislature, including proposed
155.24 legislation for a new rate methodology for the consolidated chemical dependency
155.25 treatment fund. The new methodology must replace county-negotiated rates with a
155.26 uniform statewide methodology that must include:

155.27 (1) a graduated reimbursement scale based on the patients' level of acuity and
155.28 complexity; and

155.29 (2) beginning July 1, 2012, retroactive quality incentive payments up to four percent
155.30 of each provider's prior-year approved chemical dependency fund claims.

155.31 (b) The quality incentive payments under paragraph (a), clause (2), must be based on
155.32 each provider's performance in the prior year relating to certain program criteria, based on
155.33 best practices in addiction treatment. The quality incentive criteria under paragraph (a),
155.34 clause (2), may include program completion rates, national outcome measures, program

156.1 innovations, lack of licensing violations, and other measures to be determined by the
156.2 commissioner.

156.3 Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 41, is amended to
156.4 read:

156.5 Subd. 41. **Residential services for children with severe emotional disturbance.**
156.6 Medical assistance covers rehabilitative services in accordance with section 256B.0945
156.7 that are provided by a ~~county through a residential facility~~ under contract with a county or
156.8 Indian tribe, for children who have been diagnosed with severe emotional disturbance and
156.9 have been determined to require the level of care provided in a residential facility.

156.10 Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 47, is amended to
156.11 read:

156.12 Subd. 47. **Treatment foster care services.** Effective July 1, ~~2007~~ 2011, and subject
156.13 to federal approval, medical assistance covers treatment foster care services according to
156.14 section 256B.0946.

156.15 Sec. 14. Minnesota Statutes 2008, section 256B.0944, is amended by adding a
156.16 subdivision to read:

156.17 Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that,
156.18 due to geographic or other barriers, it is not feasible to provide mobile crisis intervention
156.19 services 24 hours a day, seven days a week, according to the standards in subdivision 4,
156.20 paragraph (b), clause (1), the commissioner may approve a crisis response provider based
156.21 on an alternative plan proposed by a provider entity. The alternative plan must:

156.22 (1) result in increased access and a reduction in disparities in the availability of
156.23 crisis services; and

156.24 (2) provide mobile services outside of the usual nine-to-five office hours and on
156.25 weekends and holidays.

156.26 Sec. 15. Minnesota Statutes 2008, section 256B.0945, subdivision 4, is amended to
156.27 read:

156.28 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041,
156.29 payments to counties for residential services provided by a residential facility shall only
156.30 be made of federal earnings for services provided under this section, and the nonfederal
156.31 share of costs for services provided under this section shall be paid by the county from
156.32 sources other than federal funds or funds used to match other federal funds. Payment to

157.1 counties for services provided according to this section shall be a proportion of the per
157.2 day contract rate that relates to rehabilitative mental health services and shall not include
157.3 payment for costs or services that are billed to the IV-E program as room and board.

157.4 ~~(b) Per diem rates paid to providers under this section by prepaid plans shall be the~~
157.5 ~~proportion of the per-day contract rate that relates to rehabilitative mental health services~~
157.6 ~~and shall not include payment for group foster care costs or services that are billed to the~~
157.7 ~~county of financial responsibility.~~

157.8 ~~(e)~~ (b) The commissioner shall set aside a portion not to exceed five percent of the
157.9 federal funds earned for county expenditures under this section to cover the state costs of
157.10 administering this section. Any unexpended funds from the set-aside shall be distributed
157.11 to the counties in proportion to their earnings under this section.

157.12 (c) The payment rate negotiated and paid to a provider by prepaid health plans
157.13 under section 256B.69 for services under this section must be supplemented by the
157.14 commissioner from state appropriations to cover the nontreatment costs at a rate equal to
157.15 the portion of the county negotiated per diem attributable to nontreatment service costs for
157.16 that provider as determined by the commissioner of human services.

157.17 (d) Payment for mental health rehabilitative services provided under this section by
157.18 or under contract with an Indian tribe or tribal organization or by agencies operated by or
157.19 under contract with an Indian tribe or tribal organization may be made according to section
157.20 256B.0625, subdivision 34, or other relevant federally approved rate setting methodology.

157.21 Sec. 16. Minnesota Statutes 2008, section 256B.0947, subdivision 1, is amended to
157.22 read:

157.23 Subdivision 1. **Scope.** ~~Subject to federal approval~~ Effective November 1, 2010,
157.24 medical assistance covers medically necessary, intensive nonresidential rehabilitative
157.25 mental health services as defined in subdivision 2, for recipients as defined in subdivision
157.26 3, when the services are provided by an entity meeting the standards in this section.

157.27 Sec. 17. Minnesota Statutes 2008, section 256B.761, is amended to read:

157.28 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

157.29 (a) Effective for services rendered on or after July 1, 2001, payment for medication
157.30 management provided to psychiatric patients, outpatient mental health services, day
157.31 treatment services, home-based mental health services, and family community support
157.32 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
157.33 50th percentile of 1999 charges.

158.1 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
158.2 services provided by an entity that operates: (1) a Medicare-certified comprehensive
158.3 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
158.4 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
158.5 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
158.6 when those services are provided within the comprehensive outpatient rehabilitation
158.7 facility and provided to residents of nursing facilities owned by the entity.

158.8 (c) Effective January 1, 2010, the rate for partial hospitalization for children is
158.9 increased to equal the rate for partial hospitalization for adults.

158.10 Sec. 18. **MENTAL HEALTH PORTION OF CHILDREN'S AND COMMUNITY**
158.11 **SERVICES ACT GRANTS.**

158.12 The commissioner of human services shall consult with stakeholders to develop a
158.13 recommendation to the 2010 legislative session regarding administration of the mental
158.14 health services portion of those funds to be allocated to mental health starting January 1,
158.15 2011, from the children's and community services act grants under Minnesota Statutes,
158.16 section 256M.40. The recommendation must include:

158.17 (1) an effective and efficient process to administer these funds together with other
158.18 mental health services funding;

158.19 (2) identification of the priorities and services to be funded;

158.20 (3) a reporting and monitoring methodology that is efficient and ensures
158.21 accountability; and

158.22 (4) a funding allocation method.

158.23 Sec. 19. **AUTISM SPECTRUM DISORDER JOINT TASK FORCE.**

158.24 (a) The Autism Spectrum Disorder Joint Task Force is composed of 25 members,
158.25 appointed as follows:

158.26 (1) two members of the senate, one appointed by the majority leader and one
158.27 appointed by the minority leader;

158.28 (2) two members of the house of representatives, one from the majority party,
158.29 appointed by the speaker of the house, and one from the minority party, appointed by
158.30 the minority leader; and

158.31 (3) 11 public members appointed by the legislature, with regard to geographic
158.32 diversity in the state, with the senate Subcommittee on Committees of the Committee on
158.33 Rules and Administration making the appointments for the senate, and the speaker of the
158.34 house making the appointments for the house;

159.1 (i) three members who are parents of children with autism spectrum disorder (ASD),
159.2 two of whom shall be appointed by the senate, and one of whom shall be appointed by
159.3 the house;

159.4 (ii) two members who have ASD, one of whom shall be appointed by the senate, and
159.5 one by the house;

159.6 (iii) one member representing an agency that provides residential housing services to
159.7 individuals with ASD, appointed by the house;

159.8 (iv) one member representing an agency that provides employment services to
159.9 individuals with ASD, appointed by the senate;

159.10 (v) one member who is a behavior analyst, appointed by the house;

159.11 (vi) two members who are providers of ASD therapy, with one member appointed
159.12 by the senate and one member appointed by the house; and

159.13 (vii) one member who is a director of public school student support services;

159.14 (4) two members appointed by the Minnesota chapter of the American Academy
159.15 of Pediatrics, one who is a developmental behavioral pediatrician and one who is a
159.16 general pediatrician;

159.17 (5) one member appointed by the Minnesota Psychological Society who is a
159.18 neuropsychologist;

159.19 (6) one member appointed by the Association of Minnesota Counties;

159.20 (7) one member appointed by the Minnesota Association of School Administrators;

159.21 (8) one member appointed by the Somali American Autism Foundation;

159.22 (9) one member appointed by the ARC of Minnesota;

159.23 (10) one member appointed by the Autism Society of Minnesota;

159.24 (11) one member appointed by the Parent Advocacy Coalition for Educational
159.25 Rights; and

159.26 (12) one member appointed by the Minnesota Council of Health Plans.

159.27 Appointments must be made by September 1, 2009. The Legislative Coordinating
159.28 Commission shall provide meeting space for the task force. The senate member appointed
159.29 by the minority leader of the senate shall convene the first meeting of the task force no
159.30 later than October 1, 2009. The task force shall elect a chair from among the public
159.31 members at the first meeting.

159.32 (b) The commissioners of education, employment and economic development,
159.33 health, and human services shall provide assistance to the task force, including providing
159.34 the task force with a count of children who have ASD with an individual education
159.35 program or an individual family service plan and children with ASD who have a 504 plan.
159.36 Additionally, the commissioner of human services shall submit a count of the adults with

160.1 ASD enrolled in social service programs and the number of individuals with ASD who are
160.2 enrolled in medical assistance and other waiver programs.

160.3 (c) The task force shall develop recommendations and report on the following topics:

160.4 (1) ways to improve services provided by all state and political subdivisions;

160.5 (2) sources of public and private funding available for treatment and ways to
160.6 improve efficiency in the use of these funds;

160.7 (3) methods to improve coordination in the delivery of service between public and
160.8 private agencies, health providers, and schools;

160.9 (4) increasing the availability of and the training for medical providers and educators
160.10 who identify and provide services to individuals with ASD;

160.11 (5) ways to enhance Minnesota's role in ASD research and delivery of service;

160.12 (6) methods to educate parents, family members, and the public on ASD and the
160.13 available services; and

160.14 (7) treatment options supported by peer-reviewed, established scientific research
160.15 for individuals with ASD.

160.16 (d) The task force shall coordinate with existing efforts at the Departments of
160.17 Education, Health, Human Services, and Employment and Economic Development
160.18 related to ASD.

160.19 (e) By January 15 of each year, the task force shall provide a report regarding its
160.20 findings and consideration of the topics listed under paragraph (c), and the action taken
160.21 under paragraph (d), including draft legislation if necessary, to the chairs and ranking
160.22 minority members of the legislative committees with jurisdiction over health and human
160.23 services.

160.24 **EFFECTIVE DATE.** This section is effective July 1, 2009, and expires June 30,
160.25 2011.

160.26 Sec. 20. **LAND SALE; MORATORIUM.**

160.27 Surplus land surrounding the Anoka-Metro Regional Treatment Center must not be
160.28 sold for five years.

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

160.30 Sec. 21. **STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT**
160.31 **PROJECT.**

160.32 Subdivision 1. **Establishment; purpose.** There is established a state-county
160.33 chemical health care home pilot project. The purpose of the pilot project is to redesign the

161.1 structural relationship between the state and counties to promote greater accountability,
161.2 productivity, and results in the delivery of state chemical dependency services. The pilot
161.3 project must give counties authority to design and operate a new state-county governance
161.4 model for the delivery of chemical health services.

161.5 Subd. 2. **Requirements.** (a) The pilot projects established under this section must
161.6 meet the requirements in this subdivision.

161.7 (b) For the purposes of this section, "county" or "counties" means either an
161.8 individual county or a voluntary multicounty entity.

161.9 (c) Counties participating in the pilot projects must develop binding agreements
161.10 with the Department of Human Services that clarifies the roles, responsibilities, and
161.11 performance outcomes of the delivery of chemical health services. These agreements
161.12 must include a:

161.13 (1) governance agreement that redefines the respective authority, powers, roles,
161.14 and responsibilities of the state and participating counties. As part of the governance
161.15 agreement, the participating counties must be held accountable for improving targeted
161.16 performance outcomes and through the use of the waivers described in paragraph (e), be
161.17 granted greater local control and flexibility to determine the most cost-effective means of
161.18 achieving those outcomes;

161.19 (2) performance agreement that defines measurable goals in key operational areas.
161.20 This agreement must identify: dependencies and requirements necessary for the state and
161.21 participating counties to maintain service outcomes; respective resource commitments;
161.22 funding or expenditure flexibilities which may include exemptions to requirements in
161.23 section 254B.02; and essential reporting and accountability measures; and

161.24 (3) service level agreement that specifies the expectations and responsibilities of
161.25 each entity regarding administrative and information technology support required to
161.26 achieve the measurable goals as defined in the performance agreement.

161.27 (d) Counties are responsible for meeting the outcomes, goals, and responsibilities
161.28 described in the agreements made in paragraph (c) using the payments in subdivision 4.
161.29 Counties accept any financial responsibility above and beyond those payments. Counties
161.30 may retain any funds not spent or any savings incurred as a result of these pilot projects,
161.31 so long as funds are reinvested in chemical health service delivery.

161.32 (e) In order to grant greater local control and flexibility to determine the most
161.33 cost-effective means of achieving performance outcomes, the pilot projects in this section
161.34 are exempt from any state or federal requirements on the use of consolidated chemical
161.35 dependency treatment funds.

162.1 Subd. 3. **Waivers.** The commissioner of human services shall seek any necessary
162.2 federal waivers to carry out this section.

162.3 Subd. 4. **Capitated payment.** (a) Participating counties must be allocated funds
162.4 from the consolidated chemical dependency treatment (CCDT) fund as provided in this
162.5 subdivision.

162.6 (b) The average of CCDT funds allocated to participating counties for calendar years
162.7 2006 through 2008 must be allocated to counties in the form of a capitated payment.

162.8 (c) Counties are required to offset the capitated payment in paragraph (b) with
162.9 a contribution of each participating county's average of the contributed amount of
162.10 maintenance of effort for calendar years 2006 through 2008.

162.11 (d) When managed care contracts are renegotiated, the portion of the capitated
162.12 payment earmarked for chemical dependency services must be redirected to participating
162.13 counties.

162.14 Subd. 5. **Report.** The Department of Human Services shall report back to the
162.15 legislative committees having jurisdiction over chemical health by January 15, 2011,
162.16 evaluating the effectiveness of pilot projects, including recommendations for how to
162.17 implement the pilot projects on a statewide basis.

162.18 Subd. 6. **Expiration.** These pilot projects expire June 30, 2013.

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

162.20 **ARTICLE 9**

162.21 **CONTINUING CARE**

162.22 Section 1. Minnesota Statutes 2008, section 144.0724, subdivision 2, is amended to
162.23 read:

162.24 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
162.25 meanings given.

162.26 (a) "Assessment reference date" means the last day of the minimum data set
162.27 observation period. The date sets the designated endpoint of the common observation
162.28 period, and all minimum data set items refer back in time from that point.

162.29 (b) "Case mix index" means the weighting factors assigned to the RUG-III
162.30 classifications.

162.31 (c) "Index maximization" means classifying a resident who could be assigned to
162.32 more than one category, to the category with the highest case mix index.

162.33 (d) "Minimum data set" means the assessment instrument specified by the Centers for
162.34 Medicare and Medicaid Services and designated by the Minnesota Department of Health.

163.1 (e) "Representative" means a person who is the resident's guardian or conservator,
163.2 the person authorized to pay the nursing home expenses of the resident, a representative
163.3 of the nursing home ombudsman's office whose assistance has been requested, or any
163.4 other individual designated by the resident.

163.5 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
163.6 facility's residents according to their clinical and functional status identified in data
163.7 supplied by the facility's minimum data set.

163.8 (g) "Activities of daily living" means grooming, dressing, bathing, transferring,
163.9 mobility, positioning, eating, and toileting.

163.10 (h) "Nursing facility level of care determination" means the assessment process
163.11 that results in a determination of a resident's or prospective resident's need for nursing
163.12 facility level of care as established in subdivision 11 for purposes of medical assistance
163.13 payment of long-term care services for:

163.14 (1) nursing facility services under section 256B.434 or 256B.441;

163.15 (2) elderly waiver services under section 256B.0915;

163.16 (3) CADI and TBI waiver services under section 256B.49; and

163.17 (4) state payment of alternative care services under section 256B.0913.

163.18 **EFFECTIVE DATE.** The section is effective July 1, 2011.

163.19 Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 4, is amended to read:

163.20 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
163.21 electronically submit to the commissioner of health case mix assessments that conform
163.22 with the assessment schedule defined by Code of Federal Regulations, title 42, section
163.23 483.20, and published by the United States Department of Health and Human Services,
163.24 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
163.25 Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made
163.26 in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0,
163.27 August 1996. The commissioner of health may substitute successor manuals or question
163.28 and answer documents published by the United States Department of Health and Human
163.29 Services, Centers for Medicare and Medicaid Services, to replace or supplement the
163.30 current version of the manual or document.

163.31 (b) The assessments used to determine a case mix classification for reimbursement
163.32 include the following:

163.33 (1) a new admission assessment must be completed by day 14 following admission;

163.34 (2) an annual assessment must be completed within 366 days of the last
163.35 comprehensive assessment;

164.1 (3) a significant change assessment must be completed within 14 days of the
164.2 identification of a significant change; and

164.3 (4) the second quarterly assessment following either a new admission assessment,
164.4 an annual assessment, or a significant change assessment, and all quarterly assessments
164.5 beginning October 1, 2006. Each quarterly assessment must be completed within 92
164.6 days of the previous assessment.

164.7 (c) In addition to the assessments listed in paragraph (b), the assessments used to
164.8 determine nursing facility level of care include the following:

164.9 (1) preadmission screening completed under section 256B.0911, subdivision 4a,
164.10 by a county, tribe, or managed care organization under contract with the Department
164.11 of Human Services; and

164.12 (2) a face-to-face long-term care consultation assessment completed under section
164.13 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization
164.14 under contract with the Department of Human Services.

164.15 **EFFECTIVE DATE.** The section is effective July 1, 2011.

164.16 Sec. 3. Minnesota Statutes 2008, section 144.0724, subdivision 8, is amended to read:

164.17 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident,
164.18 or resident's representative, or the nursing facility or boarding care home may request that
164.19 the commissioner of health reconsider the assigned reimbursement classification. The
164.20 request for reconsideration must be submitted in writing to the commissioner within
164.21 30 days of the day the resident or the resident's representative receives the resident
164.22 classification notice. The request for reconsideration must include the name of the
164.23 resident, the name and address of the facility in which the resident resides, the reasons for
164.24 the reconsideration, the requested classification changes, and documentation supporting
164.25 the requested classification. The documentation accompanying the reconsideration request
164.26 is limited to documentation which establishes that the needs of the resident at the time of
164.27 the assessment justify a classification which is different than the classification established
164.28 by the commissioner of health.

164.29 (b) Upon request, the nursing facility must give the resident or the resident's
164.30 representative a copy of the assessment form and the other documentation that was given
164.31 to the commissioner of health to support the assessment findings. The nursing facility
164.32 shall also provide access to and a copy of other information from the resident's record that
164.33 has been requested by or on behalf of the resident to support a resident's reconsideration
164.34 request. A copy of any requested material must be provided within three working days of
164.35 receipt of a written request for the information. If a facility fails to provide the material

165.1 within this time, it is subject to the issuance of a correction order and penalty assessment
165.2 under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order
165.3 issued under this subdivision must require that the nursing facility immediately comply
165.4 with the request for information and that as of the date of the issuance of the correction
165.5 order, the facility shall forfeit to the state a \$100 fine for the first day of noncompliance, and
165.6 an increase in the \$100 fine by \$50 increments for each day the noncompliance continues.

165.7 (c) In addition to the information required under paragraphs (a) and (b), a
165.8 reconsideration request from a nursing facility must contain the following information: (i)
165.9 the date the reimbursement classification notices were received by the facility; (ii) the date
165.10 the classification notices were distributed to the resident or the resident's representative;
165.11 and (iii) a copy of a notice sent to the resident or to the resident's representative. This
165.12 notice must inform the resident or the resident's representative that a reconsideration of the
165.13 resident's classification is being requested, the reason for the request, that the resident's
165.14 rate will change if the request is approved by the commissioner, the extent of the change,
165.15 that copies of the facility's request and supporting documentation are available for review,
165.16 and that the resident also has the right to request a reconsideration. If the facility fails to
165.17 provide the required information with the reconsideration request, the request must be
165.18 denied, and the facility may not make further reconsideration requests on that specific
165.19 reimbursement classification.

165.20 (d) Reconsideration by the commissioner must be made by individuals not involved
165.21 in reviewing the assessment, audit, or reconsideration that established the disputed
165.22 classification. The reconsideration must be based upon the initial assessment and upon the
165.23 information provided to the commissioner under paragraphs (a) and (b). If necessary for
165.24 evaluating the reconsideration request, the commissioner may conduct on-site reviews.
165.25 Within 15 working days of receiving the request for reconsideration, the commissioner
165.26 shall affirm or modify the original resident classification. The original classification
165.27 must be modified if the commissioner determines that the assessment resulting in the
165.28 classification did not accurately reflect the needs or assessment characteristics of the
165.29 resident at the time of the assessment. The resident and the nursing facility or boarding
165.30 care home shall be notified within five working days after the decision is made. A decision
165.31 by the commissioner under this subdivision is the final administrative decision of the
165.32 agency for the party requesting reconsideration.

165.33 (e) The resident classification established by the commissioner shall be the
165.34 classification that applies to the resident while the request for reconsideration is pending.
165.35 If a request for reconsideration applies to an assessment used to determine nursing facility

166.1 level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible
166.2 for nursing facility level of care while the request for reconsideration is pending.

166.3 (f) The commissioner may request additional documentation regarding a
166.4 reconsideration necessary to make an accurate reconsideration determination.

166.5 **EFFECTIVE DATE.** The section is effective July 1, 2011.

166.6 Sec. 4. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
166.7 to read:

166.8 **Subd. 11. Nursing facility level of care.** (a) For purposes of medical assistance
166.9 payment of long-term care services, a recipient must be determined, using assessments
166.10 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

166.11 (1) the person needs the assistance of another person or constant supervision to
166.12 begin and complete at least four activities of daily living;

166.13 (2) the person needs the assistance of another person or constant supervision to begin
166.14 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

166.15 (3) the person has significant difficulty with memory, using information, daily
166.16 decision making, or behavioral needs that require intervention;

166.17 (4) the person has had a previous qualifying nursing facility stay of at least 90
166.18 days; or

166.19 (5) the person is determined to be at risk for nursing facility admission or
166.20 readmission through a face-to-face long-term care consultation assessment as specified
166.21 in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care
166.22 organization under contract with the Department of Human Services. The person is
166.23 considered at risk under this clause if the person currently lives alone or will live alone
166.24 upon discharge and also meets one of the following criteria:

166.25 (i) the person has experienced a fall resulting in a fracture;

166.26 (ii) the person has been determined to be at risk of maltreatment or neglect,
166.27 including self-neglect; or

166.28 (iii) the person has a sensory impairment that substantially impacts functional ability
166.29 and maintenance of a community residence.

166.30 (b) The assessment used to establish medical assistance payment for nursing facility
166.31 services must be the most recent assessment performed under subdivision 4, paragraph
166.32 (b), that occurred no more than 90 calendar days before the effective date of medical
166.33 assistance financial eligibility determination. In no case shall medical assistance payment
166.34 for long-term care services occur prior to the date of the determination of nursing facility
166.35 level of care.

167.1 (c) The assessment used to establish medical assistance payment for services
167.2 provided under sections 256B.0915 and 256B.49 and alternative care payment for services
167.3 provided under section 256B.0913 must be the most recent face-to-face assessment
167.4 performed under subdivision 4, paragraph (c), clause (2), that occurred no more than 60
167.5 calendar days before the effective date of financial eligibility determination.

167.6 **EFFECTIVE DATE.** The section is effective July 1, 2011.

167.7 Sec. 5. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision
167.8 to read:

167.9 **Subd. 12. Appeal of nursing facility level of care determination.** A resident or
167.10 prospective resident whose level of care determination results in a denial of long-term care
167.11 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
167.12 paragraph (h), clause (7).

167.13 **EFFECTIVE DATE.** The section is effective July 1, 2011.

167.14 Sec. 6. Minnesota Statutes 2008, section 144A.073, is amended by adding a
167.15 subdivision to read:

167.16 **Subd. 12. Extension of approval of moratorium exception projects.**
167.17 Notwithstanding subdivision 3, the commissioner of health shall extend project approval
167.18 by an additional 18 months for an approved proposal for an exception to the nursing home
167.19 licensure and certification moratorium if the proposal was approved under this section
167.20 between July 1, 2007, and June 30, 2009.

167.21 Sec. 7. Minnesota Statutes 2008, section 144A.44, subdivision 2, is amended to read:

167.22 **Subd. 2. Interpretation and enforcement of rights.** These rights are established
167.23 for the benefit of persons who receive home care services. "Home care services" means
167.24 home care services as defined in section 144A.43, subdivision 3, and unlicensed personal
167.25 care assistance services, including services covered by medical assistance under section
167.26 256B.0625, subdivision 19a. A home care provider may not require a person to surrender
167.27 these rights as a condition of receiving services. A guardian or conservator or, when there
167.28 is no guardian or conservator, a designated person, may seek to enforce these rights. This
167.29 statement of rights does not replace or diminish other rights and liberties that may exist
167.30 relative to persons receiving home care services, persons providing home care services, or
167.31 providers licensed under Laws 1987, chapter 378. A copy of these rights must be provided
167.32 to an individual at the time home care services, including personal care assistance

168.1 services, are initiated. The copy shall also contain the address and phone number of the
168.2 Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care
168.3 and a brief statement describing how to file a complaint with these offices. Information
168.4 about how to contact the Office of Ombudsman for Long-Term Care shall be included in
168.5 notices of change in client fees and in notices where home care providers initiate transfer
168.6 or discontinuation of services.

168.7 Sec. 8. Minnesota Statutes 2008, section 245A.03, is amended by adding a subdivision
168.8 to read:

168.9 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
168.10 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
168.11 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
168.12 9555.6265, under this chapter for a physical location that will not be the primary residence
168.13 of the license holder for the entire period of licensure. If a license is issued during this
168.14 moratorium, and the license holder changes the license holder's primary residence away
168.15 from the physical location of the foster care license, the commissioner shall revoke the
168.16 license according to section 245A.07. Exceptions to the moratorium include:

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

168.18 (2) foster care licenses replacing foster care licenses in existence on the effective
168.19 date of this section and determined to be needed by the commissioner under paragraph (b);

168.20 (3) new foster care licenses determined to be needed by the commissioner under
168.21 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;

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

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

168.27 (b) The commissioner shall determine the need for newly licensed foster care homes
168.28 as defined under this subdivision. As part of the determination, the commissioner shall
168.29 consider the availability of foster care capacity in the area which the licensee seeks to
168.30 operate, and the recommendation of the local county board. The determination by the
168.31 commissioner must be final. A determination of need is not required for a change in
168.32 ownership at the same address.

168.33 (c) The commissioner shall study the effects of the license moratorium under this
168.34 subdivision and shall report back to the legislature by January 15, 2011.

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

169.1 Sec. 9. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision
169.2 to read:

169.3 Subd. 8. **Community residential setting license.** (a) The commissioner shall
169.4 establish provider standards for residential support services that integrate service standards
169.5 and the residential setting under one license. The commissioner shall propose statutory
169.6 language and an implementation plan for licensing requirements for residential support
169.7 services to the legislature by January 15, 2011.

169.8 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
169.9 for services in settings licensed as adult foster care under Minnesota Rules, parts
169.10 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to
169.11 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
169.12 (b), must be required to obtain a community residential setting license.

169.13 Sec. 10. Minnesota Statutes 2008, section 252.43, is amended to read:

169.14 **252.43 COMMISSIONER'S DUTIES.**

169.15 The commissioner shall supervise county boards' provision of day training and
169.16 habilitation services to adults with developmental disabilities. The commissioner shall:

169.17 (1) determine the need for day training and habilitation services under section 252.28;

169.18 ~~(2) approve payment rates established by a county under section 252.46, subdivision~~

169.19 ~~†;~~

169.20 ~~(3)~~ adopt rules for the administration and provision of day training and habilitation
169.21 services under sections 252.40 to 252.46 and sections 245A.01 to 245A.16 and 252.28,
169.22 subdivision 2;

169.23 ~~(4)~~ (3) enter into interagency agreements necessary to ensure effective coordination
169.24 and provision of day training and habilitation services;

169.25 ~~(5)~~ (4) monitor and evaluate the costs and effectiveness of day training and
169.26 habilitation services; and

169.27 ~~(6)~~ (5) provide information and technical help to county boards and vendors in their
169.28 administration and provision of day training and habilitation services.

169.29 Sec. 11. Minnesota Statutes 2008, section 252.46, is amended by adding a subdivision
169.30 to read:

169.31 Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish
169.32 a statewide rate-setting methodology for all day training and habilitation services. The
169.33 rate-setting methodology must abide by the principles of transparency and equitability

170.1 across the state. The methodology must involve a uniform process of structuring rates for
170.2 each service and must promote quality and participant choice.

170.3 Sec. 12. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
170.4 to read:

170.5 Subd. 29. State medical review team. (a) To ensure the timely processing of
170.6 determinations of disability by the commissioner's state medical review team under
170.7 sections 256B.055, subdivision 7, paragraph (b), and 256B.057, subdivision 9, paragraph
170.8 (j), the commissioner shall review all medical evidence submitted by county agencies with
170.9 a referral and seek additional information from providers, applicants, and enrollees to
170.10 support the determination of disability where necessary.

170.11 (b) Prior to a denial or withdrawal of a requested determination of disability due
170.12 to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is
170.13 necessary and appropriate to a determination of disability, and (2) assist applicants and
170.14 enrollees to obtain the evidence, including, but not limited to, medical examinations
170.15 and electronic medical records.

170.16 (c) The commissioner shall provide the chairs of the legislative committees with
170.17 jurisdiction over health and human services finance and budget the following information
170.18 on the activities of the state medical review team by February 1, 2010, and annually
170.19 thereafter:

170.20 (1) the number of applications to the state medical review team that were denied,
170.21 approved, or withdrawn;

170.22 (2) the average length of time from receipt of the application to a decision;

170.23 (3) the number of appeals and appeal results;

170.24 (4) for applicants, their age, health coverage at the time of application, hospitalization
170.25 history within three months of application, and whether an application for Social Security
170.26 or Supplemental Security Income benefits is pending; and

170.27 (5) specific information on the medical certification, licensure, or other credentials
170.28 of the person or persons performing the medical review determinations and length of
170.29 time in that position.

170.30 Sec. 13. **[256.0281] INTERAGENCY DATA EXCHANGE.**

170.31 The Department of Human Services, the Department of Health, and the Office of the
170.32 Ombudsman for Mental Health and Developmental Disabilities may establish interagency
170.33 agreements governing the electronic exchange of data on providers and individuals

171.1 collected, maintained, or used by each agency when such exchange is outlined by each
171.2 agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):
171.3 (1) to improve provider enrollment processes for home and community-based
171.4 services and state plan home care services;
171.5 (2) to improve quality management of providers between state agencies;
171.6 (3) to establish and maintain provider eligibility to participate as providers under
171.7 Minnesota health care programs; and
171.8 (4) to meet the quality assurance reporting requirements under federal law under
171.9 section 1915(c) of the Social Security Act related to home and community-based waiver
171.10 programs.

171.11 Each interagency agreement must include provisions to ensure anonymity of individuals,
171.12 including mandated reporters, and must outline the specific uses of and access to shared
171.13 data within each agency. Electronic interfaces between source data systems developed
171.14 under these interagency agreements must incorporate these provisions as well as other
171.15 HIPPA provisions related to individual data.

171.16 Sec. 14. Minnesota Statutes 2008, section 256.975, subdivision 7, is amended to read:

171.17 Subd. 7. **Consumer information and assistance; senior linkage.** (a) The
171.18 Minnesota Board on Aging shall operate a statewide information and assistance service
171.19 to aid older Minnesotans and their families in making informed choices about long-term
171.20 care options and health care benefits. Language services to persons with limited English
171.21 language skills may be made available. The service, known as Senior LinkAge Line, must
171.22 be available during business hours through a statewide toll-free number and must also
171.23 be available through the Internet.

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

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

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

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

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

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

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

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

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

172.9 (9) incorporate information about housing with services and consumer rights

172.10 within the MinnesotaHelp.info network long-term care database to facilitate consumer

172.11 comparison of services and costs among housing with services establishments and with

172.12 other in-home services and to support financial self-sufficiency as long as possible.

172.13 Housing with services establishments and their arranged home care providers shall provide

172.14 ~~information to the commissioner of human services that is consistent with information~~

172.15 ~~required by the commissioner of health under section 144G.06, the Uniform Consumer~~

172.16 ~~Information Guide~~ price and other information requested by the commissioner of human

172.17 services regarding rents and services. The commissioners of human services and health

172.18 shall align the data elements required by this section, and section 144G.06, the Uniform

172.19 Consumer Information Guide, to provide consumers standardized information and ease

172.20 of comparison of long-term care options. The commissioner of human services shall

172.21 provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info

172.22 network long-term care database.

172.23 (c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness

172.24 of the statewide information and assistance, and submit this evaluation to the legislature

172.25 by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps

172.26 in service delivery, continuity in information between the service and identified linkages,

172.27 and potential use of private funding to enhance the service.

172.28 Sec. 15. Minnesota Statutes 2008, section 256B.055, subdivision 7, is amended to read:

172.29 Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for

172.30 a person who meets the categorical eligibility requirements of the supplemental security

172.31 income program or, who would meet those requirements except for excess income or

172.32 assets, and who meets the other eligibility requirements of this section.

172.33 (b) Following a determination that the applicant is not aged or blind and does not

172.34 meet any other category of eligibility for medical assistance and has not been determined

172.35 disabled by the Social Security Administration, applicants under this subdivision shall be

173.1 referred to the commissioner's state medical review team for a determination of disability.
173.2 Disability shall be determined according to the rules of title XVI and title XIX of the
173.3 Social Security Act and pertinent rules and policies of the Social Security Administration.

173.4 Sec. 16. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

173.5 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
173.6 for a person who is employed and who:

173.7 (1) meets the definition of disabled under the supplemental security income program;

173.8 (2) is at least 16 but less than 65 years of age;

173.9 (3) meets the asset limits in paragraph (c); and

173.10 (4) effective November 1, 2003, pays a premium and other obligations under

173.11 paragraph (e).

173.12 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
173.13 determinations.

173.14 (b) After the month of enrollment, a person enrolled in medical assistance under
173.15 this subdivision who:

173.16 (1) is temporarily unable to work and without receipt of earned income due to a
173.17 medical condition, as verified by a physician, may retain eligibility for up to four calendar
173.18 months; or

173.19 (2) effective January 1, 2004, loses employment for reasons not attributable to the
173.20 enrollee, may retain eligibility for up to four consecutive months after the month of job
173.21 loss. To receive a four-month extension, enrollees must verify the medical condition or
173.22 provide notification of job loss. All other eligibility requirements must be met and the
173.23 enrollee must pay all calculated premium costs for continued eligibility.

173.24 (c) For purposes of determining eligibility under this subdivision, a person's assets
173.25 must not exceed \$20,000, excluding:

173.26 (1) all assets excluded under section 256B.056;

173.27 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
173.28 Keogh plans, and pension plans; and

173.29 (3) medical expense accounts set up through the person's employer.

173.30 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65
173.31 earned income disregard. To be eligible, a person applying for medical assistance under
173.32 this subdivision must have earned income above the disregard level.

173.33 (2) Effective January 1, 2004, to be considered earned income, Medicare, Social
173.34 Security, and applicable state and federal income taxes must be withheld. To be eligible,
173.35 a person must document earned income tax withholding.

174.1 (e)(1) A person whose earned and unearned income is equal to or greater than 100
174.2 percent of federal poverty guidelines for the applicable family size must pay a premium
174.3 to be eligible for medical assistance under this subdivision. The premium shall be based
174.4 on the person's gross earned and unearned income and the applicable family size using a
174.5 sliding fee scale established by the commissioner, which begins at one percent of income
174.6 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
174.7 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual
174.8 adjustments in the premium schedule based upon changes in the federal poverty guidelines
174.9 shall be effective for premiums due in July of each year.

174.10 (2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for
174.11 medical assistance under this subdivision. An enrollee shall pay the greater of a \$35
174.12 premium or the premium calculated in clause (1).

174.13 (3) Effective November 1, 2003, all enrollees who receive unearned income must
174.14 pay one-half of one percent of unearned income in addition to the premium amount.

174.15 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
174.16 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
174.17 commissioner must reimburse the enrollee for Medicare Part B premiums under section
174.18 256B.0625, subdivision 15, paragraph (a).

174.19 (5) Increases in benefits under title II of the Social Security Act shall not be counted
174.20 as income for purposes of this subdivision until July 1 of each year.

174.21 (f) A person's eligibility and premium shall be determined by the local county
174.22 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
174.23 the commissioner.

174.24 (g) Any required premium shall be determined at application and redetermined at
174.25 the enrollee's six-month income review or when a change in income or household size is
174.26 reported. Enrollees must report any change in income or household size within ten days
174.27 of when the change occurs. A decreased premium resulting from a reported change in
174.28 income or household size shall be effective the first day of the next available billing month
174.29 after the change is reported. Except for changes occurring from annual cost-of-living
174.30 increases, a change resulting in an increased premium shall not affect the premium amount
174.31 until the next six-month review.

174.32 (h) Premium payment is due upon notification from the commissioner of the
174.33 premium amount required. Premiums may be paid in installments at the discretion of
174.34 the commissioner.

174.35 (i) Nonpayment of the premium shall result in denial or termination of medical
174.36 assistance unless the person demonstrates good cause for nonpayment. Good cause exists

175.1 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
175.2 D, are met. Except when an installment agreement is accepted by the commissioner,
175.3 all persons disenrolled for nonpayment of a premium must pay any past due premiums
175.4 as well as current premiums due prior to being reenrolled. Nonpayment shall include
175.5 payment with a returned, refused, or dishonored instrument. The commissioner may
175.6 require a guaranteed form of payment as the only means to replace a returned, refused,
175.7 or dishonored instrument.

175.8 (j) Following a determination that the applicant is not aged or blind and does not
175.9 meet any other category of eligibility for medical assistance and has not been determined
175.10 disabled by the Social Security Administration, applicants under this subdivision shall be
175.11 referred to the commissioner's state medical review team for a determination of disability.
175.12 Disability shall be determined according to the rules of title XVI and title XIX of the
175.13 Social Security Act and pertinent rules and policies of the Social Security Administration.

175.14 Sec. 17. Minnesota Statutes 2008, section 256B.0625, subdivision 6a, is amended to
175.15 read:

175.16 Subd. 6a. **Home health services.** Home health services are those services specified
175.17 in ~~Minnesota Rules, part 9505.0295~~ sections 256B.0651 and 256B.0653. Medical
175.18 assistance covers home health services at a recipient's home residence. Medical assistance
175.19 does not cover home health services for residents of a hospital, nursing facility, or
175.20 intermediate care facility, unless the commissioner of human services has ~~prior~~ authorized
175.21 skilled nurse visits for less than 90 days for a resident at an intermediate care facility for
175.22 persons with developmental disabilities, to prevent an admission to a hospital or nursing
175.23 facility or unless a resident who is otherwise eligible is on leave from the facility and the
175.24 facility either pays for the home health services or forgoes the facility per diem for the
175.25 leave days that home health services are used. Home health services must be provided by
175.26 a Medicare certified home health agency. All nursing and home health aide services must
175.27 be provided according to sections 256B.0651 to ~~256B.0656~~ 256B.0653.

175.28 Sec. 18. Minnesota Statutes 2008, section 256B.0625, subdivision 7, is amended to
175.29 read:

175.30 Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing
175.31 services in a recipient's home. Recipients who are authorized to receive private duty
175.32 nursing services in their home may use approved hours outside of the home during hours
175.33 when normal life activities take them outside of their home. To use private duty nursing
175.34 services at school, the recipient or responsible party must provide written authorization in

176.1 the care plan identifying the chosen provider and the daily amount of services to be used at
176.2 school. Medical assistance does not cover private duty nursing services for residents of a
176.3 hospital, nursing facility, intermediate care facility, or a health care facility licensed by the
176.4 commissioner of health, except as authorized in section 256B.64 for ventilator-dependent
176.5 recipients in hospitals or unless a resident who is otherwise eligible is on leave from the
176.6 facility and the facility either pays for the private duty nursing services or forgoes the
176.7 facility per diem for the leave days that private duty nursing services are used. Total hours
176.8 of service and payment allowed for services outside the home cannot exceed that which is
176.9 otherwise allowed in an in-home setting according to sections 256B.0651 and ~~256B.0653~~
176.10 256B.0654 to 256B.0656. All private duty nursing services must be provided according to
176.11 the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private
176.12 duty nursing services may not be reimbursed if the nurse is the foster care provider of
176.13 a recipient who is under age 18.

176.14 Sec. 19. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to
176.15 read:

176.16 Subd. 8. **Physical therapy.** Medical assistance covers physical therapy, as
176.17 described in section 148.65, and related services, including specialized maintenance
176.18 therapy. Services provided by a physical therapy assistant shall be reimbursed at the
176.19 same rate as services performed by a physical therapist when the services of the physical
176.20 therapy assistant are provided under the direction of a physical therapist who is on the
176.21 premises. Services provided by a physical therapy assistant that are provided under the
176.22 direction of a physical therapist who is not on the premises shall be reimbursed at 65
176.23 percent of the physical therapist rate.

176.24 Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to
176.25 read:

176.26 Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy,
176.27 as described in section 148.6404, and related services, including specialized maintenance
176.28 therapy. Services provided by an occupational therapy assistant shall be reimbursed at
176.29 the same rate as services performed by an occupational therapist when the services of
176.30 the occupational therapy assistant are provided under the direction of the occupational
176.31 therapist who is on the premises. Services provided by an occupational therapy assistant
176.32 that are provided under the direction of an occupational therapist who is not on the
176.33 premises shall be reimbursed at 65 percent of the occupational therapist rate.

177.1 Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to
177.2 read:

177.3 Subd. 19a. **Personal care assistant services.** Medical assistance covers personal
177.4 care assistant services in a recipient's home. To qualify for personal care assistant services,
177.5 a recipient must require assistance and be determined dependent in one activity of daily
177.6 living as defined in section 256B.0659 or have a level I behavior as defined in section
177.7 256B.0659. Recipients or responsible parties must be able to identify the recipient's needs,
177.8 direct and evaluate task accomplishment, and provide for health and safety. Approved
177.9 hours may be used outside the home when normal life activities take them outside the
177.10 home. To use personal care assistant services at school, the recipient or responsible party
177.11 must provide written authorization in the care plan identifying the chosen provider and the
177.12 daily amount of services to be used at school. Total hours for services, whether actually
177.13 performed inside or outside the recipient's home, cannot exceed that which is otherwise
177.14 allowed for personal care assistant services in an in-home setting according to sections
177.15 256B.0651 ~~and 256B.0653~~ to 256B.0656. Medical assistance does not cover personal care
177.16 assistant services for residents of a hospital, nursing facility, intermediate care facility,
177.17 health care facility licensed by the commissioner of health, or unless a resident who is
177.18 otherwise eligible is on leave from the facility and the facility either pays for the personal
177.19 care assistant services or forgoes the facility per diem for the leave days that personal care
177.20 assistant services are used. All personal care assistant services must be provided according
177.21 to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656. Personal care assistant services may
177.22 not be reimbursed if the personal care assistant is the spouse or ~~legal~~ paid guardian of the
177.23 recipient or the parent of a recipient under age 18, or the responsible party or the foster
177.24 care provider ~~of a recipient who cannot direct the recipient's own care unless, in the case of~~
177.25 ~~a foster care provider, a county or state case manager visits the recipient as needed, but not~~
177.26 ~~less than every six months, to monitor the health and safety of the recipient and to ensure~~
177.27 ~~the goals of the care plan are met. Parents of adult recipients, adult children of the recipient~~
177.28 ~~or adult siblings of the recipient may be reimbursed for personal care assistant services,~~
177.29 ~~if they are granted a waiver under sections 256B.0651 and 256B.0653 to 256B.0656.~~
177.30 Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause~~
177.31 ~~(4) 256B.0659,~~ the ~~noncorporate~~ legal unpaid guardian or conservator of an adult, who
177.32 is not the responsible party and not the personal care provider organization, may be
177.33 ~~granted a hardship waiver under sections 256B.0651 and 256B.0653 to 256B.0656, to be~~
177.34 reimbursed to provide personal care assistant services to the recipient if the guardian or
177.35 conservator meet all criteria for a personal care assistant according to section 256B.0659,

178.1 and shall not be considered to have a service provider interest for purposes of participation
178.2 on the screening team under section 256B.092, subdivision 7.

178.3 Sec. 22. Minnesota Statutes 2008, section 256B.0625, subdivision 19c, is amended to
178.4 read:

178.5 Subd. 19c. **Personal care.** (a) Medical assistance covers personal care assistant
178.6 services provided by an individual who is qualified to provide the services according
178.7 to subdivision 19a and sections 256B.0651 and 256B.0653 to 256B.0656, where the
178.8 services have a statement of need by a physician, provided in accordance with a plan, and
178.9 are supervised by the recipient or a qualified professional. The physician's statement of
178.10 need for personal care assistant services shall be documented on a form approved by the
178.11 commissioner and include the diagnosis or condition of the person that results in a need
178.12 for personal care assistant services and be updated when the person's medical condition
178.13 requires a change, but at least annually if the need for personal care assistant services is
178.14 ongoing.

178.15 (b) "Qualified professional" means a mental health professional as defined in section
178.16 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in
178.17 sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21; or
178.18 qualified developmental disabilities professional under Code of Federal Regulations, title
178.19 42. As part of the assessment, the county public health nurse will assist the recipient or
178.20 responsible party to identify the most appropriate person to provide supervision of the
178.21 personal care assistant. The qualified professional shall perform the duties described
178.22 required in Minnesota Rules, part 9505.0335, subpart 4 section 256B.0659.

178.23 Sec. 23. Minnesota Statutes 2008, section 256B.0651, is amended to read:

178.24 **256B.0651 HOME CARE SERVICES.**

178.25 Subdivision 1. **Definitions.** (a) "Activities of daily living" includes eating, toileting,
178.26 grooming, dressing, bathing, transferring, mobility, and positioning. For the purposes of
178.27 sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g)
178.28 have the meanings given.

178.29 (b) "Activities of daily living" has the meaning given in section 256B.0659,
178.30 subdivision 1, paragraph (b).

178.31 ~~(b)~~ (c) "Assessment" means a review and evaluation of a recipient's need for home
178.32 care services conducted in person as required in section 256B.0911. Assessments for home
178.33 health agency services shall be conducted by a home health agency nurse. Assessments
178.34 for medical assistance home care services for developmental disability and alternative care

179.1 ~~services for developmentally disabled home and community-based waived recipients~~
179.2 ~~may be conducted by the county public health nurse to ensure coordination and avoid~~
179.3 ~~duplication. Assessments must be completed on forms provided by the commissioner~~
179.4 ~~within 30 days of a request for home care services by a recipient or responsible party.~~

179.5 ~~(e) (d) "Home care services" means a health service, determined by the commissioner~~
179.6 ~~as medically necessary, that is ordered by a physician and documented in a service plan~~
179.7 ~~that is reviewed by the physician at least once every 60 days for the provision of home~~
179.8 ~~health services, or private duty nursing, or at least once every 365 days for personal care.~~
179.9 ~~Home care services are provided to the recipient at the recipient's residence that is a~~
179.10 ~~place other than a hospital or long-term care facility or as specified in section 256B.0625~~
179.11 ~~means medical assistance covered services that are home health agency services, including~~
179.12 ~~skilled nurse visits; home health aide visits; physical therapy, occupational therapy,~~
179.13 ~~respiratory therapy, and language-speech pathology therapy; private duty nursing; and~~
179.14 ~~personal care assistance.~~

179.15 ~~(e) "Home residence" means a residence owned or rented by the recipient either~~
179.16 ~~alone, with roommates of the recipient's choosing, or with an unpaid responsible party~~
179.17 ~~or legal representative; or a family foster home where the license holder lives with the~~
179.18 ~~recipient and is not paid to provide home care services for the recipient.~~

179.19 ~~(d) (f) "Medically necessary" has the meaning given in Minnesota Rules, parts~~
179.20 ~~9505.0170 to 9505.0475.~~

179.21 ~~(e) "Telehomecare" means the use of telecommunications technology by a home~~
179.22 ~~health care professional to deliver home health care services, within the professional's~~
179.23 ~~scope of practice, to a patient located at a site other than the site where the practitioner~~
179.24 ~~is located.~~

179.25 ~~(g) "Ventilator-dependent" means an individual who receives mechanical ventilation~~
179.26 ~~for life support at least six hours per day and is expected to be or has been dependent on a~~
179.27 ~~ventilator for at least 30 consecutive days.~~

179.28 Subd. 2. **Services covered.** Home care services covered under this section and
179.29 sections ~~256B.0653~~ 256B.0652 to 256B.0656 and 256B.0659 include:

179.30 (1) nursing services under ~~section~~ sections 256B.0625, subdivision 6a, and
179.31 256B.0653;

179.32 (2) private duty nursing services under ~~section~~ sections 256B.0625, subdivision
179.33 7, and 256B.0654;

179.34 (3) home health services under ~~section~~ sections 256B.0625, subdivision 6a, and
179.35 256B.0653;

180.1 (4) personal care assistant services under ~~section~~ sections 256B.0625, subdivision
180.2 19a, and 256B.0659;

180.3 (5) supervision of personal care assistant services provided by a qualified
180.4 professional under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659;

180.5 ~~(6) qualified professional of personal care assistant services under the fiscal~~
180.6 ~~intermediary option as specified in section 256B.0655, subdivision 7;~~

180.7 ~~(7) (6) face-to-face assessments by county public health nurses for services under~~
180.8 ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659; and

180.9 ~~(8) (7) service updates and review of temporary increases for personal care assistant~~
180.10 ~~services by the county public health nurse for services under~~ section sections 256B.0625,
180.11 subdivision 19a, and 256B.0659.

180.12 Subd. 3. **Noncovered home care services.** The following home care services are
180.13 not eligible for payment under medical assistance:

180.14 ~~(1) skilled nurse visits for the sole purpose of supervision of the home health aide;~~

180.15 ~~(2) a skilled nursing visit:~~

180.16 ~~(i) only for the purpose of monitoring medication compliance with an established~~
180.17 ~~medication program for a recipient; or~~

180.18 ~~(ii) to administer or assist with medication administration, including injections,~~
180.19 ~~prefilling syringes for injections, or oral medication set-up of an adult recipient, when as~~
180.20 ~~determined and documented by the registered nurse, the need can be met by an available~~
180.21 ~~pharmacy or the recipient is physically and mentally able to self-administer or prefill~~
180.22 ~~a medication;~~

180.23 ~~(3) home care services to a recipient who is eligible for covered services under the~~
180.24 ~~Medicare program or any other insurance held by the recipient;~~

180.25 ~~(4) services to other members of the recipient's household;~~

180.26 ~~(5) a visit made by a skilled nurse solely to train other home health agency workers;~~

180.27 ~~(6) any home care service included in the daily rate of the community-based~~
180.28 ~~residential facility where the recipient is residing;~~

180.29 ~~(7) nursing and rehabilitation therapy services that are reasonably accessible to a~~
180.30 ~~recipient outside the recipient's place of residence, excluding the assessment, counseling~~
180.31 ~~and education, and personal assistant care;~~

180.32 ~~(8) any home health agency service, excluding personal care assistant services and~~
180.33 ~~private duty nursing services, which are performed in a place other than the recipient's~~
180.34 ~~residence; and~~

180.35 ~~(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients~~
180.36 ~~that do not qualify for Medicare visit billing.~~

181.1 (1) services provided in a nursing facility, hospital, or intermediate care facility with
181.2 exceptions in section 256B.0653;

181.3 (2) services for the sole purpose of monitoring medication compliance with an
181.4 established medication program for a recipient;

181.5 (3) home care services for covered services under the Medicare program or any other
181.6 insurance held by the recipient;

181.7 (4) services to other members of the recipient's household;

181.8 (5) any home care service included in the daily rate of the community-based
181.9 residential facility where the recipient is residing;

181.10 (6) nursing and rehabilitation therapy services that are reasonably accessible to a
181.11 recipient outside the recipient's place of residence, excluding the assessment, counseling
181.12 and education, and personal assistance care; or

181.13 (7) Medicare evaluation or administrative nursing visits on dual-eligible recipients
181.14 that do not qualify for Medicare visit billing.

181.15 Subd. 4. **Prior Authorization; exceptions.** All home care services above the limits
181.16 in subdivision 11 must receive the commissioner's ~~prior~~ authorization before services
181.17 begin, except when:

181.18 (1) the home care services were required to treat an emergency medical condition
181.19 that if not immediately treated could cause a recipient serious physical or mental disability,
181.20 continuation of severe pain, or death. The provider must request retroactive authorization
181.21 no later than five working days after giving the initial service. The provider must be able
181.22 to substantiate the emergency by documentation such as reports, notes, and admission or
181.23 discharge histories;

181.24 ~~(2) the home care services were provided on or after the date on which the recipient's~~
181.25 ~~eligibility began, but before the date on which the recipient was notified that the case was~~
181.26 ~~opened. Authorization will be considered if the request is submitted by the provider~~
181.27 ~~within 20 working days of the date the recipient was notified that the case was opened;~~
181.28 a recipient's medical assistance eligibility has lapsed, is then retroactively reinstated,
181.29 and an authorization for home care services is completed based on the date of a current
181.30 assessment, eligibility, and request for authorization;

181.31 (3) a third-party payor for home care services has denied or adjusted a payment.
181.32 Authorization requests must be submitted by the provider within 20 working days of the
181.33 notice of denial or adjustment. A copy of the notice must be included with the request;

181.34 (4) the commissioner has determined that a county or state human services agency
181.35 has made an error; or

182.1 (5) ~~the professional nurse determines an immediate need for up to 40 skilled nursing~~
182.2 ~~or home health aide visits per calendar year and submits a request for authorization within~~
182.3 ~~20 working days of the initial service date, and medical assistance is determined to be~~
182.4 ~~the appropriate payer. if a recipient enrolled in managed care experiences a temporary~~
182.5 ~~disenrollment from a health plan, the commissioner shall accept the current health plan~~
182.6 ~~authorization for personal care assistance services for up to 60 days. The request must~~
182.7 ~~be received within the first 30 days of the disenrollment. If the recipient's reenrollment~~
182.8 ~~in managed care is after the 60 days and before 90 days, the provider shall request an~~
182.9 ~~additional 30-day extension of the current health plan authorization, for a total limit of~~
182.10 ~~90 days from the time of disenrollment.~~

182.11 ~~Subd. 5. **Retroactive authorization.** A request for retroactive authorization will be~~
182.12 ~~evaluated according to the same criteria applied to prior authorization requests.~~

182.13 Subd. 6. **Prior Authorization.** (a) The commissioner, or the commissioner's
182.14 designee, shall review the assessment, ~~service update,~~ request for temporary services,
182.15 ~~request for flexible use option,~~ service plan, and any additional information that is
182.16 submitted. The commissioner shall, within 30 days after receiving a complete request,
182.17 assessment, and service plan, authorize home care services as ~~follows:~~ provided in this
182.18 section.

182.19 (a) ~~Home health services.~~ (b) All Home health services provided by a home health
182.20 aide including skilled nurse visits and home health aide visits must be prior authorized
182.21 by the commissioner or the commissioner's designee. Prior Authorization must be based
182.22 on medical necessity and cost-effectiveness when compared with other care options.
182.23 The commissioner must receive the request for authorization of skilled nurse visits and
182.24 home health aide visits within 20 working days of the start of service. When home health
182.25 services are used in combination with personal care and private duty nursing, the cost of
182.26 all home care services shall be considered for cost-effectiveness. The commissioner shall
182.27 limit home health aide visits to no more than one visit each per day. The commissioner, or
182.28 the commissioner's designee, may authorize up to two skilled nurse visits per day.

182.29 (b) ~~Ventilator-dependent recipients.~~ (c) If the recipient is ventilator-dependent, the
182.30 monthly medical assistance authorization for home care services shall not exceed what the
182.31 commissioner would pay for care at the highest cost hospital designated as a long-term
182.32 hospital under the Medicare program. For purposes of this paragraph, home care services
182.33 means all direct care services provided in the home that would be included in the payment
182.34 for care at the long-term hospital. ~~"Ventilator-dependent" means an individual who~~
182.35 ~~receives mechanical ventilation for life support at least six hours per day and is expected~~
182.36 ~~to be or has been dependent for at least 30 consecutive days. Recipients who meet the~~

183.1 definition of ventilator dependent and the EN home care rating and utilize a combination
183.2 of home care services are limited up to a total of 24 hours of home care services per day.
183.3 Additional hours may be authorized when a recipient's assessment indicates a need for two
183.4 staff to perform activities. Additional time is limited to four hours per day.

183.5 Subd. 7. **Prior Authorization; time limits.** (a) The commissioner or the
183.6 commissioner's designee shall determine the time period for which a ~~prior~~ an authorization
183.7 shall be effective ~~and, if flexible use has been requested, whether to allow the flexible use~~
183.8 ~~option.~~ If the recipient continues to require home care services beyond the duration of
183.9 the ~~prior~~ authorization, the home care provider must request a new ~~prior~~ authorization.
183.10 A personal care provider agency must request a new personal care assistant services
183.11 assessment, or service update if allowed, at least 60 days prior to the end of the current
183.12 ~~prior~~ authorization time period. The request for the assessment must be made on a form
183.13 approved by the commissioner. ~~Under no circumstances, other than the exceptions~~
183.14 ~~in subdivision 4, shall a prior~~ An authorization must be valid ~~prior to the date the~~
183.15 ~~commissioner receives the request or~~ for no more than 12 months.

183.16 (b) A recipient who appeals a reduction in previously authorized home care
183.17 services may continue previously authorized services, other than temporary services
183.18 under subdivision 8, pending an appeal under section 256.045. The commissioner must
183.19 provide a detailed explanation of why the authorized services are reduced ~~in amount from~~
183.20 ~~those requested by the home care provider.~~

183.21 Subd. 8. **Prior Authorization requests; temporary services.** The agency nurse,
183.22 ~~the~~ independently enrolled private duty nurse, or county public health nurse may request
183.23 a temporary authorization for home care services ~~by telephone.~~ The commissioner may
183.24 approve a temporary level of home care services based on the assessment, and service
183.25 or care plan information, and primary payer coverage determination information as
183.26 required. Authorization for a temporary level of home care services including nurse
183.27 supervision is limited to the time specified by the commissioner, but shall not exceed
183.28 45 days, ~~unless extended because the county public health nurse has not completed the~~
183.29 ~~required assessment and service plan, or the commissioner's determination has not been~~
183.30 ~~made.~~ The level of services authorized under this provision shall have no bearing on a
183.31 future ~~prior~~ authorization.

183.32 Subd. 9. **Prior Authorization for foster care setting.** (a) Home care services
183.33 provided in an adult or child foster care setting must receive ~~prior~~ authorization by the
183.34 ~~department~~ commissioner according to the limits established in subdivision 11.

183.35 (b) The commissioner may not authorize:

184.1 (1) home care services that are the responsibility of the foster care provider under
184.2 the terms of the foster care placement agreement and administrative rules;

184.3 (2) personal care assistant services when the foster care license holder is also
184.4 the personal care provider or personal care assistant ~~unless the recipient can direct the~~
184.5 ~~recipient's own care, or case management is provided as required in section 256B.0625,~~
184.6 ~~subdivision 19a; or~~

184.7 ~~(3) personal care assistant services when the responsible party is an employee of, or~~
184.8 ~~under contract with, or has any direct or indirect financial relationship with the personal~~
184.9 ~~care provider or personal care assistant, unless case management is provided as required~~
184.10 ~~in section 256B.0625, subdivision 19a; or~~

184.11 ~~(4)~~ (3) personal care assistant and private duty nursing services when the **number**
184.12 ~~of foster care residents~~ licensed capacity is greater than four ~~unless the county responsible~~
184.13 ~~for the recipient's foster placement made the placement prior to April 1, 1992, requests~~
184.14 ~~that personal care assistant and private duty nursing services be provided, and case~~
184.15 ~~management is provided as required in section 256B.0625, subdivision 19a.~~

184.16 ~~Subd. 10. **Limitation on payments.** Medical assistance payments for home care~~
184.17 ~~services shall be limited according to subdivisions 4 to 12 and sections 256B.0654,~~
184.18 ~~subdivision 2, and 256B.0655, subdivisions 3 and 4.~~

184.19 Subd. 11. **Limits on services without prior authorization.** A recipient may receive
184.20 the following home care services during a calendar year:

184.21 (1) up to two face-to-face assessments to determine a recipient's need for personal
184.22 care assistant services;

184.23 (2) one service update done to determine a recipient's need for personal care assistant
184.24 services; and

184.25 (3) up to nine face-to-face skilled nurse visits.

184.26 Subd. 12. **Approval of home care services.** The commissioner or the
184.27 commissioner's designee shall determine the medical necessity of home care services, the
184.28 level of caregiver according to subdivision 2, and the institutional comparison according to
184.29 subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and ~~256B.0655, subdivisions~~
184.30 ~~3 and 4~~ 256B.0659, the cost-effectiveness of services, and the amount, scope, and duration
184.31 of home care services reimbursable by medical assistance, based on the assessment,
184.32 primary payer coverage determination information as required, the service plan, the
184.33 recipient's age, the cost of services, the recipient's medical condition, and diagnosis or
184.34 disability. The commissioner may publish additional criteria for determining medical
184.35 necessity according to section 256B.04.

185.1 Subd. 13. **Recovery of excessive payments.** The commissioner shall seek
185.2 monetary recovery from providers of payments made for services which exceed the limits
185.3 established in this section and sections 256B.0653 to 256B.0656 and 256B.0659. This
185.4 subdivision does not apply to services provided to a recipient at the previously authorized
185.5 level pending an appeal under section 256.045, subdivision 10.

185.6 Subd. 14. **Referrals to Medicare providers required.** Home care providers that
185.7 do not participate in or accept Medicare assignment must refer and document the referral
185.8 of dual-eligible recipients to Medicare providers when Medicare is determined to be the
185.9 appropriate payer for services and supplies and equipment. Providers must be terminated
185.10 from participation in the medical assistance program for failure to make these referrals.

185.11 Subd. 15. **Quality assurance for program integrity.** The commissioner shall
185.12 maintain processes for monitoring ongoing program integrity including provider standards
185.13 and training, consumer surveys, and random reviews of documentation.

185.14 Subd. 16. **Oversight of enrolled providers.** The commissioner shall establish
185.15 an ongoing quality assurance process for home care services. The commissioner has
185.16 the authority to request proof of documentation of meeting provider standards, quality
185.17 standards of care, correct billing practices, and other information. Failure to provide access
185.18 and information to demonstrate compliance with laws, rules, or policies must result in
185.19 suspension, denial, or termination of the provider agency's enrollment with the department.

185.20 Sec. 24. Minnesota Statutes 2008, section 256B.0652, is amended to read:

185.21 **256B.0652 PRIOR AUTHORIZATION AND REVIEW OF HOME CARE**
185.22 **SERVICES.**

185.23 Subdivision 1. **State coordination.** The commissioner shall supervise the
185.24 coordination of the ~~prior~~ authorization and review of home care services that are
185.25 reimbursed by medical assistance.

185.26 Subd. 2. **Duties.** (a) The commissioner may contract with or employ ~~qualified~~
185.27 ~~registered nurses and necessary support~~ staff, or contract with qualified agencies, to
185.28 provide home care ~~prior~~ authorization and review services for medical assistance
185.29 recipients who are receiving home care services.

185.30 (b) Reimbursement for the ~~prior~~ authorization function shall be made through the
185.31 medical assistance administrative authority. The state shall pay the nonfederal share.
185.32 The functions will be to:

185.33 (1) assess the recipient's individual need for services required to be cared for safely
185.34 in the community;

- 186.1 (2) ensure that a ~~service~~ care plan that meets the recipient's needs is developed
186.2 by the appropriate agency or individual;
- 186.3 (3) ensure cost-effectiveness and nonduplication of medical assistance home care
186.4 services;
- 186.5 (4) recommend the approval or denial of the use of medical assistance funds to pay
186.6 for home care services;
- 186.7 (5) reassess the recipient's need for and level of home care services at a frequency
186.8 determined by the commissioner; ~~and~~
- 186.9 (6) conduct on-site assessments when determined necessary by the commissioner
186.10 and recommend changes to care plans that will provide more efficient and appropriate
186.11 home care; and
- 186.12 (7) on the department's Web site:
- 186.13 (i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies
186.14 with the following information: main office address, contact information for the agency,
186.15 counties in which services are provided, type of home care services provided, whether
186.16 the personal care assistance choice option is offered, types of qualified professionals
186.17 employed, number of personal care assistants employed, and data on staff turnover; and
- 186.18 (ii) post data on home care services including information from both fee-for-service
186.19 and managed care plans on recipients as available.
- 186.20 (c) In addition, the commissioner or the commissioner's designee may:
- 186.21 (1) review care service plans and reimbursement data for utilization of services that
186.22 exceed community-based standards for home care, inappropriate home care services,
186.23 medical necessity, home care services that do not meet quality of care standards, or
186.24 unauthorized services and make appropriate referrals within the department or to other
186.25 appropriate entities based on the findings;
- 186.26 (2) assist the recipient in obtaining services necessary to allow the recipient to
186.27 remain safely in or return to the community;
- 186.28 (3) coordinate home care services with other medical assistance services under
186.29 section 256B.0625;
- 186.30 (4) assist the recipient with problems related to the provision of home care services;
- 186.31 (5) assure the quality of home care services; and
- 186.32 (6) assure that all liable third-party payers including, but not limited to, Medicare
186.33 have been used prior to medical assistance for home care services; ~~including but not~~
186.34 ~~limited to, home health agency, elected hospice benefit, waived services, alternative care~~
186.35 ~~program services, and personal care services.~~

187.1 (d) For the purposes of this section, "home care services" means medical assistance
 187.2 services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

187.3 Subd. 3. **Assessment and ~~prior~~ authorization process for persons receiving**
 187.4 **personal care assistance and developmental disabilities services.** ~~Effective January 1,~~
 187.5 ~~1996,~~ For purposes of providing informed choice, coordinating of local planning decisions,
 187.6 and streamlining administrative requirements, the assessment and ~~prior~~ authorization
 187.7 process for persons receiving both home care and home and community-based waived
 187.8 services for persons with developmental disabilities shall meet the requirements of
 187.9 sections 256B.0651 and 256B.0653 to 256B.0656 with the following exceptions:

187.10 (a) Upon request for home care services and subsequent assessment by the public
 187.11 health nurse under sections 256B.0651 and 256B.0653 to 256B.0656, the public health
 187.12 nurse shall participate in the screening process, as appropriate, and, if home care
 187.13 services are determined to be necessary, participate in the development of a service plan
 187.14 coordinating the need for home care and home and community-based waived services
 187.15 with the assigned county case manager, the recipient of services, and the recipient's legal
 187.16 representative, if any.

187.17 (b) The public health nurse shall give ~~prior~~ authorization for home care services
 187.18 to the extent that home care services are:

187.19 (1) medically necessary;

187.20 (2) chosen by the recipient and their legal representative, if any, from the array of
 187.21 home care and home and community-based waived services available;

187.22 (3) coordinated with other services to be received by the recipient as described
 187.23 in the service plan; and

187.24 (4) provided within the county's reimbursement limits for home care and home and
 187.25 community-based waived services for persons with developmental disabilities.

187.26 (c) If the public health agency is or may be the provider of home care services to the
 187.27 recipient, the public health agency shall provide the commissioner of human services with
 187.28 a written plan that specifies how the assessment and ~~prior~~ authorization process will be
 187.29 held separate and distinct from the provision of services.

187.30 Sec. 25. Minnesota Statutes 2008, section 256B.0653, is amended to read:

187.31 **256B.0653 HOME HEALTH AGENCY ~~COVERED~~ SERVICES.**

187.32 Subdivision 1. ~~Homecare; skilled nurse visits~~ **Scope.** ~~"Skilled nurse visits" are~~
 187.33 ~~provided in a recipient's residence under a plan of care or service plan that specifies a level~~
 187.34 ~~of care which the nurse is qualified to provide. These services are:~~

188.1 ~~(1) nursing services according to the written plan of care or service plan and accepted~~
188.2 ~~standards of medical and nursing practice in accordance with chapter 148;~~
188.3 ~~(2) services which due to the recipient's medical condition may only be safely and~~
188.4 ~~effectively provided by a registered nurse or a licensed practical nurse;~~
188.5 ~~(3) assessments performed only by a registered nurse; and~~
188.6 ~~(4) teaching and training the recipient, the recipient's family, or other caregivers~~
188.7 ~~requiring the skills of a registered nurse or licensed practical nurse. This section applies to~~
188.8 ~~home health agency services including, home health aide, skilled nursing visits, physical~~
188.9 ~~therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.~~

188.10 Subd. 2. ~~**Telehomecare; skilled nurse visits**~~ Definitions. Medical assistance
188.11 ~~covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via~~
188.12 ~~telehomecare, for services which do not require hands-on care between the home care~~
188.13 ~~nurse and recipient. The provision of telehomecare must be made via live, two-way~~
188.14 ~~interactive audiovisual technology and may be augmented by utilizing store-and-forward~~
188.15 ~~technologies. Store-and-forward technology includes telehomecare services that do not~~
188.16 ~~occur in real time via synchronous transmissions, and that do not require a face-to-face~~
188.17 ~~encounter with the recipient for all or any part of any such telehomecare visit. Individually~~
188.18 ~~identifiable patient data obtained through real-time or store-and-forward technology must~~
188.19 ~~be maintained as health records according to sections 144.291 to 144.298. If the video~~
188.20 ~~is used for research, training, or other purposes unrelated to the care of the patient, the~~
188.21 ~~identity of the patient must be concealed. A communication between the home care nurse~~
188.22 ~~and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or~~
188.23 ~~a consultation between two health care practitioners, is not to be considered a telehomecare~~
188.24 ~~visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage~~
188.25 ~~of telehomecare is limited to two visits per day. All skilled nurse visits provided via~~
188.26 ~~telehomecare must be prior authorized by the commissioner or the commissioner's~~
188.27 ~~designee and will be covered at the same allowable rate as skilled nurse visits provided~~
188.28 ~~in-person. For the purposes of this section, the following terms have the meanings given.~~

188.29 (a) "Assessment" means an evaluation of the recipient's medical need for home
188.30 health agency services by a registered nurse or appropriate therapist that is conducted
188.31 within 30 days of a request and as specified in Code of Federal Regulations, title 42,
188.32 sections 484.1 to 494.55.

188.33 (b) "Home care therapies" means occupational, physical, and respiratory therapy
188.34 and speech-language pathology services, provided in the home by a Medicare-certified
188.35 home health agency.

189.1 (c) "Home health agency services" means services delivered in the recipient's home
189.2 residence, except as specified in section 256B.0625, by a home health agency to a recipient
189.3 with medical needs due to illness, disability, or physical conditions.

189.4 (d) "Home health aide" means an employee of a home health agency who meets
189.5 the requirements of Code of Federal Regulations, title 42, sections 484.1 to 494.55, and
189.6 completes medically oriented tasks written in the plan of care for a recipient.

189.7 (e) "Home health agency" means a home care provider agency that is
189.8 Medicare-certified satisfying the requirements of Code of Federal Regulations, title 42,
189.9 sections 484.1 to 494.55.

189.10 (f) "Occupational therapy services" mean the services defined in section 148.6402.

189.11 (g) "Physical therapy services" mean the services defined in section 148.65.

189.12 (h) "Respiratory therapy services" mean the services defined in chapter 147C and
189.13 Minnesota Rules, part 4668.0003, subpart 37.

189.14 (i) "Speech-language pathology services" mean the services defined in section
189.15 148.512.

189.16 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
189.17 required due to a recipient's medical condition that can only be safely provided by a
189.18 professional nurse to restore and maintain optimal health.

189.19 (k) "Store-and-forward technology" means telehomecare services that do not occur
189.20 in real time via synchronous transmissions such as diabetic and vital sign monitoring.

189.21 (l) "Telehomecare" means the use of telecommunications technology via
189.22 live, two-way interactive audiovisual technology which may be augmented by
189.23 store-and-forward technology.

189.24 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to
189.25 deliver a skilled nurse visit to a recipient located at a site other than the site where the
189.26 nurse is located and is used in combination with face-to-face skilled nurse visits to
189.27 adequately meet the recipient's needs.

189.28 Subd. 3. ~~Therapies through home health agencies~~ Home health aide visits.

189.29 ~~(a) Medical assistance covers physical therapy and related services, including specialized~~
189.30 ~~maintenance therapy. Services provided by a physical therapy assistant shall be~~
189.31 ~~reimbursed at the same rate as services performed by a physical therapist when the~~
189.32 ~~services of the physical therapy assistant are provided under the direction of a physical~~
189.33 ~~therapist who is on the premises. Services provided by a physical therapy assistant that are~~
189.34 ~~provided under the direction of a physical therapist who is not on the premises shall be~~
189.35 ~~reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy~~
189.36 ~~assistant must be provided by the physical therapist as described in Minnesota Rules, part~~

190.1 ~~9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may~~
190.2 ~~not both bill for services provided to a recipient on the same day.~~

190.3 ~~(b) Medical assistance covers occupational therapy and related services, including~~
190.4 ~~specialized maintenance therapy. Services provided by an occupational therapy assistant~~
190.5 ~~shall be reimbursed at the same rate as services performed by an occupational therapist~~
190.6 ~~when the services of the occupational therapy assistant are provided under the direction of~~
190.7 ~~the occupational therapist who is on the premises. Services provided by an occupational~~
190.8 ~~therapy assistant under the direction of an occupational therapist who is not on the~~
190.9 ~~premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction~~
190.10 ~~of the occupational therapy assistant must be provided by the occupational therapist as~~
190.11 ~~described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational~~
190.12 ~~therapist and occupational therapist assistant may not both bill for services provided~~
190.13 ~~to a recipient on the same day.~~

190.14 (a) Home health aide visits must be provided by a certified home health aide
190.15 using a written plan of care that is updated in compliance with Medicare regulations.
190.16 A home health aide shall provide hands-on personal care, perform simple procedures
190.17 as an extension of therapy or nursing services, and assist in instrumental activities of
190.18 daily living as defined in section 256B.0659. Home health aide visits must be provided
190.19 in the recipient's home.

190.20 (b) All home health aide visits must have authorization under section 256B.0652.
190.21 The commissioner shall limit home health aide visits to no more than one visit per day
190.22 per recipient.

190.23 (c) Home health aides must be supervised by a registered nurse or an appropriate
190.24 therapist when providing services that are an extension of therapy.

190.25 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be
190.26 provided by a registered nurse or a licensed practical nurse under the supervision of a
190.27 registered nurse, according to the written plan of care and accepted standards of medical
190.28 and nursing practice according to chapter 148. Skilled nurse visit services must be ordered
190.29 by a physician and documented in a plan of care that is reviewed and approved by the
190.30 ordering physician at least once every 60 days. All skilled nurse visits must be medically
190.31 necessary and provided in the recipient's home residence except as allowed under section
190.32 256B.0625, subdivision 6a.

190.33 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of
190.34 up to two visits per day per recipient. All visits must be based on assessed needs.

190.35 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status
190.36 can be accurately measured and assessed without a need for a face-to-face, hands-on

191.1 encounter. All telehomecare skilled nurse visits must have authorization and are paid at
191.2 the same allowable rates as face-to-face skilled nurse visits.

191.3 (d) The provision of telehomecare must be made via live, two-way interactive
191.4 audiovisual technology and may be augmented by utilizing store-and-forward
191.5 technologies. Individually identifiable patient data obtained through real-time or
191.6 store-and-forward technology must be maintained as health records according to sections
191.7 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated
191.8 to the care of the patient, the identity of the patient must be concealed.

191.9 (e) Authorization for skilled nurse visits must be completed under section
191.10 256B.0652. A total of nine face-to-face skilled nurses visits per calendar year do not
191.11 require authorization. All telehomecare skilled nurse visits require authorization.

191.12 Subd. 5. **Home care therapies.** (a) Home care therapies include the following:
191.13 physical therapy, occupational therapy, respiratory therapy, and speech and language
191.14 pathology therapy services.

191.15 (b) Home care therapies must be:

191.16 (1) provided in the recipient's residence after it has been determined the recipient is
191.17 unable to access outpatient therapy;

191.18 (2) prescribed, ordered, or referred by a physician and documented in a plan of care
191.19 and reviewed, according to Minnesota Rules, part 9505.0390;

191.20 (3) assessed by an appropriate therapist; and

191.21 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid
191.22 provider agency.

191.23 (c) Restorative and specialized maintenance therapies must be provided according to
191.24 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be
191.25 used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

191.26 (d) For both physical and occupational therapies, the therapist and the therapist's
191.27 assistant may not both bill for services provided to a recipient on the same day.

191.28 Subd. 6. **Noncovered home health agency services.** The following are not eligible
191.29 for payment under medical assistance as a home health agency service:

191.30 (1) telehomecare skilled nurses services that is communication between the home
191.31 care nurse and recipient that consists solely of a telephone conversation, facsimile,
191.32 electronic mail, or a consultation between two health care practitioners;

191.33 (2) the following skilled nurse visits:

191.34 (i) for the purpose of monitoring medication compliance with an established
191.35 medication program for a recipient;

192.1 (ii) administering or assisting with medication administration, including injections,
 192.2 prefilling syringes for injections, or oral medication setup of an adult recipient, when,
 192.3 as determined and documented by the registered nurse, the need can be met by an
 192.4 available pharmacy or the recipient or a family member is physically and mentally able
 192.5 to self-administer or prefill a medication;

192.6 (iii) services done for the sole purpose of supervision of the home health aide or
 192.7 personal care assistant;

192.8 (iv) services done for the sole purpose to train other home health agency workers;

192.9 (v) services done for the sole purpose of blood samples or lab draw or Synagis
 192.10 injections when the recipient is able to access these services outside the home; and

192.11 (vi) Medicare evaluation or administrative nursing visits required by Medicare;

192.12 (3) home health aide visits when the following activities are the sole purpose for the
 192.13 visit: companionship, socialization, household tasks, transportation, and education; and

192.14 (4) home care therapies provided in other settings such as a clinic, day program, or as
 192.15 an inpatient or when the recipient can access therapy outside of the recipient's residence.

192.16 Sec. 26. Minnesota Statutes 2008, section 256B.0654, is amended to read:

192.17 **256B.0654 PRIVATE DUTY NURSING.**

192.18 Subdivision 1. **Definitions.** ~~(a) "Assessment" means a review and evaluation of a~~
 192.19 ~~recipient's need for home care services conducted in person. Assessments for private duty~~
 192.20 ~~nursing shall be conducted by a registered private duty nurse. Assessments for medical~~
 192.21 ~~assistance home care services for developmental disabilities and alternative care services~~
 192.22 ~~for developmentally disabled home and community-based waived recipients may be~~
 192.23 ~~conducted by the county public health nurse to ensure coordination and avoid duplication.~~

192.24 ~~(b) (a) "Complex and regular private duty nursing care" means:~~

192.25 ~~(1) complex care is private duty nursing services provided to recipients who are~~
 192.26 ~~ventilator dependent or for whom a physician has certified that were it not for private~~
 192.27 ~~duty nursing the recipient would meet meets the criteria for inpatient hospital intensive~~
 192.28 ~~care unit (ICU) level of care; and~~

192.29 ~~(2) regular care is private duty nursing provided to all other recipients.~~

192.30 (b) "Private duty nursing" means ongoing professional nursing services by a
 192.31 registered or licensed practical nurse including assessment, professional nursing tasks, and
 192.32 education, based on an assessment and physician orders to maintain or restore optimal
 192.33 health of the recipient.

192.34 (c) "Private duty nursing agency" means a medical assistance enrolled provider
 192.35 licensed under chapter 144A to provide private duty nursing services.

193.1 (d) "Regular private duty nursing" means nursing services provided to a recipient
193.2 who is considered stable and not at an inpatient hospital intensive care unit level of care,
193.3 but may have episodes of instability that are not life threatening.

193.4 (e) "Shared private duty nursing" means the provision of nursing services by a
193.5 private duty nurse to two recipients at the same time and in the same setting.

193.6 Subd. 2. **Authorization; private duty nursing services.** (a) All private duty
193.7 nursing services shall be ~~prior~~ authorized by the commissioner or the commissioner's
193.8 designee. ~~Prior~~ Authorization for private duty nursing services shall be based on
193.9 medical necessity and cost-effectiveness when compared with alternative care options.
193.10 The commissioner may authorize medically necessary private duty nursing services in
193.11 quarter-hour units when:

193.12 (1) the recipient requires more individual and continuous care than can be provided
193.13 during a skilled nurse visit; or

193.14 (2) the cares are outside of the scope of services that can be provided by a home
193.15 health aide or personal care assistant.

193.16 (b) The commissioner may authorize:

193.17 (1) up to two times the average amount of direct care hours provided in nursing
193.18 facilities statewide for case mix classification "K" as established by the annual cost report
193.19 submitted to the department by nursing facilities in May 1992;

193.20 (2) private duty nursing in combination with other home care services up to the total
193.21 cost allowed under section 256B.0655, subdivision 4;

193.22 (3) up to 16 hours per day if the recipient requires more nursing than the maximum
193.23 number of direct care hours as established in clause (1) and the recipient meets the hospital
193.24 admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

193.25 (c) The commissioner may authorize up to 16 hours per day of medically necessary
193.26 private duty nursing services or up to 24 hours per day of medically necessary private duty
193.27 nursing services until such time as the commissioner is able to make a determination of
193.28 eligibility for recipients who are cooperatively applying for home care services under
193.29 the community alternative care program developed under section 256B.49, or until it is
193.30 determined by the appropriate regulatory agency that a health benefit plan is or is not
193.31 required to pay for appropriate medically necessary health care services. Recipients
193.32 or their representatives must cooperatively assist the commissioner in obtaining this
193.33 determination. Recipients who are eligible for the community alternative care program
193.34 may not receive more hours of nursing under this section and sections 256B.0651,
193.35 256B.0653, ~~256B.0655, and~~ 256B.0656, and 256B.0659 than would otherwise be
193.36 authorized under section 256B.49.

194.1 Subd. 2a. **Private duty nursing services.** (a) Private duty nursing services must
194.2 be used:

194.3 (1) in the recipient's home or outside the home when normal life activities require;

194.4 (2) when the recipient requires more individual and continuous care than can be
194.5 provided during a skilled nurse visit; and

194.6 (3) when the care required is outside of the scope of services that can be provided by
194.7 a home health aide or personal care assistant.

194.8 (b) Private duty nursing services must be:

194.9 (1) assessed by a registered nurse on a form approved by the commissioner;

194.10 (2) ordered by a physician and documented in a plan of care that is reviewed by the
194.11 physician at least once every 60 days; and

194.12 (3) authorized by the commissioner under section 256B.0652.

194.13 Subd. 2b. **Noncovered private duty nursing services.** Private duty nursing
194.14 services do not cover the following:

194.15 (1) nursing services by a nurse who is the foster care provider of a person who has
194.16 not reached 18 years of age unless allowed under subdivision 4;

194.17 (2) nursing services to more than two persons receiving shared private duty nursing
194.18 services from a private duty nurse in a single setting; and

194.19 (3) nursing services provided by a registered nurse or licensed practical nurse who is
194.20 the recipient's legal guardian or related to the recipient as spouse, parent, or child, whether
194.21 by blood, marriage, or adoption except as specified in section 256B.0652, subdivision 4.

194.22 Subd. 3. **Shared private duty nursing care option.** (a) Medical assistance
194.23 payments for shared private duty nursing services by a private duty nurse shall be limited
194.24 according to this subdivision. ~~For the purposes of this section and sections 256B.0651,~~
194.25 ~~256B.0653, 256B.0655, and 256B.0656, "private duty nursing agency" means an agency~~
194.26 ~~licensed under chapter 144A to provide private duty nursing services.~~ Unless otherwise
194.27 provided in this subdivision, all other statutory and regulatory provisions relating to
194.28 private duty nursing services apply to shared private duty nursing services. Nothing in
194.29 this subdivision shall be construed to reduce the total number of private duty nursing
194.30 hours authorized for an individual recipient.

194.31 ~~(b) Recipients of private duty nursing services may share nursing staff and the~~
194.32 ~~commissioner shall provide a rate methodology for shared private duty nursing. For two~~
194.33 ~~persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the~~
194.34 ~~regular private duty nursing rates paid for serving a single individual by a registered nurse~~
194.35 ~~or licensed practical nurse. These rates apply only to situations in which both recipients~~
194.36 ~~are present and receive shared private duty nursing care on the date for which the service~~

195.1 ~~is billed. No more than two persons may receive shared private duty nursing services~~
195.2 ~~from a private duty nurse in a single setting.~~

195.3 ~~(e)~~ (b) Shared private duty nursing ~~care~~ is the provision of nursing services by a
195.4 private duty nurse to two medical assistance eligible recipients at the same time and in
195.5 the same setting. This subdivision does not apply when a private duty nurse is caring for
195.6 multiple recipients in more than one setting.

195.7 (c) For the purposes of this subdivision, "setting" means:

195.8 (1) the home residence or foster care home of one of the individual recipients as
195.9 defined in section 256B.0651; or

195.10 (2) a child care program licensed under chapter 245A or operated by a local school
195.11 district or private school; ~~or~~

195.12 (3) an adult day care service licensed under chapter 245A; or

195.13 (4) outside the home residence or foster care home of one of the recipients when
195.14 normal life activities take the recipients outside the home.

195.15 ~~This subdivision does not apply when a private duty nurse is caring for multiple~~
195.16 ~~recipients in more than one setting.~~

195.17 (d) The private duty nursing agency must offer the recipient the option of shared or
195.18 one-on-one private duty nursing services. The recipient may withdraw from participating
195.19 in a shared service arrangement at any time.

195.20 ~~(d)~~ (e) The recipient or the recipient's legal representative, and the recipient's
195.21 physician, in conjunction with the ~~home health care~~ private duty nursing agency, shall
195.22 determine:

195.23 (1) whether shared private duty nursing care is an appropriate option based on the
195.24 individual needs and preferences of the recipient; and

195.25 (2) the amount of shared private duty nursing services authorized as part of the
195.26 overall authorization of nursing services.

195.27 ~~(e)~~ (f) The recipient or the recipient's legal representative, in conjunction with the
195.28 private duty nursing agency, shall approve the setting, grouping, and arrangement of
195.29 shared private duty nursing care based on the individual needs and preferences of the
195.30 recipients. Decisions on the selection of recipients to share services must be based on the
195.31 ages of the recipients, compatibility, and coordination of their care needs.

195.32 ~~(f)~~ (g) The following items must be ~~considered~~ by the recipient or the recipient's
195.33 legal representative and the private duty nursing agency, and documented in the recipient's
195.34 health service record:

196.1 (1) the additional training needed by the private duty nurse to provide care to
196.2 two recipients in the same setting and to ensure that the needs of the recipients are met
196.3 appropriately and safely;

196.4 (2) the setting in which the shared private duty nursing care will be provided;

196.5 (3) the ongoing monitoring and evaluation of the effectiveness and appropriateness
196.6 of the service and process used to make changes in service or setting;

196.7 (4) a contingency plan which accounts for absence of the recipient in a shared private
196.8 duty nursing setting due to illness or other circumstances;

196.9 (5) staffing backup contingencies in the event of employee illness or absence; and

196.10 (6) arrangements for additional assistance to respond to urgent or emergency care
196.11 needs of the recipients.

196.12 ~~(g) The provider must offer the recipient or responsible party the option of shared or~~
196.13 ~~one-on-one private duty nursing services. The recipient or responsible party can withdraw~~
196.14 ~~from participating in a shared service arrangement at any time.~~

196.15 ~~(h) The private duty nursing agency must document the following in the~~
196.16 ~~health service record for each individual recipient sharing private duty nursing care~~
196.17 The documentation for shared private duty nursing must be on a form approved by
196.18 the commissioner for each individual recipient sharing private duty nursing. The
196.19 documentation must be part of the recipient's health service record and include:

196.20 (1) permission by the recipient or the recipient's legal representative for the
196.21 maximum number of shared nursing care hours per week chosen by the recipient and
196.22 permission for shared private duty nursing services provided in and outside the recipient's
196.23 home residence;

196.24 ~~(2) permission by the recipient or the recipient's legal representative for shared~~
196.25 ~~private duty nursing services provided outside the recipient's residence;~~

196.26 ~~(3) permission by the recipient or the recipient's legal representative for others to~~
196.27 ~~receive shared private duty nursing services in the recipient's residence;~~

196.28 ~~(4) (2) revocation by the recipient or the recipient's legal representative of for the~~
196.29 ~~shared private duty nursing care authorization, or the shared care to be provided to others in~~
196.30 ~~the recipient's residence, or the shared private duty nursing services to be provided outside~~
196.31 permission, or services provided to others in and outside the recipient's residence; and

196.32 ~~(5) (3) daily documentation of the shared private duty nursing services provided by~~
196.33 each identified private duty nurse, including:

196.34 (i) the names of each recipient receiving shared private duty nursing services
196.35 together;

197.1 (ii) the setting for the shared services, including the starting and ending times that
197.2 the recipient received shared private duty nursing care; and

197.3 (iii) notes by the private duty nurse regarding changes in the recipient's condition,
197.4 problems that may arise from the sharing of private duty nursing services, and scheduling
197.5 and care issues.

197.6 ~~(i) Unless otherwise provided in this subdivision, all other statutory and regulatory~~
197.7 ~~provisions relating to private duty nursing services apply to shared private duty nursing~~
197.8 ~~services.~~

197.9 ~~Nothing in this subdivision shall be construed to reduce the total number of private~~
197.10 ~~duty nursing hours authorized for an individual recipient under subdivision 2.~~

197.11 (i) The commissioner shall provide a rate methodology for shared private duty
197.12 nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed
197.13 1.5 times the regular private duty nursing rates paid for serving a single individual by a
197.14 registered nurse or licensed practical nurse. These rates apply only to situations in which
197.15 both recipients are present and receive shared private duty nursing care on the date for
197.16 which the service is billed.

197.17 Subd. 4. **Hardship criteria; private duty nursing.** (a) Payment is allowed for
197.18 extraordinary services that require specialized nursing skills and are provided by parents
197.19 of minor children, family foster parents, spouses, and legal guardians who are providing
197.20 private duty nursing care under the following conditions:

197.21 (1) the provision of these services is not legally required of the parents, family
197.22 foster parents, spouses, or legal guardians;

197.23 (2) the services are necessary to prevent hospitalization of the recipient; and

197.24 (3) the recipient is eligible for state plan home care or a home and community-based
197.25 waiver and one of the following hardship criteria are met:

197.26 (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to
197.27 provide nursing care for the recipient; ~~or~~

197.28 (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with
197.29 less compensation to provide nursing care for the recipient; ~~or~~

197.30 (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to
197.31 provide nursing care for the recipient; or

197.32 (iv) because of labor conditions, special language needs, or intermittent hours of
197.33 care needed, the parent, spouse, or legal guardian is needed in order to provide adequate
197.34 private duty nursing services to meet the medical needs of the recipient.

197.35 (b) Private duty nursing may be provided by a parent, spouse, or legal guardian who
197.36 is a nurse licensed in Minnesota. Private duty nursing services provided by a parent,

198.1 spouse, or legal guardian cannot be used in lieu of nursing services covered and available
198.2 under liable third-party payors, including Medicare. The private duty nursing provided by
198.3 a parent, family foster parent, spouse, or legal guardian must be included in the service
198.4 plan. Authorized ~~skilled~~ nursing services for a single recipient or recipients with the same
198.5 residence and provided by the parent, family foster parent, spouse, or legal guardian
198.6 may not exceed 50 percent of the total approved nursing hours, or eight hours per day,
198.7 whichever is less, up to a maximum of 40 hours per week. A parent or parents, family
198.8 foster parents, spouse, or legal guardian shall not provide more than 40 hours of services in
198.9 a seven-day period. For parents, family foster parents, and legal guardians, 40 hours is the
198.10 total amount allowed regardless of the number of children or adults who receive services.
198.11 Nothing in this subdivision precludes the parent's, family foster parents', spouse's, or legal
198.12 guardian's obligation of assuming the nonreimbursed family responsibilities of emergency
198.13 backup caregiver and primary caregiver.

198.14 (c) A parent, family foster parent, or a spouse may not be paid to provide private
198.15 duty nursing care if:

198.16 (1) the parent or spouse fails to pass a criminal background check according to
198.17 chapter 245C, ~~or if;~~

198.18 (2) it has been determined by the home ~~health~~ care agency, the case manager, or the
198.19 physician that the private duty nursing ~~care~~ provided by the parent, family foster parents,
198.20 spouse, or legal guardian is unsafe; or

198.21 (3) the parent, family foster parents, spouse, or legal guardian do not follow
198.22 physician orders.

198.23 (d) For purposes of this section, "assessment" means a review and evaluation of a
198.24 recipient's need for home care services conducted in person. Assessments for private duty
198.25 nursing must be conducted by a registered nurse.

198.26 Sec. 27. Minnesota Statutes 2008, section 256B.0655, subdivision 1b, is amended to
198.27 read:

198.28 Subd. 1b. **Assessment.** "Assessment" means a review and evaluation of a recipient's
198.29 need for home care services conducted in person. Assessments for personal care assistant
198.30 services shall be conducted by the county public health nurse or a certified public
198.31 health nurse under contract with the county. ~~A face-to-face~~ An in-person assessment
198.32 must include: documentation of health status, determination of need, evaluation of
198.33 service effectiveness, identification of appropriate services, service plan development
198.34 or modification, coordination of services, referrals and follow-up to appropriate payers
198.35 and community resources, completion of required reports, recommendation of service

199.1 authorization, and consumer education. Once the need for personal care assistant
199.2 services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654,
199.3 and 256B.0656, the county public health nurse or certified public health nurse under
199.4 contract with the county is responsible for communicating this recommendation to the
199.5 commissioner and the recipient. ~~A face-to-face assessment for personal care assistant~~
199.6 ~~services is conducted on those recipients who have never had a county public health~~
199.7 ~~nurse assessment. A face-to-face~~ An in-person assessment must occur at least annually or
199.8 when there is a significant change in the recipient's condition or when there is a change
199.9 in the need for personal care assistant services. A service update may substitute for
199.10 the annual face-to-face assessment when there is not a significant change in recipient
199.11 condition or a change in the need for personal care assistant service. A service update
199.12 may be completed by telephone, used when there is no need for an increase in personal
199.13 care assistant services, and used for two consecutive assessments if followed by a
199.14 face-to-face assessment. A service update must be completed on a form approved by the
199.15 commissioner. A service update or review for temporary increase includes a review of
199.16 initial baseline data, evaluation of service effectiveness, redetermination of service need,
199.17 modification of service plan and appropriate referrals, update of initial forms, obtaining
199.18 service authorization, and on going consumer education. Assessments must be completed
199.19 on forms provided by the commissioner within 30 days of a request for home care services
199.20 by a recipient or responsible party or personal care provider agency.

199.21 Sec. 28. Minnesota Statutes 2008, section 256B.0655, subdivision 4, is amended to
199.22 read:

199.23 Subd. 4. **Prior Authorization; personal care assistance and qualified**
199.24 **professional.** ~~The commissioner, or the commissioner's designee, shall review the~~
199.25 ~~assessment, service update, request for temporary services, request for flexible use option,~~
199.26 ~~service plan, and any additional information that is submitted. The commissioner shall,~~
199.27 ~~within 30 days after receiving a complete request, assessment, and service plan, authorize~~
199.28 ~~home care services as follows:~~

199.29 ~~(1)~~ (a) All personal care assistant services ~~and,~~ supervision by a qualified
199.30 professional, ~~if requested by the recipient, and additional services beyond the limits~~
199.31 ~~established in section 256B.0652, subdivision 11, must be prior authorized by the~~
199.32 commissioner or the commissioner's designee before services begin except for the
199.33 assessments established in ~~section~~ sections 256B.0651, subdivision 11, and 256B.0911.
199.34 The authorization for personal care assistance and qualified professional services under

200.1 section 256B.0659 must be completed within 30 calendar days after receiving a complete
200.2 request.

200.3 (b) The amount of personal care assistant services authorized must be based on
200.4 the recipient's home care rating. The home care rating shall be determined by the
200.5 commissioner or the commissioner's designee based on information submitted to the
200.6 commissioner identifying the following:

200.7 ~~A child may not be found to be dependent in an activity of daily living if because~~
200.8 ~~of the child's age an adult would either perform the activity for the child or assist the~~
200.9 ~~child with the activity and the amount of assistance needed is similar to the assistance~~
200.10 ~~appropriate for a typical child of the same age. Based on medical necessity, the~~
200.11 ~~commissioner may authorize:~~

200.12 ~~(A) up to two times the average number of direct care hours provided in nursing~~
200.13 ~~facilities for the recipient's comparable case mix level; or~~

200.14 ~~(B) up to three times the average number of direct care hours provided in nursing~~
200.15 ~~facilities for recipients who have complex medical needs or are dependent in at least seven~~
200.16 ~~activities of daily living and need physical assistance with eating or have a neurological~~
200.17 ~~diagnosis; or~~

200.18 ~~(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care~~
200.19 ~~provided in a regional treatment center for recipients who have Level I behavior, plus any~~
200.20 ~~inflation adjustment as provided by the legislature for personal care service; or~~

200.21 ~~(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any~~
200.22 ~~inflation adjustment provided for home care services, for care provided in a regional~~
200.23 ~~treatment center for recipients referred to the commissioner by a regional treatment center~~
200.24 ~~preadmission evaluation team. For purposes of this clause, home care services means~~
200.25 ~~all services provided in the home or community that would be included in the payment~~
200.26 ~~to a regional treatment center; or~~

200.27 ~~(E) up to the amount medical assistance would reimburse for facility care for~~
200.28 ~~recipients referred to the commissioner by a preadmission screening team established~~
200.29 ~~under section 256B.0911 or 256B.092; and~~

200.30 ~~(F) a reasonable amount of time for the provision of supervision by a qualified~~
200.31 ~~professional of personal care assistant services, if a qualified professional is requested by~~
200.32 ~~the recipient or responsible party.~~

200.33 ~~(2) The number of direct care hours shall be determined according to the annual cost~~
200.34 ~~report submitted to the department by nursing facilities. The average number of direct care~~
200.35 ~~hours, as established by May 1, 1992, shall be calculated and incorporated into the home~~
200.36 ~~care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.~~

201.1 ~~(3) The home care rating shall be determined by the commissioner or the~~
201.2 ~~commissioner's designee based on information submitted to the commissioner by the~~
201.3 ~~county public health nurse on forms specified by the commissioner. The home care rating~~
201.4 ~~shall be a combination of current assessment tools developed under sections 256B.0911~~
201.5 ~~and 256B.501 with an addition for seizure activity that will assess the frequency and~~
201.6 ~~severity of seizure activity and with adjustments, additions, and clarifications that are~~
201.7 ~~necessary to reflect the needs and conditions of recipients who need home care including~~
201.8 ~~children and adults under 65 years of age. The commissioner shall establish these forms~~
201.9 ~~and protocols under this section and sections 256B.0651, 256B.0653, 256B.0654, and~~
201.10 ~~256B.0656 and shall use an advisory group, including representatives of recipients,~~
201.11 ~~providers, and counties, for consultation in establishing and revising the forms and~~
201.12 ~~protocols:~~

201.13 ~~(4) A recipient shall qualify as having complex medical needs if the care required is~~
201.14 ~~difficult to perform and because of recipient's medical condition requires more time than~~
201.15 ~~community-based standards allow or requires more skill than would ordinarily be required~~
201.16 ~~and the recipient needs or has one or more of the following:~~

201.17 ~~(A) daily tube feedings;~~

201.18 ~~(B) daily parenteral therapy;~~

201.19 ~~(C) wound or decubiti care;~~

201.20 ~~(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy~~
201.21 ~~care, oxygen, mechanical ventilation;~~

201.22 ~~(E) catheterization;~~

201.23 ~~(F) ostomy care;~~

201.24 ~~(G) quadriplegia; or~~

201.25 ~~(H) other comparable medical conditions or treatments the commissioner determines~~
201.26 ~~would otherwise require institutional care.~~

201.27 ~~(5) A recipient shall qualify as having Level I behavior if there is reasonable~~
201.28 ~~supporting evidence that the recipient exhibits, or that without supervision, observation, or~~
201.29 ~~redirection would exhibit, one or more of the following behaviors that cause, or have the~~
201.30 ~~potential to cause:~~

201.31 ~~(A) injury to the recipient's own body;~~

201.32 ~~(B) physical injury to other people; or~~

201.33 ~~(C) destruction of property.~~

201.34 ~~(6) Time authorized for personal care relating to Level I behavior in paragraph~~
201.35 ~~(5), clauses (A) to (C), shall be based on the predictability, frequency, and amount of~~
201.36 ~~intervention required.~~

202.1 ~~(7) A recipient shall qualify as having Level II behavior if the recipient exhibits on a~~
202.2 ~~daily basis one or more of the following behaviors that interfere with the completion of~~
202.3 ~~personal care assistant services under subdivision 2, paragraph (a):~~

202.4 ~~(A) unusual or repetitive habits;~~

202.5 ~~(B) withdrawn behavior; or~~

202.6 ~~(C) offensive behavior.~~

202.7 ~~(8) A recipient with a home care rating of Level II behavior in paragraph (7), clauses~~
202.8 ~~(A) to (C), shall be rated as comparable to a recipient with complex medical needs under~~
202.9 ~~paragraph (4). If a recipient has both complex medical needs and Level II behavior, the~~
202.10 ~~home care rating shall be the next complex category up to the maximum rating under~~
202.11 ~~paragraph (1), clause (B):~~

202.12 (1) total number of dependencies of activities of daily living as defined in section
202.13 256B.0659;

202.14 (2) number of complex health-related functions as defined in section 256B.0659; and

202.15 (3) number of behavior descriptions as defined in section 256B.0659.

202.16 (c) The methodology to determine total time for personal care assistance services is
202.17 based on the median paid units per day for each home care rating from fiscal year 2007
202.18 data. Each home care rating has a base level of hours assigned. Additional time is added
202.19 through the assessment and identification of the following:

202.20 (1) 30 additional minutes per day for a dependency in each critical activity of daily
202.21 living as defined in section 256B.0659;

202.22 (2) 30 additional minutes per day for each complex health-related function as
202.23 defined in section 256B.0659; and

202.24 (3) 30 additional minutes per day for each behavior issue as defined in section
202.25 256B.0659.

202.26 (d) A limit of 96 units of qualified professional supervision may be authorized for
202.27 each recipient receiving personal care assistance services. A request to the commissioner
202.28 to exceed this total in a calendar year must be requested by the personal care provider
202.29 agency on a form approved by the commissioner.

202.30 **Sec. 29. [256B.0659] PERSONAL CARE ASSISTANCE PROGRAM.**

202.31 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
202.32 paragraphs (b) to (p) have the meanings given unless otherwise provided in text.

202.33 (b) "Activities of daily living" means grooming, dressing, bathing, transferring,
202.34 mobility, positioning, eating, and toileting.

203.1 (c) "Behavior" means categories to determine the home care rating and is based on
203.2 the criteria found in this section. Level I behavior means physical aggression to self or
203.3 others and destruction of property.

203.4 (d) "Complex health-related functions" means a category to determine the home care
203.5 rating and is based on the criteria found in this section.

203.6 (e) "Critical activities of daily living" means transferring, mobility, eating, and
203.7 toileting.

203.8 (f) "Dependency in activities of daily living" means a person requires assistance to
203.9 begin or complete one or more of the activities of daily living.

203.10 (g) "Health-related functions" means functions that can be delegated or assigned
203.11 by a licensed health care professional under state law to be performed by a personal
203.12 care assistant.

203.13 (h) "Instrumental activities of daily living" means activities to include meal planning
203.14 and preparation; basic assistance with paying bills; shopping for food, clothing, and
203.15 other essential items; performing household tasks integral to the personal care assistance
203.16 services; communication by telephone and other media; and traveling and participating
203.17 in the community.

203.18 (i) "Managerial official" has the same definition as described in Code of Federal
203.19 Regulations, title 42, section 455.

203.20 (j) "Qualified professional" means a professional providing supervision of personal
203.21 care assistance services and staff as defined in section 256B.0625, subdivision 19c.

203.22 (k) "Personal care assistance provider agency" means a medical assistance enrolled
203.23 provider that provides or assists with providing personal care assistance services and
203.24 includes personal care assistance provider organizations, personal care assistance choice
203.25 agency, class A licensed nursing agency, and Medicare-certified home health agency.

203.26 (l) "Personal care assistant" means an individual employed by a personal care
203.27 assistance agency that provides personal care assistance services.

203.28 (m) "Personal care assistance care plan" means a written description of personal
203.29 care assistance services developed by the personal care assistance provider according
203.30 to the service plan.

203.31 (n) "Responsible party" means an individual who is capable of providing the support
203.32 necessary to assist the recipient to live in the community.

203.33 (o) "Self-administered medication" means medication taken orally, by injection or
203.34 insertion, or applied topically without the need for assistance.

203.35 (p) "Service plan" means a written summary of the assessment and description of the
203.36 services needed by the recipient.

- 204.1 Subd. 2. Personal care assistance services; covered services. (a) The personal
204.2 care assistance services eligible for payment include services and supports furnished
204.3 to an individual, as needed, to assist in:
- 204.4 (1) activities of daily living;
 - 204.5 (2) health-related procedures and tasks;
 - 204.6 (3) assistance with behavior needs; and
 - 204.7 (4) instrumental activities of daily living.
- 204.8 (b) Activities of daily living include the following covered services:
- 204.9 (1) dressing, including assistance with choosing, application, and changing of
204.10 clothing and application of special appliances, wraps, or clothing;
 - 204.11 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
204.12 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
204.13 except for recipients who are diabetic or have poor circulation;
 - 204.14 (3) bathing, including assistance with basic personal hygiene and skin care;
 - 204.15 (4) eating, including assistance with hand washing and application of orthotics
204.16 required for eating, transfers, and feeding;
 - 204.17 (5) transfers, including assistance with transferring the recipient from one seating or
204.18 reclining area to another;
 - 204.19 (6) mobility, including assistance with ambulation, including use of a wheelchair.
204.20 Mobility does not include providing transportation for a recipient;
 - 204.21 (7) positioning, including assistance with positioning or turning a recipient for
204.22 necessary care and comfort; and
 - 204.23 (8) toileting, including assistance with helping recipient with bowel or bladder
204.24 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
204.25 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
204.26 adjusting clothing.
- 204.27 (c) Health-related procedures or tasks include the following covered services:
- 204.28 (1) range of motion and passive exercise to maintain a recipient's optimal level of
204.29 strength and muscle functioning;
 - 204.30 (2) assistance with self-administered medication as defined by this section, including
204.31 reminders to take medication, bringing medication to the recipient, and assistance with
204.32 opening medication under the direction of the recipient or responsible party;
 - 204.33 (3) interventions for seizure disorders, including monitoring and observation; and
 - 204.34 (4) other activities considered within the scope of the personal care service and
204.35 meeting the definition of health-related procedures or tasks under this section.

205.1 (d) A personal care assistant may perform health-related procedures and tasks
205.2 associated with the complex health-related needs of a recipient if the tasks meet the
205.3 definition of health-related procedures and tasks under this section and the personal care
205.4 assistant is trained by a qualified professional and demonstrates competency to safely
205.5 complete the task. Delegation of health-related procedures and tasks and all training must
205.6 be documented in the personal care assistance care plan and the recipient's and personal
205.7 care assistant's files.

205.8 (e) For a personal care assistant to provide the health-related procedures and tasks of
205.9 tracheostomy suctioning and services to recipients on ventilator support there must be:

205.10 (1) delegation and training by a registered nurse, certified or licensed respiratory
205.11 therapist, or a physician;

205.12 (2) utilization of clean rather than sterile procedure;

205.13 (3) specialized training about the health-related functions and equipment, including
205.14 ventilator operation and maintenance;

205.15 (4) individualized training regarding the needs of the recipient; and

205.16 (5) supervision by a qualified professional who is a registered nurse.

205.17 (f) A personal care assistant may observe and redirect the recipient for episodes
205.18 where there is a need for redirection due to behaviors. Training of the personal care
205.19 assistant must occur based on the needs of the recipient, the personal care assistance care
205.20 plan, and any other support services provided.

205.21 (g) Instrumental activities of daily living under subdivision 1, paragraph (h), include
205.22 accompanying a recipient to obtain medical diagnosis or treatment when assistance is
205.23 required by the recipient during the appointment.

205.24 Subd. 3. **Noncovered personal care assistance services.** (a) Personal care
205.25 assistance services are not eligible for medical assistance payment under this section
205.26 when provided:

205.27 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
205.28 guardian, licensed foster provider, or responsible party;

205.29 (2) in lieu of other staffing options in a residential or child care setting;

205.30 (3) solely as a child care or babysitting service; or

205.31 (4) without authorization by the commissioner or the commissioner's designee.

205.32 (b) The following personal care services are not eligible for medical assistance
205.33 payment under this section when provided in residential settings:

205.34 (1) when the provider of home care services who is not related by blood, marriage,
205.35 or adoption owns or otherwise controls the living arrangement, including licensed or
205.36 unlicensed services; or

206.1 (2) when personal care assistance services are the responsibility of a residential or
206.2 program license holder under the terms of a service agreement and administrative rules.

206.3 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible
206.4 for medical assistance reimbursement for personal care assistance services under this
206.5 section include:

206.6 (1) sterile procedures;

206.7 (2) injections of fluids and medications into veins, muscles, or skin;

206.8 (3) instrumental activities of daily living without a dependency in at least two
206.9 activities of daily living;

206.10 (4) home maintenance or chore services;

206.11 (5) homemaker services not an integral part of assessed personal care assistance
206.12 services needed by a recipient;

206.13 (6) application of restraints or implementation of procedures under section 245.825;

206.14 (7) instrumental activities of daily living for children under the age of 18; and

206.15 (8) assessments for personal care assistance services by personal care assistance
206.16 provider agencies or by independently enrolled registered nurses.

206.17 Subd. 4. **Assessment for personal care assistance services.** (a) An assessment as
206.18 defined in section 256B.0911 must be completed for personal care assistance services.

206.19 (b) The following conditions apply to the assessment:

206.20 (1) a person must be assessed as dependent in an activity of daily living based
206.21 on the person's need, on a daily basis, for:

206.22 (i) cueing or supervision to complete the task; or

206.23 (ii) hands-on assistance to complete the task;

206.24 (2) an adult may not be found to be dependent in an activity of daily living because
206.25 of individual choices; and

206.26 (3) a child may not be found to be dependent in an activity of daily living if because
206.27 of the child's age an adult would either perform the activity for the child or assist the child
206.28 with the activity. Assistance needed is the assistance appropriate for a typical child of
206.29 the same age.

206.30 (c) Assessment for complex health-related functions must meet the criteria in
206.31 this paragraph. During the assessment process, a recipient qualifies as having complex
206.32 health-related functions if the recipient has one or more of the interventions that are
206.33 ordered by a physician, specified in a personal care assistance care plan, and found in
206.34 the following:

206.35 (1) tube feedings requiring:

206.36 (i) a gastro/jejunostomy tube; or

- 207.1 (ii) continuous tube feeding lasting longer than 12 hours per day;
- 207.2 (2) wounds described as:
- 207.3 (i) stage III or stage IV;
- 207.4 (ii) multiple wounds;
- 207.5 (iii) requiring sterile or clean dressing changes or a wound vac; or
- 207.6 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
- 207.7 specialized care;
- 207.8 (3) parenteral therapy described as:
- 207.9 (i) IV therapy more than two times per week lasting longer than four hours for
- 207.10 each treatment; or
- 207.11 (ii) total parenteral nutrition (TPN) daily;
- 207.12 (4) respiratory interventions including:
- 207.13 (i) oxygen required more than eight hours per day;
- 207.14 (ii) respiratory vest more than one time per day;
- 207.15 (iii) bronchial drainage treatments more than two times per day;
- 207.16 (iv) sterile or clean suctioning more than six times per day;
- 207.17 (v) dependence on another to apply respiratory ventilation augmentation devices
- 207.18 such as BiPAP and CPAP; and
- 207.19 (vi) ventilator dependence under section 256B.0652;
- 207.20 (5) insertion and maintenance of catheter including:
- 207.21 (i) sterile catheter changes more than one time per month;
- 207.22 (ii) clean self-catheterization more than six times per day; or
- 207.23 (iii) bladder irrigations;
- 207.24 (6) bowel program more than two times per week requiring more than 30 minutes to
- 207.25 perform each time;
- 207.26 (7) neurological intervention including:
- 207.27 (i) seizures more than two times per week and requiring significant physical
- 207.28 assistance to maintain safety; or
- 207.29 (ii) swallowing disorders diagnosed by a physician and requiring specialized
- 207.30 assistance from another on a daily basis; and
- 207.31 (8) other congenital or acquired diseases creating a need for significantly increased
- 207.32 direct hands-on assistance and interventions in six to eight activities of daily living.
- 207.33 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
- 207.34 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
- 207.35 assistance at least four times per week and shows one or more of the following behaviors:

208.1 (1) physical aggression towards self, others, or property that requires immediate
208.2 response of another;

208.3 (2) increased vulnerability due to cognitive deficits or socially inappropriate
208.4 behavior; or

208.5 (3) verbally aggressive and resistive to care.

208.6 Subd. 5. **Service and support planning.** (a) The assessor, with the recipient or
208.7 responsible party, shall review the assessment information and determine referrals for
208.8 other payers, services, and community supports as appropriate.

208.9 (b) The recipient must be referred for evaluation, services, or supports that are
208.10 appropriate to help meet the recipient's needs including, but not limited to, the following
208.11 circumstances:

208.12 (1) when there is another payer who is responsible to provide the service to meet
208.13 the recipient's needs;

208.14 (2) when the recipient qualifies for assistance with behaviors under this section,
208.15 a referral into the mental health system for a mental health diagnostic and functional
208.16 assessment must be completed;

208.17 (3) when the recipient is eligible for medical assistance and meets medical assistance
208.18 eligibility for a home health aide or skilled nurse visit;

208.19 (4) when the recipient would benefit from an evaluation for another service; and

208.20 (5) when there is a more appropriate service to meet the assessed needs.

208.21 (c) The reimbursement rates for public health nurse visits that relate to the provision
208.22 of personal care assistance services under this section and section 256B.0625, subdivision
208.23 19a, are:

208.24 (1) \$210.50 for a face-to-face assessment visit;

208.25 (2) \$105.25 for each service update; and

208.26 (3) \$105.25 for each request for a temporary service increase.

208.27 (d) The rates specified in paragraph (c) must be adjusted to reflect provider rate
208.28 increases for personal care assistance services that are approved by the legislature for the
208.29 fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied
208.30 by the legislature to provider rate increases for personal care assistance services also
208.31 apply to adjustments under this paragraph.

208.32 (e) Effective July 1, 2008, the payment rate for an assessment under this section and
208.33 section 256B.0651 shall be reduced by 25 percent when the assessment is not completed
208.34 on time and the service agreement documentation is not submitted in time to continue
208.35 services. The commissioner shall reduce the amount of the claim for those assessments
208.36 that are not submitted on time.

209.1 Subd. 6. **Service plan.** The service plan must be completed by the assessor with the
209.2 recipient and responsible party on a form determined by the commissioner and include
209.3 a summary of the assessment with a description of the need, authorized amount, and
209.4 expected outcomes and goals of personal care assistance services. The recipient and
209.5 the provider chosen by the recipient or responsible party must be given a copy of the
209.6 completed service plan. The recipient or responsible party must be given information by
209.7 the assessor about the options in the personal care assistance program to allow for review
209.8 and decision making.

209.9 Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current
209.10 personal care assistance care plan based on the service plan in subdivision 21 that is
209.11 developed by the qualified professional with the recipient and responsible party. A copy of
209.12 the most current personal care assistance care plan is required to be in the recipient's home
209.13 and in the recipient's file at the provider agency.

209.14 (b) The personal care assistance care plan must have the following components:

209.15 (1) start and end date of the care plan;

209.16 (2) recipient demographic information, including name and telephone number;

209.17 (3) emergency numbers and procedures, including a backup plan;

209.18 (4) name of responsible party and instructions for contact;

209.19 (5) description of the recipient's individualized needs for assistance with activities of
209.20 daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

209.21 (6) dated signatures of recipient or responsible party and qualified professional.

209.22 (c) The personal care assistance care plan must have instructions and comments

209.23 about the recipient's needs for assistance and any special instructions or procedures

209.24 required. The month-to-month plan for the use of personal care assistance services is part

209.25 of the personal care assistance care plan. The personal care assistance care plan must

209.26 be completed within the first week after start of services with a personal care provider

209.27 agency and must be updated as needed when there is a change in need for personal care

209.28 assistance services. A new personal care assistance care plan is required annually at the

209.29 time of the reassessment.

209.30 Subd. 8. **Communication with recipient's physician.** The personal care assistance

209.31 program requires communication with the recipient's physician about a recipient's assessed

209.32 needs for personal care assistance services. The commissioner shall work with the state

209.33 medical director to develop options for communication with the recipient's physician.

209.34 Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an

209.35 individual who is capable of providing the support necessary to assist the recipient to live

209.36 in the community.

210.1 (b) A responsible party must be 18 years of age, actively participate in planning and
210.2 directing of personal care assistance services, and attend all assessments for the recipient.

210.3 (c) A responsible party must not have a direct or indirect financial interest in care
210.4 provided to the recipient and must not be the:

210.5 (1) personal care assistant;

210.6 (2) home care provider agency staff; or

210.7 (3) county staff acting as part of employment.

210.8 (d) A licensed family foster parent who lives with the recipient may be the
210.9 responsible party as long as the foster parent does not also have a direct or indirect
210.10 financial interest in the provision of personal care assistance services.

210.11 (e) A responsible party is required when:

210.12 (1) the person is a minor according to section 524.5-102, subdivision 10;

210.13 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
210.14 6, resulting in a court-appointed guardian; or

210.15 (3) the assessment according to section 256B.0911 determines that the recipient is in
210.16 need of a responsible party to direct the recipient's care.

210.17 (f) There may be two persons designated as the responsible party for reasons such
210.18 as divided households and court-ordered custodies. Each person named as responsible
210.19 party must meet the program criteria and responsibilities.

210.20 (g) The recipient or the recipient's legal representative shall appoint a responsible
210.21 party if necessary to direct and supervise the care provided to the recipient. The
210.22 responsible party must be identified at the time of assessment and listed on the recipient's
210.23 service agreement and personal care assistance care plan.

210.24 Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party with a
210.25 personal care assistance provider agency shall enter into a written agreement, on a form
210.26 determined by the commissioner, to perform the following duties:

210.27 (1) be available while care is provided in a method agreed upon by the individual
210.28 or the individual's legal representative and documented in the recipient's personal care
210.29 assistance care plan;

210.30 (2) monitor personal care assistance services to ensure the recipient's personal care
210.31 assistance care plan is being followed; and

210.32 (3) review and sign personal care assistance time sheets after services are provided
210.33 to provide verification that personal care assistance services were provided.

210.34 Failure to provide the support required by the recipient must result in a referral to the
210.35 county common entry point.

211.1 (b) Responsible parties who are parents of minors or guardians of minors or
211.2 incapacitated persons may delegate the responsibility to another adult who is not the
211.3 personal care assistant during a temporary absence of at least 24 hours but not more
211.4 than six months. The person delegated as a responsible party must be able to meet the
211.5 definition of the responsible party, except that the delegated responsible party is required
211.6 to reside with the recipient only while serving as the responsible party. The responsible
211.7 party must ensure that the delegate performs the functions of the responsible party, is
211.8 identified at the time of the assessment, and is listed on the personal care assistance
211.9 care plan. The responsible party must communicate to the personal care assistance
211.10 provider agency about the need for a delegate responsible party, including the name of the
211.11 delegated responsible party, dates the delegated responsible party will be acting as the
211.12 responsible party, and contact numbers.

211.13 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
211.14 must meet the following requirements:

211.15 (1) be at least 18 years of age and if 16 or 17 years of age only if:

211.16 (i) supervised by a qualified professional every 60 days; and

211.17 (ii) employed by only one personal care assistance provider agency responsible
211.18 for compliance with current labor laws;

211.19 (2) be employed by a personal care assistance provider agency;

211.20 (3) enroll with the department as a non-pay-to provider after clearing a background
211.21 study. Before a personal care assistant provides services, the personal care assistance
211.22 provider agency must initiate a background study on the personal care assistant under
211.23 chapter 245C, and the personal care assistance provider agency must have received a
211.24 notice from the commissioner that the personal care assistant is:

211.25 (i) not disqualified under section 245C.14; or

211.26 (ii) is disqualified, but the personal care assistant has received a set aside of the
211.27 disqualification under section 245C.22;

211.28 (4) be able to effectively communicate with the recipient and personal care
211.29 assistance provider agency;

211.30 (5) be able to provide covered personal care assistance services according to the
211.31 recipient's personal care assistance care plan, respond appropriately to recipient needs,
211.32 and report changes in the recipient's condition to the supervising qualified professional
211.33 or physician;

211.34 (6) not be a consumer of personal care assistance services;

211.35 (7) maintain daily written records including, but not limited to, time sheets under
211.36 subdivision 12;

212.1 (8) complete standardized training as determined or approved by the commissioner
212.2 before completing enrollment. Personal care assistant training must include successful
212.3 completion of the following training components: basic first aid, vulnerable adult, child
212.4 maltreatment, OSHA universal precautions, basic roles and responsibilities of personal
212.5 care assistants including information about assistance with lifting and transfers for
212.6 recipients, orientation to positive behavior practices, emergency preparedness, fraud
212.7 issues, and completion of time sheets. Included with the basic training is a need for the
212.8 personal care assistant to demonstrate competency of ability to understand and provide
212.9 assistance. Personal care assistant training and orientation must be completed within the
212.10 first seven days after the services begin and be directed to the needs of the recipient and
212.11 the recipient's personal care assistance care plan; and

212.12 (9) be limited to providing and being paid for no more than 310 hours per month of
212.13 personal care assistance services that is determined by the commissioner regardless of
212.14 the number of recipients being served or the number of personal care assistance provider
212.15 agencies enrolled with.

212.16 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
212.17 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

212.18 (c) Persons who do not qualify as a personal care assistant include parents and
212.19 stepparents of minors, spouses, paid legal guardians, foster care providers, except as
212.20 otherwise allowed in section 256B.0625, or staff of a residential setting.

212.21 **Subd. 12. Documentation of personal care assistance services provided.** (a)
212.22 Personal care assistance services for a recipient must be documented daily, on a form
212.23 approved by the commissioner by each personal care assistant, and kept in the recipient's
212.24 home for the current month of service. The completed form must be submitted on a
212.25 monthly basis to the provider and kept in the recipient's health record.

212.26 (b) The activity documentation must correspond to the personal care assistance care
212.27 plan and be reviewed by the qualified professional.

212.28 (c) The personal care assistant time sheet must be on a form approved by the
212.29 commissioner documenting time the personal care assistant provides services in the home.
212.30 The following criteria must be included in the time sheet:

212.31 (1) full name of personal care assistant and individual provider number;

212.32 (2) provider name and telephone numbers;

212.33 (3) full name of recipient;

212.34 (4) consecutive dates, including month, day, and year, and arrival and departure
212.35 time with a.m. or p.m. notations;

212.36 (5) signatures of recipient or the responsible party;

213.1 (6) personal signature of the personal care assistant;

213.2 (7) any shared care provided, if applicable;

213.3 (8) a statement that it is a federal crime to provide false information on personal

213.4 care service billings for medical assistance payments; and

213.5 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

213.6 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional

213.7 must be employed by a personal care assistance provider agency and meet the definition

213.8 under section 256B.0625, subdivision 19c. Before a qualified professional provides

213.9 services, the personal care assistance provider agency must initiate a background study on

213.10 the qualified professional under chapter 245C, and the personal care assistance provider

213.11 agency must have received a notice from the commissioner that the qualified professional:

213.12 (1) is not disqualified under section 245C.14; or

213.13 (2) is disqualified, but the qualified professional has received a set aside of the

213.14 disqualification under section 245C.22.

213.15 (b) The qualified professional shall perform the duties of training, supervision, and

213.16 evaluation of the personal care assistance staff and evaluation of the effectiveness of

213.17 personal care assistance services. The qualified professional shall:

213.18 (1) develop and monitor with the recipient a personal care assistance care plan based
213.19 on the service plan and individualized needs of the recipient;

213.20 (2) develop and monitor with the recipient a monthly plan for the use of personal
213.21 care assistance services;

213.22 (3) review documentation of personal care assistance services provided;

213.23 (4) provide training and ensure competency for the personal care assistant in the
213.24 individual needs of the recipient; and

213.25 (5) document all training, communication, evaluations, and needed actions to
213.26 improve performance of the personal care assistants.

213.27 (c) The qualified professional shall complete the provider training with basic
213.28 information about the personal care assistance program approved by the commissioner
213.29 within six months of the date hired by a personal care assistance provider agency.

213.30 Qualified professionals who have completed the required trainings as an employee with a
213.31 personal care assistance provider agency do not need to repeat the required trainings if they
213.32 are hired by another agency, if they have completed the training within the last three years.

213.33 Subd. 14. **Qualified professional; duties.** (a) All personal care assistants must
213.34 be supervised by a qualified professional or in a joint supervision relationship with the
213.35 recipient or the responsible party.

- 214.1 (b) Through direct training, observation, return demonstrations, and consultation
214.2 with the staff and the recipient, the qualified professional must ensure and document
214.3 that the personal care assistant is:
- 214.4 (1) capable of providing the required personal care assistance services;
214.5 (2) knowledgeable about the plan of personal care assistance services before services
214.6 are performed; and
- 214.7 (3) able to identify conditions that should be immediately brought to the attention of
214.8 the qualified professional.
- 214.9 (c) The qualified professional shall evaluate the personal care assistant within the
214.10 first 14 days of starting to provide services for a recipient. The qualified professional shall
214.11 evaluate the personal care assistance services for a recipient through direct observation of
214.12 a personal care assistant's work:
- 214.13 (1) at least every 90 days thereafter for the first year of services; and
214.14 (2) every 120 days after the first year of service, or whenever needed for response to
214.15 a recipient's request for increased supervision of the personal care assistance staff.
- 214.16 (d) Communication with the recipient is a part of the evaluation process of the
214.17 personal care assistance staff.
- 214.18 (e) At each supervisory visit, the qualified professional shall evaluate personal care
214.19 assistance services including the following information:
- 214.20 (1) satisfaction level of the recipient with personal care assistance services;
214.21 (2) review of the month-to-month plan for use of personal care assistance services;
214.22 (3) review of documentation of personal care assistance services provided;
214.23 (4) whether the personal care assistance services are meeting the goals of the service
214.24 as stated in the personal care assistance care plan and service plan;
- 214.25 (5) a written record of the results of the evaluation and actions taken to correct any
214.26 deficiencies in the work of a personal care assistant; and
- 214.27 (6) revision of the personal care assistance care plan as necessary in consultation
214.28 with the recipient or responsible party, to meet the needs of the recipient.
- 214.29 (f) The qualified professional shall complete the required documentation in the
214.30 agency recipient and employee files and the recipient's home, including the following
214.31 documentation:
- 214.32 (1) the personal care assistance care plan based on the service plan and individualized
214.33 needs of the recipient;
- 214.34 (2) a month-to-month plan for use of personal care assistance services;
214.35 (3) changes in need of the recipient requiring a change to the level of service and the
214.36 personal care assistance care plan;

215.1 (4) evaluation results of supervision visits and identified issues with personal care
215.2 assistance staff with actions taken;

215.3 (5) all communication with the recipient and personal care assistance staff; and

215.4 (6) hands-on training or individualized training for the care of the recipient.

215.5 (g) The documentation in paragraph (f) must be completed on agency forms.

215.6 (h) The services that are not eligible for payment as qualified professional services
215.7 include:

215.8 (1) direct professional nursing tasks that could be assessed and authorized as skilled
215.9 nursing tasks;

215.10 (2) supervision of personal care assistance completed by telephone;

215.11 (3) agency administrative activities;

215.12 (4) training other than the individualized training required to provide care for a
215.13 recipient; and

215.14 (5) any other activity that is not described in this section.

215.15 Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized
215.16 hours of personal care assistance services, which vary within a service authorization
215.17 period covering no more than six months, in order to more effectively meet the needs and
215.18 schedule of the recipient. Each 12-month service agreement is divided into two six-month
215.19 authorization date spans. No more than 75 percent of the total authorized units for a
215.20 12-month service agreement may be used in a six-month date span.

215.21 (b) Authorization of flexible use occurs during the authorization process under
215.22 section 256B.0652. The flexible use of authorized hours does not increase the total
215.23 amount of authorized hours available to a recipient. The commissioner shall not authorize
215.24 additional personal care assistance services to supplement a service authorization that
215.25 is exhausted before the end date under a flexible service use plan, unless the assessor
215.26 determines a change in condition and a need for increased services is established.
215.27 Authorized hours not used within the six-month period must not be carried over to another
215.28 time period.

215.29 (c) A recipient who has terminated personal care assistance services before the end
215.30 of the 12-month authorization period must not receive additional hours upon reapplying
215.31 during the same 12-month authorization period, except if a change in condition is
215.32 documented. Services must be prorated for the remainder of the 12-month authorization
215.33 period based on the first six-month assessment.

215.34 (d) The recipient, responsible party, and qualified professional must develop a
215.35 written month-to-month plan of the projected use of personal care assistance services that
215.36 is part of the personal care assistance care plan and ensures:

216.1 (1) that the health and safety needs of the recipient are met throughout both date
216.2 spans of the authorization period; and

216.3 (2) that the total authorized amount of personal care assistance services for each date
216.4 span must not be used before the end of each date span in the authorization period.

216.5 (e) The personal care assistance provider agency shall monitor the use of personal
216.6 care assistance services to ensure health and safety needs of the recipient are met
216.7 throughout both date spans of the authorization period. The commissioner or the
216.8 commissioner's designee shall provide written notice to the provider and the recipient or
216.9 responsible party when a recipient is at risk of exceeding the personal care assistance
216.10 services prior to the end of the six-month period.

216.11 (f) Misuse and abuse of the flexible use of personal care assistance services resulting
216.12 in the overuse of units in a manner where the recipient will not have enough units to meet
216.13 their needs for assistance and ensure health and safety for the entire six-month date span
216.14 may lead to an action by the commissioner. The commissioner may take action including,
216.15 but not limited to: (1) restricting recipients to service authorizations of no more than one
216.16 month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring
216.17 a qualified professional to monitor and report services on a monthly basis.

216.18 Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal
216.19 care assistance services are limited according to this subdivision.

216.20 (b) Shared service is the provision of personal care assistance services by a personal
216.21 care assistant to two or three recipients, eligible for medical assistance, who voluntarily
216.22 enter into an agreement to receive services at the same time and in the same setting.

216.23 (c) For the purposes of this subdivision, "setting" means:

216.24 (1) the home residence or family foster care home of one or more of the individual
216.25 recipients; or

216.26 (2) a child care program licensed under chapter 245A or operated by a local school
216.27 district or private school.

216.28 (d) Shared personal care assistance services follow the same criteria for covered
216.29 services as subdivision 2.

216.30 (e) Noncovered shared personal care assistance services include the following:

216.31 (1) services for more than three recipients by one personal care assistant at one time;

216.32 (2) staff requirements for child care programs under chapter 245C;

216.33 (3) caring for multiple recipients in more than one setting;

216.34 (4) additional units of personal care assistance based on the selection of the option;

216.35 and

217.1 (5) use of more than one personal care assistance provider agency for the shared
217.2 care services.

217.3 (f) The option of shared personal care assistance is elected by the recipient or the
217.4 responsible party with the assistance of the assessor. The option must be determined
217.5 appropriate based on the ages of the recipients, compatibility, and coordination of their
217.6 assessed care needs. The recipient or the responsible party, in conjunction with the
217.7 qualified professional, shall arrange the setting and grouping of shared services based
217.8 on the individual needs and preferences of the recipients. The personal care assistance
217.9 provider agency shall offer the recipient or the responsible party the option of shared or
217.10 one-on-one personal care assistance services or a combination of both. The recipient or
217.11 the responsible party may withdraw from participating in a shared services arrangement at
217.12 any time.

217.13 (g) Authorization for the shared service option must be determined by the
217.14 commissioner based on the criteria that the shared service is appropriate to meet all of the
217.15 recipients' needs and their health and safety is maintained. The authorization of shared
217.16 services is part of the overall authorization of personal care assistance services. Nothing
217.17 in this subdivision must be construed to reduce the total number of hours authorized for
217.18 an individual recipient.

217.19 (h) A personal care assistant providing shared personal care assistance services must:

217.20 (1) receive training specific for each recipient served; and

217.21 (2) follow all required documentation requirements for time and services provided.

217.22 (i) A qualified professional shall:

217.23 (1) evaluate the ability of the personal care assistant to provide services for all of
217.24 the recipients in a shared setting;

217.25 (2) visit the shared setting as services are being provided at least once every six
217.26 months or whenever needed for response to a recipient's request for increased supervision
217.27 of the personal care assistance staff;

217.28 (3) provide ongoing monitoring and evaluation of the effectiveness and
217.29 appropriateness of the shared services;

217.30 (4) develop a contingency plan with each of the recipients which accounts for
217.31 absence of the recipient in a share services setting due to illness or other circumstances;

217.32 (5) obtain permission from each of the recipients who are sharing a personal care
217.33 assistant for number of shared hours for services provided inside and outside the home
217.34 residence; and

217.35 (6) document the training completed by the personal care assistants specific to the
217.36 shared setting and recipients sharing services.

218.1 Subd. 17. **Shared services; rates.** The commissioner shall establish a rate system
218.2 for shared personal care assistance services. For two persons sharing services, the rate
218.3 paid to a provider must not exceed one and one-half times the rate paid for serving a single
218.4 individual, and for three persons sharing services, the rate paid to a provider must not
218.5 exceed twice the rate paid for serving a single individual. These rates apply only when all
218.6 of the criteria for the shared care personal care assistance service have been met.

218.7 Subd. 18. **Personal care assistance choice option; generally.** (a) The
218.8 commissioner may allow a recipient of personal care assistance services to use a fiscal
218.9 intermediary to assist the recipient in paying and account for medically necessary covered
218.10 personal care assistance services. Unless otherwise provided in this section, all other
218.11 statutory and regulatory provisions relating to personal care assistance services apply to a
218.12 recipient using the personal care assistance choice option.

218.13 (b) Personal care assistance choice is an option of the personal care assistance
218.14 program that allows the recipient who receives personal care assistance services to be
218.15 responsible for the hiring, training, and termination of personal care assistants. This
218.16 program offers greater control and choice for the recipient in deciding who provides
218.17 the personal care assistance service and when the service is scheduled. The recipient or
218.18 the recipient's responsible party must choose a personal care assistance choice provider
218.19 agency as a fiscal intermediary. This personal care assistance choice provider agency
218.20 manages payroll, invoices the state, is responsible for all payroll related taxes and
218.21 insurance, and is responsible for providing the consumer training and support in managing
218.22 the recipient's personal care assistance services.

218.23 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)
218.24 Under personal care assistance choice, the recipient or responsible party shall:

218.25 (1) recruit, hire, and terminate personal care assistants and a qualified professional;

218.26 (2) develop a personal care assistance care plan based on the assessed needs
218.27 and addressing the health and safety of the recipient with the assistance of a qualified
218.28 professional as needed;

218.29 (3) orient and train the personal care assistant with assistance as needed from the
218.30 qualified professional;

218.31 (4) supervise and evaluate the personal care assistant with the qualified professional;

218.32 (5) monitor and verify in writing and report to the personal care assistance choice
218.33 agency the number of hours worked by the personal care assistant and the qualified
218.34 professional;

218.35 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
218.36 and service authorization; and

219.1 (7) use the same personal care assistance choice provider agency if shared personal
219.2 assistance care is being used.

219.3 (b) The personal care assistance choice provider agency shall:

219.4 (1) meet all personal care assistance provider agency standards;

219.5 (2) enter into a written agreement with the recipient, responsible party, and personal
219.6 care assistants;

219.7 (3) not be related as a parent, child, sibling, or spouse to the recipient, qualified
219.8 professional, or the personal care assistant; and

219.9 (4) ensure arm's-length transactions without undue influence or coercion with the
219.10 recipient and personal care assistant.

219.11 (c) The duties of the personal care assistance choice provider agency are to:

219.12 (1) be the employer of the personal care assistant and the qualified professional for
219.13 employment law and related regulations including but not limited to purchasing and
219.14 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
219.15 and liability insurance, and submit any or all necessary documentation including, but not
219.16 limited to, workers' compensation and unemployment insurance;

219.17 (2) bill the medical assistance program for personal care assistance services and
219.18 qualified professional services;

219.19 (3) request and complete background studies that comply with the requirements for
219.20 personal care assistants and qualified professionals;

219.21 (4) pay the personal care assistant and qualified professional based on actual hours
219.22 of services provided;

219.23 (5) withhold and pay all applicable federal and state taxes;

219.24 (6) verify and keep records of hours worked by the personal care assistant and
219.25 qualified professional;

219.26 (7) make the arrangements and pay taxes and other benefits, if any; and comply with
219.27 any legal requirements for a Minnesota employer;

219.28 (8) enroll in the medical assistance program as a personal care assistance choice
219.29 agency; and

219.30 (9) enter into a written agreement as specified in subdivision 20 before services
219.31 are provided.

219.32 **Subd. 20. Personal care assistance choice option; administration.** (a) Before
219.33 services commence under the personal care assistance choice option, and annually
219.34 thereafter, the personal care assistance choice provider agency, recipient, or responsible
219.35 party, each personal care assistant, and the qualified professional shall enter into a written
219.36 agreement. The agreement must include at a minimum:

- 220.1 (1) duties of the recipient, qualified professional, personal care assistant, and
220.2 personal care assistance choice provider agency;
- 220.3 (2) salary and benefits for the personal care assistant and the qualified professional;
220.4 (3) administrative fee of the personal care assistance choice provider agency and
220.5 services paid for with that fee, including background study fees;
220.6 (4) grievance procedures to respond to complaints;
220.7 (5) procedures for hiring and terminating the personal care assistant; and
220.8 (6) documentation requirements including, but not limited to, time sheets, activity
220.9 records, and the personal care assistance care plan.
- 220.10 (b) Except for the administrative fee of the personal care assistance choice provider
220.11 agency as reported on the written agreement, the remainder of the rates paid to the
220.12 personal care assistance choice provider agency must be used to pay for the salary and
220.13 benefits for the personal care assistant or the qualified professional. The personal care
220.14 assistance choice provider agency must provide a minimum of 75 percent of the revenue
220.15 generated by the medical assistance rate for personal care assistance for employee
220.16 personal care assistant wages and benefits.
- 220.17 (c) The commissioner shall deny, revoke, or suspend the authorization to use the
220.18 personal care assistance choice option if:
- 220.19 (1) it has been determined by the qualified professional or public health nurse that
220.20 the use of this option jeopardizes the recipient's health and safety;
- 220.21 (2) the parties have failed to comply with the written agreement specified in
220.22 subdivision 20;
- 220.23 (3) the use of the option has led to abusive or fraudulent billing for personal care
220.24 assistance services; or
- 220.25 (4) the department terminates the personal care assistance choice option.
- 220.26 (d) The recipient or responsible party may appeal the commissioner's decision in
220.27 paragraph (c) according to section 256.045. The denial, revocation, or suspension to
220.28 use the personal care assistance choice option must not affect the recipient's authorized
220.29 level of personal care assistance services.
- 220.30 **Subd. 21. Requirements for initial enrollment of personal care assistance**
220.31 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
220.32 time of enrollment as a personal care assistance provider agency in a format determined
220.33 by the commissioner, information and documentation that includes, but is not limited to,
220.34 the following:
- 220.35 (1) the personal care assistance provider agency's current contact information
220.36 including address, telephone number, and e-mail address;

- 221.1 (2) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
221.2 provider's payments from Medicaid in the previous year, whichever is less;
- 221.3 (3) proof of fidelity bond coverage in the amount of \$20,000;
- 221.4 (4) proof of workers' compensation insurance coverage;
- 221.5 (5) a description of the personal care assistance provider agency's organization
221.6 identifying the names of all owners, managerial officials, staff, board of directors, and the
221.7 affiliations of the directors, owners, or staff to other service providers;
- 221.8 (6) a copy of the personal care assistance provider agency's written policies and
221.9 procedures including: hiring of employees; training requirements; service delivery;
221.10 and employee and consumer safety including process for notification and resolution
221.11 of consumer grievances, identification and prevention of communicable diseases, and
221.12 employee misconduct;
- 221.13 (7) copies of all other forms the personal care assistance provider agency uses in
221.14 the course of daily business including, but not limited to:
- 221.15 (i) a copy of the personal care assistance provider agency's time sheet if the time
221.16 sheet varies from the standard time sheet for personal care assistance services approved
221.17 by the commissioner, and a letter requesting approval of the personal care assistance
221.18 provider agency's nonstandard time sheet;
- 221.19 (ii) the personal care assistance provider agency's template for the personal care
221.20 assistance care plan; and
- 221.21 (iii) the personal care assistance provider agency's template and the written
221.22 agreement in subdivision 20 for recipients using the personal care assistance choice
221.23 option, if applicable;
- 221.24 (8) a list of all trainings and classes that the personal care assistance provider agency
221.25 requires of its staff providing personal care assistance services;
- 221.26 (9) documentation that the personal care assistance provider agency and staff have
221.27 successfully completed all the training required by this section;
- 221.28 (10) disclosure of ownership, leasing, or management of all residential properties
221.29 that is used or could be used for providing home care services;
- 221.30 (11) documentation of the agency's marketing practices; and
- 221.31 (12) documentation that the agency will provide 75 percent for the personal care
221.32 assistance choice provider agency and 65 percent for regular personal care assistance
221.33 agency, or revenue generated from the medical assistance rate paid for personal care
221.34 assistance services for employee personal care assistant wages and benefits.
- 221.35 (b) Personal care assistance provider agencies shall provide the information specified
221.36 in paragraph (a) to the commissioner at the time the personal care assistance provider

222.1 agency enrolls as a vendor or upon request from the commissioner. The commissioner
222.2 shall collect the information specified in paragraph (a) from all personal care assistance
222.3 providers beginning upon enactment of this section.

222.4 (c) All personal care assistance provider agencies shall complete mandatory training
222.5 as determined by the commissioner before enrollment as a provider. Personal care
222.6 assistance provider agencies are required to send all owners employed by the agency
222.7 and all other managerial officials to the initial and subsequent trainings. Personal care
222.8 assistance provider agency billing staff shall complete training about personal care
222.9 assistance program financial management. This training is effective upon enactment of
222.10 this section. Any personal care assistance provider agency enrolled before that date shall,
222.11 if it has not already, complete the provider training within 18 months of the effective
222.12 date of this section. Any new owners, new qualified professionals, and new managerial
222.13 officials are required to complete mandatory training as a requisite of hiring.

222.14 Subd. 22. **Annual review for personal care providers.** (a) All personal care
222.15 assistance provider agencies shall resubmit, on an annual basis, the information specified
222.16 in subdivision 21, in a format determined by the commissioner, and provide a copy of the
222.17 personal care assistance provider agency's most current version of its grievance policies
222.18 and procedures along with a written record of grievances and resolutions of the grievances
222.19 that the personal care assistance provider agency has received in the previous year and any
222.20 other information requested by the commissioner.

222.21 (b) The commissioner shall send annual review notification to personal care
222.22 assistance provider agencies 30 days prior to renewal. The notification must:

222.23 (1) list the materials and information the personal care assistance provider agency is
222.24 required to submit;

222.25 (2) provide instructions on submitting information to the commissioner; and

222.26 (3) provide a due date by which the commissioner must receive the requested
222.27 information.

222.28 Personal care assistance provider agencies shall submit required documentation for
222.29 annual review within 30 days of notification from the commissioner. If no documentation
222.30 is submitted, the personal care assistance provider agency enrollment number must be
222.31 terminated or suspended.

222.32 (c) Personal care assistance provider agencies also currently licensed under
222.33 Minnesota Rules, part 4668.0012, as a class A provider or currently certified for
222.34 participation in Medicare as a home health agency under Code of Federal Regulations,
222.35 title 42, part 484, are deemed in compliance with the personal care assistance requirements
222.36 for enrollment, annual review process, and documentation.

223.1 Subd. 23. Enrollment requirements following termination. (a) A terminated
223.2 personal care assistance provider agency, including all named individuals on the current
223.3 enrollment disclosure form and known or discovered affiliates of the personal care
223.4 assistance provider agency, is not eligible to enroll as a personal care assistance provider
223.5 agency for two years following the termination.

223.6 (b) After the two-year period in paragraph (a), if the provider seeks to reenroll
223.7 as a personal care assistance provider agency, the personal care assistance provider
223.8 agency must be placed on a one-year probation period, beginning after completion of
223.9 the following:

223.10 (1) the department's provider trainings under this section; and

223.11 (2) initial enrollment requirements under subdivision 21.

223.12 (c) During the probationary period the commissioner shall complete site visits and
223.13 request submission of documentation to review compliance with program policies.

223.14 Subd. 24. Personal care assistance provider agency; general duties. A personal
223.15 care assistance provider agency shall:

223.16 (1) enroll as a Medicaid provider meeting all provider standards, including
223.17 completion of the required provider training;

223.18 (2) comply with general medical assistance coverage requirements;

223.19 (3) demonstrate compliance with law and policies of the personal care assistance
223.20 program to be determined by the commissioner;

223.21 (4) comply with background study requirements;

223.22 (5) verify and keep records of hours worked by the personal care assistant and
223.23 qualified professional;

223.24 (6) pay the personal care assistant and qualified professional based on actual hours
223.25 of services provided, and a minimum of 75 percent of the medical assistance rate paid for
223.26 personal care assistance and qualified professional services in wages and benefits to the
223.27 personal care assistant and qualified professional;

223.28 (7) withhold and pay all applicable federal and state taxes;

223.29 (8) make the arrangements and pay unemployment insurance, taxes, workers'
223.30 compensation, liability insurance, and other benefits, if any;

223.31 (9) enter into a written agreement under subdivision 21 before services are provided;

223.32 (10) report suspected neglect and abuse to the common entry point according to
223.33 section 256B.0651;

223.34 (11) provide the recipient with a copy of the home care bill of rights at start of
223.35 service; and

224.1 (12) market agency services only through printed information in brochures and on
224.2 Web sites and not engage in any direct contact or marketing in person, by telephone, or
224.3 other electronic means to potential recipients, guardians, or family members.

224.4 **Subd. 25. Personal care assistance provider agency; background studies.**

224.5 Personal care assistance provider agencies enrolled to provide personal care assistance
224.6 services under the medical assistance program shall comply with the following:

224.7 (1) owners who have a five percent interest or more and all managerial officials are
224.8 subject to a background study as provided in chapter 245C. This applies to currently
224.9 enrolled personal care assistance provider agencies and those agencies seeking enrollment
224.10 as a personal care assistance provider agency. Managerial official has the same meaning
224.11 as Code of Federal Regulations, title 42, section 455. An organization is barred from
224.12 enrollment if:

224.13 (i) the organization has not initiated background studies on owners and managerial
224.14 officials; or

224.15 (ii) the organization has initiated background studies on owners and managerial
224.16 officials, but the commissioner has sent the organization a notice that an owner or
224.17 managerial official of the organization has been disqualified under section 245C.14,
224.18 and the owner or managerial official has not received a set aside of the disqualification
224.19 under section 245C.22;

224.20 (2) a background study must be initiated and completed for all qualified
224.21 professionals; and

224.22 (3) a background study must be initiated and completed for all personal care
224.23 assistants.

224.24 **Subd. 26. Personal care assistance provider agency; communicable disease**

224.25 **prevention.** A personal care assistance provider agency shall establish and implement
224.26 policies and procedures for prevention, control, and investigation of infections and
224.27 communicable diseases according to current nationally recognized infection control
224.28 practices or guidelines established by the United States Centers for Disease Control and
224.29 Prevention, as well as applicable regulations of other federal or state agencies.

224.30 **Subd. 27. Personal care assistance provider agency; ventilator training.** The
224.31 personal care assistance provider agency is required to provide training for the personal
224.32 care assistant responsible for working with a recipient who is ventilator dependent. All
224.33 training must be administered by a respiratory therapist, nurse, or physician. Qualified
224.34 professional supervision by a nurse must be completed and documented on file in the
224.35 personal care assistant's employment record and the recipient's health record. If offering

225.1 personal care services to a ventilator-dependent recipient, the personal care assistance
225.2 provider agency shall demonstrate the ability to:

225.3 (1) train the personal care assistant;

225.4 (2) supervise the personal care assistant in ventilator operation and maintenance; and

225.5 (3) supervise the recipient and responsible party in ventilator operation and
225.6 maintenance.

225.7 **Subd. 28. Personal care assistance provider agency; required documentation.**

225.8 Required documentation must be completed and kept in the personal care assistance

225.9 provider agency file or the recipient's home residence. The required documentation

225.10 consists of:

225.11 (1) employee files, including:

225.12 (i) applications for employment;

225.13 (ii) background study requests and results;

225.14 (iii) orientation records about the agency policies;

225.15 (iv) trainings completed with demonstration of competence;

225.16 (v) supervisory visits;

225.17 (vi) evaluations of employment; and

225.18 (vii) signature on fraud statement;

225.19 (2) recipient files, including:

225.20 (i) demographics;

225.21 (ii) emergency contact information and emergency backup plan;

225.22 (iii) personal care assistance service plan;

225.23 (iv) personal care assistance care plan;

225.24 (v) month-to-month service use plan;

225.25 (vi) all communication records;

225.26 (vii) start of service information, including the written agreement with recipient; and

225.27 (viii) date the home care bill of rights was given to the recipient;

225.28 (3) agency policy manual, including:

225.29 (i) policies for employment and termination;

225.30 (ii) grievance policies with resolution of consumer grievances;

225.31 (iii) staff and consumer safety;

225.32 (iv) staff misconduct; and

225.33 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and

225.34 resolution of consumer grievances; and

225.35 (4) time sheets for each personal care assistant along with completed activity sheets

225.36 for each recipient served.

226.1 Subd. 29. **Transitional assistance.** Notwithstanding any contrary provision in
226.2 this section, the commissioner, counties, and personal care assistance providers shall
226.3 work together to provide transitional assistance for recipients and families to come into
226.4 compliance with the new live-in responsible party requirements of this section, and ensure
226.5 that personal care assistance services are not provided by the housing provider. The
226.6 commissioner and counties shall provide this assistance until July 1, 2010.

226.7 Subd. 30. **Notice of service changes to recipients.** All recipients who will be
226.8 affected by the changes in medical assistance home care services must be provided notice
226.9 of the changes at least 30 days before the effective date of the change. The notice shall
226.10 include how to get further information on the changes, how to get help to obtain other
226.11 services, if eligible, and appeal rights.

226.12 Sec. 30. Minnesota Statutes 2008, section 256B.0911, subdivision 1, is amended to
226.13 read:

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

226.25 (b) These services must be coordinated with ~~services~~ long-term care options
226.26 counseling provided under section 256.975, subdivision 7, and ~~with services provided by~~
226.27 ~~other public and private agencies in the community~~ section 256.01, subdivision 24, for
226.28 telephone assistance and follow up and to offer a variety of cost-effective alternatives
226.29 to persons with disabilities and elderly persons. The county or tribal agency providing
226.30 long-term care consultation services shall encourage the use of volunteers from families,
226.31 religious organizations, social clubs, and similar civic and service organizations to provide
226.32 community-based services.

226.33 Sec. 31. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, is amended to
226.34 read:

- 227.1 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
- 227.2 (a) "Long-term care consultation services" means:
- 227.3 ~~(1) providing information and education to the general public regarding availability~~
- 227.4 ~~of the services authorized under this section;~~
- 227.5 ~~(2) an intake process that provides access to the services described in this section;~~
- 227.6 ~~(3) assessment of the health, psychological, and social needs of referred individuals;~~
- 227.7 ~~(4) (1) assistance in identifying services needed to maintain an individual in the~~
- 227.8 ~~least restrictive most inclusive environment;~~
- 227.9 ~~(5) (2) providing recommendations on cost-effective community services that are~~
- 227.10 available to the individual;
- 227.11 ~~(6) (3) development of an individual's person-centered community support plan;~~
- 227.12 ~~(7) (4) providing information regarding eligibility for Minnesota health care~~
- 227.13 programs;
- 227.14 (5) face-to-face long-term care consultation assessments, which may be completed
- 227.15 in a hospital, nursing facility, intermediate care facility for persons with developmental
- 227.16 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
- 227.17 residence;
- 227.18 ~~(8) preadmission (6) federally mandated screening to determine the need for~~
- 227.19 ~~a nursing facility institutional level of care under section 256B.0911, subdivision 4,~~
- 227.20 ~~paragraph (a);~~
- 227.21 ~~(9) preliminary (7) determination of Minnesota health care programs home and~~
- 227.22 ~~community-based waiver service eligibility including level of care determination for~~
- 227.23 ~~individuals who need a nursing facility an institutional level of care as defined under~~
- 227.24 ~~section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan~~
- 227.25 ~~home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs~~
- 227.26 ~~(a) and (c), based on assessment and support plan development with appropriate referrals~~
- 227.27 ~~for final determination;~~
- 227.28 ~~(10) (8) providing recommendations for nursing facility placement when there are~~
- 227.29 no cost-effective community services available; and
- 227.30 ~~(11) (9) assistance to transition people back to community settings after facility~~
- 227.31 admission.
- 227.32 (b) "Long-term options counseling" means the services provided by the linkage
- 227.33 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
- 227.34 telephone assistance and follow up once a long-term care consultation assessment has
- 227.35 been completed. Long-term care options counselors shall:

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

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

228.9 (3) provide long-term care futures planning defined as providing assistance to
228.10 individuals who anticipate having long-term care needs to develop a plan for the more
228.11 distant future; and

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

228.16 ~~(b)~~ (c) "Minnesota health care programs" means the medical assistance program
228.17 under chapter 256B and the alternative care program under section 256B.0913.

228.18 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
228.19 plans administering long-term care consultation assessment and support planning services.

228.20 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (7), replacing a
228.21 reference to nursing facility level of care with institutional level of care as defined under
228.22 Minnesota Statutes, section 144.0724, subdivision 11, or 256B.092, is effective July 1,
228.23 2011.

228.24 Sec. 32. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
228.25 subdivision to read:

228.26 Subd. 2b. **Certified assessors.** (a) Beginning January 1, 2011, each lead agency
228.27 shall have certified assessors who have completed training and certification process
228.28 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
228.29 best practices in assessment and support planning including person-centered planning
228.30 principals and have a common set of skills that must ensure consistency and equitable
228.31 access to services statewide.

228.32 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
228.33 work, nursing with a public health nursing certificate, or other closely related field with at
228.34 least one year of home and community-based experience or a two-year registered nursing
228.35 degree with at least three years of home and community-based experience that have

229.1 received training and certification specific to assessment and consultation for long-term
229.2 care services in the state.

229.3 Sec. 33. Minnesota Statutes 2008, section 256B.0911, is amended by adding a
229.4 subdivision to read:

229.5 Subd. 2c. **Assessor training and certification.** The commissioner shall develop
229.6 curriculum and a certification process to begin no later than January 1, 2010. All existing
229.7 lead agency staff designated to provide the services defined in subdivision 1a must be
229.8 certified by December 30, 2010. Each lead agency is required to ensure that they have
229.9 sufficient numbers of certified assessors to provide long-term consultation assessment and
229.10 support planning within the timelines and parameters of the service by January 1, 2011.
229.11 Certified assessors are required to be recertified every three years.

229.12 Sec. 34. Minnesota Statutes 2008, section 256B.0911, subdivision 3, is amended to
229.13 read:

229.14 **Subd. 3. Long-term care consultation team.** (a) Until January 1, 2011, a long-term
229.15 care consultation team shall be established by the county board of commissioners. Each
229.16 local consultation team shall consist of at least one social worker and at least one public
229.17 health nurse from their respective county agencies. The board may designate public
229.18 health or social services as the lead agency for long-term care consultation services. If a
229.19 county does not have a public health nurse available, it may request approval from the
229.20 commissioner to assign a county registered nurse with at least one year experience in
229.21 home care to participate on the team. Two or more counties may collaborate to establish
229.22 a joint local consultation team or teams.

229.23 (b) The team is responsible for providing long-term care consultation services to
229.24 all persons located in the county who request the services, regardless of eligibility for
229.25 Minnesota health care programs.

229.26 (c) The commissioner shall allow arrangements and make recommendations that
229.27 encourage counties to collaborate to establish joint local long-term care consultation
229.28 teams to ensure that long-term care consultations are done within the timelines and
229.29 parameters of the service. This includes integrated service models as required in section
229.30 256B.0911, subdivision 1, paragraph (b).

229.31 Sec. 35. Minnesota Statutes 2008, section 256B.0911, subdivision 3a, is amended to
229.32 read:

230.1 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
230.2 services planning, or other assistance intended to support community-based living,
230.3 including persons who need assessment in order to determine personal care assistance
230.4 services, private duty nursing services, home health agency services, waiver or alternative
230.5 care program eligibility, must be visited by a long-term care consultation team on or after
230.6 January 1, 2011, a certified assessor within ~~ten working~~ 15 calendar days after the date on
230.7 which an assessment was requested or recommended. Face-to-face assessments must be
230.8 conducted according to paragraphs (b) to ~~(i)~~ (k).

230.9 (b) The county may utilize a team of either the social worker or public health nurse,
230.10 or both, after January 1, 2011, lead agencies shall use a certified assessor to conduct the
230.11 assessment in a face-to-face interview. The consultation team members must confer
230.12 regarding the most appropriate care for each individual screened or assessed.

230.13 (c) ~~The long-term care consultation team must assess the health and social needs of~~
230.14 ~~the person~~ assessment must be comprehensive and include a person-centered assessment
230.15 of the health, psychological, functional, environmental, and social needs of referred
230.16 individuals and provide information necessary to develop a support plan that meets the
230.17 consumers needs, using an assessment form provided by the commissioner.

230.18 (d) ~~The team must conduct the~~ assessment must be conducted in a face-to-face
230.19 interview with the person being assessed and the person's legal representative, ~~if applicable~~
230.20 as required by legally executed documents, and other individuals as requested by the
230.21 person, who can provide information on the needs, strengths, and preferences of the
230.22 person necessary to develop a support plan that ensures the person's health and safety, but
230.23 who is not a provider of service or has any financial interest in the provision of services.

230.24 (e) ~~The team must provide the~~ person, or the person's legal representative, must
230.25 be provided with written recommendations for ~~facility- or~~ community-based services:
230.26 ~~The team must document~~ or institutional care that include documentation that the most
230.27 cost-effective alternatives available were offered to the individual. For purposes of
230.28 this requirement, "cost-effective alternatives" means community services and living
230.29 arrangements that cost the same as or less than ~~nursing facility~~ institutional care.

230.30 (f) If the person chooses to use community-based services, ~~the team must provide~~
230.31 ~~the person or the person's legal representative~~ must be provided with a written community
230.32 support plan, regardless of whether the individual is eligible for Minnesota health care
230.33 programs. ~~The~~ A person may request assistance in ~~developing a community support plan~~
230.34 identifying community supports without participating in a complete assessment. Upon
230.35 a request for assistance identifying community support, the person must be transferred

231.1 or referred to the services available under sections 256.975, subdivision 7, and 256.01,
231.2 subdivision 24, for telephone assistance and follow up.

231.3 (g) The person has the right to make the final decision between ~~nursing~~
231.4 ~~facility~~ institutional placement and community placement after the ~~screening team's~~
231.5 ~~recommendation~~ recommendations have been provided, except as provided in subdivision
231.6 4a, paragraph (c).

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

231.10 (1) the need for and purpose of preadmission screening if the person selects nursing
231.11 facility placement;

231.12 (2) the role of the long-term care consultation assessment and support planning in
231.13 waiver and alternative care program eligibility determination;

231.14 (3) information about Minnesota health care programs;

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

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

231.18 (6) the long-term care consultant's decision regarding the person's need for ~~nursing~~
231.19 ~~facility~~ institutional level of care as determined under criteria established in section
231.20 144.0724, subdivision 11, or 256B.092; and

231.21 (7) the person's right to appeal the decision regarding the need for nursing facility
231.22 level of care or the county's final decisions regarding public programs eligibility according
231.23 to section 256.045, subdivision 3.

231.24 (i) Face-to-face assessment completed as part of eligibility determination for
231.25 the alternative care, elderly waiver, community alternatives for disabled individuals,
231.26 community alternative care, and traumatic brain injury waiver programs under sections
231.27 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
231.28 than 60 calendar days after the date of assessment. The effective eligibility start date
231.29 for these programs can never be prior to the date of assessment. If an assessment was
231.30 completed more than 60 days before the effective waiver or alternative care program
231.31 eligibility start date, assessment and support plan information must be updated in a
231.32 face-to-face visit and documented in the department's Medicaid Management Information
231.33 System (MMIS). The effective date of program eligibility in this case cannot be prior to
231.34 the date the updated assessment is completed.

231.35 **EFFECTIVE DATE.** The amendment to paragraph (h), clause (6), is effective
231.36 July 1, 2011.

232.1 Sec. 36. Minnesota Statutes 2008, section 256B.0911, subdivision 4a, is amended to
232.2 read:

232.3 Subd. 4a. **Preadmission screening activities related to nursing facility**

232.4 **admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified
232.5 boarding care facilities, must be screened prior to admission regardless of income, assets,
232.6 or funding sources for nursing facility care, except as described in subdivision 4b. The
232.7 purpose of the screening is to determine the need for nursing facility level of care as
232.8 described in paragraph (d) and to complete activities required under federal law related to
232.9 mental illness and developmental disability as outlined in paragraph (b).

232.10 (b) A person who has a diagnosis or possible diagnosis of mental illness or
232.11 developmental disability must receive a preadmission screening before admission
232.12 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need
232.13 for further evaluation and specialized services, unless the admission prior to screening is
232.14 authorized by the local mental health authority or the local developmental disabilities case
232.15 manager, or unless authorized by the county agency according to Public Law 101-508.

232.16 The following criteria apply to the preadmission screening:

232.17 (1) the county must use forms and criteria developed by the commissioner to identify
232.18 persons who require referral for further evaluation and determination of the need for
232.19 specialized services; and

232.20 (2) the evaluation and determination of the need for specialized services must be
232.21 done by:

232.22 (i) a qualified independent mental health professional, for persons with a primary or
232.23 secondary diagnosis of a serious mental illness; or

232.24 (ii) a qualified developmental disability professional, for persons with a primary or
232.25 secondary diagnosis of developmental disability. For purposes of this requirement, a
232.26 qualified developmental disability professional must meet the standards for a qualified
232.27 developmental disability professional under Code of Federal Regulations, title 42, section
232.28 483.430.

232.29 (c) The local county mental health authority or the state developmental disability
232.30 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
232.31 nursing facility if the individual does not meet the nursing facility level of care criteria or
232.32 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
232.33 purposes of this section, "specialized services" for a person with developmental disability
232.34 means active treatment as that term is defined under Code of Federal Regulations, title
232.35 42, section 483.440 (a)(1).

233.1 (d) The determination of the need for nursing facility level of care must be made
233.2 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
233.3 using forms developed by the commissioner. In assessing a person's needs, consultation
233.4 team members shall have a physician available for consultation and shall consider the
233.5 assessment of the individual's attending physician, if any. The individual's physician must
233.6 be included if the physician chooses to participate. Other personnel may be included on
233.7 the team as deemed appropriate by the county.

233.8 **EFFECTIVE DATE.** The section is effective July 1, 2011.

233.9 Sec. 37. Minnesota Statutes 2008, section 256B.0911, subdivision 5, is amended to
233.10 read:

233.11 Subd. 5. **Administrative activity.** The commissioner shall minimize the number
233.12 of ~~forms required in the provision of long-term care consultation services and shall~~
233.13 ~~limit the screening document to items necessary for community support plan approval,~~
233.14 ~~reimbursement, program planning, evaluation, and policy development~~ business processes
233.15 required to provide the services in this section and shall implement integrated solutions
233.16 to automate the business processes to the extent necessary for community support plan
233.17 approval, reimbursement, program planning, evaluation, and policy development.

233.18 Sec. 38. Minnesota Statutes 2008, section 256B.0911, subdivision 6, is amended to
233.19 read:

233.20 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
233.21 for each county must be paid monthly by certified nursing facilities in the county. The
233.22 monthly amount to be paid by each nursing facility for each fiscal year must be determined
233.23 by dividing the county's annual allocation for long-term care consultation services by 12
233.24 to determine the monthly payment and allocating the monthly payment to each nursing
233.25 facility based on the number of licensed beds in the nursing facility. Payments to counties
233.26 in which there is no certified nursing facility must be made by increasing the payment
233.27 rate of the two facilities located nearest to the county seat.

233.28 (b) The commissioner shall include the total annual payment determined under
233.29 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
233.30 according to section 256B.431, subdivision 2b, paragraph (g).

233.31 (c) In the event of the layaway, delicensure and decertification, or removal from
233.32 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
233.33 the per diem payment amount in paragraph (b) and may adjust the monthly payment
233.34 amount in paragraph (a). The effective date of an adjustment made under this paragraph

234.1 shall be on or after the first day of the month following the effective date of the layaway,
234.2 delicensure and decertification, or removal from layaway.

234.3 (d) Payments for long-term care consultation services are available to the county
234.4 or counties to cover staff salaries and expenses to provide the services described in
234.5 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
234.6 the limits of available funding, sufficient personnel to provide long-term care consultation
234.7 services while meeting the state's long-term care outcomes and objectives as defined in
234.8 section 256B.0917, subdivision 1. The county shall be accountable for meeting local
234.9 objectives as approved by the commissioner in the biennial home and community-based
234.10 services quality assurance plan on a form provided by the commissioner.

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

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

234.15 (g) The county may bill, as case management services, assessments, support
234.16 planning, and follow-along provided to persons determined to be eligible for case
234.17 management under Minnesota health care programs. No individual or family member
234.18 shall be charged for an initial assessment or initial support plan development provided
234.19 under subdivision 3a or 3b.

234.20 (h) The commissioner shall develop an alternative payment methodology for
234.21 long-term care consultation services that includes the funding available under this
234.22 subdivision, and sections 256B.092 and 256B.0659. In developing the new payment
234.23 methodology, the commissioner shall consider the maximization of federal funding for
234.24 this activity.

234.25 Sec. 39. Minnesota Statutes 2008, section 256B.0911, subdivision 7, is amended to
234.26 read:

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

235.1 recipient with developmental disability is approved by the state developmental disability
235.2 authority.

235.3 (b) The nursing facility must not bill a person who is not a medical assistance
235.4 recipient for resident days that preceded the date of completion of screening activities as
235.5 required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed
235.6 resident days in the nursing facility resident day totals reported to the commissioner.

235.7 **EFFECTIVE DATE.** The section is effective July 1, 2011.

235.8 Sec. 40. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to
235.9 read:

235.10 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

235.11 (a) Funding for services under the alternative care program is available to persons who
235.12 meet the following criteria:

235.13 (1) the person has been determined by a community assessment under section
235.14 256B.0911 to be a person who would require the level of care provided in a nursing
235.15 facility according to the criteria established in section 144.0724, subdivision 11, but for
235.16 the provision of services under the alternative care program;

235.17 (2) the person is age 65 or older;

235.18 (3) the person would be eligible for medical assistance within 135 days of admission
235.19 to a nursing facility;

235.20 (4) the person is not ineligible for the payment of long-term care services by the
235.21 medical assistance program due to an asset transfer penalty under section 256B.0595 or
235.22 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

235.23 (5) the person needs long-term care services that are not funded through other state
235.24 or federal funding;

235.25 (6) the monthly cost of the alternative care services funded by the program for
235.26 this person does not exceed 75 percent of the monthly limit described under section
235.27 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care
235.28 client from payment for additional services, but in no case may the cost of additional
235.29 services purchased under this section exceed the difference between the client's monthly
235.30 service limit defined under section 256B.0915, subdivision 3, and the alternative care
235.31 program monthly service limit defined in this paragraph. If care-related supplies and
235.32 equipment or environmental modifications and adaptations are or will be purchased for
235.33 an alternative care services recipient, the costs may be prorated on a monthly basis for
235.34 up to 12 consecutive months beginning with the month of purchase. If the monthly cost
235.35 of a recipient's other alternative care services exceeds the monthly limit established in

236.1 this paragraph, the annual cost of the alternative care services shall be determined. In this
236.2 event, the annual cost of alternative care services shall not exceed 12 times the monthly
236.3 limit described in this paragraph; and

236.4 (7) the person is making timely payments of the assessed monthly fee.

236.5 A person is ineligible if payment of the fee is over 60 days past due, unless the person
236.6 agrees to:

236.7 (i) the appointment of a representative payee;

236.8 (ii) automatic payment from a financial account;

236.9 (iii) the establishment of greater family involvement in the financial management of
236.10 payments; or

236.11 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

236.12 The lead agency may extend the client's eligibility as necessary while making
236.13 arrangements to facilitate payment of past-due amounts and future premium payments.

236.14 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
236.15 reinstated for a period of 30 days.

236.16 (b) Alternative care funding under this subdivision is not available for a person
236.17 who is a medical assistance recipient or who would be eligible for medical assistance
236.18 without a spenddown or waiver obligation. A person whose initial application for medical
236.19 assistance and the elderly waiver program is being processed may be served under the
236.20 alternative care program for a period up to 60 days. If the individual is found to be eligible
236.21 for medical assistance, medical assistance must be billed for services payable under the
236.22 federally approved elderly waiver plan and delivered from the date the individual was
236.23 found eligible for the federally approved elderly waiver plan. Notwithstanding this
236.24 provision, alternative care funds may not be used to pay for any service the cost of which:
236.25 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
236.26 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
236.27 to participate in the federally approved elderly waiver program under the special income
236.28 standard provision.

236.29 (c) Alternative care funding is not available for a person who resides in a licensed
236.30 nursing home, certified boarding care home, hospital, or intermediate care facility, except
236.31 for case management services which are provided in support of the discharge planning
236.32 process for a nursing home resident or certified boarding care home resident to assist with
236.33 a relocation process to a community-based setting.

236.34 (d) Alternative care funding is not available for a person whose income is greater
236.35 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal
236.36 to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal

237.1 year for which alternative care eligibility is determined, who would be eligible for the
237.2 elderly waiver with a waiver obligation.

237.3 **EFFECTIVE DATE.** The section is effective July 1, 2011.

237.4 Sec. 41. Minnesota Statutes 2008, section 256B.0915, subdivision 3e, is amended to
237.5 read:

237.6 Subd. 3e. **Customized living service rate.** (a) Payment for customized living
237.7 services shall be a monthly rate ~~negotiated and~~ authorized by the lead agency within the
237.8 parameters established by the commissioner. The payment agreement must delineate the
237.9 ~~services that have been customized for each recipient and specify the amount of each~~
237.10 component service included in the recipient's customized living service to be provided
237.11 plan. The lead agency shall ensure that there is a documented need ~~for all~~ within the
237.12 parameters established by the commissioner for all component customized living services
237.13 authorized. ~~Customized living services must not include rent or raw food costs.~~

237.14 (b) The negotiated payment rate must be based on the amount of component services
237.15 to be provided utilizing component rates established by the commissioner. Counties and
237.16 tribes shall use tools issued by the commissioner to develop and document customized
237.17 living service plans and rates.

237.18 ~~Negotiated~~ (c) Component service rates must not exceed payment rates for
237.19 comparable elderly waiver or medical assistance services and must reflect economies of
237.20 scale. ~~Customized living services must not include rent or raw food costs.~~

237.21 ~~(b)~~ (d) The individualized monthly negotiated authorized payment for the
237.22 customized living services service plan shall not exceed the nonfederal share, in effect
237.23 on July 1 of the state fiscal year for which the rate limit is being calculated; 50 percent
237.24 of the greater of either the statewide or any of the geographic groups' weighted average
237.25 monthly nursing facility rate of the case mix resident class to which the elderly waiver
237.26 eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
237.27 less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until
237.28 the July 1 of the state fiscal year in which the resident assessment system as described
237.29 in section 256B.438 for nursing home rate determination is implemented. Effective on
237.30 July 1 of the state fiscal year in which the resident assessment system as described in
237.31 section 256B.438 for nursing home rate determination is implemented and July 1 of each
237.32 subsequent state fiscal year, the individualized monthly negotiated authorized payment
237.33 for the services described in this clause shall not exceed the limit described in this clause
237.34 which was in effect on June 30 of the previous state fiscal year and which has been
237.35 adjusted by the greater of any legislatively adopted home and community-based services

238.1 ~~cost-of-living percentage increase or any legislatively adopted statewide percent rate~~
238.2 ~~increase for nursing facilities~~ updated annually based on legislatively adopted changes to
238.3 all service rate maximums for home and community-based service providers.

238.4 ~~(e)~~ (e) Customized living services are delivered by a provider licensed by the
238.5 Department of Health as a class A or class F home care provider and provided in a
238.6 building that is registered as a housing with services establishment under chapter 144D.

238.7 Sec. 42. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to
238.8 read:

238.9 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The
238.10 payment rates for 24-hour customized living services ~~is~~ are a monthly rate ~~negotiated and~~
238.11 authorized by the lead agency within the parameters established by the commissioner
238.12 of human services. The payment agreement must delineate the ~~services that have been~~
238.13 ~~customized for each recipient and specify the~~ amount of each component service included
238.14 in each recipient's customized living service to be provided plan. The lead agency
238.15 shall ensure that there is a documented need within the parameters established by the
238.16 commissioner for all component customized living services authorized. The lead agency
238.17 shall not authorize 24-hour customized living services unless there is a documented need
238.18 for 24-hour supervision.

238.19 (b) For purposes of this section, "24-hour supervision" means that the recipient
238.20 requires assistance due to needs related to one or more of the following:

238.21 (1) intermittent assistance with toileting or transferring;

238.22 (2) cognitive or behavioral issues;

238.23 (3) a medical condition that requires clinical monitoring; or

238.24 (4) other conditions or needs as defined by the commissioner of human services.

238.25 The lead agency shall ensure that the frequency and mode of supervision of the recipient
238.26 and the qualifications of staff providing supervision are described and meet the needs of
238.27 the recipient. ~~Customized living services must not include rent or raw food costs.~~

238.28 (c) The ~~negotiated~~ payment rate for 24-hour customized living services must be
238.29 based on the amount of component services to be provided utilizing component rates
238.30 established by the commissioner. Counties and tribes will use tools issued by the
238.31 commissioner to develop and document customized living plans and authorize rates.

238.32 ~~Negotiated~~ (d) Component service rates must not exceed payment rates for
238.33 comparable elderly waiver or medical assistance services and must reflect economies
238.34 of scale.

239.1 (e) The individually ~~negotiated~~ authorized 24-hour customized living payments,
239.2 in combination with the payment for other elderly waiver services, including case
239.3 management, must not exceed the recipient's community budget cap specified in
239.4 subdivision 3a. Customized living services must not include rent or raw food costs.

239.5 (f) The individually authorized 24-hour customized living payment rates shall not
239.6 exceed the 95 percentile of statewide monthly authorizations for 24-hour customized
239.7 living services in effect and in the Medicaid management information systems on March
239.8 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050
239.9 to 9549.0059, to which elderly waiver service clients are assigned. When there are
239.10 fewer than 50 authorizations in effect in the case mix resident class, the commissioner
239.11 shall multiply the calculated service payment rate maximum for the A classification by
239.12 the standard weight for that classification under Minnesota Rules, parts 9549.0050 to
239.13 9549.0059, to determine the applicable payment rate maximum. Service payment rate
239.14 maximums shall be updated annually based on legislatively adopted changes to all service
239.15 rates for home and community-based service providers.

239.16 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner
239.17 may establish an alternative payment rate system for 24-hour customized living services
239.18 by applying a single hourly rate for direct services provided in establishments, which
239.19 meet the following criteria:

239.20 (1) 24-hour customized living services must be provided in a shared living unit; and
239.21 (2) the unit is licensed as an adult foster care for no more than five residents or
239.22 licensed as a board and lodge facility with no more than ten residents.

239.23 Sec. 43. Minnesota Statutes 2008, section 256B.0915, subdivision 5, is amended to
239.24 read:

239.25 **Subd. 5. Assessments and reassessments for waiver clients.** (a) Each client
239.26 shall receive an initial assessment of strengths, informal supports, and need for services
239.27 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
239.28 client served under the elderly waiver must be conducted at least every 12 months and at
239.29 other times when the case manager determines that there has been significant change in
239.30 the client's functioning. This may include instances where the client is discharged from
239.31 the hospital. There must be a determination that the client requires nursing facility level of
239.32 care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments
239.33 to initiate and maintain participation in the waiver program.

239.34 (b) Regardless of other assessments identified in section 144.0724, subdivision
239.35 4, as appropriate to determine nursing facility level of care for purposes of medical

240.1 assistance payment for nursing facility services, only face-to-face assessments conducted
240.2 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
240.3 level of care determination will be accepted for purposes of initial and ongoing access to
240.4 waiver service payment.

240.5 **EFFECTIVE DATE.** The section is effective July 1, 2011.

240.6 Sec. 44. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
240.7 subdivision to read:

240.8 **Subd. 10. Waiver payment rates; managed care organizations.** The
240.9 commissioner shall adjust the elderly waiver capitation payment rates for managed care
240.10 organizations paid under section 256B.69, subdivisions 6a and 23, to reflect the maximum
240.11 service rate limits for customized living services and 24-hour customized living services
240.12 under subdivisions 3e and 3h for the contract period beginning January 1, 2010. Medical
240.13 assistance rates paid to customized living providers by managed care organizations
240.14 under this section shall not exceed the maximum service rate limits determined by the
240.15 commissioner under subdivisions 3e and 3h.

240.16 Sec. 45. Minnesota Statutes 2008, section 256B.0917, is amended by adding a
240.17 subdivision to read:

240.18 **Subd. 14. Essential community supports grants.** (a) The purpose of the essential
240.19 community supports grant program is to provide targeted services to persons 65 years and
240.20 older who need essential community support, but whose needs do not meet the level of
240.21 care required for nursing facility placement under section 144.0724, subdivision 11.

240.22 (b) Within the limits of the appropriation and not to exceed \$400 per person per
240.23 month, funding must be available to a person who:

240.24 (1) is age 65 or older;

240.25 (2) is not eligible for medical assistance;

240.26 (3) would otherwise be financially eligible for the alternative care program under
240.27 section 256B.0913, subdivision 4;

240.28 (4) has received a community assessment under section 256B.0911, subdivision 3a
240.29 or 3b, and does not require the level of care provided in a nursing facility;

240.30 (5) has a community support plan; and

240.31 (6) has been determined by a community assessment under section 256B.0911,
240.32 subdivision 3a or 3b, to be a person who would require provision of at least one of the
240.33 following services, as defined in the approved elderly waiver plan, in order to maintain
240.34 their community residence:

241.1 (i) caregiver support;

241.2 (ii) homemaker;

241.3 (iii) chore; or

241.4 (iv) a personal emergency response device or system.

241.5 (c) The person receiving any of the essential community supports in this subdivision
241.6 must also receive service coordination as part of their community support plan.

241.7 (d) A person who has been determined to be eligible for an essential community
241.8 support grant must be reassessed at least annually and continue to meet the criteria in
241.9 paragraph (b) to remain eligible for an essential community support grant.

241.10 (e) The commissioner shall allocate grants to counties and tribes under contract with
241.11 the department based upon the historic use of the medical assistance elderly waiver and
241.12 alternative care grant programs and other criteria as determined by the commissioner.

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

241.14 Sec. 46. Minnesota Statutes 2008, section 256B.092, subdivision 8a, is amended to
241.15 read:

241.16 Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes
241.17 to place a person in another county for services, the county of financial responsibility shall
241.18 seek concurrence from the proposed county of service and the placement shall be made
241.19 cooperatively between the two counties. Arrangements shall be made between the two
241.20 counties for ongoing social service, including annual reviews of the person's individual
241.21 service plan. The county where services are provided may not make changes in the
241.22 person's service plan without approval by the county of financial responsibility.

241.23 (b) When a person has been screened and authorized for services in an intermediate
241.24 care facility for persons with developmental disabilities or for home and community-based
241.25 services for persons with developmental disabilities, the case manager shall assist that
241.26 person in identifying a service provider who is able to meet the needs of the person
241.27 according to the person's individual service plan. If the identified service is to be provided
241.28 in a county other than the county of financial responsibility, the county of financial
241.29 responsibility shall request concurrence of the county where the person is requesting to
241.30 receive the identified services. The county of service may refuse to concur if:

241.31 (1) it can demonstrate that the provider is unable to provide the services identified in
241.32 the person's individual service plan as services that are needed and are to be provided; or

241.33 (2) in the case of an intermediate care facility for persons with developmental
241.34 disabilities, there has been no authorization for admission by the admission review team
241.35 as required in section 256B.0926; ~~or.~~

242.1 ~~(3) in the case of home and community-based services for persons with~~
242.2 ~~developmental disabilities, the county of service can demonstrate that the prospective~~
242.3 ~~provider has failed to substantially comply with the terms of a past contract or has had a~~
242.4 ~~prior contract terminated within the last 12 months for failure to provide adequate services;~~
242.5 ~~or has received a notice of intent to terminate the contract.~~

242.6 (c) The county of service shall notify the county of financial responsibility of
242.7 concurrence or refusal to concur no later than 20 working days following receipt of the
242.8 written request. Unless other mutually acceptable arrangements are made by the involved
242.9 county agencies, the county of financial responsibility is responsible for costs of social
242.10 services and the costs associated with the development and maintenance of the placement.
242.11 The county of service may request that the county of financial responsibility purchase
242.12 case management services from the county of service or from a contracted provider
242.13 of case management when the county of financial responsibility is not providing case
242.14 management as defined in this section and rules adopted under this section, unless other
242.15 mutually acceptable arrangements are made by the involved county agencies. Standards
242.16 for payment limits under this section may be established by the commissioner. Financial
242.17 disputes between counties shall be resolved as provided in section 256G.09.

242.18 Sec. 47. Minnesota Statutes 2008, section 256B.092, is amended by adding a
242.19 subdivision to read:

242.20 Subd. 11. Residential support services. (a) Upon federal approval, there is
242.21 established a new service called residential support that is available on the CAC, CADI,
242.22 DD, and TBI waivers. Existing waiver service descriptions must be modified to the extent
242.23 necessary to ensure there is no duplication between other services. Residential support
242.24 services must be provided by vendors licensed under category community residential
242.25 setting as defined in section 245A.11, subdivision 8.

242.26 (b) Residential support services must meet the following criteria:

242.27 (1) providers of residential support services must own or control the residential site;

242.28 (2) the residential site must not be the primary residence of the license holder;

242.29 (3) the residential site must have a designated program supervisor responsible for
242.30 program oversight, development, and implementation of policies and procedures;

242.31 (4) the provider of residential support services must provide supervision, training,
242.32 and assistance as described in the person's community support plan; and

242.33 (5) the provider of residential support services must meet the requirements of
242.34 licensure and additional requirements of the person's community support plan.

243.1 (c) Providers of residential support services that meet the definition in paragraph (a)
243.2 must be registered using a process determined by the commissioner beginning July 1, 2009.

243.3 Sec. 48. Minnesota Statutes 2008, section 256B.092, is amended by adding a
243.4 subdivision to read:

243.5 Subd. 12. **Waivered services waiting list.** (a) The commissioner shall establish
243.6 statewide priorities for individuals on the waiting list for developmental disabilities (DD)
243.7 waiver services, as of January 1, 2010. The statewide priorities must include, but are not
243.8 limited to, individuals who continue to have a need for waiver services after they have
243.9 maximized the use of state plan services and other funding resources, including natural
243.10 supports, prior to accessing waiver services, and who meet at least one of the following
243.11 criteria:

243.12 (1) have unstable living situations due to the age, incapacity, or sudden loss of
243.13 the primary caregivers;

243.14 (2) are moving from an institution due to bed closures;

243.15 (3) experience a sudden closure of their current living arrangement;

243.16 (4) require protection from confirmed abuse, neglect, or exploitation;

243.17 (5) experience a sudden change in need that can no longer be met through state plan
243.18 services or other funding resources alone; or

243.19 (6) meet other priorities established by the department.

243.20 (b) When allocating resources to lead agencies, the commissioner shall take into
243.21 consideration the number of individuals waiting who meet statewide priorities.

243.22 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
243.23 provide recommendations to the legislature on whether to continue the use of statewide
243.24 priorities by January 1, 2012.

243.25 Sec. 49. Minnesota Statutes 2008, section 256B.437, subdivision 6, is amended to read:

243.26 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
243.27 services shall calculate the amount of the planned closure rate adjustment available under
243.28 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

243.29 (1) the amount available is the net reduction of nursing facility beds multiplied
243.30 by \$2,080;

243.31 (2) the total number of beds in the nursing facility or facilities receiving the planned
243.32 closure rate adjustment must be identified;

243.33 (3) capacity days are determined by multiplying the number determined under
243.34 clause (2) by 365; and

244.1 (4) the planned closure rate adjustment is the amount available in clause (1), divided
244.2 by capacity days determined under clause (3).

244.3 (b) A planned closure rate adjustment under this section is effective on the first day
244.4 of the month following completion of closure of the facility designated for closure in the
244.5 application and becomes part of the nursing facility's total operating payment rate.

244.6 (c) Applicants may use the planned closure rate adjustment to allow for a property
244.7 payment for a new nursing facility or an addition to an existing nursing facility or as an
244.8 operating payment rate adjustment. Applications approved under this subdivision are
244.9 exempt from other requirements for moratorium exceptions under section 144A.073,
244.10 subdivisions 2 and 3.

244.11 (d) Upon the request of a closing facility, the commissioner must allow the facility a
244.12 closure rate adjustment as provided under section 144A.161, subdivision 10.

244.13 (e) A facility that has received a planned closure rate adjustment may reassign it
244.14 to another facility that is under the same ownership at any time within three years of its
244.15 effective date. The amount of the adjustment shall be computed according to paragraph (a).

244.16 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
244.17 the commissioner shall recalculate planned closure rate adjustments for facilities that
244.18 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
244.19 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
244.20 from the date the per bed dollar amount is increased.

244.21 (g) For planned closures approved after June 30, 2009, the commissioner of human
244.22 services shall calculate the amount of the planned closure rate adjustment available under
244.23 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

244.24 Sec. 50. Minnesota Statutes 2008, section 256B.441, is amended by adding a
244.25 subdivision to read:

244.26 Subd. 24a. **Medicare costs.** For purposes of computing rates under this section for
244.27 rate years beginning on or after October 1, 2009, "Medicare costs" means 70.4 percent of
244.28 Medicare Part A and Part B revenues received during the reporting year.

244.29 Sec. 51. Minnesota Statutes 2008, section 256B.441, subdivision 48, is amended to
244.30 read:

244.31 **Subd. 48. Calculation of operating per diems.** The direct care per diem for
244.32 each facility shall be the facility's direct care costs divided by its standardized days.
244.33 The other care-related per diem shall be the sum of the facility's activities costs, other
244.34 direct care costs, raw food costs, therapy costs, and social services costs, divided by the

245.1 facility's resident days. The other operating per diem shall be the sum of the facility's
245.2 administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance
245.3 and plant operations costs divided by the facility's resident days. For rate years beginning
245.4 on or after October 1, 2009, the calculations of the direct care per diem, other care-related
245.5 per diem, and other operating per diem shall:

245.6 (1) have allowable costs reduced by Medicare costs as defined in subdivision 24a.
245.7 The Medicare costs must be allocated between direct care, other care-related, and other
245.8 operating based on a ratio of allowable expenses from the cost report; and

245.9 (2) have resident days and standardized days computed without using days paid
245.10 by Medicare.

245.11 Sec. 52. Minnesota Statutes 2008, section 256B.441, subdivision 55, is amended to
245.12 read:

245.13 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
245.14 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
245.15 under this section shall be phased in by blending the operating rate with the operating
245.16 payment rate determined under section 256B.434. For purposes of this subdivision, the
245.17 rate to be used that is determined under section 256B.434 shall not include the portion of
245.18 the operating payment rate related to performance-based incentive payments under section
245.19 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the
245.20 operating payment rate for each facility shall be 13 percent of the operating payment rate
245.21 from this section, and 87 percent of the operating payment rate from section 256B.434.
245.22 For the rate ~~year~~ period beginning October 1, 2009, through September 30, 2013, the
245.23 operating payment rate for each facility shall be 14 percent of the operating payment rate
245.24 from this section, and 86 percent of the operating payment rate from section 256B.434.
245.25 ~~For the rate year beginning October 1, 2010, the operating payment rate for each facility~~
245.26 ~~shall be 14 percent of the operating payment rate from this section, and 86 percent of the~~
245.27 ~~operating payment rate from section 256B.434. For the rate year beginning October 1,~~
245.28 ~~2011, the operating payment rate for each facility shall be 31 percent of the operating~~
245.29 ~~payment rate from this section, and 69 percent of the operating payment rate from section~~
245.30 ~~256B.434. For the rate year beginning October 1, 2012, the operating payment rate for~~
245.31 ~~each facility shall be 48 percent of the operating payment rate from this section, and 52~~
245.32 ~~percent of the operating payment rate from section 256B.434. For the rate year beginning~~
245.33 October 1, 2013, the operating payment rate for each facility shall be 65 percent of the
245.34 operating payment rate from this section, and 35 percent of the operating payment rate
245.35 from section 256B.434. For the rate year beginning October 1, 2014, the operating

246.1 payment rate for each facility shall be 82 percent of the operating payment rate from this
246.2 section, and 18 percent of the operating payment rate from section 256B.434. For the rate
246.3 year beginning October 1, 2015, the operating payment rate for each facility shall be the
246.4 operating payment rate determined under this section. The blending of operating payment
246.5 rates under this section shall be performed separately for each RUG's class.

246.6 (b) For the rate year beginning October 1, 2008, the commissioner shall apply limits
246.7 to the operating payment rate increases under paragraph (a) by creating a minimum
246.8 percentage increase and a maximum percentage increase.

246.9 (1) Each nursing facility that receives a blended October 1, 2008, operating payment
246.10 rate increase under paragraph (a) of less than one percent, when compared to its operating
246.11 payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00,
246.12 shall receive a rate adjustment of one percent.

246.13 (2) The commissioner shall determine a maximum percentage increase that will
246.14 result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing
246.15 facilities with a blended October 1, 2008, operating payment rate increase under paragraph
246.16 (a) greater than the maximum percentage increase determined by the commissioner, when
246.17 compared to its operating payment rate on September 30, 2008, computed using rates with
246.18 a RUG's weight of 1.00, shall receive the maximum percentage increase.

246.19 (3) Nursing facilities with a blended October 1, 2008, operating payment rate
246.20 increase under paragraph (a) greater than one percent and less than the maximum
246.21 percentage increase determined by the commissioner, when compared to its operating
246.22 payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00,
246.23 shall receive the blended October 1, 2008, operating payment rate increase determined
246.24 under paragraph (a).

246.25 (4) The October 1, 2009, through October 1, 2015, operating payment rate for
246.26 facilities receiving the maximum percentage increase determined in clause (2) shall be
246.27 the amount determined under paragraph (a) less the difference between the amount
246.28 determined under paragraph (a) for October 1, 2008, and the amount allowed under clause
246.29 (2). This rate restriction does not apply to rate increases provided in any other section.

246.30 (c) A portion of the funds received under this subdivision that are in excess of
246.31 operating payment rates that a facility would have received under section 256B.434, as
246.32 determined in accordance with clauses (1) to (3), shall be subject to the requirements in
246.33 section 256B.434, subdivision 19, paragraphs (b) to (h).

246.34 (1) Determine the amount of additional funding available to a facility, which shall be
246.35 equal to total medical assistance resident days from the most recent reporting year times

247.1 the difference between the blended rate determined in paragraph (a) for the rate year being
247.2 computed and the blended rate for the prior year.

247.3 (2) Determine the portion of all operating costs, for the most recent reporting year,
247.4 that are compensation related. If this value exceeds 75 percent, use 75 percent.

247.5 (3) Subtract the amount determined in clause (2) from 75 percent.

247.6 (4) The portion of the fund received under this subdivision that shall be subject to
247.7 the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal
247.8 the amount determined in clause (1) times the amount determined in clause (3).

247.9 Sec. 53. Minnesota Statutes 2008, section 256B.441, is amended by adding a
247.10 subdivision to read:

247.11 Subd. 59. **Single-bed payments for medical assistance recipients.**

247.12 Notwithstanding Minnesota Rules, part 9549.0070, subpart 3, beginning on October 1,
247.13 2009, the commissioner shall allow a single-bed payment rate for any medical assistance
247.14 recipient residing in a single-bed room regardless of having physician's orders for a
247.15 single-bed room. The amount of the single-bed payment shall be 110 percent of the
247.16 payment rate for the individual recipient. This subdivision does not affect the use of the
247.17 single-bed election under Minnesota Rules, part 9549.0060, subpart 11.

247.18 Sec. 54. Minnesota Statutes 2008, section 256B.49, is amended by adding a
247.19 subdivision to read:

247.20 Subd. 11a. **Waivered services waiting list.** (a) The commissioner shall establish
247.21 statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver
247.22 services, as of January 1, 2010. The statewide priorities must include, but are not limited
247.23 to, individuals who continue to have a need for waiver services after they have maximized
247.24 the use of state plan services and other funding resources, including natural supports, prior
247.25 to accessing waiver services, and who meet at least one of the following criteria:

247.26 (1) have unstable living situations due to the age, incapacity, or sudden loss of
247.27 the primary caregivers;

247.28 (2) are moving from an institution due to bed closures;

247.29 (3) experience a sudden closure of their current living arrangement;

247.30 (4) require protection from confirmed abuse, neglect, or exploitation;

247.31 (5) experience a sudden change in need that can no longer be met through state plan
247.32 services or other funding resources alone; or

247.33 (6) meet other priorities established by the department.

248.1 (b) When allocating resources to lead agencies, the commissioner shall take into
248.2 consideration the number of individuals waiting who meet statewide priorities.

248.3 (c) The commissioner shall evaluate the impact of the use of statewide priorities and
248.4 provide recommendations to the legislature on whether to continue the use of statewide
248.5 priorities by January 1, 2012.

248.6 Sec. 55. Minnesota Statutes 2008, section 256B.49, subdivision 12, is amended to read:

248.7 Subd. 12. **Informed choice.** Persons who are determined likely to require the
248.8 level of care provided in a nursing facility as determined under sections 256B.0911 and
248.9 144.0724, subdivision 11, or hospital shall be informed of the home and community-based
248.10 support alternatives to the provision of inpatient hospital services or nursing facility
248.11 services. Each person must be given the choice of either institutional or home and
248.12 community-based services using the provisions described in section 256B.77, subdivision
248.13 2, paragraph (p).

248.14 **EFFECTIVE DATE.** The section is effective July 1, 2011.

248.15 Sec. 56. Minnesota Statutes 2008, section 256B.49, subdivision 14, is amended to read:

248.16 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
248.17 strengths, informal support systems, and need for services shall be completed within
248.18 20 working days of the recipient's request. Reassessment of each recipient's strengths,
248.19 support systems, and need for services shall be conducted at least every 12 months and at
248.20 other times when there has been a significant change in the recipient's functioning.

248.21 (b) There must be a determination that the client requires a hospital level of care or a
248.22 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
248.23 subsequent assessments to initiate and maintain participation in the waiver program.

248.24 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
248.25 appropriate to determine nursing facility level of care for purposes of medical assistance
248.26 payment for nursing facility services, only face-to-face assessments conducted according
248.27 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
248.28 determination or a nursing facility level of care determination must be accepted for
248.29 purposes of initial and ongoing access to waiver services payment.

248.30 (d) Persons with developmental disabilities who apply for services under the nursing
248.31 facility level waiver programs shall be screened for the appropriate level of care according
248.32 to section 256B.092.

249.1 ~~(e)~~ (e) Recipients who are found eligible for home and community-based services
249.2 under this section before their 65th birthday may remain eligible for these services after
249.3 their 65th birthday if they continue to meet all other eligibility factors.

249.4 **EFFECTIVE DATE.** The section is effective July 1, 2011.

249.5 Sec. 57. Minnesota Statutes 2008, section 256B.49, is amended by adding a
249.6 subdivision to read:

249.7 **Subd. 22. Residential support services.** For the purposes of this section, the
249.8 provisions of section 256B.092, subdivision 11, are controlling.

249.9 Sec. 58. **[256B.4912] HOME AND COMMUNITY-BASED WAIVERS;**
249.10 **PROVIDERS AND PAYMENT.**

249.11 **Subdivision 1. Provider qualifications.** For the home and community-based
249.12 waivers providing services to seniors and individuals with disabilities, the commissioner
249.13 shall establish:

249.14 **(1) agreements with enrolled waiver service providers to ensure providers meet**
249.15 **qualifications defined in the waiver plans;**

249.16 **(2) regular reviews of provider qualifications; and**

249.17 **(3) processes to gather the necessary information to determine provider**
249.18 **qualifications.**

249.19 **By July 2010, staff that provide direct contact, as defined in section 245C.02, subdivision**
249.20 **11, that are employees of waiver service providers must meet the requirements of chapter**
249.21 **245C prior to providing waiver services and as part of ongoing enrollment. Upon federal**
249.22 **approval, this requirement must also apply to consumer-directed community supports.**

249.23 **Subd. 2. Rate-setting methodologies.** The commissioner shall establish
249.24 **statewide rate-setting methodologies that meet federal waiver requirements for home**
249.25 **and community-based waiver services for individuals with disabilities. The rate-setting**
249.26 **methodologies must abide by the principles of transparency and equitability across the**
249.27 **state. The methodologies must involve a uniform process of structuring rates for each**
249.28 **service and must promote quality and participant choice.**

249.29 Sec. 59. Minnesota Statutes 2008, section 256B.5011, subdivision 2, is amended to
249.30 read:

249.31 **Subd. 2. Contract provisions.** (a) The service contract with each intermediate
249.32 care facility must include provisions for:

250.1 (1) modifying payments when significant changes occur in the needs of the
250.2 consumers;

250.3 ~~(2) the establishment and use of a quality improvement plan. Using criteria and~~
250.4 ~~options for performance measures developed by the commissioner, each intermediate care~~
250.5 ~~facility must identify a minimum of one performance measure on which to focus its efforts~~
250.6 ~~for quality improvement during the contract period;~~

250.7 ~~(3)~~ appropriate and necessary statistical information required by the commissioner;

250.8 ~~(4)~~ annual aggregate facility financial information; and

250.9 ~~(5)~~ (4) additional requirements for intermediate care facilities not meeting the
250.10 standards set forth in the service contract.

250.11 (b) The commissioner of human services and the commissioner of health, in
250.12 consultation with representatives from counties, advocacy organizations, and the provider
250.13 community, shall review the consolidated standards under chapter 245B and the supervised
250.14 living facility rule under Minnesota Rules, chapter 4665, to determine what provisions
250.15 in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for
250.16 intermediate care facilities in order to enable facilities to implement the performance
250.17 measures in their contract and provide quality services to residents without a duplication
250.18 of or increase in regulatory requirements.

250.19 Sec. 60. Minnesota Statutes 2008, section 256B.5012, is amended by adding a
250.20 subdivision to read:

250.21 Subd. 8. **ICF/MR rate decreases effective July 1, 2009.** The commissioner shall
250.22 decrease each facility reimbursed under this section operating payment adjustments
250.23 equal to 3.0 percent of the operating payment rates in effect on June 30, 2009. For each
250.24 facility, the commissioner shall implement the rate reduction, based on occupied beds,
250.25 using the percentage specified in this subdivision multiplied by the total payment rate,
250.26 including the variable rate but excluding the property-related payment rate, in effect on
250.27 the preceding date. The total rate reduction shall include the adjustment provided in
250.28 section 256B.502, subdivision 7.

250.29 Sec. 61. Minnesota Statutes 2008, section 256B.5013, subdivision 1, is amended to
250.30 read:

250.31 Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after
250.32 October 1, 2000, when there is a documented increase in the needs of a current ICF/MR
250.33 recipient, the county of financial responsibility may recommend a variable rate to enable
250.34 the facility to meet the individual's increased needs. Variable rate adjustments made under

251.1 this subdivision replace payments for persons with special needs under section 256B.501,
251.2 subdivision 8, and payments for persons with special needs for crisis intervention services
251.3 under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a base rate
251.4 above the 50th percentile of the statewide average reimbursement rate for a Class A
251.5 facility or Class B facility, whichever matches the facility licensure, are not eligible for a
251.6 variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,
251.7 except when approved for purposes established in paragraph (b), clause (1). Variable rate
251.8 adjustments approved solely on the basis of changes on a developmental disabilities
251.9 screening document will end June 30, 2002.

251.10 (b) A variable rate may be recommended by the county of financial responsibility
251.11 for increased needs in the following situations:

251.12 (1) a need for resources due to an individual's full or partial retirement from
251.13 participation in a day training and habilitation service when the individual: (i) has reached
251.14 the age of 65 or has a change in health condition that makes it difficult for the person
251.15 to participate in day training and habilitation services over an extended period of time
251.16 because it is medically contraindicated; and (ii) has expressed a desire for change through
251.17 the developmental disability screening process under section 256B.092;

251.18 (2) a need for additional resources for intensive short-term programming which is
251.19 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

251.20 (3) a demonstrated medical need that significantly impacts the type or amount of
251.21 services needed by the individual; or

251.22 (4) a demonstrated behavioral need that significantly impacts the type or amount of
251.23 services needed by the individual.

251.24 (c) The county of financial responsibility must justify the purpose, the projected
251.25 length of time, and the additional funding needed for the facility to meet the needs of
251.26 the individual.

251.27 (d) ~~The facility shall provide a quarterly report to the county case manager on~~
251.28 ~~the use of the variable rate funds and the status of the individual on whose behalf the~~
251.29 ~~funds were approved. The county case manager will forward the facility's report with a~~
251.30 ~~recommendation to the commissioner to approve or disapprove a continuation of the~~
251.31 ~~variable rate.~~

251.32 (e) Funds made available through the variable rate process that are not used by
251.33 the facility to meet the needs of the individual for whom they were approved shall be
251.34 returned to the state.

251.35 Sec. 62. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

252.1 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
252.2 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
252.3 basis beginning January 1, 1996. Managed care contracts which were in effect on June
252.4 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
252.5 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
252.6 commissioner may issue separate contracts with requirements specific to services to
252.7 medical assistance recipients age 65 and older.

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

252.13 (c) Effective for services rendered on or after January 1, 2003, the commissioner
252.14 shall withhold five percent of managed care plan payments under this section for the
252.15 prepaid medical assistance and general assistance medical care programs pending
252.16 completion of performance targets. Each performance target must be quantifiable,
252.17 objective, measurable, and reasonably attainable, except in the case of a performance
252.18 target based on a federal or state law or rule. Criteria for assessment of each performance
252.19 target must be outlined in writing prior to the contract effective date. The managed
252.20 care plan must demonstrate, to the commissioner's satisfaction, that the data submitted
252.21 regarding attainment of the performance target is accurate. The commissioner shall
252.22 periodically change the administrative measures used as performance targets in order
252.23 to improve plan performance across a broader range of administrative services. The
252.24 performance targets must include measurement of plan efforts to contain spending
252.25 on health care services and administrative activities. The commissioner may adopt
252.26 plan-specific performance targets that take into account factors affecting only one plan,
252.27 including characteristics of the plan's enrollee population. The withheld funds must be
252.28 returned no sooner than July of the following year if performance targets in the contract
252.29 are achieved. The commissioner may exclude special demonstration projects under
252.30 subdivision 23. A managed care plan or a county-based purchasing plan under section
252.31 256B.692 may include as admitted assets under section 62D.044 any amount withheld
252.32 under this paragraph that is reasonably expected to be returned.

252.33 (d)(1) Effective for services rendered on or after January 1, 2009, the commissioner
252.34 shall withhold three percent of managed care plan payments under this section for the
252.35 prepaid medical assistance and general assistance medical care programs. The withheld

253.1 funds must be returned no sooner than July 1 and no later than July 31 of the following
253.2 year. The commissioner may exclude special demonstration projects under subdivision 23.

253.3 (2) A managed care plan or a county-based purchasing plan under section 256B.692
253.4 may include as admitted assets under section 62D.044 any amount withheld under
253.5 this paragraph. The return of the withhold under this paragraph is not subject to the
253.6 requirements of paragraph (c).

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

253.12 Sec. 63. Minnesota Statutes 2008, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

254.10 (d) The county agency shall continue to pay a monthly allowance of \$68 for
254.11 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
254.12 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
254.13 until the person has not received Minnesota supplemental aid for one full calendar month
254.14 or until the person's living arrangement changes and the person no longer meets the criteria
254.15 for the restaurant meal allowance, whichever occurs first.

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

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

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

254.35 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
254.36 exceed 40 percent of the assistance unit's gross income before the application of this

255.1 special needs standard. "Gross income" for the purposes of this section is the applicant's or
255.2 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
255.3 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or
255.4 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
255.5 considered shelter needy for purposes of this paragraph.

255.6 (g) Notwithstanding this subdivision, recipients of home and community-based
255.7 services may relocate to services without 24-hour supervision and receive the equivalent
255.8 of the recipient's group residential housing allocation in Minnesota supplemental
255.9 assistance shelter needy funding if the cost of the services and housing is equal to or less
255.10 than provided to the recipient in home and community-based services and the relocation is
255.11 the recipient's choice and is approved by the recipient or guardian.

255.12 (h) To access housing and services as provided in paragraph (g), the recipient may
255.13 choose housing that may or may not be owned, operated, or controlled by the recipient's
255.14 service provider.

255.15 (i) The provisions in paragraphs (g) and (h) are effective to June 30, 2011. The
255.16 commissioner shall assess the development of publicly owned housing, other housing
255.17 alternatives, and whether a public equity housing fund may be established that would
255.18 maintain the state's interest, to the extent paid from group residential housing and
255.19 Minnesota supplemental aid shelter needy funds in provider-owned housing so that when
255.20 sold, the state would recover its share for a public equity fund to be used for future public
255.21 needs under this chapter. The commissioner shall report findings and recommendations to
255.22 the legislative committees and budget divisions with jurisdiction over health and human
255.23 services policy and financing by January 15, 2012.

255.24 (j) In selecting prospective services needed by recipients for whom home and
255.25 community-based services have been authorized, the recipient and the recipient's guardian
255.26 shall first consider alternatives to home and community-based services. Minnesota
255.27 supplemental aid shelter needy funding for recipients who utilize Minnesota supplemental
255.28 aid shelter needy funding as provided in this section shall remain permanent unless the
255.29 recipient with the recipient's guardian later chooses to access home and community-based
255.30 services.

255.31 Sec. 64. Minnesota Statutes 2008, section 626.556, subdivision 3c, is amended to read:

255.32 Subd. 3c. **Local welfare agency, Department of Human Services or Department**
255.33 **of Health responsible for assessing or investigating reports of maltreatment.** (a)

255.34 The county local welfare agency is the agency responsible for assessing or investigating
255.35 allegations of maltreatment in child foster care, family child care, ~~and~~ legally unlicensed

256.1 child care ~~and in~~, juvenile correctional facilities licensed under section 241.021 located
256.2 in the local welfare agency's county, and unlicensed personal care assistance provider
256.3 organizations providing services and receiving reimbursements under chapter 256B.

256.4 (b) The Department of Human Services is the agency responsible for assessing or
256.5 investigating allegations of maltreatment in facilities licensed under chapters 245A and
256.6 245B, except for child foster care and family child care.

256.7 (c) The Department of Health is the agency responsible for assessing or investigating
256.8 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
256.9 144A.46, and in unlicensed home health care.

256.10 (d) The commissioners of human services, public safety, and education must
256.11 jointly submit a written report by January 15, 2007, to the education policy and finance
256.12 committees of the legislature recommending the most efficient and effective allocation
256.13 of agency responsibility for assessing or investigating reports of maltreatment and must
256.14 specifically address allegations of maltreatment that currently are not the responsibility
256.15 of a designated agency.

256.16 Sec. 65. Minnesota Statutes 2008, section 626.556, is amended by adding a subdivision
256.17 to read:

256.18 Subd. 16. Abuse prevention plan. Home health care agencies and personal care
256.19 assistance services providers shall develop an individual abuse prevention plan for each
256.20 child receiving services from them. The plan shall contain an individualized assessment of:

256.21 (1) the child's susceptibility to abuse by other individuals, including other children;

256.22 (2) the child's risk of abusing other children; and

256.23 (3) statements of the specific measures to be taken to minimize the risk of abuse
256.24 to that child and other children.

256.25 For the purposes of this subdivision, the term "abuse" includes self-abuse.

256.26 Sec. 66. **COMMISSIONER TO REPORT ON PERSONAL CARE ASSISTANCE**
256.27 **PROGRAM.**

256.28 The commissioner of human services must report to the legislative committees with
256.29 jurisdiction over health and human services policy and finance by January 1, 2010, on the
256.30 training developed and delivered for all types of participants in the personal care assistance
256.31 program, audit and financial integrity measures and results, information developed for
256.32 consumers and responsible parties, and quality assurance measures and results.

256.33 Sec. 67. **COLA COMPENSATION REQUIREMENTS.**

257.1 Effective July 1, 2009, providers who received rate increases under Laws 2007,
257.2 chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15,
257.3 section 17, and Minnesota Statutes, section 256B.5012, subdivision 7, for state fiscal years
257.4 2008 and 2009 are no longer required to continue or retain employee compensation or
257.5 wage-related increases required by those sections.

257.6 **Sec. 68. AGING AND DISABILITY SERVICES FOR ADULTS.**

257.7 (a) The commissioner of human services shall form a work group with counties, in
257.8 consultation with other stakeholders, to develop recommendations and priorities for the
257.9 portion of funding to be allocated to counties for aging and disability services for adults.
257.10 This funding must be transferred from the Children and Community Services Act (CCSA)
257.11 distribution beginning July 1, 2011, and the CCSA distribution of county social services
257.12 block grant funds beginning January 1, 2011.

257.13 (b) Starting January 1, 2011, funding for aging and disability services for adults
257.14 must be governed under the CCSA under Minnesota Statutes, chapter 256M, pending final
257.15 enactment of the legislation in paragraph (d).

257.16 (c) The work group's recommendations must include:

257.17 (1) identification of the priorities and targeted activities for this funding; and

257.18 (2) the funding allocation method to counties that must be effective January 1, 2011.

257.19 (d) The commissioner shall draft legislation for the 2010 legislative session that is
257.20 necessary for the implementation of this funding allocation method. This allocation shall
257.21 thereafter be referred to as the "Protecting Adults Act."

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

257.23 **Sec. 69. PROVIDER RATE AND GRANT REDUCTIONS.**

257.24 (a) The commissioner of human services shall decrease grants, allocations,
257.25 reimbursement rates, or rate limits, as applicable, by 3.0 percent effective July 1, 2009, for
257.26 services rendered on or after that date. County or tribal contracts for services specified
257.27 in this section must be amended to pass through these rate reductions within 60 days of
257.28 the effective date of the decrease and must be retroactive from the effective date of the
257.29 rate decrease.

257.30 (b) The annual rate decreases described in this section must be provided to:

257.31 (1) home and community-based waived services for persons with developmental
257.32 disabilities or related conditions, including consumer-directed community supports, under
257.33 Minnesota Statutes, section 256B.501;

- 258.1 (2) home and community-based waived services for the elderly, including
258.2 consumer-directed community supports, under Minnesota Statutes, section 256B.0915;
- 258.3 (3) waived services under community alternatives for disabled individuals,
258.4 including consumer-directed community supports, under Minnesota Statutes, section
258.5 256B.49;
- 258.6 (4) community alternative care waived services, including consumer-directed
258.7 community supports, under Minnesota Statutes, section 256B.49;
- 258.8 (5) traumatic brain injury waived services, including consumer-directed
258.9 community supports, under Minnesota Statutes, section 256B.49;
- 258.10 (6) nursing services and home health services under Minnesota Statutes, section
258.11 256B.0625, subdivision 6a;
- 258.12 (7) personal care services and qualified professional supervision of personal care
258.13 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;
- 258.14 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
258.15 subdivision 7;
- 258.16 (9) day training and habilitation services for adults with developmental disabilities
258.17 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
258.18 additional cost of rate adjustments on day training and habilitation services, provided as a
258.19 social service under Minnesota Statutes, section 256M.60;
- 258.20 (10) alternative care services under Minnesota Statutes, section 256B.0913;
- 258.21 (11) the group residential housing supplementary service rate under Minnesota
258.22 Statutes, section 256I.05, subdivision 1a;
- 258.23 (12) semi-independent living services (SILS) under Minnesota Statutes, section
258.24 252.275, including SILS funding under county social services grants formerly funded
258.25 under Minnesota Statutes, chapter 256I;
- 258.26 (13) community support services for deaf and hard-of-hearing adults with mental
258.27 illness who use or wish to use sign language as their primary means of communication
258.28 under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing
258.29 grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9;
258.30 and Laws 1997, First Special Session chapter 5, section 20;
- 258.31 (14) physical therapy services under Minnesota Statutes, sections 256B.0625,
258.32 subdivision 8, and 256D.03, subdivision 4;
- 258.33 (15) occupational therapy services under Minnesota Statutes, sections 256B.0625,
258.34 subdivision 8a, and 256D.03, subdivision 4;
- 258.35 (16) speech-language therapy services under Minnesota Statutes, section 256D.03,
258.36 subdivision 4, and Minnesota Rules, part 9505.0390;

- 259.1 (17) respiratory therapy services under Minnesota Statutes, section 256D.03,
259.2 subdivision 4, and Minnesota Rules, part 9505.0295;
259.3 (18) consumer support grants under Minnesota Statutes, section 256.476;
259.4 (19) family support grants under Minnesota Statutes, section 252.32;
259.5 (20) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917,
259.6 and 256B.0928;
259.7 (21) disability linkage line grants under Minnesota Statutes, section 256.01,
259.8 subdivision 24; and
259.9 (22) housing access grants under Minnesota Statutes, section 256B.0658.
259.10 (c) A managed care plan receiving state payments for the services in this section
259.11 must include these decreases in their payments to providers effective on January 1
259.12 following the effective date of the rate decrease.

259.13 **Sec. 70. RECOMMENDATIONS FOR PERSONAL CARE ASSISTANCE**
259.14 **SERVICES CHANGES AND CONSULTATION WITH STAKEHOLDERS.**

259.15 The commissioner shall consult with representatives of interested stakeholders
259.16 beginning in July 2009 to examine and develop recommendations for the personal care
259.17 assistance services program, including recommendations to streamline the home care
259.18 ratings and assignment of units of service to eligible recipients. The recommendations
259.19 shall include proposed changes, alternative services, and costs for those whose services
259.20 will change, as well as personal care assistance program data for public reporting. The
259.21 recommendations are to result in a reduction of spending growth by \$..... in personal care
259.22 assistance services beginning January 1, 2011. The recommendations shall be provided to
259.23 the chairs and ranking minority members of the legislative committees having jurisdiction
259.24 over health and human services by January 15, 2010.

259.25 **Sec. 71. PROGRAM INTEGRITY; PERSONAL CARE ASSISTANCE**
259.26 **PROGRAM.**

259.27 The commissioner of human services must provide data to the legislative committees
259.28 with jurisdiction over health and human services policy and finance by January 1, 2010,
259.29 on the training developed and delivered for all types of participants in the personal
259.30 care assistance program, audit and financial integrity measures and results, information
259.31 developed for consumers and responsible parties, and quality assurance measures and
259.32 results.

259.33 **Sec. 72. ESTABLISHING A SINGLE SET OF STANDARDS.**

260.1 (a) The commissioner of human services shall consult with disability service
260.2 providers, advocates, counties, and consumer families to develop a single set of standards
260.3 governing services for people with disabilities receiving services under the home and
260.4 community-based waiver services program to replace all or portions of existing laws and
260.5 rules including, but not limited to, data practices, licensure of facilities and providers,
260.6 background studies, reporting of maltreatment of minors, reporting of maltreatment of
260.7 vulnerable adults, and the psychotropic medication checklist. The standards must:

260.8 (1) enable optimum consumer choice;

260.9 (2) be consumer driven;

260.10 (3) link services to individual needs and life goals;

260.11 (4) be based on quality assurance and individual outcomes;

260.12 (5) utilize the people closest to the recipient, who may include family, friends, and
260.13 health and service providers, in conjunction with the recipient's risk management plan to
260.14 assist the recipient or the recipient's guardian in making decisions that meet the recipient's
260.15 needs in a cost-effective manner and assure the recipient's health and safety;

260.16 (6) utilize person-centered planning; and

260.17 (7) maximize federal financial participation.

260.18 (b) The commissioner may consult with existing stakeholder groups convened under
260.19 the commissioner's authority, including the home and community-based expert services
260.20 panel established by the commissioner in 2008, to meet all or some of the requirements
260.21 of this section.

260.22 (c) The commissioner shall provide the reports and plans required by this section to
260.23 the legislative committees and budget divisions with jurisdiction over health and human
260.24 services policy and finance by January 15, 2012.

260.25 **Sec. 73. COMMON SERVICE MENU FOR HOME AND COMMUNITY-BASED**
260.26 **WAIVER PROGRAMS.**

260.27 The commissioner of human services shall confer with representatives of recipients,
260.28 advocacy groups, counties, providers, and health plans to develop and update a common
260.29 service menu for home and community-based waiver programs. The commissioner may
260.30 consult with existing stakeholder groups convened under the commissioner's authority to
260.31 meet all or some of the requirements of this section.

260.32 **Sec. 74. INTERMEDIATE CARE FACILITIES FOR PERSONS WITH**
260.33 **DEVELOPMENTAL DISABILITIES REPORT.**

261.1 The commissioner of human services shall consult with providers and advocates of
 261.2 intermediate care facilities for persons with developmental disabilities to monitor progress
 261.3 made in response to the commissioner's December 15, 2008, report to the legislature
 261.4 regarding intermediate care facilities for persons with developmental disabilities.

261.5 **Sec. 75. HOUSING OPTIONS.**

261.6 The commissioner of human services, in consultation with the commissioner of
 261.7 administration and the Minnesota Housing Finance Agency, and representatives of
 261.8 counties, residents' advocacy groups, consumers of housing services, and provider
 261.9 agencies shall explore ways to maximize the availability and affordability of housing
 261.10 choices available to persons with disabilities or who need care assistance due to other
 261.11 health challenges. A goal shall also be to minimize state physical plant costs in order to
 261.12 serve more persons with appropriate program and care support. Consideration shall be
 261.13 given to:

- 261.14 (1) improved access to rent subsidies;
- 261.15 (2) use of cooperatives, land trusts, and other limited equity ownership models;
- 261.16 (3) the desirability of the state acquiring an ownership interest or promoting the
 261.17 use of publicly owned housing;
- 261.18 (4) promoting more choices in the market for accessible housing that meets the
 261.19 needs of persons with physical challenges; and
- 261.20 (5) what consumer ownership models, if any, are appropriate.

261.21 The commissioner shall provide a written report on the findings of the evaluation of
 261.22 housing options to the chairs and ranking minority members of the house of representatives
 261.23 and senate standing committees with jurisdiction over health and human services policy
 261.24 and funding by December 15, 2010.

261.25 **Sec. 76. REVISOR'S INSTRUCTION.**

261.26 **Subdivision 1. Renumbering of Minnesota Statutes, section 256B.0652,**
 261.27 **authorization and review of home care services.** (a) The revisor of statutes shall
 261.28 renumber each section of Minnesota Statutes listed in column A with the number in
 261.29 column B.

<u>Column A</u>	<u>Column B</u>
261.30 <u>256B.0652, subdivision 3</u>	<u>256B.0652, subdivision 14</u>
261.31 <u>256B.0651, subdivision 6, paragraph (a)</u>	<u>256B.0652, subdivision 3</u>
261.32 <u>256B.0651, subdivision 6, paragraph (b)</u>	<u>256B.0652, subdivision 4</u>
261.33 <u>256B.0651, subdivision 6, paragraph (c)</u>	<u>256B.0652, subdivision 7</u>
261.34 <u>256B.0651, subdivision 7, paragraph (a)</u>	<u>256B.0652, subdivision 8</u>

262.1	<u>256B.0651, subdivision 7, paragraph (b)</u>	<u>256B.0652, subdivision 14</u>
262.2	<u>256B.0651, subdivision 8</u>	<u>256B.0652, subdivision 9</u>
262.3	<u>256B.0651, subdivision 9</u>	<u>256B.0652, subdivision 10</u>
262.4	<u>256B.0651, subdivision 11</u>	<u>256B.0652, subdivision 11</u>
262.5	<u>256B.0654, subdivision 2</u>	<u>256B.0652, subdivision 5</u>
262.6	<u>256B.0655, subdivision 4</u>	<u>256B.0652, subdivision 6</u>

262.7 (b) The revisor of statutes shall make necessary cross-reference changes in statutes
 262.8 and rules consistent with the renumbering in paragraph (a). The Department of Human
 262.9 Services shall assist the revisor with any cross-reference changes. The revisor may make
 262.10 changes necessary to correct the punctuation, grammar, or structure of the remaining text
 262.11 to conform with the intent of the renumbering in paragraph (a).

262.12 Subd. 2. **Renumbering personal care assistance services.** The revisor of statutes
 262.13 shall replace any reference to Minnesota Statutes, section 256B.0655 with section
 262.14 256B.0659, wherever it appears in statutes or rules. The revisor shall correct any cross
 262.15 reference changes that are necessary as a result of this section. The Department of Human
 262.16 Services shall assist the revisor in making these changes, and if necessary, shall draft a
 262.17 corrections bill with changes for introduction in the 2010 legislative session. The revisor
 262.18 may make changes to punctuation, grammar, or sentence structure to preserve the integrity
 262.19 of statutes and effectuate the intention of this section.

262.20 Sec. 77. **REPEALER.**

262.21 Minnesota Statutes 2008, sections 256B.0655, subdivisions 1, 1a, 1c, 1d, 1e, 1f, 1g,
 262.22 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13; and 256B.071, subdivisions 1, 2, 3, and
 262.23 4, are repealed.

262.24 **ARTICLE 10**

262.25 **STATE-COUNTY RESULTS, ACCOUNTABILITY, AND SERVICE** 262.26 **DELIVERY REFORM ACT**

262.27 Section 1. **[402A.01] CITATION.**

262.28 Sections 402A.01 to 402A.50 may be cited as the "State-County Results,
 262.29 Accountability, and Service Delivery Reform Act."

262.30 Sec. 2. **[402A.10] DEFINITIONS.**

262.31 Subdivision 1. **Terms defined.** For the purposes of this chapter, the terms defined in
 262.32 this subdivision have the meanings given.

262.33 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human
 262.34 services.

263.1 Subd. 3. **Council.** "Council" means the Council on State-County Results,
263.2 Accountability, and Service Delivery Redesign established in section 402A.40.

263.3 Subd. 4. **Essential human services programs.** "Essential human services
263.4 programs" means assistance and services to recipients or potential recipients of public
263.5 welfare and other services delivered by counties that are mandated in state law that are
263.6 to be available in all counties of the state.

263.7 Subd. 5. **Redesign.** "Redesign" means the State-County Results, Accountability,
263.8 and Service Delivery Redesign under this chapter.

263.9 Subd. 6. **Service delivery authority.** "Service delivery authority" means a single
263.10 county, or group of counties operating by execution of a joint powers agreement under
263.11 section 471.59 or other contractual agreement, that has voluntarily chosen by resolution of
263.12 the county board of commissioners to participate in the redesign under this chapter.

263.13 Subd. 7. **Steering committee.** "Steering committee" means the Steering Committee
263.14 on Performance and Outcome Reforms.

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

263.16 Sec. 3. **[402A.15] STEERING COMMITTEE ON PERFORMANCE AND**
263.17 **OUTCOME REFORMS.**

263.18 Subdivision 1. **Duties.** (a) The Steering Committee on Performance and Outcome
263.19 Reforms shall develop a uniform process to establish and review performance and
263.20 outcome standards for essential human services programs, and to develop appropriate
263.21 reporting measures and a uniform accountability process for responding to a county's
263.22 or human service authority's failure to make adequate progress on achieving outcome
263.23 goals. The accountability process shall focus on the performance measures rather than
263.24 inflexible implementation requirements.

263.25 (b) The steering committee shall:

263.26 (1) by November 1, 2009, establish an agreed upon list of essential services;

263.27 (2) by January 10, 2010, develop and recommend to the legislature a uniform,
263.28 graduated process for responding to a county's failure to make adequate progress on
263.29 achieving outcome goals, which may include a provision for requiring a county to enter
263.30 into and participate in a service delivery authority if adequate resources are allocated to
263.31 the county to establish a service delivery authority;

263.32 (3) by December 15, 2009, establish a three-year schedule of ongoing program
263.33 reviews to evaluate and establish outcome goals, modify the reporting system, and review
263.34 the distribution of state and federal funds for those services, taking into consideration
263.35 program demand and the unique differences of local areas in geography and the

264.1 populations served. Priority shall be given to services with the greatest variation in
264.2 availability and greatest administrative demands. The schedule shall be published on the
264.3 agency Web site and reported to the legislative committees with jurisdiction over health
264.4 and human services.

264.5 (c) As far as possible, the outcome goals, reporting system, and distribution formulas
264.6 shall be consistent across program areas. The development of outcome goals shall
264.7 consider the manner in which achievement of these goals will be reported. An estimate
264.8 of increased or decreased state and local administrative costs in collecting and reporting
264.9 outcomes shall be included when outcome goals are established. The steering committee
264.10 shall take into consideration that the goal of implementing changes to program monitoring
264.11 and reporting the progress toward achieving outcomes is to significantly minimize the
264.12 cost of administrative requirements and to allow funds freed by reduced administrative
264.13 expenditures to be used to provide additional services, allow flexibility in service design
264.14 and management, and focus energies on achieving program and client outcomes.

264.15 (d) In making its recommendations, the steering committee shall consider input from
264.16 the council established in section 402A.30. The steering committee shall review the
264.17 measurable goals established under section 402A.30, subdivision 2, paragraph (b), and
264.18 consider whether they may be applied as statewide performance outcomes.

264.19 (e) The steering committee may form work groups that include persons who provide
264.20 or receive essential services and representatives of organizations who advocate on behalf
264.21 of those persons.

264.22 (f) By January 15 of each year starting January 15, 2010, the steering committee
264.23 shall report to the legislative committees with jurisdiction over health and human services
264.24 its recommendations for outcome goals, a reporting system, and funding distribution
264.25 formulas. The steering committee shall also identify statutory provisions, administrative
264.26 rules and requirements, and reports that should be repealed or eliminated. In addition, the
264.27 commissioner shall post quarterly updates on the progress of the steering committee on
264.28 the department Web site.

264.29 (g) The commissioner shall publish instructional bulletins in a timely manner that
264.30 contain the outcome goals and reporting requirements adopted by the legislature. The
264.31 commissioner shall initiate state plan amendments necessary to implement provisions of
264.32 this section in a timely manner.

264.33 Subd. 2. **Composition.** (a) The steering committee shall include:

264.34 (1) the commissioner of human services, or designee;

264.35 (2) three county commissioners, representative of rural, suburban, and urban
264.36 counties, selected by the Association of Minnesota Counties;

265.1 (3) three county directors of human services, representative of rural, suburban,
265.2 and urban counties, selected by the Minnesota Association of County Social Service
265.3 Administrators; and

265.4 (4) four clients or client advocates representing different populations receiving
265.5 services from the Department of Human Services, who are appointed by the commissioner.

265.6 (b) The commissioner, or designee, and a county commissioner shall serve as
265.7 cochairs of the committee. The committee shall be convened within 60 days of final
265.8 enactment of this legislation.

265.9 (c) State agency staff shall serve as informational resources and staff to the steering
265.10 committee. Statewide county associations shall assemble county program data as required.

265.11 (d) To promote information sharing and coordination between the steering committee
265.12 and council, one of the county representatives from paragraph (a), clause (2), and one of the
265.13 county representatives from paragraph (a), clause (3), must also serve as a representative
265.14 on the council under section 402A.40, subdivision 1, paragraph (b), clause (5) or (6).

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

265.16 Sec. 4. **[402A.20] STATE-COUNTY RESULTS, ACCOUNTABILITY, AND**
265.17 **SERVICE DELIVERY REDESIGN.**

265.18 The State-County Results, Accountability, and Service Delivery Redesign is
265.19 established to authorize implementation of methods and procedures for administering
265.20 assistance and services to recipients or potential recipients of public welfare and other
265.21 services delivered by counties which encourage greater transparency, more effective
265.22 governance, and innovation through the use of flexibility and performance measurement.

265.23 Sec. 5. **[402A.30] DESIGNATION OF SERVICE DELIVERY AUTHORITY.**

265.24 Subdivision 1. **Establishment.** A county or consortium of counties may establish
265.25 a service delivery authority to redesign the delivery of some or all essential services,
265.26 or other services as appropriate.

265.27 Subd. 2. **New state-county governance framework.** (a) Upon recommendation
265.28 of the council and approval of the commissioner, a single county with a population over
265.29 55,000, or two or more counties meeting the criteria in subdivision 4 may, by resolution of
265.30 their county boards of commissioners, establish a service delivery authority having the
265.31 composition, powers, and duties agreed upon. These counties may, by agreement entered
265.32 into through action of their bodies, jointly or cooperatively exercise any power common to
265.33 the contracting parties in carrying out their duties under current law, including, but not

266.1 limited to, chapters 245 to 267, 393, and 402. Participating county boards shall establish
266.2 acceptable ways of apportioning the cost of the services.

266.3 (b) To establish a service delivery authority, each participating county and the
266.4 state must enter into the following binding agreements to establish a joint state-county
266.5 governance framework:

266.6 (1) a governance agreement which defines the scope of essential services or other
266.7 services over which the service delivery authority has jurisdiction and the respective
266.8 authority, powers, roles, and responsibilities of the state and service delivery authorities.

266.9 As part of the governance agreement, the service delivery authority shall be held
266.10 accountable for achieving measurable goals as defined in the performance agreement
266.11 under clause (2). The service delivery authorities must be granted waivers, as necessary,
266.12 to ensure greater local control and flexibility to determine the most cost-effective means
266.13 of achieving specified measurable goals;

266.14 (2) a performance agreement which defines measurable goals in key operational
266.15 areas that the service delivery authority is expected to achieve. This agreement must
266.16 identify dependencies and other requirements necessary for the service delivery
266.17 authority to achieve the measurable goals as defined in the performance agreement. The
266.18 dependencies and requirements may include, but are not limited to:

266.19 (i) specific resource commitments of the state and the service delivery authority; and

266.20 (ii) funding or expenditure flexibility, which may include, but are not limited to,
266.21 exemptions to the requirements in sections 245.4835 and 245.714.

266.22 The performance goals must at a minimum satisfy performance outcomes
266.23 recommended by the steering committee and enacted into law; and

266.24 (3) a service level agreement which specifies the expectations and responsibilities
266.25 of the state and the service delivery authority regarding administrative and information
266.26 technology support necessary to achieve the measurable goals specified in the performance
266.27 agreement under clause (2). The service level agreement shall propose a reasonable level
266.28 of targeted reductions in overhead and administrative costs for each county participating
266.29 in the service delivery authority.

266.30 (c) After January 1, 2010, each county board in Minnesota shall vote to determine
266.31 whether the county intends to participate in a service delivery authority under this
266.32 chapter. Participating counties in the redesign must have the option of withdrawing from
266.33 participation if the following criteria are met:

266.34 (1) the county shall submit written notification to the council in the first quarter of
266.35 the calendar year in which the county wishes to withdraw; and

267.1 (2) if a county wishing to withdraw has received an appropriation from the state for
267.2 costs related to the county's participation in the redesign, those funds must be repaid. If a
267.3 county withdraws after participating in the redesign for:

267.4 (i) one year or less, the county must repay 75 percent of the money appropriated;

267.5 (ii) more than one year but less than two years, the county must repay 50 percent of
267.6 the money appropriated;

267.7 (iii) two years or more but less than three years, the county must repay 25 percent of
267.8 the money appropriated; or

267.9 (iv) three years or more, the county is not required to repay the appropriation.

267.10 The commissioner may waive the repayment requirement in clause (2).

267.11 (d) Nothing in this chapter precludes local governments from utilizing sections
267.12 465.81 and 465.82 to establish procedures for local governments to merge, with the
267.13 consent of the voters. Any agreement under subdivision 2, paragraph (b), must be
267.14 governed by this chapter. Nothing in this chapter limits the authority of a county board
267.15 to enter into contractual agreements for services not covered by the provisions of the
267.16 redesign with other agencies or with other units of government.

267.17 Subd. 3. **Duties.** (a) The service delivery authority shall:

267.18 (1) carry out the responsibilities required of local agencies under chapter 393 and
267.19 human service boards under chapter 402;

267.20 (2) manage the public resources devoted to human services and other public services
267.21 delivered or purchased by the counties that are subsidized or regulated by the Department
267.22 of Human Services under chapter 245 or 267;

267.23 (3) employ staff to assist in carrying out the redesign;

267.24 (4) develop and maintain a continuity of operations plan to ensure the continued
267.25 operation or resumption of essential human services functions in the event of any business
267.26 interruption according to local, state, and federal emergency planning requirements;

267.27 (5) receive and expend funds received for the redesign;

267.28 (6) plan and deliver services directly or through contract with other governmental
267.29 or nongovernmental providers;

267.30 (7) rent, purchase, sell, and otherwise dispose of real and personal property as
267.31 necessary to carry out the redesign; and

267.32 (8) carry out any other service designated as a responsibility of a county.

267.33 (b) Each service delivery authority certified under subdivision 3 shall designate a
267.34 single administrative structure that has the powers and duties assigned to the service
267.35 delivery authority.

268.1 Subd. 4. **Certification of service delivery authority.** The council shall recommend
268.2 certification of a county or consortium of counties as a service delivery authority to the
268.3 commissioner of human services if:

268.4 (1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and

268.5 (2) the county or consortium of counties are:

268.6 (i) a single county with a population of 55,000 or more;

268.7 (ii) a consortium of counties with a total combined population of 55,000 or more and
268.8 the counties comprising the consortium are in reasonable geographic proximity;

268.9 (iii) four or more counties in reasonable geographic proximity without regard to
268.10 population; or

268.11 (iv) a single county or consortium of counties meeting the criteria for exemption
268.12 from minimum population standards in this subdivision and subdivision 6.

268.13 Subd. 5. **Single county service delivery authority.** For counties with populations
268.14 over 55,000, the board of county commissioners may be the service delivery authority
268.15 and retain existing authority under law. Counties with populations over 55,000 that serve
268.16 as their own service delivery authority may enter into shared services arrangements with
268.17 other service delivery authorities or smaller counties. These shared services arrangements
268.18 may include, but are not limited to, human services, corrections, public health, veterans
268.19 planning, human resources, program development and operations, training, technical
268.20 systems, joint purchasing, and consultative services or direct services to transient, special
268.21 needs, or low-incidence populations. The council may recommend that the commissioner
268.22 of human services exempt a single county service delivery authority from the minimum
268.23 population standard in this subdivision if that service delivery authority can demonstrate
268.24 that it can otherwise meet the requirements of the redesign.

268.25 Subd. 6. **Exemption.** The council may recommend that the commissioner of
268.26 human services exempt a single county or multicounty service delivery authority from the
268.27 minimum population standard in this subdivision if that service delivery authority can
268.28 demonstrate that it can otherwise meet the requirements of this chapter.

268.29 Subd. 7. **Commissioner remedies.** The commissioner may submit to the council
268.30 a recommendation of remedies for performance improvement for any service delivery
268.31 authority not meeting the measurable goals agreed upon in performance agreements
268.32 under subdivision 2, paragraph (b). This provision does not preclude other powers of the
268.33 commissioner of human services to remedy county performance issues in a county or
268.34 counties not certified as a service delivery authority.

268.35 Sec. 6. **[402A.40] COUNCIL.**

269.1 Subdivision 1. Council. (a) A State-County Results, Accountability, and Service
269.2 Delivery Redesign Council is established. The council is responsible for review of the
269.3 redesign and must be convened by the commissioner of human services. Appointed council
269.4 members must be appointed by their respective agencies, associations, or governmental
269.5 units by November 1, 2009. The council shall be cochaired by the commissioner of human
269.6 services, or designee, and a county representative from paragraph (b), clause (5) or (6),
269.7 appointed by the Association of Minnesota Counties. Recommendations of the council
269.8 must be approved by a majority of the council members. The provisions of section 15.059
269.9 do not apply to this council, and this council does not expire.

269.10 (b) The council must consist of the following members:

269.11 (1) one representative from the governor's office;

269.12 (2) from the house of representatives, one member of the majority party and one
269.13 member of the minority party, appointed by the speaker of the house;

269.14 (3) from the senate, one member of the majority party and one member of the
269.15 minority party, appointed by the senate majority leader;

269.16 (4) the commissioner of human services, or designee, and two employees from
269.17 the department;

269.18 (5) two county commissioners appointed by the Association of Minnesota Counties;

269.19 (6) two county representatives appointed by the Minnesota Association of County
269.20 Social Service Administrators;

269.21 (7) one representative appointed by AFSCME; and

269.22 (8) one representative appointed by the Teamsters.

269.23 (c) Administrative support to the council may be provided by the Association of
269.24 Minnesota Counties and affiliates.

269.25 (d) Member agencies and associations are responsible for initial and subsequent
269.26 appointments to the council.

269.27 Subd. 2. Council duties. (a) The council shall:

269.28 (1) provide oversight of administration of the redesign;

269.29 (2) recommend the approval of waivers from statutory requirements, administrative
269.30 rules, and standards necessary to achieve the requirements of the agreements under
269.31 section 402A.30, subdivision 2, paragraph (b), to the commissioner of human services
269.32 or other appropriate entity, for counties certified as service delivery authorities under
269.33 section 402A.30;

269.34 (3) recommend approval of the agreements in section 402A.30, subdivision 2,
269.35 paragraph (b), to the commissioner of human services and ensure the consistency of the

270.1 agreements with the performance standards recommended by the steering committee and
270.2 enacted by the legislature;

270.3 (4) recommend certification of a county or consortium of counties as a service
270.4 delivery authority to the commissioner of human services;

270.5 (5) recommend approval of shared services arrangements under section 402A.30,
270.6 subdivision 5;

270.7 (6) form work groups as necessary to carry out the duties of the council under the
270.8 redesign; and

270.9 (7) establish a process for the mediation of conflicts among participating counties or
270.10 between participating counties and the commissioner of human services.

270.11 (b) In order to carry out the provisions of the redesign, and to effectuate the
270.12 agreements established under section 402A.30, subdivision 2, paragraph (b), the
270.13 commissioner of human services shall exercise authority under section 256.01, subdivision
270.14 2, paragraph (1), including seeking all necessary waivers. The commissioner of human
270.15 services has authority to approve shared service arrangements as defined in section
270.16 402A.30, subdivision 5.

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

270.18 **Sec. 7. [402A.50] AID AND INCENTIVES TO COUNTIES; PRIVATE SECTOR**
270.19 **FUNDING.**

270.20 The council may support stakeholder agencies, if not otherwise prohibited by law, to
270.21 separately or jointly seek and receive funds to provide expert technical assistance to the
270.22 council, the council's work group, and any sub-work groups for executing the provisions
270.23 of the redesign.

270.24 **Sec. 8. APPROPRIATION.**

270.25 \$..... is appropriated for the biennium beginning July 1, 2009, from the general fund
270.26 to the Council on State-County Results, Accountability, and Service Delivery Redesign,
270.27 for the purposes of the State-County Results, Accountability, and Service Delivery Reform
270.28 Act under Minnesota Statutes, sections 402A.01 to 402A.50. The council shall establish a
270.29 methodology for distributing funds to certified service delivery authorities for the purposes
270.30 of carrying out the requirements of the redesign.

ARTICLE 11

HUMAN SERVICES FORECAST ADJUSTMENTS

271.1
271.2

271.3 **Section 1. SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
271.4 **SERVICES FORECAST ADJUSTMENT.**

271.5 The dollar amounts shown are added to or, if shown in parentheses, are subtracted
271.6 from the appropriations in Laws 2008, chapter 363, from the general fund, or any other
271.7 fund named, to the Department of Human Services for the purposes specified in this article,
271.8 to be available for the fiscal year indicated for each purpose. The figure "2009" used in
271.9 this article means that the appropriation or appropriations listed are available for the fiscal
271.10 year ending June 30, 2009. Supplemental appropriations and reductions to appropriations
271.11 for the fiscal year ending June 30, 2009, are effective the day following final enactment.

271.12 **Sec. 2. COMMISSIONER OF HUMAN**
271.13 **SERVICES**

271.14 **Subdivision 1. Total Appropriation** **\$ (478,994,000)**

271.15	<u>Appropriations by Fund</u>	
271.16		<u>2009</u>
271.17	<u>General</u>	<u>(445,130,000)</u>
271.18	<u>Health Care Access</u>	<u>(19,460,000)</u>
271.19	<u>Federal TANF</u>	<u>(14,404,000)</u>

271.20 **Subd. 2. Revenue and Pass-Through**

271.21 Federal TANF 1,107,000

271.22 **Subd. 3. Children and Economic Assistance**
271.23 **Grants**

271.24	<u>General</u>	<u>27,002,000</u>
271.25	<u>Federal TANF</u>	<u>(16,211,000)</u>
271.26	<u>Total</u>	<u>10,791,000</u>

271.27 The amounts that may be spent from this
271.28 appropriation for each purpose are as follows:

271.29 **(a) MFIP/DWP Grants**

271.30	<u>General</u>	<u>17,530,000</u>
271.31	<u>Federal TANF</u>	<u>(16,211,000)</u>

271.32 **(b) MFIP Child Care Assistance Grants** 4,933,000

271.33 **(c) General Assistance Grants** 1,458,000

271.34 **(d) Minnesota Supplemental Aid Grants** 513,000

272.1	<u>(e) Group Residential Housing Grants</u>		<u>2,568,000</u>
272.2	<u>Subd. 4. Basic Health Care Grants</u>		
272.3	<u>General</u>	<u>(224,341,000)</u>	
272.4	<u>Health Care Access</u>	<u>(19,460,000)</u>	
272.5	<u>Total</u>	<u>(243,801,000)</u>	
272.6	<u>The amounts that may be spent from this</u>		
272.7	<u>appropriation for each purpose are as follows:</u>		
272.8	<u>(a) MinnesotaCare</u>		
272.9	<u>Health Care Access</u>	<u>(19,460,000)</u>	
272.10	<u>(b) MA Basic Health Care - Families and</u>		
272.11	<u>Children</u>		<u>(100,055,000)</u>
272.12	<u>(c) MA Basic Health Care - Elderly and</u>		
272.13	<u>Disabled</u>		<u>(136,795,000)</u>
272.14	<u>(d) General Assistance Medical Care</u>		<u>12,539,000</u>
272.15	<u>Subd. 5. Continuing Care Grants</u>		<u>(247,791,000)</u>
272.16	<u>The amounts that may be spent from this</u>		
272.17	<u>appropriation for each purpose are as follows:</u>		
272.18	<u>(a) MA Long-Term Care Facilities</u>		<u>(59,204,000)</u>
272.19	<u>(b) MA Long-Term Care Waivers</u>		<u>(168,927,000)</u>
272.20	<u>(c) Chemical Dependency Entitlement Grants</u>		<u>(19,660,000)</u>

ARTICLE 12

HEALTH AND HUMAN SERVICES APPROPRIATIONS

272.23 Section 1. **SUMMARY OF APPROPRIATIONS.**

272.24 The amounts shown in this section summarize direct appropriations by fund made
 272.25 in this article.

	<u>2010</u>	<u>2011</u>	<u>Total</u>
272.27 <u>General</u>	\$ <u>4,276,443,000</u> \$	<u>5,150,311,000</u> \$	<u>9,426,754,000</u>
272.28 <u>State Government Special</u>			
272.29 <u>Revenue</u>	<u>15,488,000</u>	<u>14,841,000</u>	<u>30,329,000</u>
272.30 <u>Health Care Access</u>	<u>463,239,000</u>	<u>560,223,000</u>	<u>1,023,462,000</u>
272.31 <u>Federal TANF</u>	<u>276,848,000</u>	<u>257,526,000</u>	<u>534,374,000</u>
272.32 <u>Lottery Prize</u>	<u>1,665,000</u>	<u>1,665,000</u>	<u>3,330,000</u>

273.1	<u>Federal Fund</u>		<u>99,800,000</u>		<u>0</u>		<u>99,800,000</u>
273.2	<u>Total</u>	\$	<u>5,133,483,000</u>	\$	<u>5,984,566,000</u>	\$	<u>11,118,049,000</u>

273.3 **Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATION.**

273.4 The sums shown in the columns marked "Appropriations" are appropriated to the
 273.5 agencies and for the purposes specified in this article. The appropriations are from the
 273.6 general fund, or another named fund, and are available for the fiscal years indicated
 273.7 for each purpose. The figures "2010" and "2011" used in this article mean that the
 273.8 appropriations listed under them are available for the fiscal year ending June 30, 2010, or
 273.9 June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal
 273.10 year 2011. "The biennium" is fiscal years 2010 and 2011. Appropriations from the federal
 273.11 fund are from money received under the American Reinvestment and Recovery Act of
 273.12 2009, Public Law 111-5, unless otherwise specified. Appropriations for the fiscal year
 273.13 ending June 30, 2009, are effective the day following final enactment.

273.14		<u>APPROPRIATIONS</u>
273.15		<u>Available for the Year</u>
273.16		<u>Ending June 30</u>
273.17		<u>2010</u> <u>2011</u>

273.18 **Sec. 3. HUMAN SERVICES**

273.19	<u>Subdivision 1. Total Appropriation</u>	\$	<u>5,083,386,000</u>	\$	<u>5,950,114,000</u>
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273.20	<u>Appropriations by Fund</u>	
273.21	<u>2010</u>	<u>2011</u>
273.22	<u>General</u>	<u>4,263,602,000</u> <u>5,141,510,000</u>
273.23	<u>State Government</u>	
273.24	<u>Special Revenue</u>	<u>1,315,000</u> <u>565,000</u>
273.25	<u>Health Care Access</u>	<u>450,156,000</u> <u>548,848,000</u>
273.26	<u>Federal TANF</u>	<u>276,848,000</u> <u>257,526,000</u>
273.27	<u>Lottery Prize</u>	<u>1,665,000</u> <u>1,665,000</u>
273.28	<u>Federal Fund</u>	<u>89,800,000</u> <u>0</u>

273.29 **Receipts for Systems Projects.**

273.30 Appropriations and federal receipts for
 273.31 information systems projects for MAXIS,
 273.32 PRISM, MMIS, and SSIS must be deposited
 273.33 in the state system account authorized in
 273.34 Minnesota Statutes, section 256.014. Money
 273.35 appropriated for computer projects approved
 273.36 by the Minnesota Office of Enterprise

274.1 Technology, funded by the legislature, and
274.2 approved by the commissioner of finance,
274.3 may be transferred from one project to
274.4 another and from development to operations
274.5 as the commissioner of human services
274.6 considers necessary. Any unexpended
274.7 balance in the appropriation for these
274.8 projects does not cancel but is available for
274.9 ongoing development and operations.

274.10 **Nonfederal Share Transfers.** The
274.11 nonfederal share of activities for which
274.12 federal administrative reimbursement is
274.13 appropriated to the commissioner may be
274.14 transferred to the special revenue fund.

274.15 **TANF Maintenance of Effort.**

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

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

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

274.32 (3) state and county MFIP administrative
274.33 costs under Minnesota Statutes, chapters
274.34 256J and 256K;

275.1 (4) state, county, and tribal MFIP
275.2 employment services under Minnesota
275.3 Statutes, chapters 256J and 256K;
275.4 (5) expenditures made on behalf of
275.5 noncitizen MFIP recipients who qualify
275.6 for the medical assistance without federal
275.7 financial participation program under
275.8 Minnesota Statutes, section 256B.06,
275.9 subdivision 4, paragraphs (d), (e), and (j);
275.10 and
275.11 (6) qualifying working family credit
275.12 expenditures under Minnesota Statutes,
275.13 section 290.0671.
275.14 (b) The commissioner shall ensure that
275.15 sufficient qualified nonfederal expenditures
275.16 are made each year to meet the state's
275.17 TANF/MOE requirements. For the activities
275.18 listed in paragraph (a), clauses (2) to
275.19 (6), the commissioner may only report
275.20 expenditures that are excluded from the
275.21 definition of assistance under Code of
275.22 Federal Regulations, title 45, section 260.31.
275.23 (c) For fiscal years beginning with state
275.24 fiscal year 2003, the commissioner shall
275.25 ensure that the maintenance of effort used
275.26 by the commissioner of finance for the
275.27 February and November forecasts required
275.28 under Minnesota Statutes, section 16A.103,
275.29 contains expenditures under paragraph (a),
275.30 clause (1), equal to at least 16 percent of
275.31 the total required under Code of Federal
275.32 Regulations, title 45, section 263.1.
275.33 (d) For the federal fiscal year beginning
275.34 October 1, 2007, the commissioner may not
275.35 claim an amount of TANF/MOE in excess of

276.1 the 75 percent standard in Code of Federal
276.2 Regulations, title 45, section 263.1(a)(2),
276.3 except:
276.4 (1) to the extent necessary to meet the 80
276.5 percent standard under Code of Federal
276.6 Regulations, title 45, section 263.1(a)(1),
276.7 if it is determined by the commissioner
276.8 that the state will not meet the TANF work
276.9 participation target rate for the current year;
276.10 (2) to provide any additional amounts
276.11 under Code of Federal Regulations, title 45,
276.12 section 264.5, that relate to replacement of
276.13 TANF funds due to the operation of TANF
276.14 penalties; and
276.15 (3) to provide any additional amounts that
276.16 may contribute to avoiding or reducing
276.17 TANF work participation penalties through
276.18 the operation of the excess MOE provisions
276.19 of Code of Federal Regulations, title 45,
276.20 section 261.43(a)(2).
276.21 For the purposes of clauses (1) to (3),
276.22 the commissioner may supplement the
276.23 MOE claim with working family credit
276.24 expenditures to the extent such expenditures
276.25 or other qualified expenditures are otherwise
276.26 available after considering the expenditures
276.27 allowed in this section.
276.28 (e) Minnesota Statutes, section 256.011,
276.29 subdivision 3, which requires that federal
276.30 grants or aids secured or obtained under that
276.31 subdivision be used to reduce any direct
276.32 appropriations provided by law, do not apply
276.33 if the grants or aids are federal TANF funds.

277.1 (f) Notwithstanding any contrary provision
277.2 in this article, this provision expires June 30,
277.3 2013.

277.4 **Working Family Credit Expenditures as**
277.5 **TANF/MOE.** The commissioner may claim
277.6 as TANF/MOE up to \$6,707,000 per year for
277.7 fiscal year 2010 through fiscal year 2011.

277.8 **Working Family Credit Expenditures**
277.9 **to be Claimed for TANF/MOE.** The
277.10 commissioner may count the following
277.11 amounts of working family credit expenditure
277.12 as TANF/MOE:

277.13 (1) fiscal year 2010, \$6,707,000;
277.14 (2) fiscal year 2011, \$32,387,000;
277.15 (3) fiscal year 2012, \$38,052,000; and
277.16 (4) fiscal year 2013, \$42,555,000.

277.17 Notwithstanding any contrary provision in
277.18 this article, this rider expires June 30, 2013.

277.19 **TANF Transfer to Federal Child Care**
277.20 **and Development Fund.** The following
277.21 TANF fund amounts are appropriated to the
277.22 commissioner for the purposes of MFIP and
277.23 transition year child care under Minnesota
277.24 Statutes, section 119B.05:

277.25 (1) fiscal year 2010, \$0;
277.26 (2) fiscal year 2011, \$25,680,000;
277.27 (3) fiscal year 2012, \$31,345,000; and
277.28 (4) fiscal year 2013, \$35,848,000.

277.29 The commissioner shall authorize the
277.30 transfer of sufficient TANF funds to the
277.31 federal child care and development fund to
277.32 meet this appropriation and shall ensure that
277.33 all transferred funds are expended according

278.1 to federal child care and development fund
278.2 regulations. The transferred funds shall be
278.3 used to offset any general fund reductions to
278.4 MFIP child care in this article.

278.5 **Child Care and Development Fund**

278.6 **Unexpended Balance.** The commissioner
278.7 shall determine the unexpended balance of
278.8 the federal Child Care and Development
278.9 Fund (CCDF) for the basic sliding fee child
278.10 care program by February 28, 2009. The
278.11 balance must first be used to fund programs
278.12 described in paragraph (b) and the remainder
278.13 must be available for the basic sliding fee
278.14 child care under Minnesota Statutes, section
278.15 119B.03.

278.16 **Food Stamps Employment and Training.**

278.17 Notwithstanding Minnesota Statutes, sections
278.18 256J.626 and 256D.051, subdivisions 1a, 6b,
278.19 and 6c, federal food stamps employment and
278.20 training funds received as reimbursement of
278.21 MFIP consolidated fund grant expenditures
278.22 and child care assistance program
278.23 expenditures for two-parent families must be
278.24 deposited in the general fund. The amount of
278.25 funds must be limited to \$3,400,000 in fiscal
278.26 year 2010 and \$4,400,000 in fiscal years
278.27 2011 through 2013, contingent on approval
278.28 by the federal Food and Nutrition Service.
278.29 Consistent with the receipt of these federal
278.30 funds, the commissioner may adjust the
278.31 level of working family credit expenditures
278.32 claimed as TANF maintenance of effort.
278.33 Notwithstanding any contrary provision in
278.34 this article, this rider expires June 30, 2013.

279.1 **Emergency Fund for the TANF Program.**

279.2 TANF Emergency Contingency funds
 279.3 available under the American Recovery
 279.4 and Reinvestment Act of 2009 (Public Law
 279.5 111-5) are appropriated to the commissioner.

279.6 The commissioner must request TANF
 279.7 Emergency Contingency funds from the
 279.8 Secretary of the Department of Health
 279.9 and Human Services to the extent the
 279.10 commissioner meets or expects to meet the
 279.11 requirements of section 403(c) of the Social
 279.12 Security Act. The commissioner must seek
 279.13 to maximize such grants. The funds received
 279.14 must be used as appropriated.

279.15 **Subd. 2. Agency Management**

279.16 The amounts that may be spent from the
 279.17 appropriation for each purpose are as follows:

279.18 **(a) Financial Operations**

279.19	<u>Appropriations by Fund</u>		
279.20	<u>General</u>	<u>3,380,000</u>	<u>3,908,000</u>
279.21	<u>Health Care Access</u>	<u>1,241,000</u>	<u>1,016,000</u>
279.22	<u>Federal TANF</u>	<u>122,000</u>	<u>122,000</u>

279.23 **(b) Legal and Regulatory Operations**

279.24	<u>Appropriations by Fund</u>		
279.25	<u>General</u>	<u>13,710,000</u>	<u>13,495,000</u>
279.26	<u>State Government</u>		
279.27	<u>Special Revenue</u>	<u>440,000</u>	<u>440,000</u>
279.28	<u>Health Care Access</u>	<u>943,000</u>	<u>943,000</u>
279.29	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

279.30 **Base Adjustment.** The general fund base
 279.31 is decreased \$4,550,000 in fiscal year 2012
 279.32 and \$4,550,000 in fiscal year 2013. The state
 279.33 government special revenue fund base is
 279.34 increased \$4,500,000 in fiscal year 2012 and
 279.35 \$4,500,000 in fiscal year 2013.

280.1 **(c) Management Operations**

280.2 Appropriations by Fund

280.3 General 4,715,000 4,715,000

280.4 Health Care Access 242,000 242,000

280.5 **(d) Information Technology Operations**

280.6 Appropriations by Fund

280.7 General 28,077,000 28,077,000

280.8 Health Care Access 4,856,000 4,868,000

280.9 **Subd. 3. Revenue and Pass-Through Revenue**

280.10 **Expenditures** 65,746,000 92,748,000

280.11 This appropriation is from the federal TANF

280.12 fund.

280.13 **Subd. 4. Children and Economic Assistance**

280.14 **Grants**

280.15 The amounts that may be spent from this

280.16 appropriation for each purpose are as follows:

280.17 **(a) MFIP/DWP Grants**

280.18 Appropriations by Fund

280.19 General 68,634,000 98,587,000

280.20 Federal TANF 96,333,000 64,709,000

280.21 **(b) Support Services Grants**

280.22 Appropriations by Fund

280.23 General 8,715,000 8,715,000

280.24 Federal TANF 113,711,000 99,111,000

280.25 **MFIP Consolidated Fund.** The MFIP

280.26 consolidated fund TANF appropriation is

280.27 reduced by \$5,500,000 in fiscal year 2011.

280.28 **TANF Emergency Fund; Nonrecurrent**

280.29 **Short-Term Benefits.** TANF Emergency

280.30 Contingency fund grants received due to

280.31 increases in expenditures for nonrecurrent

280.32 short-term benefits must be used to offset the

280.33 increase in these expenditures for counties

280.34 under the MFIP consolidated fund under

281.1 Minnesota Statutes, section 256J.626,
 281.2 and the diversionary work program. The
 281.3 commissioner shall develop procedures
 281.4 to maximize reimbursement of these
 281.5 expenditures over the TANF emergency fund
 281.6 base year quarters.

281.7 **(c) MFIP Child Care Assistance Grants** 0 (25,680,000)

281.8 **ARRA Child Care and Development Block**
 281.9 **Grant Funds.** The funds available from the
 281.10 child care development block grant under
 281.11 the American Recovery and Reinvestment
 281.12 Act of 2009 (ARRA) must be used for MFIP
 281.13 child care to the extent that those funds are
 281.14 not earmarked for quality expansion or to
 281.15 improve the quality of infant and toddler
 281.16 care.

281.17 **(d) Child Care Development Grants** 4,000 4,000

281.18 **(e) Child Support Enforcement Grants** 3,705,000 3,705,000

281.19 **(f) Children's Services Grants**

281.20	<u>Appropriations by Fund</u>		
281.21	<u>General</u>	<u>47,533,000</u>	<u>50,498,000</u>
281.22	<u>Federal TANF</u>	<u>340,000</u>	<u>240,000</u>

281.23 **Base Adjustment.** The general fund base is
 281.24 increased by \$3,094,000 in fiscal year 2012
 281.25 and \$18,907,000 in fiscal year 2013.

281.26 **Privatized Adoption Grants.** Federal
 281.27 reimbursement for privatized adoption grant
 281.28 and foster care recruitment grant expenditures
 281.29 is appropriated to the commissioner for
 281.30 adoption grants and foster care and adoption
 281.31 administrative purposes.

281.32 **Adoption Assistance Incentive Grants.**
 281.33 Federal funds available during fiscal year
 281.34 2010 and fiscal year 2011 for the adoption

282.1 incentive grants are appropriated to the
 282.2 commissioner for these purposes.

282.3 **Adoption Assistance and Relative Custody**
 282.4 **Assistance.** The commissioner may transfer
 282.5 unencumbered appropriation balances for
 282.6 adoption assistance and relative custody
 282.7 assistance between fiscal years and between
 282.8 programs.

282.9 <u>(g) Children and Community Services Grants</u>	<u>67,604,000</u>	<u>67,463,000</u>
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282.10 **Targeted Case Management Temporary**
 282.11 **Funding Adjustment.** The commissioner
 282.12 shall recover from each county and tribe
 282.13 receiving a targeted case management
 282.14 temporary funding payment in fiscal year
 282.15 2008 an amount equal to that payment. The
 282.16 commissioner shall recover one-half of the
 282.17 funds by February 1, 2010, and the remainder
 282.18 by February 1, 2011. At the commissioner's
 282.19 discretion and at the request of a county
 282.20 or tribe, the commissioner may revise
 282.21 the payment schedule, but full payment
 282.22 must not be delayed beyond May 1, 2011.
 282.23 The commissioner may use the recovery
 282.24 procedure under Minnesota Statutes, section
 282.25 256.017, to recover the funds. Recovered
 282.26 funds must be deposited into the general
 282.27 fund.

282.28 <u>(h) General Assistance Grants</u>	<u>49,315,000</u>	<u>49,708,000</u>
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282.29 **General Assistance Standard.** The
 282.30 commissioner shall set the monthly standard
 282.31 of assistance for general assistance units
 282.32 consisting of an adult recipient who is
 282.33 childless and unmarried or living apart
 282.34 from parents or a legal guardian at \$203.
 282.35 The commissioner may reduce this amount

283.1 according to Laws 1997, chapter 85, article
 283.2 3, section 54.

283.3 **Combining Emergency Assistance for**
 283.4 **MSA and GA.** The amount appropriated
 283.5 for emergency general assistance funds is
 283.6 limited to no more than \$8,989,812 in fiscal
 283.7 year 2010 and \$8,989,812 in fiscal year 2011.
 283.8 Funds to counties must be allocated by the
 283.9 commissioner using the allocation method
 283.10 specified in Minnesota Statutes, section
 283.11 256D.06.

283.12	<u>(i) Minnesota Supplemental Aid Grants</u>	<u>32,830,000</u>	<u>34,091,000</u>
283.13	<u>(j) Group Residential Housing Grants</u>	<u>111,689,000</u>	<u>113,937,000</u>
283.14	<u>(k) Other Children and Economic Assistance</u>		
283.15	<u>Grants</u>	<u>285,000</u>	<u>569,000</u>
283.16	<u>(l) Children's Mental Health Grants</u>	<u>16,885,000</u>	<u>16,882,000</u>

283.17 **Funding Usage.** Up to 75 percent of a fiscal
 283.18 year's appropriation for children's mental
 283.19 health grants may be used to fund allocations
 283.20 in that portion of the fiscal year ending
 283.21 December 31.

283.22 **Subd. 5. Children and Economic Assistance**
 283.23 **Management**

283.24 The amounts that may be spent from the
 283.25 appropriation for each purpose are as follows:

283.26 **(a) Children and Economic Assistance**
 283.27 **Administration**

283.28	<u>Appropriations by Fund</u>		
283.29	<u>General</u>	<u>10,218,000</u>	<u>10,208,000</u>
283.30	<u>Federal TANF</u>	<u>496,000</u>	<u>496,000</u>

283.31 **(b) Children and Economic Assistance**
 283.32 **Operations**

283.33	<u>Appropriations by Fund</u>		
283.34	<u>General</u>	<u>33,773,000</u>	<u>33,423,000</u>
283.35	<u>Health Care Access</u>	<u>361,000</u>	<u>361,000</u>

284.1 **Financial Institution Data Match and**
 284.2 **Payment of Fees.** The commissioner is
 284.3 authorized to allocate up to \$310,000 each
 284.4 year in fiscal years 2010 and 2011 from the
 284.5 PRISM special revenue account to make
 284.6 payments to financial institutions in exchange
 284.7 for performing data matches between account
 284.8 information held by financial institutions
 284.9 and the public authority's database of child
 284.10 support obligors as authorized by Minnesota
 284.11 Statutes, section 13B.06, subdivision 7.

284.12 **Subd. 6. Basic Health Care Grants**

284.13 **ARRA Food Support Administration.**
 284.14 The funds available for food support
 284.15 administration under American Recovery
 284.16 and Reinvestment Act of 2009 must
 284.17 be appropriated to the commissioner
 284.18 for implementing the food support benefit
 284.19 increases, increased eligibility determinations
 284.20 and outreach. Of these funds, 20 percent
 284.21 shall be allocated to the commissioner and
 284.22 80 percent must be allocated to counties.
 284.23 The commissioner shall reimburse counties
 284.24 proportionate to their food support caseload
 284.25 based on data for the most recent quarter
 284.26 available. Tribal reimbursement must be
 284.27 made from the state portion based on a
 284.28 caseload factor equivalent to that of a county.

284.29 The amounts that may be spent from this
 284.30 appropriation for each purpose are as follows:

284.31 <u>(a) MinnesotaCare Grants</u>	<u>414,258,000</u>	<u>513,994,000</u>
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284.32 This appropriation is from the health care
 284.33 access fund.

284.34 <u>(b) MA Basic Health Care Grants - Families</u>		
284.35 <u>and Children</u>	<u>755,064,000</u>	<u>1,002,267,000</u>

285.1 **Medical Education Research Costs**

285.2 **(MERC).** Of these funds, the commissioner
285.3 of human services shall transfer \$38,000,000
285.4 in fiscal year 2010 to the medical education
285.5 research fund. These funds must restore the
285.6 fiscal year 2009 unallotment of the transfers
285.7 under Minnesota Statutes, section 256B.69,
285.8 subdivision 5c, paragraph (a), for the July 1,
285.9 2008, through June 30, 2009, period.

285.10 **Local Share Payment Modification**

285.11 **Required for ARRA Compliance.**

285.12 Effective retroactively from October 1, 2008,
285.13 to June 30, 2009, the state shall reduce
285.14 Hennepin County's monthly contribution to
285.15 the nonfederal share of medical assistance
285.16 costs to the percentage required on September
285.17 1, 2008, to meet federal requirements for
285.18 enhanced federal match under the American
285.19 Reinvestment and Recovery Act of 2009.
285.20 Notwithstanding the requirements of
285.21 Minnesota Statutes 2008, section 256B.19,
285.22 subdivision 1c, paragraph (d), for the period
285.23 beginning October 1, 2008, to June 30, 2009,
285.24 Hennepin County's monthly payment under
285.25 that provision is reduced to \$434,688.

285.26 **Capitation Payments.** Effective

285.27 retroactively from October 1, 2008, to
285.28 December 31, 2010, and notwithstanding
285.29 the requirements of Minnesota Statutes
285.30 2008, section 256B.19, subdivision 1c,
285.31 paragraph (c), the commissioner of human
285.32 services shall increase capitation payments
285.33 made to the Metropolitan Health Plan
285.34 under Minnesota Statutes 2008, section
285.35 256B.69, by \$6,800,000 to recognize higher
285.36 than average medical education costs. The

286.1 increased amount includes federal matching
 286.2 money.

286.3 **(c) MA Basic Health Care Grants - Elderly and**
 286.4 **Disabled**

969,013,000 1,177,139,000

286.5 **Minnesota Disability Health Options.**

286.6 Notwithstanding Minnesota Statutes, section
 286.7 256B.69, subdivision 5a, paragraph (b),
 286.8 for the period beginning July 1, 2009, to
 286.9 June 30, 2011, the monthly enrollment of
 286.10 people receiving home and community-based
 286.11 waivered services under Minnesota Disability
 286.12 Health Options shall not exceed 1,000. If
 286.13 the budget neutrality provision in Minnesota
 286.14 Statutes, section 256B.69, subdivision 23,
 286.15 paragraph (f), is reached prior to June 30,
 286.16 2011, the commissioner may waive this
 286.17 monthly enrollment requirement.

286.18 **(d) General Assistance Medical Care Grants**

286.19	<u>Appropriations by Fund</u>		
286.20	<u>General</u>	<u>252,061,000</u>	<u>380,555,000</u>
286.21	<u>Federal</u>	<u>99,300,000</u>	<u>0</u>

286.22 **Use of Federal Funds.** \$99,300,000 in fiscal
 286.23 year 2010 is appropriated from the fiscal
 286.24 stabilization funds in the federal fund. This
 286.25 is a onetime appropriation.

286.26 **(e) Other Health Care Grants**

286.27	<u>Appropriations by Fund</u>		
286.28	<u>General</u>	<u>295,000</u>	<u>295,000</u>
286.29	<u>Health Care Access</u>	<u>940,000</u>	<u>190,000</u>

286.30 **Subd. 7. Health Care Management**

286.31 The amounts that may be spent from the
 286.32 appropriation for each purpose are as follows:

286.33 **(a) Health Care Administration**

287.1	<u>Appropriations by Fund</u>		
287.2	<u>General</u>	<u>7,779,000</u>	<u>7,535,000</u>
287.3	<u>Health Care Access</u>	<u>1,812,000</u>	<u>906,000</u>

287.4 **(b) Health Care Operations**

287.5	<u>Appropriations by Fund</u>		
287.6	<u>General</u>	<u>19,902,000</u>	<u>18,869,000</u>
287.7	<u>Health Care Access</u>	<u>24,753,000</u>	<u>25,578,000</u>

287.8 **Base Adjustment.** The health care access
 287.9 fund base is decreased by \$62,000 in fiscal
 287.10 year 2012 and \$149,000 in fiscal year 2013.

287.11 The general fund base is decreased by
 287.12 \$157,000 in fiscal year 2012 and \$157,000 in
 287.13 fiscal year 2013.

287.14 **Subd. 8. Continuing Care Grants**

287.15 The amounts that may be spent from the
 287.16 appropriation for each purpose are as follows:

287.17 **(a) Aging and Adult Services Grants**

287.18	<u>Appropriations by Fund</u>		
287.19	<u>General</u>	<u>13,186,000</u>	<u>13,702,000</u>
287.20	<u>Federal</u>	<u>500,000</u>	<u>0</u>

287.21 **Base Adjustment.** The general fund base is
 287.22 increased by \$6,643,000 in fiscal year 2012
 287.23 and \$7,511,000 in fiscal year 2013.

287.24 **Information and Assistance**

287.25 **Reimbursement.** Federal administrative
 287.26 reimbursement obtained from information
 287.27 and assistance services provided by the
 287.28 Senior LinkAge or Disability Linkage lines
 287.29 to people who are identified as eligible for
 287.30 medical assistance shall be appropriated to
 287.31 the commissioner for this activity.

287.32 **Community Service Development Grant**

287.33 **Reduction.** Funding for community service
 287.34 development grants must be reduced by

288.1 \$240,000 per year for fiscal years 2010 and
 288.2 2011. This reduction shall not adjust the base
 288.3 appropriation.

288.4 **Senior Nutrition Use of Federal Funds.**

288.5 For fiscal year 2010, general fund grants
 288.6 for home-delivered meals shall be reduced
 288.7 by \$250,000 and general fund grants for
 288.8 congregate dining shall be reduced by
 288.9 \$250,000. The commissioner must replace
 288.10 these general fund reductions with equal
 288.11 amounts from federal funding for senior
 288.12 nutrition from the American Recovery and
 288.13 Reinvestment Act of 2009.

288.14 <u>(b) Alternative Care Grants</u>	<u>51,165,000</u>	<u>50,976,000</u>
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288.15 **Base Adjustment.** The general fund base is
 288.16 decreased by \$6,068,000 in fiscal year 2012
 288.17 and \$6,449,000 in fiscal year 2013.

288.18 **Alternative Care Transfer.** Any money
 288.19 allocated to the alternative care program that
 288.20 is not spent for the purposes indicated does
 288.21 not cancel but must be transferred to the
 288.22 medical assistance account.

288.23 <u>(c) Medical Assistance Grants; Long-Term</u> 288.24 <u>Care Facilities.</u>	<u>366,293,000</u>	<u>426,549,000</u>
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288.25 <u>(d) Medical Assistance Long-Term Care</u> 288.26 <u>Waivers and Home Care Grants</u>	<u>853,824,000</u>	<u>1,054,067,000</u>
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288.27 **Manage Growth in TBI and CADI**

288.28 **Waivers.** During the fiscal years beginning
 288.29 on July 1, 2011, and July 1, 2012, the
 288.30 commissioner shall allocate money for home
 288.31 and community-based waiver programs
 288.32 under Minnesota Statutes, section 256B.49,
 288.33 to ensure a reduction in state spending that is
 288.34 equivalent to limiting the caseload growth of
 288.35 the TBI waiver to 12.5 allocations per month

289.1 each year of the biennium and the CADI
289.2 waiver to 95 allocations per month each year
289.3 of the biennium. Limits do not apply: (1)
289.4 when there is an approved plan for nursing
289.5 facility bed closures for individuals under
289.6 age 65 who require relocation due to the
289.7 bed closure; (2) to fiscal year 2009 waiver
289.8 allocations delayed due to unallotment; or (3)
289.9 to transfers authorized by the commissioner
289.10 from the personal care assistance program
289.11 of individuals having a home care rating
289.12 of "CS," "MT," or "HL." Priorities for the
289.13 allocation of funds must be for individuals
289.14 anticipated to be discharged from institutional
289.15 settings or who are at imminent risk of a
289.16 placement in an institutional setting.

289.17 **Manage Growth in DD Waiver.** The
289.18 commissioner shall manage the growth in
289.19 the DD waiver by limiting the allocations
289.20 included in the February 2009 forecast to 15
289.21 additional diversion allocations each month
289.22 for the calendar years that begin on January
289.23 1, 2012, and January 1, 2013. Additional
289.24 allocations must be made available for
289.25 transfers authorized by the commissioner
289.26 from the personal care program of individuals
289.27 having a home care rating of "CS," "MT,"
289.28 or "HL."

289.29 **Adjustment to Lead Agency Waiver**
289.30 **allocations.** Prior to the availability of the
289.31 alternative license defined in Minnesota
289.32 Statutes, section 245A.11, subdivision 8,
289.33 the commissioner shall reduce lead agency
289.34 waiver allocations for the purposes of
289.35 implementing a moratorium on corporate
289.36 foster care.

290.1 **(e) Mental Health Grants**

290.2 Appropriations by Fund

290.3	<u>General</u>	<u>75,089,000</u>	<u>77,539,000</u>
290.4	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
290.5	<u>Lottery Prize</u>	<u>1,508,000</u>	<u>1,508,000</u>

290.6 **Funding Usage.** Up to 75 percent of a fiscal
 290.7 year's appropriation for adult mental health
 290.8 grants may be used to fund allocations in that
 290.9 portion of the fiscal year ending December
 290.10 31.

290.11 **Base Adjustment.** The general fund base is
 290.12 reduced by \$525,000 in fiscal year 2012 and
 290.13 \$525,000 in fiscal year 2013.

290.14 **(f) Deaf and Hard-of-Hearing Grants** 1,924,000 1,909,000

290.15 **(g) Chemical Dependency Entitlement Grants** 109,989,000 120,133,000

290.16 **Payments for Substance Abuse Treatment.**

290.17 For services provided in fiscal years 2010
 290.18 and 2011, county-negotiated rates and
 290.19 provider claims to the consolidated chemical
 290.20 dependency fund must not exceed rates
 290.21 charged for services in excess of those
 290.22 in effect on January 1, 2009. If statutes
 290.23 authorize a cost-of-living adjustment
 290.24 during fiscal years 2010 and 2011, then
 290.25 notwithstanding any law to the contrary,
 290.26 fiscal years 2010 and 2011 rates must
 290.27 not exceed those in effect on January 2,
 290.28 2009, plus any authorized cost-of-living
 290.29 adjustments.

290.30 **Chemical Dependency Special Revenue**

290.31 **Account.** For fiscal year 2010, \$750,000
 290.32 must be transferred from the consolidated
 290.33 chemical dependency treatment fund

291.1 administrative account and deposited into the
 291.2 general fund by September 1, 2010.

291.3 **(h) Chemical Dependency Nonentitlement**
 291.4 **Grants**

1,729,000 1,729,000

291.5 **(i) Other Continuing Care Grants**

17,958,000 11,941,000

291.6 **Base Adjustment.** The general fund base is
 291.7 increased \$424,000 in fiscal year 2012 and
 291.8 decreased \$505,000 in fiscal year 2013.

291.9 **Other Continuing Care Grants; HIV**

291.10 **Grants.** Money appropriated for the HIV
 291.11 drug and insurance grant program in fiscal
 291.12 year 2010 may be used in either year of the
 291.13 biennium.

291.14 **Subd. 9. Continuing Care Management**

291.15	<u>Appropriations by Fund</u>		
291.16	<u>General</u>	<u>21,775,000</u>	<u>21,119,000</u>
291.17	<u>State Government</u>		
291.18	<u>Special Revenue</u>	<u>875,000</u>	<u>125,000</u>
291.19	<u>Lottery Prize</u>	<u>157,000</u>	<u>157,000</u>

291.20 **County Maintenance of Effort.** \$350,000 in
 291.21 fiscal year 2010 is from the general fund for
 291.22 the State-County Results Accountability and
 291.23 Service Delivery Reform under Minnesota
 291.24 Statutes, chapter 402A.

291.25 The general fund base is increased
 291.26 \$1,000,000 in fiscal year 2012 and \$950,000
 291.27 in fiscal year 2013.

291.28 **Subd. 10. State-Operated Services** 255,484,000 262,881,000

291.29 The amounts that may be spent from the
 291.30 appropriation for each purpose are as follows:

291.31 **Transfer Authority Related to**

291.32 **State-Operated Services.** Money
 291.33 appropriated to finance state-operated
 291.34 services may be transferred between the

292.1 fiscal years of the biennium with the approval
 292.2 of the commissioner of finance.

292.3 **County Past Due Receivables.** The
 292.4 commissioner is authorized to withhold
 292.5 county federal administrative reimbursement
 292.6 when the county of financial responsibility
 292.7 for cost-of-care payments due the state
 292.8 under Minnesota Statutes, section 246.54
 292.9 or 253B.045, is 90 days past due. The
 292.10 commissioner shall deposit the withheld
 292.11 federal administrative earnings for the county
 292.12 into the general fund to settle the claims with
 292.13 the county of financial responsibility. The
 292.14 process for withholding funds is governed by
 292.15 Minnesota Statutes, section 256.017.

292.16 <u>(a) Adult Mental Health Services</u>	<u>106,906,000</u>	<u>111,643,000</u>
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292.17 **Appropriation Limitation.** No part of
 292.18 the appropriation in this article to the
 292.19 commissioner for mental health treatment
 292.20 services provided by state-operated services
 292.21 shall be used for the Minnesota sex offender
 292.22 program.

292.23 **Community Behavioral Health Hospitals.**
 292.24 Under Minnesota Statutes, section 246.51,
 292.25 subdivision 1, a determination order for the
 292.26 clients served in a community behavioral
 292.27 health hospital operated by the commissioner
 292.28 of human services is only required when
 292.29 a client's third-party coverage has been
 292.30 exhausted.

292.31 <u>(b) Minnesota Sex Offender Services</u>	<u>64,843,000</u>	<u>67,503,000</u>
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292.32 <u>(c) Minnesota Security</u>		
292.33 <u>Hospital and METO</u>		
292.34 <u>Services</u>	<u>83,735,000</u>	<u>83,735,000</u>

294.1 In performing this study, the commissioner
294.2 shall consult with and seek input from
294.3 health plans, health care providers, and
294.4 employers. The commissioner shall report to
294.5 the legislature by January 15, 2010.

294.6 **Health Information Technology.** Of the
294.7 general fund appropriation, \$4,000,000 is
294.8 to fund the revolving loan account under
294.9 Minnesota Statutes, section 62J.496. This
294.10 appropriation must not be expended unless
294.11 it is matched with federal funding under the
294.12 federal Health Information Technology for
294.13 Economic and Clinical Health (HITECH)
294.14 Act. This appropriation must not be included
294.15 in the agency's base budget for the fiscal year
294.16 beginning July 1, 2012.

294.17 **Base Adjustment.** The general fund
294.18 base is \$8,801,000 in fiscal year 2012 and
294.19 \$8,593,000 in fiscal year 2013. The health
294.20 care access fund base is \$10,775,000 in fiscal
294.21 year 2012 and \$6,641,000 in fiscal year 2013.
294.22 The state government special revenue fund
294.23 base is \$14,234,000 for each of fiscal years
294.24 2012 and 2013.

294.25 Sec. 5. Laws 2007, chapter 147, article 19, section 3, subdivision 4, as amended by
294.26 Laws 2008, chapter 277, article 5, section 1; and Laws 2008, chapter 363, article 18,
294.27 section 7, is amended to read:

294.28 Subd. 4. **Children and Economic Assistance**
294.29 **Grants**

294.30 The amounts that may be spent from this
294.31 appropriation for each purpose are as follows:

294.32 (a) **MFIP/DWP Grants**

295.1	Appropriations by Fund		
295.2	General	62,069,000	62,405,000
295.3	Federal TANF	75,904,000	80,841,000

295.4 **(b) Support Services Grants**

295.5	Appropriations by Fund		
295.6	General	8,715,000	8,715,000
295.7	Federal TANF	113,429,000	115,902,000

295.8 **TANF Prior Appropriation Cancellation.**

295.9 Notwithstanding Laws 2001, First Special
 295.10 Session chapter 9, article 17, section
 295.11 2, subdivision 11, paragraph (b), any
 295.12 unexpended TANF funds appropriated to the
 295.13 commissioner to contract with the Board of
 295.14 Trustees of Minnesota State Colleges and
 295.15 Universities, to provide tuition waivers to
 295.16 employees of health care and human service
 295.17 providers that are members of qualifying
 295.18 consortia operating under Minnesota
 295.19 Statutes, sections 116L.10 to 116L.15, must
 295.20 cancel at the end of fiscal year 2007.

295.21 **MFIP Pilot Program.** Of the TANF
 295.22 appropriation, \$100,000 in fiscal year 2008
 295.23 and \$750,000 in fiscal year 2009 are for a
 295.24 grant to the Stearns-Benton Employment and
 295.25 Training Council for the Workforce U pilot
 295.26 program. Base level funding for this program
 295.27 shall be \$750,000 in 2010 and \$0 in 2011.

295.28 **Supported Work.** (1) Of the TANF
 295.29 appropriation, \$5,468,000 in fiscal year 2008
 295.30 is for supported work for MFIP participants,
 295.31 to be allocated to counties and tribes based
 295.32 on the criteria under clauses (2) and (3), and
 295.33 is available until expended. Paid transitional
 295.34 work experience and other supported
 295.35 employment under this rider provides

296.1 a continuum of employment assistance,
296.2 including outreach and recruitment,
296.3 program orientation and intake, testing and
296.4 assessment, job development and marketing,
296.5 preworksite training, supported worksite
296.6 experience, job coaching, and postplacement
296.7 follow-up, in addition to extensive case
296.8 management and referral services. * **(The**
296.9 **preceding text "and \$7,291,000 in fiscal**
296.10 **year 2009" was indicated as vetoed by the**
296.11 **governor.)**

296.12 (2) A county or tribe is eligible to receive an
296.13 allocation under this rider if:

296.14 (i) the county or tribe is not meeting the
296.15 federal work participation rate;

296.16 (ii) the county or tribe has participants who
296.17 are required to perform work activities under
296.18 Minnesota Statutes, chapter 256J, but are not
296.19 meeting hourly work requirements; and

296.20 (iii) the county or tribe has assessed
296.21 participants who have completed six weeks
296.22 of job search or are required to perform
296.23 work activities and are not meeting the
296.24 hourly requirements, and the county or tribe
296.25 has determined that the participant would
296.26 benefit from working in a supported work
296.27 environment.

296.28 (3) A county or tribe may also be eligible for
296.29 funds in order to contract for supplemental
296.30 hours of paid work at the participant's child's
296.31 place of education, child care location, or the
296.32 child's physical or mental health treatment
296.33 facility or office. This grant to counties and
296.34 tribes is specifically for MFIP participants
296.35 who need to work up to five hours more

297.1 per week in order to meet the hourly work
 297.2 requirement, and the participant's employer
 297.3 cannot or will not offer more hours to the
 297.4 participant.

297.5 **Work Study.** Of the TANF appropriation,
 297.6 \$750,000 each year are to the commissioner
 297.7 to contract with the Minnesota Office of
 297.8 Higher Education for the biennium beginning
 297.9 July 1, 2007, for work study grants under
 297.10 Minnesota Statutes, section 136A.233,
 297.11 specifically for low-income individuals who
 297.12 receive assistance under Minnesota Statutes,
 297.13 chapter 256J, and for grants to opportunities
 297.14 industrialization centers. * (The preceding
 297.15 text beginning "Work Study. Of the TANF
 297.16 appropriation," was indicated as vetoed
 297.17 by the governor.)

297.18 **Integrated Service Projects.** \$2,500,000
 297.19 in fiscal year 2008 and \$2,500,000 in fiscal
 297.20 year 2009 are appropriated from the TANF
 297.21 fund to the commissioner to continue to
 297.22 fund the existing integrated services projects
 297.23 for MFIP families, and if funding allows,
 297.24 additional similar projects.

297.25 **Base Adjustment.** The TANF base for fiscal
 297.26 year 2010 is \$115,902,000 and for fiscal year
 297.27 2011 is \$115,152,000.

297.28 (c) **MFIP Child Care Assistance Grants**

297.29	General	74,654,000	71,951,000
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297.30 (d) **Basic Sliding Fee Child Care Assistance**
 297.31 **Grants**

297.32	General	42,995,000	45,008,000
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298.1 **Base Adjustment.** The general fund base
 298.2 is \$44,881,000 for fiscal year 2010 and
 298.3 \$44,852,000 for fiscal year 2011.

298.4 **At-Home Infant Care Program.** No
 298.5 funding shall be allocated to or spent on
 298.6 the at-home infant care program under
 298.7 Minnesota Statutes, section 119B.035.

298.8 **(e) Child Care Development Grants**

298.9 General	4,390,000	6,390,000
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298.10 **Prekindergarten Exploratory Projects.** Of
 298.11 the general fund appropriation, \$2,000,000
 298.12 the first year and \$4,000,000 the second
 298.13 year are for grants to the city of St. Paul,
 298.14 Hennepin County, and Blue Earth County to
 298.15 establish scholarship demonstration projects
 298.16 to be conducted in partnership with the
 298.17 Minnesota Early Learning Foundation to
 298.18 promote children's school readiness. This
 298.19 appropriation is available until June 30, 2009.

298.20 **Child Care Services Grants.** Of this
 298.21 appropriation, \$250,000 each year are for
 298.22 the purpose of providing child care services
 298.23 grants under Minnesota Statutes, section
 298.24 119B.21, subdivision 5. This appropriation
 298.25 is for the 2008-2009 biennium only, and does
 298.26 not increase the base funding.

298.27 **Early Childhood Professional**

298.28 **Development System.** Of this appropriation,
 298.29 \$250,000 each year are for purposes of the
 298.30 early childhood professional development
 298.31 system, which increases the quality and
 298.32 continuum of professional development
 298.33 opportunities for child care practitioners.
 298.34 This appropriation is for the 2008-2009

299.1 biennium only, and does not increase the
 299.2 base funding.

299.3 **Base Adjustment.** The general fund base
 299.4 is \$1,515,000 for each of fiscal years 2010
 299.5 and 2011.

299.6 **(f) Child Support Enforcement Grants**

299.7	General	11,038,000	3,705,000
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299.8 **Child Support Enforcement.** \$7,333,000
 299.9 for fiscal year 2008 is to make grants to
 299.10 counties for child support enforcement
 299.11 programs to make up for the loss under the
 299.12 2005 federal Deficit Reduction Act of federal
 299.13 matching funds for federal incentive funds
 299.14 passed on to the counties by the state.

299.15 This appropriation is available until June 30,
 299.16 2009.

299.17 **(g) Children's Services Grants**

	Appropriations by Fund		
299.18			
299.19	General	63,647,000	71,147,000
299.20	Health Care Access	250,000	-0-
299.21	TANF	240,000	340,000

299.22 **Grants for Programs Serving Young**

299.23 **Parents.** Of the TANF fund appropriation,
 299.24 \$140,000 each year is for a grant to a program
 299.25 or programs that provide comprehensive
 299.26 services through a private, nonprofit agency
 299.27 to young parents in Hennepin County who
 299.28 have dropped out of school and are receiving
 299.29 public assistance. The program administrator
 299.30 shall report annually to the commissioner on
 299.31 skills development, education, job training,
 299.32 and job placement outcomes for program
 299.33 participants.

300.1 **County Allocations for Rate Increases.**

300.2 County Children and Community Services

300.3 Act allocations shall be increased by

300.4 \$197,000 effective October 1, 2007, and

300.5 \$696,000 effective October 1, 2008, to help

300.6 counties pay for the rate adjustments to

300.7 day training and habilitation providers for

300.8 participants paid by county social service

300.9 funds. Notwithstanding the provisions of

300.10 Minnesota Statutes, section 256M.40, the

300.11 allocation to a county shall be based on

300.12 the county's proportion of social services

300.13 spending for day training and habilitation

300.14 services as determined in the most recent

300.15 social services expenditure and grant

300.16 reconciliation report.

300.17 **Privatized Adoption Grants.** Federal

300.18 reimbursement for privatized adoption grant

300.19 and foster care recruitment grant expenditures

300.20 is appropriated to the commissioner for

300.21 adoption grants and foster care and adoption

300.22 administrative purposes.

300.23 **Adoption Assistance Incentive Grants.**

300.24 Federal funds available during fiscal year

300.25 2008 and fiscal year 2009 for the adoption

300.26 incentive grants are appropriated to the

300.27 commissioner for these purposes.

300.28 **Adoption Assistance and Relative Custody**

300.29 **Assistance.** The commissioner may transfer

300.30 unencumbered appropriation balances for

300.31 adoption assistance and relative custody

300.32 assistance between fiscal years and between

300.33 programs.

300.34 **Children's Mental Health Grants.** Of the

300.35 general fund appropriation, \$5,913,000 in

301.1 fiscal year 2008 and \$6,825,000 in fiscal year
301.2 2009 are for children's mental health grants.
301.3 The purpose of these grants is to increase and
301.4 maintain the state's children's mental health
301.5 service capacity, especially for school-based
301.6 mental health services. The commissioner
301.7 shall require grantees to utilize all available
301.8 third party reimbursement sources as a
301.9 condition of using state grant funds. At
301.10 least 15 percent of these funds shall be
301.11 used to encourage efficiencies through early
301.12 intervention services. At least another 15
301.13 percent shall be used to provide respite care
301.14 services for children with severe emotional
301.15 disturbance at risk of out-of-home placement.

301.16 **Mental Health Crisis Services.** Of the
301.17 general fund appropriation, \$2,528,000 in
301.18 fiscal year 2008 and \$2,850,000 in fiscal year
301.19 2009 are for statewide funding of children's
301.20 mental health crisis services. Providers must
301.21 utilize all available funding streams.

301.22 **Children's Mental Health Evidence-Based**
301.23 **and Best Practices.** Of the general fund
301.24 appropriation, \$375,000 in fiscal year 2008
301.25 and \$750,000 in fiscal year 2009 are for
301.26 children's mental health evidence-based and
301.27 best practices including, but not limited
301.28 to: Adolescent Integrated Dual Diagnosis
301.29 Treatment services; school-based mental
301.30 health services; co-location of mental
301.31 health and physical health care, and; the
301.32 use of technological resources to better
301.33 inform diagnosis and development of
301.34 treatment plan development by mental
301.35 health professionals. The commissioner
301.36 shall require grantees to utilize all available

302.1 third-party reimbursement sources as a
302.2 condition of using state grant funds.

302.3 **Culturally Specific Mental Health**

302.4 **Treatment Grants.** Of the general fund
302.5 appropriation, \$75,000 in fiscal year 2008
302.6 and \$300,000 in fiscal year 2009 are for
302.7 children's mental health grants to support
302.8 increased availability of mental health
302.9 services for persons from cultural and
302.10 ethnic minorities within the state. The
302.11 commissioner shall use at least 20 percent
302.12 of these funds to help members of cultural
302.13 and ethnic minority communities to become
302.14 qualified mental health professionals and
302.15 practitioners. The commissioner shall assist
302.16 grantees to meet third-party credentialing
302.17 requirements and require them to utilize all
302.18 available third-party reimbursement sources
302.19 as a condition of using state grant funds.

302.20 **Mental Health Services for Children with**

302.21 **Special Treatment Needs.** Of the general
302.22 fund appropriation, \$50,000 in fiscal year
302.23 2008 and \$200,000 in fiscal year 2009 are
302.24 for children's mental health grants to support
302.25 increased availability of mental health
302.26 services for children with special treatment
302.27 needs. These shall include, but not be limited
302.28 to: victims of trauma, including children
302.29 subjected to abuse or neglect, veterans and
302.30 their families, and refugee populations;
302.31 persons with complex treatment needs, such
302.32 as eating disorders; and those with low
302.33 incidence disorders.

302.34 **MFIP and Children's Mental Health**

302.35 **Pilot Project.** Of the TANF appropriation,

303.1 \$100,000 in fiscal year 2008 and \$200,000
 303.2 in fiscal year 2009 are to fund the MFIP
 303.3 and children's mental health pilot project.
 303.4 Of these amounts, up to \$100,000 may be
 303.5 expended on evaluation of this pilot.

303.6 ~~**Prenatal Alcohol or Drug Use.** Of the~~
 303.7 ~~general fund appropriation, \$75,000 each~~
 303.8 ~~year is to award grants beginning July 1,~~
 303.9 ~~2007, to programs that provide services~~
 303.10 ~~under Minnesota Statutes, section 254A.171,~~
 303.11 ~~in Pine, Kanabec, and Carlton Counties. This~~
 303.12 ~~appropriation shall become part of the base~~
 303.13 ~~appropriation.~~

303.14 **Base Adjustment.** The general fund base
 303.15 is \$62,572,000 in fiscal year 2010 and
 303.16 \$62,575,000 in fiscal year 2011.

303.17 **(h) Children and Community Services Grants**

303.18	General	101,369,000	69,208,000
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303.19 **Base Adjustment.** The general fund base
 303.20 is \$69,274,000 in each of fiscal years 2010
 303.21 and 2011.

303.22 **Targeted Case Management Temporary**

303.23 **Funding.** (a) Of the general fund
 303.24 appropriation, \$32,667,000 in fiscal year
 303.25 2008 is transferred to the targeted case
 303.26 management contingency reserve account in
 303.27 the general fund to be allocated to counties
 303.28 and tribes affected by reductions in targeted
 303.29 case management federal Medicaid revenue
 303.30 as a result of the provisions in the federal
 303.31 Deficit Reduction Act of 2005, Public Law
 303.32 109-171.

303.33 (b) Contingent upon (1) publication by the
 303.34 federal Centers for Medicare and Medicaid

304.1 Services of final regulations implementing
304.2 the targeted case management provisions
304.3 of the federal Deficit Reduction Act of
304.4 2005, Public Law 109-171, or (2) the
304.5 issuance of a finding by the Centers for
304.6 Medicare and Medicaid Services of federal
304.7 Medicaid overpayments for targeted case
304.8 management expenditures, up to \$32,667,000
304.9 is appropriated to the commissioner of human
304.10 services. Prior to distribution of funds, the
304.11 commissioner shall estimate and certify the
304.12 amount by which the federal regulations or
304.13 federal disallowance will reduce targeted
304.14 case management Medicaid revenue over the
304.15 2008-2009 biennium.

304.16 (c) Within 60 days of a contingency described
304.17 in paragraph (b), the commissioner shall
304.18 distribute the grants proportionate to each
304.19 affected county or tribe's targeted case
304.20 management federal earnings for calendar
304.21 year 2005, not to exceed the lower of (1) the
304.22 amount of the estimated reduction in federal
304.23 revenue or (2) \$32,667,000.

304.24 (d) These funds are available in either year of
304.25 the biennium. Counties and tribes shall use
304.26 these funds to pay for social service-related
304.27 costs, but the funds are not subject to
304.28 provisions of the Children and Community
304.29 Services Act grant under Minnesota Statutes,
304.30 chapter 256M.

304.31 (e) This appropriation shall be available to
304.32 pay counties and tribes for expenses incurred
304.33 on or after July 1, 2007. The appropriation
304.34 shall be available until expended.

304.35 **(i) General Assistance Grants**

305.1 General 37,876,000 38,253,000

305.2 **General Assistance Standard.** The
 305.3 commissioner shall set the monthly standard
 305.4 of assistance for general assistance units
 305.5 consisting of an adult recipient who is
 305.6 childless and unmarried or living apart
 305.7 from parents or a legal guardian at \$203.
 305.8 The commissioner may reduce this amount
 305.9 according to Laws 1997, chapter 85, article
 305.10 3, section 54.

305.11 **Emergency General Assistance.** The
 305.12 amount appropriated for emergency general
 305.13 assistance funds is limited to no more
 305.14 than \$7,889,812 in fiscal year 2008 and
 305.15 \$7,889,812 in fiscal year 2009. Funds
 305.16 to counties must be allocated by the
 305.17 commissioner using the allocation method
 305.18 specified in Minnesota Statutes, section
 305.19 256D.06.

305.20 **(j) Minnesota Supplemental Aid Grants**

305.21 General 30,505,000 30,812,000

305.22 **Emergency Minnesota Supplemental**
 305.23 **Aid Funds.** The amount appropriated for
 305.24 emergency Minnesota supplemental aid
 305.25 funds is limited to no more than \$1,100,000
 305.26 in fiscal year 2008 and \$1,100,000 in fiscal
 305.27 year 2009. Funds to counties must be
 305.28 allocated by the commissioner using the
 305.29 allocation method specified in Minnesota
 305.30 Statutes, section 256D.46.

305.31 **(k) Group Residential Housing Grants**

305.32 General 91,069,000 98,671,000

305.33 **People Incorporated.** Of the general fund
 305.34 appropriation, \$460,000 each year is to

306.1 augment community support and mental
 306.2 health services provided to individuals
 306.3 residing in facilities under Minnesota
 306.4 Statutes, section 256I.05, subdivision 1m.

306.5 **(1) Other Children and Economic Assistance**
 306.6 **Grants**

306.7	General	20,183,000	16,333,000
306.8	Federal TANF	1,500,000	1,500,000

306.9 **Base Adjustment.** The general fund base
 306.10 shall be \$16,033,000 in fiscal year 2010 and
 306.11 \$15,533,000 in fiscal year 2011. The TANF
 306.12 base shall be \$1,500,000 in fiscal year 2010
 306.13 and \$1,181,000 in fiscal year 2011.

306.14 **Homeless and Runaway Youth.** Of the
 306.15 general fund appropriation, \$500,000 each
 306.16 year are for the Runaway and Homeless
 306.17 Youth Act under Minnesota Statutes, section
 306.18 256K.45. Funds shall be spent in each area
 306.19 of the continuum of care to ensure that
 306.20 programs are meeting the greatest need. This
 306.21 is a onetime appropriation.

306.22 **Long-Term Homelessness.** Of the general
 306.23 fund appropriation, \$2,000,000 in fiscal year
 306.24 2008 is for implementation of programs
 306.25 to address long-term homelessness and is
 306.26 available in either year of the biennium. This
 306.27 is a onetime appropriation.

306.28 **Minnesota Community Action Grants.** (a)
 306.29 Of the general fund appropriation, \$250,000
 306.30 each year is for the purposes of Minnesota
 306.31 community action grants under Minnesota
 306.32 Statutes, sections 256E.30 to 256E.32. This
 306.33 is a onetime appropriation.

306.34 (b) Of the TANF appropriation, \$1,500,000
 306.35 each year is for community action agencies

307.1 for auto repairs, auto loans, and auto
307.2 purchase grants to individuals who are
307.3 eligible to receive benefits under Minnesota
307.4 Statutes, chapter 256J, or who have lost
307.5 eligibility for benefits under Minnesota
307.6 Statutes, chapter 256J, due to earnings in the
307.7 prior 12 months. Base level funding for this
307.8 activity shall be \$1,500,000 in fiscal year
307.9 2010 and \$1,181,000 in fiscal year 2011. *
307.10 **(The preceding text beginning "(b) Of the**
307.11 **TANF appropriation," was indicated as**
307.12 **vetoed by the governor.)**

307.13 (c) Money appropriated under paragraphs (a)
307.14 and (b) that is not spent in the first year does
307.15 not cancel but is available for the second
307.16 year.

307.17 Sec. 6. **EXPIRATION OF UNCODIFIED LANGUAGE.**

307.18 All uncodified language contained in this article expires on June 30, 2011, unless a
307.19 different expiration date is explicit.

307.20 Sec. 7. **EFFECTIVE DATE.**

307.21 The provisions in this article are effective July 1, 2009, unless a different effective
307.22 date is specified.