STATE OF MINNESOTA

EIGHTY-SEVENTH SESSION — 2012

EIGHTY-THIRD DAY

SAINT PAUL, MINNESOTA, THURSDAY, MARCH 8, 2012

The House of Representatives convened at 3:00 p.m. and was called to order by Kurt Zellers, Speaker of the House.

Prayer was offered by the Reverend Craig Hanson, Roseville Lutheran Church, Roseville, Minnesota.

The members of the House gave the pledge of allegiance to the flag of the United States of America.

The roll was called and the following members were present:

Abeler	Davids	Hancock	Lanning	Mullery	Scott
Allen	Davnie	Hansen	Leidiger	Murphy, E.	Shimanski
Anderson, B.	Dean	Hausman	LeMieur	Murphy, M.	Simon
Anderson, D.	Dettmer	Hilstrom	Lenczewski	Murray	Slawik
Anderson, P.	Dill	Holberg	Lesch	Myhra	Slocum
Anderson, S.	Dittrich	Hoppe	Liebling	Nelson	Smith
Anzelc	Doepke	Hornstein	Lillie	Nornes	Stensrud
Atkins	Downey	Hortman	Loeffler	Norton	Swedzinski
Banaian	Drazkowski	Hosch	Lohmer	O'Driscoll	Thissen
Barrett	Eken	Howes	Loon	Paymar	Tillberry
Beard	Erickson	Huntley	Mack	Pelowski	Torkelson
Benson, J.	Falk	Johnson	Mahoney	Peppin	Urdahl
Benson, M.	Franson	Kahn	Mariani	Persell	Vogel
Bills	Fritz	Kath	Marquart	Petersen, B.	Wagenius
Brynaert	Garofalo	Kelly	Mazorol	Peterson, S.	Ward
Buesgens	Gottwalt	Kieffer	McDonald	Poppe	Wardlow
Carlson	Greene	Kiel	McElfatrick	Quam	Westrom
Champion	Greiling	Kiffmeyer	McFarlane	Rukavina	Winkler
Clark	Gruenhagen	Knuth	McNamara	Runbeck	Woodard
Cornish	Gunther	Koenen	Melin	Sanders	Spk. Zellers
Crawford	Hackbarth	Kriesel	Moran	Scalze	
Daudt	Hamilton	Laine	Morrow	Schomacker	

A quorum was present.

Fabian, Gauthier, Hilty and Murdock were excused.

The Chief Clerk proceeded to read the Journal of the preceding day. There being no objection, further reading of the Journal was dispensed with and the Journal was approved as corrected by the Chief Clerk.

PETITIONS AND COMMUNICATIONS

The following communications were received:

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

March 5, 2012

The Honorable Kurt Zellers
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Zellers:

I have vetoed and am returning H. F. No. 1467, Chapter No. 126. I greatly appreciate the House Author's sincere efforts to address the concerns of law enforcement organizations and to enlist my support. However, most of Minnesota's major law enforcement and public safety organizations remain strongly opposed to the bill and, I believe, their concerns must be honored.

The MN Police and Peace Officers Association, the MN Chiefs of Police, and the MN Sheriffs Association represent the men and women who risk their lives every day and night to protect the rest of us. When they strongly oppose a measure, because they believe it will increase the dangers to them in the performance of their duties, I cannot support it.

The US Bureau of Alcohol, Tobacco, and Firearms reports that in 2007, there were about 294 million guns in the United States: 106 million handguns, 105 million rifles, and 83 million shotguns. On a proportionate basis, that would mean there are over 5 million firearms in Minnesota. Clearly, the Second Amendment of the US Constitution is properly being supported by lawmakers and law enforcers throughout America.

The question addressed by this proposed legislation is: Under what circumstances can deadly force lawfully be used? Current Minnesota law already provides a definitive answer. **Minn. Stat., Sec. 624.711 DECLARATION OF POLICY** states:

"It is not the intent of the legislature to regulate shotguns, rifles and other longguns of the type commonly used for hunting and not defined as pistols or semiautomatic military-style assault weapons, or to place costs of administration upon those citizens who wish to possess or carry pistols or semiautomatic military-style assault weapons lawfully, or to confiscate or otherwise restrict the use of pistols or semiautomatic military-style assault weapons by law-abiding citizens."

Furthermore, the laws of Minnesota ensure the rights of most law-abiding citizens to carry firearms in their possessions outside their homes, by application to their County Sheriff. The law states that "A sheriff must issue a permit to an applicant if the person: (1) has training in the safe use of a pistol; (2) is at least 21 years old and a citizen or a permanent resident of the United States; (3) completes an application for a permit; (4) is not prohibited from possessing a firearm under certain sections of the law; (5) is not listed in the criminal gang investigative data system."

Current Minnesota law also defines the circumstances under which force can be used. **Minn. Stat., Sec. 609.06, subd. 1 AUTHORIZED USE OF FORCE**, says: "Reasonable force may be used upon or toward the person of another without the other's consent when certain circumstances exist or the actor reasonably believes them to exist." Those circumstances include: "…. (3) when used by any person in resisting or aiding another to resist an offense

against the person; or (4) when used by any person in lawful possession of real or personal property, or by another assisting the person in lawful possession, in resisting a trespass upon or other unlawful interference with such property…."

Further authorization for the use of deadly force is provided in **Minn. Stat., Sec. 609.065, JUSTIFIABLE TAKING OF LIFE**, which allows "the intentional taking of the life of another …. when necessary in resisting or preventing an offense which the actor reasonably believes exposes the actor or another to great bodily harm or death, or preventing the commission of a felony in the actor's place of abode."

The Minnesota Supreme Court's case law has defined when deadly force is reasonable. To justify the taking of a life, the "killing must have been done in the belief that it was necessary to avert death or grievous bodily harm"; the "judgment of the defendant as to the gravity of the peril to which he was exposed must have been reasonable under the circumstances"; the "defendant's election to kill must have been such as a reasonable man would have made in light of the danger to be apprehended." State v. Richardson, 670 N.W.2d 267, 277-78 (Minn. 2003).

The Supreme Court further states that, under current Minnesota law, there is no duty to retreat before using force when in one's home. "We agree that when acting in self-defense in the home, a person should not be required to retreat from the home before using reasonable force to defend himself, regardless of whether the aggressor is also rightfully in the home. Thus, we adopt the following rule: There is no duty to retreat from one's own home when acting in self-defense in the home, regardless of whether the aggressor is a co-resident. But the lack of a duty to retreat does not abrogate the obligation to act reasonably when using force in self-defense. Therefore, in all situations in which a party claims self-defense, even absent a duty to retreat, the key inquiry will still be into the reasonableness of the use of force and the level of force under the specific circumstances of each case." State v. Glowacki, 630 N.W.2d 392, 402 (Minn. 1991).

Thus, it appears clear to me that existing Minnesota Statutes and law already provide the authorizations for law-abiding citizens to use deadly force to defend themselves or others either inside or outside of their homes, so long as that use of deadly force constitutes "reasonable force." That, I believe, is a reasonable standard.

H. F. No. 1467 does go beyond current law by stating that an individual using deadly force would be presumed to possess a reasonable belief that there exists an imminent threat of substantial bodily harm, great bodily harm, or death to the individual or person. As the MN County Attorneys Association has noted, this change would effectively allow anyone to claim that he or she acted reasonably when using deadly force, making it virtually impossible to find him or her guilty of using excessive force. That change from the current standard seems, to me, ill-advised.

Of additional concern to the MN Department of Public Safety is the provision in the bill, which mandates "universal reciprocity" of firearm carry permits from any other state "or other non-Minnesota governmental jurisdiction." **Minn. Stat., Sec. 624.714, subd. 16**, **Recognition of permits from other states** already requires the Commissioner of Public Safety to determine which states and other jurisdictions have permitting laws similar to Minnesota's and which do not. The Commissioner is further required to execute reciprocity agreements regarding carry permits with those states or jurisdictions, which do have similar permitting laws. Currently, Minnesota has such reciprocity agreements with 15 other states.

However, making all permits issued by other states and governmental jurisdictions valid in Minnesota would allow people to carry guns here under the considerably lower standards for the issuance of permits of some other states.

For these reasons, I have vetoed H. F. No. 1467.

Sincerely,

MARK DAYTON
Governor

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Kurt Zellers
Speaker of the House of Representatives

The Honorable Michelle L. Fischbach
President of the Senate

I have the honor to inform you that the following enrolled Act of the 2012 Session of the State Legislature has been received from the Office of the Governor and is deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S. F. No.	*H. F. No.*	*Session Laws Chapter No.*	*Time and Date Approved 2012*	*Date Filed 2012*
1371		127	3:34 p.m. March 5	March 5

Sincerely,

MARK RITCHIE
Secretary of State

REPORTS OF STANDING COMMITTEES AND DIVISIONS

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 1416, A bill for an act relating to military affairs; extending reemployment rights protections to certain nonpublic employees; amending Minnesota Statutes 2010, section 192.261, subdivision 6.

Reported the same back with the following amendments:

Page 1, line 11, after "leave" insert "from" and after "reinstatement" insert "in the person's civilian position of employment within Minnesota"

With the recommendation that when so amended the bill pass.

The report was adopted.

Gottwalt from the Committee on Health and Human Services Reform to which was referred:

H. F. No. 1994, A bill for an act relating to state government; making changes to health and human services policy provisions; modifying provisions related to continuing care, the telephone equipment program, chemical and mental health, and health care; reforming comprehensive assessment and case management services; amending

Minnesota Statutes 2010, sections 237.50; 237.51; 237.52; 237.53; 237.54; 237.55; 237.56; 245.461, by adding a subdivision; 245.462, subdivision 20; 245.487, by adding a subdivision; 245.4871, subdivision 15; 245.4932, subdivision 1; 245A.11, subdivision 2a; 246.53, by adding a subdivision; 256.9657, subdivision 1; 256B.04, subdivision 14; 256B.056, subdivision 3c; 256B.0595, subdivision 2; 256B.0625, subdivisions 13, 13d, 42; 256B.0659, subdivisions 1, 2, 3a, 4; 256B.0911, subdivisions 1, 2b, 2c, 3, 3b, 4c, 6; 256B.0913, subdivisions 7, 8; 256B.0915, subdivisions 1a, 1b, 3c, 6; 256B.092, subdivisions 1, 1a, 1b, 1e, 1g, 2, 3, 5, 7, 8, 8a, 9, 11; 256B.19, subdivision 1c; 256B.441, subdivisions 13, 31, 53; 256B.49, subdivision 13; 256B.69, subdivision 5; 256F.13, subdivision 1; 256G.02, subdivision 6; 256L.05, subdivision 3; 514.982, subdivision 1; Minnesota Statutes 2011 Supplement, sections 125A.21, subdivision 7; 144A.071, subdivisions 3, 4a; 254B.04, subdivision 2a; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivisions 13e, 13h, 14; 256B.0631, subdivisions 1, 2; 256B.0911, subdivisions 1a, 3a, 4a; 256B.0915, subdivision 10; 256B.49, subdivisions 14, 15; 256B.69, subdivisions 5a, 28; 256L.15, subdivision 1; 626.557, subdivision 9; repealing Minnesota Statutes 2010, sections 256.01, subdivision 18b; 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l, 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e, 4g, 4h, 7, 8; 256B.435; 256B.436; Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26; Minnesota Rules, part 9555.7700.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1
CONTINUING CARE

Section 1. Minnesota Statutes 2011 Supplement, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). ~~Operating~~ If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall be determined according to Minnesota Rules, part 9549.0057, using the limits under section 256B.441. External fixed payment rates must be determined according to section 256B.441, subdivision 53. Property payment rates for facilities with beds added under this subdivision must be determined in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256B.441, subdivision 34, to the prior licensee within 120 days after delicensure or decertification.

Sec. 2. Minnesota Statutes 2011 Supplement, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care

facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status ~~under section 256B.431, subdivision 2j,~~ shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431~~, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed~~. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify a total replacement project of up to 129 beds located in Polk County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431~~, except that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed~~. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or ~~256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up~~ 256B.441; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 3. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

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

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

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

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

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

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

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

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

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

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

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

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

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

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

(e) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(f) License holders of foster care homes identified under paragraph (e) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49 must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 4. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

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

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

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

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

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

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

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

(i) individualized plan of care;

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

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

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

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

(f) The commissioner shall not issue a new adult foster care license under paragraph (e) after June 30, ~~2011~~ 2014. The commissioner shall allow a facility with an adult foster care license issued under paragraph (e) before June 30, ~~2011~~ 2014, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (e).

Sec. 5. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, ~~2011~~ 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph (b), must be required to obtain a community residential setting license.

Sec. 6. Minnesota Statutes 2010, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of 21 and who have been certified disabled under section 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving: home and community-based waivered services for persons with ~~developmental~~ disabilities authorized under section 256B.092 or 256B.49; personal care assistance under section 256B.0652; or a consumer support grant under section 256.476 are not eligible for support grants.

Families whose annual adjusted gross income is $60,000 or more are not eligible for support grants except in cases where extreme hardship is demonstrated. Beginning in state fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics Consumer Price Index (all urban) for that year.

(b) Support grants may be made available as monthly subsidy grants and lump-sum grants.

(c) Support grants may be issued in the form of cash, voucher, and direct county payment to a vendor.

(d) Applications for the support grant shall be made by the legal guardian to the county social service agency. The application shall specify the needs of the families, the form of the grant requested by the families, and the items and services to be reimbursed.

Sec. 7. **[252.34] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:

(1) home and community-based services waivers for persons with disabilities under sections 256B.092 and 256B.49;

(2) home care services under section 256B.0652; and

(3) other relevant programs and services as determined by the commissioner.

Sec. 8. Minnesota Statutes 2010, section 252A.21, subdivision 2, is amended to read:

Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter. The rules must include standards for performance of guardianship or conservatorship duties including, but not limited to: twice a year visits with the ward; ~~quarterly reviews of records from day, residential, and support services;~~ a requirement that the duties of guardianship or conservatorship and case management not be performed by the same person; specific standards for action on "do not resuscitate" orders, sterilization requests, and the use of psychotropic medication and aversive procedures.

Sec. 9. Minnesota Statutes 2010, section 256.476, subdivision 11, is amended to read:

Subd. 11. **Consumer support grant program after July 1, 2001.** Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) determining ~~50 percent of the average~~ the service authorization for each individual based on the individual's home care ~~rating~~ assessment;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to ~~the average~~ 50 percent of the service authorization level of each home care rating; and

(iv) adjusting the result for any authorized rate ~~increases~~ changes provided by the legislature~~; and~~.

~~(v) adjusting the result for the average monthly utilization per recipient.~~

(2) The commissioner ~~may review and evaluate~~ shall ensure the methodology ~~to reflect changes in~~ is consistent with the home care programs.

Sec. 10. Minnesota Statutes 2010, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. ~~Notwithstanding section 256B.431, subdivision 27, paragraph (i),~~ Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

Sec. 11. Minnesota Statutes 2010, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148D.010 and 148D.055, or a qualified developmental disabilities specialist under section 245B.07, subdivision 4. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 12. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be ~~terminated~~ reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 3, is amended to read:

Subd. 3. **Noncovered personal care assistance services.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in ~~lieu of other staffing options~~ order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; or

(4) without authorization by the commissioner or the commissioner's designee.

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) ~~effective January 1, 2010,~~ when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

(2) injections of fluids and medications into veins, muscles, or skin;

(3) home maintenance or chore services;

(4) homemaker services not an integral part of assessed personal care assistance services needed by a recipient;

(5) application of restraints or implementation of procedures under section 245.825;

(6) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor; and

(7) assessments for personal care assistance services by personal care assistance provider agencies or by independently enrolled registered nurses.

Sec. 14. Minnesota Statutes 2010, section 256B.0659, subdivision 9, is amended to read:

Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(b) A responsible party must be 18 years of age, actively participate in planning and directing of personal care assistance services, and attend all assessments for the recipient.

(c) A responsible party must not be the:

(1) personal care assistant;

(2) qualified professional;

(3) home care provider agency owner or ~~staff~~ manager; ~~or~~

(4) home care provider agency staff unless staff who are not listed in clauses (1) to (3) are related to the recipient by blood, marriage, or adoption; or

~~(3)~~ (5) county staff acting as part of employment.

(d) A licensed family foster parent who lives with the recipient may be the responsible party as long as the family foster parent meets the other responsible party requirements.

(e) A responsible party is required when:

(1) the person is a minor according to section 524.5-102, subdivision 10;

(2) the person is an incapacitated adult according to section 524.5-102, subdivision 6, resulting in a court-appointed guardian; or

(3) the assessment according to subdivision 3a determines that the recipient is in need of a responsible party to direct the recipient's care.

(f) There may be two persons designated as the responsible party for reasons such as divided households and court-ordered custodies. Each person named as responsible party must meet the program criteria and responsibilities.

(g) The recipient or the recipient's legal representative shall appoint a responsible party if necessary to direct and supervise the care provided to the recipient. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and personal care assistance care plan.

Sec. 15. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient ~~within the first seven days after the services begin~~; and

(10) be limited to providing and being paid for up to 275 hours per month~~, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011,~~ of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents ~~and~~, stepparents, and legal guardians of minors~~,~~; spouses~~,~~; paid legal guardians~~,~~ of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a~~, or~~; and staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

Sec. 16. Minnesota Statutes 2010, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency and meet the definition under section 256B.0625, subdivision 19c. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

(1) is not disqualified under section 245C.14; or

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective July 1, ~~2010~~ 2011, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training ~~shall~~ must be available ~~in languages~~

~~other than English and to those who need accommodations due to disabilities,~~ with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online~~,~~ or by electronic remote connection~~, and~~. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

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

Sec. 17. Minnesota Statutes 2010, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

(3) after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.

(d) Communication with the recipient is a part of the evaluation process of the personal care assistance staff.

(e) At each supervisory visit, the qualified professional shall evaluate personal care assistance services including the following information:

(1) satisfaction level of the recipient with personal care assistance services;

(2) review of the month-to-month plan for use of personal care assistance services;

(3) review of documentation of personal care assistance services provided;

(4) whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and service plan;

(5) a written record of the results of the evaluation and actions taken to correct any deficiencies in the work of a personal care assistant; and

(6) revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

(f) The qualified professional shall complete the required documentation in the agency recipient and employee files and the recipient's home, including the following documentation:

(1) the personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) a month-to-month plan for use of personal care assistance services;

(3) changes in need of the recipient requiring a change to the level of service and the personal care assistance care plan;

(4) evaluation results of supervision visits and identified issues with personal care assistance staff with actions taken;

(5) all communication with the recipient and personal care assistance staff; and

(6) hands-on training or individualized training for the care of the recipient.

(g) The documentation in paragraph (f) must be done on agency ~~forms~~ templates.

(h) The services that are not eligible for payment as qualified professional services include:

(1) direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks;

~~(2) supervision of personal care assistance completed by telephone;~~

~~(3)~~ (2) agency administrative activities;

~~(4)~~ (3) training other than the individualized training required to provide care for a recipient; and

~~(5)~~ (4) any other activity that is not described in this section.

Sec. 18. Minnesota Statutes 2010, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) effective January 1, 2010, supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient~~, qualified professional,~~ or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 19. Minnesota Statutes 2010, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for initial enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage in the amount of $50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available ~~in languages other than English and to those who need accommodations due to disabilities,~~ with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online~~,~~ or by electronic remote connection~~, and~~. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Sec. 20. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information; and

~~(2) notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.~~

~~The notice shall include how to get further information on the changes, how to get help to obtain other services, a list of community resources, and appeal rights. Notwithstanding section 256.045, a recipient may request continued services pending appeal within the time period allowed to request an appeal; and~~

~~(3)~~ (2) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

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

Sec. 21. Minnesota Statutes 2010, section 256B.0916, subdivision 7, is amended to read:

Subd. 7. **Annual report by commissioner.** (a) Beginning November 1, 2001, and each November 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community-based waiver for persons with developmental disabilities. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waivered services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

(b) This subdivision expires January 1, 2013.

Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's community support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (e), are considered registered under this section.

Sec. 23. Minnesota Statutes 2010, section 256B.096, subdivision 5, is amended to read:

Subd. 5. **Biennial report.** (a) The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

(b) This subdivision expires January 1, 2013.

Sec. 24. Minnesota Statutes 2010, section 256B.441, subdivision 13, is amended to read:

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; long-term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section ~~256B.436 or~~ 256B.437; or single bed room incentives under section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

Sec. 25. Minnesota Statutes 2010, section 256B.441, subdivision 31, is amended to read:

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section ~~256B.436 or~~ 256B.437, or single bed room incentives under section 256B.431, subdivision 42.

Sec. 26. Minnesota Statutes 2010, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under ~~sections 256B.436 and~~ section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Sec. 27. Minnesota Statutes 2010, section 256B.49, subdivision 21, is amended to read:

Subd. 21. **Report.** (a) The commissioner shall expand on the annual report required under section 256B.0916, subdivision 7, to include information on the county of residence and financial responsibility, age, and major diagnoses for persons eligible for the home and community-based waivers authorized under subdivision 11 who are:

(1) receiving those services;

(2) screened and waiting for waiver services; and

(3) residing in nursing facilities and are under age 65.

(b) This subdivision expires January 1, 2013.

Sec. 28. Minnesota Statutes 2011 Supplement, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) Each county board shall designate a common entry point for reports of suspected maltreatment. Two or more county boards may jointly designate a single common entry point. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, address, and telephone number of the person reporting;

(3) the time, date, and location of the incident;

(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;

(5) whether there was a risk of imminent danger to the alleged victim;

(6) a description of the suspected maltreatment;

(7) the disability, if any, of the alleged victim;

(8) the relationship of the alleged perpetrator to the alleged victim;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) any action taken by the common entry point;

(11) whether law enforcement has been notified;

(12) whether the reporter wishes to receive notification of the initial and final reports; and

(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) ~~When a centralized database is available, the common entry point has access to the centralized database and must log the reports into the database.~~ The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data.

Sec. 29. Laws 2009, chapter 79, article 8, section 81, as amended by Laws 2010, chapter 352, article 1, section 24, is amended to read:

Sec. 81. **ESTABLISHING A SINGLE SET OF STANDARDS.**

(a) The commissioner of human services shall consult with disability service providers, advocates, counties, and consumer families to develop a single set of standards, to be referred to as "quality outcome standards," governing services for people with disabilities receiving services under the home and community-based waiver services program, with the exception of customized living services because the service license is under the jurisdiction of the Department of Health, to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the psychotropic medication checklist. The standards must:

(1) enable optimum consumer choice;

(2) be consumer driven;

(3) link services to individual needs and life goals;

(4) be based on quality assurance and individual outcomes;

(5) utilize the people closest to the recipient, who may include family, friends, and health and service providers, in conjunction with the recipient's risk management plan to assist the recipient or the recipient's guardian in making decisions that meet the recipient's needs in a cost-effective manner and assure the recipient's health and safety;

(6) utilize person-centered planning; and

(7) maximize federal financial participation.

(b) The commissioner may consult with existing stakeholder groups convened under the commissioner's authority, including the home and community-based expert services panel established by the commissioner in 2008, to meet all or some of the requirements of this section.

(c) The commissioner shall provide the reports and plans required by this section to the legislative committees and budget divisions with jurisdiction over health and human services policy and finance by January 15, 2012.

Sec. 30. **DISABILITY HOME AND COMMUNITY-BASED WAIVER REQUEST.**

By December 1, 2012, the commissioner shall request all federal approvals and waiver amendments to the disability home and community-based waivers to allow properly licensed adult foster care homes to provide residential services for up to five individuals.

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

Sec. 31. **HOURLY NURSING DETERMINATION MATRIX.**

A service provider applying for medical assistance payments for private duty nursing services under Minnesota Statutes, section 256B.0654, must complete and submit to the commissioner of human services an hourly nursing determination matrix for each recipient of private duty nursing services. The commissioner of human services will collect and analyze data from the hourly nursing determination matrix.

Sec. 32. **REPEALER.**

(a) Minnesota Statutes 2010, sections 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l, 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, and 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e, 4g, 4h, 7, and 8; 256B.435; and 256B.436, are repealed.

(b) Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26, is repealed.

(c) Minnesota Rules, part 9555.7700, is repealed.

ARTICLE 2
TELEPHONE EQUIPMENT PROGRAM

Section 1. Minnesota Statutes 2010, section 237.50, is amended to read:

237.50 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in sections 237.50 to 237.56 have the meanings given them in this section.

Subd. 3. **Communication ~~impaired~~ disability.** "Communication ~~impaired~~ disability" means certified as ~~deaf, severely hearing impaired, hard-of-hearing~~ having a hearing loss, speech ~~impaired, deaf and blind~~ disability, or ~~mobility impaired if the mobility impairment significantly impedes the ability~~ physical disability that makes it difficult or impossible to use ~~standard customer premises~~ telecommunications services and equipment.

~~Subd. 4. **Communication device.** "Communication device" means a device that when connected to a telephone enables a communication impaired person to communicate with another person utilizing the telephone system. A "communication device" includes a ring signaler, an amplification device, a telephone device for the deaf, a Brailling device for use with a telephone, and any other device the Department of Human Services deems necessary.~~

Subd. 4a. **Deaf.** "Deaf" means a hearing ~~impairment~~ loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, ~~manual communication~~ sign language, and gestures.

Subd. 4b. **Deafblind.** "Deafblind" means any combination of vision and hearing loss which interferes with acquiring information from the environment to the extent that compensatory strategies and skills are necessary to access that or other information.

~~Subd. 5. **Exchange.** "Exchange" means a unit area established and described by the tariff of a telephone company for the administration of telephone service in a specified geographical area, usually embracing a city, town, or village and its environs, and served by one or more central offices, together with associated facilities used in providing service within that area.~~

Subd. 6. **Fund.** "Fund" means the telecommunications access Minnesota fund established in section 237.52.

Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing ~~impairment~~ loss resulting in a functional ~~loss~~ limitation, but not to the extent that the individual must depend primarily upon visual communication.

~~Subd. 7. **Interexchange service.** "Interexchange service" means telephone service between points in two or more exchanges.~~

~~Subd. 8. **Inter-LATA interexchange service.** "Inter-LATA interexchange service" means interexchange service originating and terminating in different LATAs.~~

~~Subd. 9. **Local access and transport area.** "Local access and transport area (LATA)" means a geographical area designated by the Modification of Final Judgment in U.S. v. Western Electric Co., Inc., 552 F. Supp. 131 (D.D.C. 1982), including modifications in effect on the effective date of sections 237.51 to 237.54.~~

~~Subd. 10. **Local exchange service.** "Local exchange service" means telephone service between points within an exchange.~~

Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device that (1) allows a person with a communication disability to have access to telecommunications services as defined in subdivision 13, and (2) is specifically selected by the Department of Human Services for its capacity to allow persons with communication disabilities to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability. A telecommunications device may include a ring signaler, an amplified telephone, a hands-free telephone, a text telephone, a captioned telephone, a wireless device, a device that produces Braille output for use with a telephone, and any other device the Department of Human Services deems appropriate.

Subd. 11. ~~**Telecommunication**~~ **Telecommunications Relay** ~~**service**~~ **Services.** "~~Telecommunication~~ Telecommunications Relay ~~service~~ Services" or "TRS" means ~~a central statewide service through which a communication-impaired person, using a communication device, may send and receive messages to and from a non-communication-impaired person whose telephone is not equipped with a communication device and through which a non-communication-impaired person may, by using voice communication, send and receive messages to and from a communication-impaired person~~ the telecommunications transmission services required under Federal Communications Commission (FCC) regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows an individual who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability.

Subd. 12. **Telecommunications.** "Telecommunications" means the transmission, between or among points specified by the user, of information of the user's choosing, without change in the form or content of the information as sent and received.

Subd. 13. **Telecommunications services.** "Telecommunications services" means the offering of telecommunications for fee directly to the public, or to such classes of users as to be effectively available to the public, regardless of the facilities used.

Sec. 2. Minnesota Statutes 2010, section 237.51, is amended to read:

237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM ADMINISTRATION.

Subdivision 1. **Creation.** The commissioner of commerce shall:

(1) administer through interagency agreement with the commissioner of human services a program to distribute ~~communication~~ telecommunications devices to eligible ~~communication-impaired~~ persons who have communication disabilities; and

(2) contract with ~~a~~ one or more qualified ~~vendor~~ vendors that ~~serves communication-impaired~~ serve persons who have communication disabilities to ~~create and maintain a telecommunication~~ provide telecommunications relay ~~service~~ services.

For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

Subd. 5. **Commissioner of commerce duties.** In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of commerce shall:

(1) prepare the reports required by section 237.55;

(2) administer the fund created in section 237.52; and

(3) adopt rules under chapter 14 to implement the provisions of sections 237.50 to 237.56.

Subd. 5a. ~~**Department**~~ **Commissioner of human services duties.** (a) In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and to determine circumstances necessitating provision of more than one ~~communication~~ telecommunications device per household;

(2) establish a method to verify eligibility requirements;

(3) establish specifications for ~~communication~~ telecommunications devices to be ~~purchased~~ provided under section 237.53, subdivision 3; ~~and~~

(4) inform the public and specifically ~~the community of communication impaired~~ persons who have communication disabilities of the program~~.~~; and

(5) provide devices based on the assessed need of eligible applicants.

(b) The commissioner may establish an advisory board to advise the department in carrying out the duties specified in this section and to advise the commissioner of commerce in carrying out duties under section 237.54. If so established, the advisory board must include, at a minimum, the following ~~communication impaired~~ persons:

(1) at least one member who is deaf;

(2) at least one member who ~~is~~ has a speech ~~impaired~~ disability;

(3) at least one member who ~~is mobility impaired~~ has a physical disability that makes it difficult or impossible for the person to access telecommunications services; and

(4) at least one member who is hard-of-hearing.

The membership terms, compensation, and removal of members and the filling of membership vacancies are governed by section 15.059. Advisory board meetings shall be held at the discretion of the commissioner.

Sec. 3. Minnesota Statutes 2010, section 237.52, is amended to read:

237.52 TELECOMMUNICATIONS ACCESS MINNESOTA FUND.

Subdivision 1. **Fund established.** A telecommunications access Minnesota fund is established as an account in the state treasury. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the fund.

Subd. 2. **Assessment.** (a) The commissioner of commerce, the commissioner of employment and economic development, and the commissioner of human services shall annually recommend to the Public Utilities Commission (PUC) an adequate and appropriate surcharge and budget to implement sections 237.50 to 237.56, 248.062, and 256C.30, respectively. The maximum annual budget for section 248.062 must not exceed $100,000 and for section 256C.30 must not exceed $300,000. The Public Utilities Commission shall review the budgets for reasonableness and may modify the budget to the extent it is unreasonable. The commission shall annually determine the funding mechanism to be used within 60 days of receipt of the recommendation of the departments and shall order the imposition of surcharges effective on the earliest practicable date. The commission shall establish a monthly charge no greater than 20 cents for each customer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1.

(b) If the fund balance falls below a level capable of fully supporting all programs eligible under subdivision 5 and sections 248.062 and 256C.30, expenditures under sections 248.062 and 256C.30 shall be reduced on a pro rata basis and expenditures under sections 237.53 and 237.54 shall be fully funded. Expenditures under sections 248.062 and 256C.30 shall resume at fully funded levels when the commissioner of commerce determines there is a sufficient fund balance to fully fund those expenditures.

Subd. 3. **Collection.** Every ~~telephone company or communications carrier that provides service~~ provider of services capable of originating a ~~telecommunications relay~~ TRS call, including cellular communications and other nonwire access services, in this state shall collect the charges established by the commission under subdivision 2 and transfer amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d). The commissioner of public safety must deposit the receipts in the fund established in subdivision 1.

Subd. 4. **Appropriation.** Money in the fund is appropriated to the commissioner of commerce to implement sections 237.51 to 237.56, to the commissioner of employment and economic development to implement section 248.062, and to the commissioner of human services to implement section 256C.30.

Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

(1) expenses of the Department of Commerce, including personnel cost, public relations, advisory board members' expenses, preparation of reports, and other reasonable expenses not to exceed ten percent of total program expenditures;

(2) reimbursing the commissioner of human services for purchases made or services provided pursuant to section 237.53;

(3) reimbursing telephone companies for purchases made or services provided under section 237.53, subdivision 5; and

(4) contracting for ~~establishment and operation of the telecommunication relay service~~ the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of ~~communication~~ telecommunications devices, and the ~~establishment and operation of the telecommunication relay service~~ provision of TRS are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with ~~the message relay service operator~~ one or more TRS providers to indemnify the ~~local exchange carriers of the relay~~ telecommunications service providers for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the ~~contractor of the telecommunication relay service~~ TRS providers if the ~~contractor establishes~~ providers establish to the commissioner's satisfaction that the advance payment is necessary for the ~~operation~~ provision of the

service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

Sec. 4. Minnesota Statutes 2010, section 237.53, is amended to read:

237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.

Subdivision 1. **Application.** A person applying for a ~~communication~~ telecommunications device under this section must apply to the program administrator on a form prescribed by the Department of Human Services.

Subd. 2. **Eligibility.** To be eligible to obtain a ~~communication~~ telecommunications device under this section, a person must ~~be~~:

(1) be able to benefit from and use the equipment for its intended purpose;

(2) have a communication ~~impaired~~ disability;

(3) be a resident of the state;

(4) be a resident in a household that has a median income at or below the applicable median household income in the state, except a ~~deaf and blind~~ person who is deafblind applying for a ~~telebraille unit~~ Braille device may reside in a household that has a median income no more than 150 percent of the applicable median household income in the state; and

(5) be a resident in a household that has ~~telephone~~ telecommunications service or that has made application for service and has been assigned a telephone number; or a resident in a residential care facility, such as a nursing home or group home where ~~telephone~~ telecommunications service is not included as part of overall service provision.

Subd. 3. **Distribution.** The commissioner of human services shall purchase and distribute a sufficient number of ~~communication~~ telecommunications devices so that each eligible household receives ~~an~~ appropriate ~~device~~ devices as determined under section 237.51, subdivision 5a. The commissioner of human services shall distribute the devices to eligible households ~~in each service area~~ free of charge ~~as determined under section 237.51, subdivision 5a~~.

Subd. 4. **Training; maintenance.** The commissioner of human services shall maintain the ~~communication~~ telecommunications devices until the warranty period expires, and provide training, without charge, to first-time users of the devices.

~~Subd. 5. **Wiring installation.** If a communication impaired person is not served by telephone service and is subject to economic hardship as determined by the Department of Human Services, the telephone company providing local service shall at the direction of the administrator of the program install necessary outside wiring without charge to the household.~~

Subd. 6. **Ownership.** ~~All communication~~ Telecommunications devices purchased pursuant to subdivision 3 ~~will become~~ are the property of the state of Minnesota. Policies and procedures for the return of devices from individuals who withdraw from the program or whose eligibility status changes shall be determined by the commissioner of human services.

Subd. 7. **Standards.** The ~~communication~~ telecommunications devices distributed under this section must comply with the electronic industries ~~association~~ alliance standards and be approved by the Federal Communications Commission. The commissioner of human services must provide each eligible person a choice of

several models of devices, the retail value of which may not exceed $600 for a ~~communication device for the deaf~~ text telephone, and a retail value of $7,000 for a ~~telebraille~~ Braille device, or an amount authorized by the Department of Human Services for ~~a telephone device for the deaf with auxiliary equipment~~ all other telecommunications devices and auxiliary equipment it deems cost-effective and appropriate to distribute according to sections 237.51 to 237.56.

Sec. 5. Minnesota Statutes 2010, section 237.54, is amended to read:

237.54 ~~TELECOMMUNICATION~~ TELECOMMUNICATIONS RELAY ~~SERVICE~~ SERVICES (TRS).

Subd. 2. **Operation.** (a) The commissioner of commerce shall contract with ~~a~~ one or more qualified ~~vendor~~ vendors for the ~~operation and maintenance of the telecommunication relay system~~ provision of Telecommunications Relay Services (TRS).

(b) The ~~telecommunication relay service provider~~ TRS providers shall operate the relay service within the state of Minnesota. The ~~operator of the system~~ TRS providers shall ~~keep all messages confidential, shall train personnel in the unique needs of communication impaired people, and shall inform communication impaired persons and the public of the availability and use of the system. Except in the case of a speech or mobility impaired person, the operator shall not relay a message unless it originates or terminates through a communication device for the deaf or a Brailling device for use with a telephone~~ comply with all current and subsequent FCC regulations at Code of Federal Regulations, title 47, sections 64.601 to 64.606, and shall inform persons who have communication disabilities and the public of the availability and use of TRS.

Sec. 6. Minnesota Statutes 2010, section 237.55, is amended to read:

237.55 ANNUAL REPORT ON ~~COMMUNICATION~~ TELECOMMUNICATIONS ACCESS.

The commissioner of commerce must prepare a report for presentation to the Public Utilities Commission by January 31 of each year. Each report must review the accessibility of ~~the telephone system to communication impaired persons, review the ability of non-communication impaired persons to communicate with communication impaired persons via the telephone system~~ telecommunications services to persons who have communication disabilities, describe services provided, account for ~~money received and disbursed annually~~ annual revenues and expenditures for each aspect of the ~~program~~ fund to date, and include predicted program future operation.

Sec. 7. Minnesota Statutes 2010, section 237.56, is amended to read:

237.56 ADEQUATE SERVICE ENFORCEMENT.

The services required to be provided under sections 237.50 to 237.55 may be enforced under section 237.081 upon a complaint of at least two ~~communication impaired~~ persons within the service area of any one ~~telephone company~~ telecommunications service provider, provided that if only one person within the service area of a company is receiving service under sections 237.50 to 237.55, the ~~commission~~ Public Utilities Commission may proceed upon a complaint from that person.

ARTICLE 3
COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM

Section 1. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 56, is amended to read:

Subd. 56. **Medical service coordination.** (a) Medical assistance covers in-reach community-based service coordination that is performed ~~in~~ through a hospital emergency department as an eligible procedure under a state healthcare program ~~or private insurance~~ for a frequent user. A frequent user is defined as an individual who has

frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(b) Reimbursement must be made in 15-minute increments ~~under current Medicaid mental health social work reimbursement methodology~~ and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. ~~A frequent user who is participating in care coordination within a health care home framework is ineligible for reimbursement under this subdivision.~~ In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

Sec. 2. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be terminated; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection<u>, nebulizer,</u> or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 3. Minnesota Statutes 2010, section 256B.0659, subdivision 2, is amended to read:

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

(6) mobility, including assistance with ambulation, including use of a wheelchair. Mobility does not include providing transportation for a recipient;

(7) positioning, including assistance with positioning or turning a recipient for necessary care and comfort; and

(8) toileting, including assistance with helping recipient with bowel or bladder elimination and care including transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting clothing.

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Sec. 4. Minnesota Statutes 2010, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section ~~or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656~~, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party ~~or personal care provider agency~~.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Sec. 5. Minnesota Statutes 2010, section 256B.0659, subdivision 4, is amended to read:

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. ~~During the assessment process,~~ A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician, specified in a personal care assistance care plan or community support plan developed under section 256B.0911, and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for recipients who are verbally aggressive ~~and~~ or resistive to care so that the time needed to perform activities of daily living is increased.

Sec. 6. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making ~~long-term~~ care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including assessment and support planning, is also intended to prevent or delay ~~certified nursing facility~~ institutional placements and to provide access to transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary ~~certified nursing facility~~ institutional admissions. Long-term consultation services must be available to any person regardless of public program eligibility. The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

(b) These services must be coordinated with long-term care options counseling provided under section 256.975, subdivision 7, and section 256.01, subdivision 24~~, for telephone assistance and follow up and to offer a variety of cost-effective alternatives to persons with disabilities and elderly persons~~. The ~~county or tribal~~ lead agency ~~or managed care plan~~ providing long-term care consultation services shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide community-based services.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 1a, is amended to read:

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

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations ~~on~~ for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated preadmission screening ~~to determine the need for an institutional level of care under subdivision 4a~~ activities described under subdivisions 4a and 4b;

(7) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under section 256B.0911, subdivision 4a, paragraph (d), ~~or 256B.092, service eligibility including state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), and 256B.0657,~~ based on assessment and community support plan development ~~with,~~ appropriate referrals to obtain necessary diagnostic information, and including ~~the option~~ an eligibility determination for consumer-directed community supports;

(8) providing recommendations for ~~nursing facility~~ institutional placement when there are no cost-effective community services available; ~~and~~

(9) providing access to assistance to transition people back to community settings after ~~facility~~ institutional admission~~.~~; and

(10) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for state plan home care services identified in:

(i) section 256B.0625, subdivisions 7, 19a, and 19c;

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, determination of eligibility for case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, determination of eligibility for family support grants under section 252.32, semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

~~(b)~~ (c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

~~(c)~~ (d) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

~~(d)~~ (e) "Lead agencies" means counties administering or ~~a collaboration of counties,~~ tribes~~,~~ and health plans ~~administering~~ under contract with the commissioner to administer long-term care consultation assessment and support planning services.

Sec. 8. Minnesota Statutes 2010, section 256B.0911, subdivision 2b, is amended to read:

Subd. 2b. **Certified assessors.** (a) ~~Beginning January 1, 2011,~~ Each lead agency shall use certified assessors who have completed training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principals and have a common set of skills that must ensure consistency and equitable access to services statewide. ~~Assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers, and other professionals as defined in paragraph (b). For persons with complex health care needs, a public health nurse or registered nurse from a multidisciplinary team must be consulted.~~ A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(b) Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a ~~two-year~~ registered ~~nursing degree~~ nurse without public health certification with at least ~~three~~ two years of home and community-based experience that ~~have~~ has received training and certification specific to assessment and consultation for long-term care services in the state.

Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 2c, is amended to read:

Subd. 2c. **Assessor training and certification.** The commissioner shall develop and implement a curriculum and an assessor certification process ~~to begin no later than January 1, 2010~~. All existing lead agency staff designated to provide the services defined in subdivision 1a must be certified ~~by December 30, 2010.~~ within timelines specified by the commissioner, but no sooner than six months after statewide availability of the training and certification process. The commissioner must establish the timelines for training and certification in a manner

that allows lead agencies to most efficiently adopt the automated process established in subdivision 5. Each lead agency is required to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service ~~by January 1, 2011~~. Certified assessors are required to be recertified every three years.

Sec. 10. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. **Long-term care consultation team.** (a) ~~Until January 1, 2011,~~ A long-term care consultation team shall be established by the county board of commissioners. ~~Each local consultation team shall consist of at least one social worker and at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team.~~ Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Certified assessors must be part of a multidisciplinary long-term care consultation team of professionals that includes public health nurses, social workers, and other professionals as defined in subdivision 2b, paragraph (b). The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within ~~15~~ 20 calendar days after the date on which an assessment was requested or recommended. ~~After January 1, 2011, these requirements also apply to~~ Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services~~,~~ and private duty nursing~~, and home health agency services, on timelines established in subdivision 5~~. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The ~~county~~ lead agency may utilize a team of either the social worker or public health nurse, or both. ~~After January 1, 2011~~ Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the ~~assessment in a face-to-face interview~~ assessment. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a community support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative~~, as required by legally executed documents~~, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services.

~~(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual, and alternatives to residential settings, including, but not limited to, foster care settings that are not the primary residence of the license holder. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.~~

~~(f)~~ (e) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to ~~the~~ long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The ~~team~~ lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening if the person selects nursing facility placement;

~~(2)~~ (4) the role of ~~the~~ long-term care consultation assessment and support planning in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (7), and (b);

~~(3)~~ (5) information about Minnesota health care programs;

~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;

~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in section ~~144.0724, subdivision 11, or 256B.092~~ 256B.0911, subdivision 4a, paragraph (d), and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

~~(7)~~ (9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b), and incorporating the decision regarding the need for ~~nursing facility~~ institutional level of care or the ~~county's~~ lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and ~~traumatic~~ brain injury waiver programs under sections 256B.0913, 256B.0915, ~~256B.0917,~~ and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for ~~these~~ programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of ~~program~~ eligibility ~~in this case~~ for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to read:

Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team~~ Lead agency certified assessors shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under section ~~256B.975~~ 256.975, subdivision ~~10~~ 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living ~~and the Senior LinkAge Line~~, Disability Linkage Line, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The ~~county~~ lead agency shall ~~develop transition processes with institutional social workers and discharge planners to~~ ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) persons ~~admitted to facilities~~ assessed in institutions receive information about transition assistance that is available;

~~(2)~~ (3) the assessment is completed for persons within ~~ten working~~ 20 calendar days of the date of request or recommendation for assessment; ~~and~~

~~(3)~~ (4) there is a plan for transition and follow-up for the individual's return to the community~~. The plan must require~~, including notification of other local agencies when a person ~~who~~ may require assistance ~~is screened by one county for admission to a facility~~ from agencies located in another county~~.~~; and

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

~~(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.~~

Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 4a, is amended to read:

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the ~~county~~ lead agency must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective no sooner than on or after July 1, 2012, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the ~~county~~ lead agency.

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to read:

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. ~~Consultation team members~~ Certified assessors shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The ~~county~~ lead agency screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 ~~or,~~ 256B.434 ~~according to section 256B.431, subdivision 2b, paragraph (g),~~ or 256B.441.

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care

consultation services while meeting the state's long-term care outcomes and objectives as defined in ~~section 256B.0917,~~ subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) Until the alternative payment methodology in paragraph (h) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(h) The commissioner shall develop an alternative payment methodology for long-term care consultation services that includes the funding available under this subdivision, and sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal funding, for ~~this~~ all long-term care consultation and preadmission screening activity.

Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. **Case management.** (a) The provision of case management under the alternative care program is governed by requirements in section 256B.0915, subdivisions 1a and 1b.

(b) The case manager must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety.

(c) The case manager is responsible for the cost-effectiveness of the alternative care individual ~~care~~ coordinated service and support plan and must not approve any ~~care~~ plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision ~~3~~ 3a, paragraph (b).

(d) Case manager responsibilities include those in section 256B.0915, subdivision 1a, paragraph (g).

Sec. 17. Minnesota Statutes 2010, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual ~~care~~ coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan ~~of care~~ for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan ~~of care~~ and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the coordinated service and support plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. **Elderly waiver case management services.** (a) ~~Elderly~~ Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of ~~elderly~~ case management services.

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services~~,~~ and assist individuals in appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated service and support plan.

(c) A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~ the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated service and support plan and review the plan ~~of care~~ at intervals specified in the federally approved waiver plan.

(e) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

(f) Except as described in paragraph (h), case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in subdivision 1b. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(g) Case management service activities provided to or arranged for a person include:

(1) development of the coordinated service and support plan under subdivision 6;

(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, which must incorporate at least one annual face-to-face visit by the case manager with each person.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 1b, is amended to read:

Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must enroll qualified providers of ~~elderly~~ case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. ~~An elderly~~ A case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and ~~care~~ coordinated service and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

(b) A health plan shall provide or arrange to provide elderly waiver case management services in subdivision 1a, paragraph (g), as part of an integrated delivery system in accordance with contract requirements established by the commissioner related to provider standards and qualifications.

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to read:

Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the ~~individual care~~ coordinated service and support plan.

(b) A lead agency is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of ~~care~~ coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written ~~care~~ coordinated service and support plan ~~that meets the requirements outlined in section 256B.0913, subdivision 8. The care plan must be implemented by the county of service when it is different than the county of financial responsibility. The county of service administering waivered services must notify the county of financial responsibility of the approved care plan.~~ which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

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

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 22. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 1, is amended to read:

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or

may have a developmental disability or has or may have a related condition. If the county of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop ~~or arrange for an individual service~~ a community support plan according to section 256B.0911, ~~provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration,~~ and authorize services identified in the person's ~~individual service~~ coordinated service and support plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by ~~the case manager~~ a certified assessor and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the ~~case manager~~ certified assessor and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the ~~case manager~~ certified assessor shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with a developmental disability when developing the person's ~~individual service~~ community support plan and coordinated service and support plan.

Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and~~ services.** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~ Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

~~(1) review of eligibility for services;~~

~~(2) screening;~~

~~(3) intake;~~

~~(4) diagnosis;~~

~~(5) the review and authorization of services based upon an individualized service plan; and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~

(b) Case management service activities provided to or arranged for a person include:

(1) development of the ~~individual service~~ coordinated service and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) ~~annual reviews of service plans and services provided~~ reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) Case managers are responsible for ~~the administrative duties and~~ service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the ~~individualized service~~ coordinated service and support plan and habilitation ~~plans~~ plan.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **~~Individual~~ Coordinated service and support plan.** ~~The individual service plan must~~ (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

~~(1) include the results of the assessment information on~~ (2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

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

~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

~~(3) identify~~ (6) identifies long- and short-range goals for the person;

~~(4) identify~~ (7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The ~~individual service~~ coordinated service and support plan shall also specify other services the person needs that are not available;

~~(5) identify~~ (8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

~~(6) identify~~ (9) identifies provider responsibilities to implement and make recommendations for modification to the ~~individual service~~ coordinated service and support plan;

~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; ~~and~~

~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services~~.~~; and

(13) includes the authorized annual and monthly amounts for the services.

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

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the ~~individual service~~ coordinated service and support plan identifies the need for individual program plans for authorized services, the case manager shall assure that individual program plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual program plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the ~~individual service~~ coordinated service and support plan;

(3) are consistent with other aspects of the ~~individual service~~ coordinated service and support plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case manager shall monitor the provision of services:

(1) to assure that the ~~individual service~~ coordinated service and support plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the ~~individual service~~ coordinated service and support plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual service~~ coordinated service and support plan.

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of ~~individual service~~ coordinated service and support plan.** Unless otherwise required by federal law, the county agency is not required to complete ~~an individual service~~ a coordinated service and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 2, is amended to read:

Subd. 2. **Medical assistance.** To assure quality case management to those persons who are eligible for medical assistance, the commissioner shall, upon request:

(1) provide consultation on the case management process;

(2) assist county agencies in the ~~screening and~~ annual reviews of clients review process to assure that appropriate levels of service are provided to persons;

(3) provide consultation on service planning and development of services with appropriate options;

(4) provide training and technical assistance to county case managers; and

(5) authorize payment for medical assistance services according to this chapter and rules implementing it.

Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to ~~individual service~~ support plans. Services provided to persons with developmental disabilities may only be authorized and terminated by case managers or certified assessors according to (1) rules of the commissioner and (2) the ~~individual service~~ coordinated service and support plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The ~~individual service~~ coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The ~~individualized service~~ coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the ~~case manager~~ lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **~~Screening teams~~ Assessments.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, ~~screening teams shall be established which~~ a certified assessor shall evaluate the need for ~~the~~ an institutional level of care. ~~provided by residential based habilitation services, residential services, training and habilitation services, and nursing facility services.~~ The ~~evaluation~~ assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60 working days of a request for service by a person with a developmental disability, and~~ within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities. ~~The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. **~~Screening team~~ Additional certified assessor duties.** In addition to the responsibilities of certified assessors described in section 256B.0911, for persons with developmental disabilities, the ~~screening team~~ certified assessor shall:

~~(1) review diagnostic data;~~

~~(2) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;~~

~~(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;~~

~~(4)~~ (1) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

~~(5)~~ (2) assess whether a person is in need of long-term residential care;

~~(6)~~ (3) make recommendations regarding placement and payment for:

(i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence;

(ii) training and habilitation service, vocational rehabilitation, and employment training activities;

(iii) community residential service placement;

(iv) regional treatment center placement; or

(v) a home and community-based service alternative to community residential ~~placement~~ service or regional treatment center placement including self-directed service options;

~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities~~; and~~.

~~(10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.~~

Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County ~~concurrence~~ notification.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's ~~individual service~~ coordinated service and support plan. The county where services are provided may not make changes in the person's ~~service~~ coordinated service and support plan without approval by the county of financial responsibility.

(b) ~~When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services.~~ The county of service ~~may refuse to concur~~ shall notify the county of financial responsibility if~~:~~

~~(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or~~

~~(2),~~ in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

(c) The county of service shall notify the county of financial responsibility of ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written ~~request~~ notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules

adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person ~~being screened by the screening team~~ receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The ~~screening team~~ certified assessor shall provide documentation that the most cost-effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's ~~community~~ coordinated service and support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's ~~community~~ coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009.

Sec. 36. Minnesota Statutes 2010, section 256B.15, subdivision 1c, is amended to read:

Subd. 1c. **Notice of potential claim.** (a) A state agency with a claim or potential claim under this section may file a notice of potential claim under this subdivision anytime before or within one year after a medical assistance recipient dies. The claimant shall be the state agency. A notice filed prior to the recipient's death shall not take effect and shall not be effective as notice until the recipient dies. A notice filed after a recipient dies shall be effective from the time of filing.

(b) The notice of claim shall be filed or recorded in the real estate records in the office of the county recorder or registrar of titles for each county in which any part of the property is located. The recorder shall accept the notice for recording or filing. The registrar of titles shall accept the notice for filing if the recipient has a recorded interest in the property. The registrar of titles shall not carry forward to a new certificate of title any notice filed more than one year from the date of the recipient's death.

(c) The notice must be dated, state the name of the claimant, the medical assistance recipient's name and last four digits of the Social Security number if filed before their death and their date of death if filed after they die, the name and date of death of any predeceased spouse of the medical assistance recipient for whom a claim may exist, a statement that the claimant may have a claim arising under this section, generally identify the recipient's interest in the property, contain a legal description for the property and whether it is abstract or registered property, a statement of when the notice becomes effective and the effect of the notice, be signed by an authorized representative of the state agency, and may include such other contents as the state agency may deem appropriate.

Sec. 37. Minnesota Statutes 2010, section 256B.15, subdivision 1f, is amended to read:

Subd. 1f. **Agency lien.** (a) The notice shall constitute a lien in favor of the Department of Human Services against the recipient's interests in the real estate it describes for a period of 20 years from the date of filing or the date of the recipient's death, whichever is later. Notwithstanding any law or rule to the contrary, a recipient's life estate and joint tenancy interests shall not end upon the recipient's death but shall continue according to subdivisions 1h, 1i, and 1j. The amount of the lien shall be equal to the total amount of the claims that could be presented in the recipient's estate under this section.

(b) If no estate has been opened for the deceased recipient, any holder of an interest in the property may apply to the lienholder for a statement of the amount of the lien or for a full or partial release of the lien. The application shall include the applicant's name, current mailing address, current home and work telephone numbers, and a description of their interest in the property, a legal description of the recipient's interest in the property, and the deceased recipient's name, date of birth, and last four digits of the Social Security number. The lienholder shall send the applicant by certified mail, return receipt requested, a written statement showing the amount of the lien, whether the lienholder is willing to release the lien and under what conditions, and inform them of the right to a hearing under section 256.045. The lienholder shall have the discretion to compromise and settle the lien upon any terms and conditions the lienholder deems appropriate.

(c) Any holder of an interest in property subject to the lien has a right to request a hearing under section 256.045 to determine the validity, extent, or amount of the lien. The request must be in writing, and must include the names, current addresses, and home and business telephone numbers for all other parties holding an interest in the property. A request for a hearing by any holder of an interest in the property shall be deemed to be a request for a hearing by all parties owning interests in the property. Notice of the hearing shall be given to the lienholder, the party filing the appeal, and all of the other holders of interests in the property at the addresses listed in the appeal by certified mail, return receipt requested, or by ordinary mail. Any owner of an interest in the property to whom notice of the hearing is mailed shall be deemed to have waived any and all claims or defenses in respect to the lien unless they appear and assert any claims or defenses at the hearing.

(d) If the claim the lien secures could be filed under subdivision 1h, the lienholder may collect, compromise, settle, or release the lien upon any terms and conditions it deems appropriate. If the claim the lien secures could be filed under subdivision 1i or 1j, the lien may be adjusted or enforced to the same extent had it been filed under subdivisions 1i and 1j, and the provisions of subdivisions 1i, clause (f), and 1j, clause (d), shall apply to voluntary payment, settlement, or satisfaction of the lien.

(e) If no probate proceedings have been commenced for the recipient as of the date the lien holder executes a release of the lien on a recipient's life estate or joint tenancy interest, created for purposes of this section, the release shall terminate the life estate or joint tenancy interest created under this section as of the date it is recorded or filed to the extent of the release. If the claimant executes a release for purposes of extinguishing a life estate or a joint tenancy interest created under this section to remove a cloud on title to real property, the release shall have the effect of extinguishing any life estate or joint tenancy interests in the property it describes which may have been continued by reason of this section retroactive to the date of death of the deceased life tenant or joint tenant except as provided for in section 514.981, subdivision 6.

(f) If the deceased recipient's estate is probated, a claim shall be filed under this section. The amount of the lien shall be limited to the amount of the claim as finally allowed. If the claim the lien secures is filed under subdivision 1h, the lien may be released in full after any allowance of the claim becomes final or according to any agreement to settle and satisfy the claim. The release shall release the lien but shall not extinguish or terminate the interest being released. If the claim the lien secures is filed under subdivision 1i or 1j, the lien shall be released after the lien under subdivision 1i or 1j is filed or recorded, or settled according to any agreement to settle and satisfy the claim. The release shall not extinguish or terminate the interest being released. If the claim is finally disallowed in full, the claimant shall release the claimant's lien at the claimant's expense.

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided ~~will~~ must include:

~~(1) assessing the needs of the individual within 20 working days of a recipient's request;~~

~~(2) developing~~ (1) finalizing the written ~~individual service~~ coordinated service and support plan within ten working days after the ~~assessment is completed~~ case manager receives the plan from the certified assessor;

~~(3)~~ (2) informing the recipient or the recipient's legal guardian or conservator of service options;

~~(4)~~ (3) assisting the recipient in the identification of potential service providers and available options for case management service and providers;

~~(5)~~ (4) assisting the recipient to access services and assisting with appeals under section 256.045; and

~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the service plan~~;~~.

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including ~~assessments, reassessments, and care plan development.~~:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

Sec. 39. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments ~~of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning~~ and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

~~(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.~~

~~(e)~~ (d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

~~(f)~~ (e) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

Sec. 40. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **~~Individualized service~~ Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which~~:~~ meets the requirements in section 256B.092, subdivision 1b.

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

~~(2) meets the assessed needs of the recipient;~~

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

~~(4) promotes independence;~~

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

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

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

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

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

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

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

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

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

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

Sec. 41. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

~~(b)~~ (2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to section 256B.0659;~~ semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

~~(c)~~ (3) any placement for a person with an indeterminate commitment, including independent living.

Sec. 42. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN AND STUDY OF COUNTY AND TRIBAL ADMINISTRATIVE FUNCTIONS.**

(a) By February 1, 2013, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation for the following:

(1) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management service services, including targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and 256B.094, and all types of home and community-based waiver case management and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

(2) recommendations on county of financial responsibility requirements and quality assurance measures for case management; and

(3) identification of county administrative functions that may remain entwined in case management service delivery models.

(b) The commissioner of human services shall evaluate county and tribal administrative functions, processes, and reimbursement methodologies for the purposes of administration of home and community-based services, and compliance and oversight functions. The commissioner shall work with county, tribal, and stakeholder representatives in the evaluation process and develop a plan for the delegation of commissioner duties to county and tribal entities after the elimination of county contracts under Minnesota Statutes, section 256B.4912, for waiver service provision and the creation of quality outcome standards under Laws 2009, chapter 79, article 8, section 81, and residential support services under Minnesota Statutes, sections 256B.092, subdivision 11, and 245A.11, subdivision 8. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by February 1, 2013, with any specific recommendations and language for proposed legislation to be effective July 1, 2013.

ARTICLE 4
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2010, section 245.461, is amended by adding a subdivision to read:

Subd. 6. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list. The commissioner shall establish an advisory committee, comprising mental health professional associations, counties, tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

Sec. 2. Minnesota Statutes 2010, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is ~~listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~ detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.

Sec. 3. Minnesota Statutes 2010, section 245.487, is amended by adding a subdivision to read:

Subd. 7. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list. The commissioner shall establish a time-limited advisory committee, comprising mental health professional associations, counties, tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

Sec. 4. Minnesota Statutes 2010, section 245.4871, subdivision 15, is amended to read:

Subd. 15. **Emotional disturbance.** "Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is ~~listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~ detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in ~~DSM-MD, current edition~~ the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Sec. 5. Minnesota Statutes 2010, section 245.4932, subdivision 1, is amended to read:

Subdivision 1. **Collaborative responsibilities.** The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative must establish an integrated fund;

(2) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

(3) the collaborative or lead county may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement;

(4) the collaborative shall use any enhanced revenue attributable to the activities of the collaborative, including administrative and service revenue, solely to provide mental health services or to expand the operational target population. The lead county or other qualified entity may not use enhanced federal revenue for any other purpose;

~~(5) the members of the collaborative must continue the base level of expenditures, as defined in section 245.492, subdivision 2, for services for children with emotional or behavioral disturbances and their families from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under sections 245.491 to 245.495, would have been available for those services. The base year for purposes of this subdivision shall be the accounting period closest to state fiscal year 1993;~~

~~(6)~~ (5) the collaborative or lead county must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the contract with the commissioner of human services;

~~(7)~~ (6) the collaborative or its members may elect to pay the nonfederal share of the medical assistance costs for services designated by the collaborative; and

~~(8)~~ (7) the lead county or other qualified entity may not use federal funds or local funds designated as matching for other federal funds to provide the nonfederal share of medical assistance.

Sec. 6. Minnesota Statutes 2010, section 246.53, is amended by adding a subdivision to read:

Subd. 4. **Exception from statute of limitations.** Any statute of limitations that limits the commissioner in recovering the cost of care obligation incurred by a client or former client shall not apply to any claim against an estate made under this section to recover the cost of care.

Sec. 7. Minnesota Statutes 2011 Supplement, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, ~~and~~ or recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18, clauses ~~(5) and~~ (1) to (6); or 245.4871, subdivision 27, clauses ~~(5) and~~ (1) to (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 9. Minnesota Statutes 2010, section 256F.13, subdivision 1, is amended to read:

Subdivision 1. **Federal revenue enhancement.** (a) The commissioner of human services may enter into an agreement with one or more family services collaboratives to enhance federal reimbursement under title IV-E of the Social Security Act and federal administrative reimbursement under title XIX of the Social Security Act. The commissioner may contract with the Department of Education for purposes of transferring the federal reimbursement to the commissioner of education to be distributed to the collaboratives according to clause (2). The commissioner shall have the following authority and responsibilities regarding family services collaboratives:

(1) the commissioner shall submit amendments to state plans and seek waivers as necessary to implement the provisions of this section;

(2) the commissioner shall pay the federal reimbursement earned under this subdivision to each collaborative based on their earnings. Payments to collaboratives for expenditures under this subdivision will only be made of federal earnings from services provided by the collaborative;

(3) the commissioner shall review expenditures of family services collaboratives using reports specified in the agreement with the collaborative to ensure ~~that the base level of expenditures is continued and~~ new federal reimbursement is used to expand education, social, health, or health-related services to young children and their families;

~~(4) the commissioner may reduce, suspend, or eliminate a family services collaborative's obligations to continue the base level of expenditures or expansion of services if the commissioner determines that one or more of the following conditions apply:~~

~~(i) imposition of levy limits that significantly reduce available funds for social, health, or health-related services to families and children;~~

~~(ii) reduction in the net tax capacity of the taxable property eligible to be taxed by the lead county or subcontractor that significantly reduces available funds for education, social, health, or health-related services to families and children;~~

~~(iii) reduction in the number of children under age 19 in the county, collaborative service delivery area, subcontractor's district, or catchment area when compared to the number in the base year using the most recent data provided by the State Demographer's Office; or~~

~~(iv) termination of the federal revenue earned under the family services collaborative agreement;~~

~~(5)~~ (4) the commissioner shall not use the federal reimbursement earned under this subdivision in determining the allocation or distribution of other funds to counties or collaboratives;

~~(6)~~ (5) the commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of this subdivision;

~~(7)~~ (6) the commissioner shall recover from the family services collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the family services collaborative's actions in the integrated fund, or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample; and

~~(8)~~ (7) the commissioner shall establish criteria for the family services collaborative for the accounting and financial management system that will support claims for federal reimbursement.

(b) The family services collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the family services collaborative shall be the party with which the commissioner contracts. A lead county shall be designated as the fiscal agency for reporting, claiming, and receiving payments;

(2) the family services collaboratives may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement, or to expand education, social, health, or health-related services to families and children;

(3) the family services collaborative must use all new federal reimbursement resulting from federal revenue enhancement to expand expenditures for education, social, health, or health-related services to families and children beyond the base level~~, except as provided in paragraph (a), clause (4)~~;

(4) the family services collaborative must ensure that expenditures submitted for federal reimbursement are not made from federal funds or funds used to match other federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family services collaborative expenditures under agreement with the department, the nonfederal share of costs shall be provided by the family services collaborative from sources other than federal funds or funds used to match other federal funds;

(5) the family services collaborative must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the agreement; and

(6) the family services collaborative shall submit an annual report to the commissioner as specified in the agreement.

Sec. 10. **TERMINOLOGY AUDIT.**

The commissioner of human services shall collaborate with individuals with disabilities, families, advocates, and other governmental agencies to solicit feedback and identify inappropriate and insensitive terminology relating to individuals with disabilities, conduct a comprehensive audit of the placement of this terminology in Minnesota Statutes and Minnesota Rules, and make recommendations for changes to the 2013 legislature on the repeal and replacement of this terminology with more appropriate and sensitive terminology.

ARTICLE 5
HEALTH CARE

Section 1. Minnesota Statutes 2011 Supplement, section 125A.21, subdivision 7, is amended to read:

Subd. 7. **District disclosure of information.** A school district may disclose information contained in a student's individualized education program, consistent with section 13.32, subdivision 3, paragraph (a), and Code of Federal Regulations, title 34, parts 99 and 300; including records of the student's diagnosis and treatment, to a health

plan company only with the signed and dated consent of the student's parent, or other legally authorized individual~~, including consent that the parent or legal representative gave as part of the application process for MinnesotaCare or medical assistance under section 256B.08, subdivision 1~~. The school district shall disclose only that information necessary for the health plan company to decide matters of coverage and payment. A health plan company may use the information only for making decisions regarding coverage and payment, and for any other use permitted by law.

Sec. 2. Minnesota Statutes 2010, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapters 256D and 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

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

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

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

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

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

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

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

(6) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

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

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 4. Minnesota Statutes 2010, section 256B.056, subdivision 3c, is amended to read:

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

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

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

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

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

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

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

(7) assets owned by children are not considered~~.~~; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

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

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9, is amended to read:

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

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

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

(3) meets the asset limits in paragraph (d); and

(4) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

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

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

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

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

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

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under ~~section 256.01, subdivision 18b~~ clause (5).

(1) An enrollee must pay the greater of a $65 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under ~~section 256.01, subdivision 18b~~ clause (5).

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

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

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

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

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

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

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.

(k) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 6. Minnesota Statutes 2010, section 256B.0595, subdivision 2, is amended to read:

Subd. 2. **Period of ineligibility for long-term care services.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for that portion of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(c) For uncompensated transfers made on or after February 8, 2006, the period of ineligibility:

(1) for uncompensated transfers by or on behalf of individuals receiving medical assistance payment of long-term care services, begins the first day of the month following advance notice of the period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or

(2) for uncompensated transfers by individuals requesting medical assistance payment of long-term care services, begins the date on which the individual is eligible for medical assistance under the Medicaid state plan and would otherwise be receiving long-term care services based on an approved application for such care but for the period of ineligibility resulting from the uncompensated transfer; and

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a period of ineligibility results in a partial month, payments for long-term care services shall be reduced in an amount equal to the fraction.

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

(f) A period of ineligibility established under paragraph (c) may be eliminated if all of the assets transferred for less than fair market value used to calculate the period of ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned ~~within 12 months after the date the period of ineligibility began~~. A period of ineligibility must not be adjusted if less than the full amount of the transferred assets or the full cash value of the transferred assets are returned.

Sec. 7. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

~~(c)~~ (d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; and (2) the number of dosage units required to complete the patient's course of therapy.

~~(d)~~ (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. ~~Over the counter medications must be dispensed in the manufacturer's unopened package.~~ The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider or the wholesale acquisition cost.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking three or more prescriptions to treat or prevent one or more chronic medical conditions; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

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

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

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

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued ~~under chapter 151~~ by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride ~~treatment~~ varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

Sec. 12. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 1, is amended to read:

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

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

~~(2) $3 for eyeglasses;~~

~~(3)~~ (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

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

~~(5)~~ (4) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

~~(6)~~ (5) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

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

Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; ~~and~~

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room~~.~~; and

(10) services, fee-for-service payments subject to volume purchase through competitive bidding.

Sec. 14. Minnesota Statutes 2010, section 256B.19, subdivision 1c, is amended to read:

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to ~~the metropolitan health plan~~ a demonstration provider serving eligible individuals in Hennepin County under section 256B.69 for the prepaid medical assistance program by approximately $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

Sec. 15. Minnesota Statutes 2010, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older. ~~Payments for elderly waiver services shall be made no earlier than the month following the month in which services were received.~~

Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care and county-based purchasing plans and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) Beginning January 1, 2007, the commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this ~~subdivision~~ section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 18. Minnesota Statutes 2010, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health

coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

Sec. 19. Minnesota Statutes 2011 Supplement, section 256L.12, subdivision 9, is amended to read:

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care and county-based purchasing plans and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

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

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

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

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

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

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

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

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold

each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

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

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

Sec. 20. Minnesota Statutes 2011 Supplement, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 21. Minnesota Statutes 2010, section 514.982, subdivision 1, is amended to read:

Subdivision 1. **Contents.** A medical assistance lien notice must be dated and must contain:

(1) the full name, last known address, and last four digits of the Social Security number of the medical assistance recipient;

(2) a statement that medical assistance payments have been made to or for the benefit of the medical assistance recipient named in the notice, specifying the first date of eligibility for benefits;

(3) a statement that all interests in real property owned by the persons named in the notice may be subject to or affected by the rights of the agency to be reimbursed for medical assistance benefits; and

(4) the legal description of the real property upon which the lien attaches, and whether the property is registered property.

Sec. 22. **HEALTH SERVICES ADVISORY COUNCIL.**

The Health Services Advisory Council shall review currently available literature regarding the efficacy of various treatments for autism spectrum disorder, including an evaluation of age-based variation in the appropriateness of existing medical and behavioral interventions. The council shall recommend to the commissioner of human services authorization criteria for services based on existing evidence. The council may recommend coverage with ongoing collection of outcomes evidence in circumstances where evidence is currently unavailable, or where the strength of the evidence is low. The council shall make this recommendation by December 31, 2012.

Sec. 23. **REPEALER.**

Minnesota Statutes 2010, section 256.01, subdivision 18b, is repealed.

ARTICLE 6
TECHNICAL

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Sec. 2. **REVISOR'S INSTRUCTION.**

(a) In Minnesota Statutes, sections 256B.038, 256B.0911, 256B.0918, 256B.092, 256B.097, 256B.49, and 256B.765, the revisor of statutes shall delete the word "traumatic" when it comes before the word "brain."

(b) In Minnesota Statutes, section 256B.093, subdivision 1, clauses (4) and (5), and subdivision 3, clause (2), the revisor of statutes shall delete the word "traumatic" when it comes before the word "brain."

(c) In Minnesota Statutes, sections 144.0724 and 144G.05, the revisor of statutes shall delete "TBI" and replace it with "BI.""

Delete the title and insert:

"A bill for an act relating to state government; making changes to health and human services policy provisions; modifying provisions related to continuing care, the telephone equipment program, chemical and mental health, and health care; reforming comprehensive assessment and case management services; making technical changes; requiring reports; amending Minnesota Statutes 2010, sections 144A.071, subdivision 5a; 237.50; 237.51; 237.52; 237.53; 237.54; 237.55; 237.56; 245.461, by adding a subdivision; 245.462, subdivision 20; 245.487, by adding a subdivision; 245.4871, subdivision 15; 245.4932, subdivision 1; 245A.11, subdivisions 2a, 8; 246.53, by adding a subdivision; 252.32, subdivision 1a; 252A.21, subdivision 2; 256.476, subdivision 11; 256.9657, subdivision 1; 256B.04, subdivision 14; 256B.056, subdivision 3c; 256B.0595, subdivision 2; 256B.0625, subdivisions 13, 13d, 19c, 42; 256B.0659, subdivisions 1, 2, 3, 3a, 4, 9, 13, 14, 19, 21, 30; 256B.0911, subdivisions 1, 2b, 2c, 3, 3b, 4c, 6; 256B.0913, subdivisions 7, 8; 256B.0915, subdivisions 1a, 1b, 3c, 6; 256B.0916, subdivision 7; 256B.092, subdivisions 1, 1a, 1b, 1e, 1g, 2, 3, 5, 7, 8, 8a, 9, 11; 256B.096, subdivision 5; 256B.15, subdivisions 1c, 1f; 256B.19, subdivision 1c; 256B.441, subdivisions 13, 31, 53; 256B.49, subdivisions 13, 21; 256B.69, subdivision 5; 256F.13, subdivision 1; 256G.02, subdivision 6; 256L.05, subdivision 3; 514.982, subdivision 1; Minnesota Statutes 2011 Supplement, sections 125A.21, subdivision 7; 144A.071, subdivisions 3, 4a; 245A.03, subdivision 7; 254B.04, subdivision 2a; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivisions 13e, 13h, 14, 56; 256B.0631, subdivisions 1, 2; 256B.0659, subdivision 11; 256B.0911, subdivisions 1a, 3a, 4a; 256B.0915, subdivision 10; 256B.49, subdivisions 14, 15; 256B.69, subdivisions 5a, 28; 256L.12, subdivision 9; 256L.15, subdivision 1; 626.557, subdivision 9; Laws 2009, chapter 79, article 8, section 81, as amended; proposing coding for new law in Minnesota Statutes, chapter 252; repealing Minnesota Statutes 2010, sections 256.01, subdivision 18b; 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l, 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e, 4g, 4h, 7, 8; 256B.435; 256B.436; Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26; Minnesota Rules, part 9555.7700."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Civil Law.

The report was adopted.

Gottwalt from the Committee on Health and Human Services Reform to which was referred:

H. F. No. 2009, A bill for an act relating to human services; changing human services legal provisions; modifying provisions related to human services licensing, licensing data, and the Office of Inspector General; amending the Human Services Background Studies Act; amending Minnesota Statutes 2010, sections 13.46, subdivision 4; 245A.02, by adding subdivisions; 245A.04, subdivisions 1, 5, 7, 11, by adding a subdivision; 245A.05; 245A.07, subdivision 3; 245A.08, subdivision 2a; 245A.14, subdivision 11, by adding a subdivision; 245A.146, subdivisions 2, 3; 245A.16, subdivision 4, by adding a subdivision; 245A.18, subdivision 1; 245A.22, subdivision 2; 245A.66, subdivisions 2, 3; 245C.03, subdivision 1; 245C.04, subdivision 1; 245C.05, subdivisions 2,

4, 6, 7, by adding a subdivision; 245C.07; 245C.08, subdivisions 1, 2, 3, by adding a subdivision; 245C.14, subdivision 2; 245C.15; 245C.16, subdivision 1; 245C.17, subdivision 2; 245C.22, subdivision 5; 245C.23, subdivision 2; 245C.24, subdivision 2; 245C.28, subdivisions 1, 3; 245C.29, subdivision 2; 256.045, subdivision 3b; Minnesota Statutes 2011 Supplement, section 256B.04, subdivision 21; proposing coding for new law in Minnesota Statutes, chapter 245A; repealing Minnesota Rules, part 9503.0150, item E.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1
DATA PRACTICES

Section 1. Minnesota Statutes 2010, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically provides a different classification, data on individuals collected, maintained, used, or disseminated by the welfare system is private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system and an investigator acting on behalf of a county, the state, or the federal government, including a law enforcement person~~,~~ or attorney~~, or investigator acting for it~~ in the investigation or prosecution of a criminal ~~or~~, civil, or administrative proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; evaluate the effectiveness of programs; assess parental contribution amounts; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Employment and Economic Development, and when applicable, the Department of Education, for the following purposes:

(i) to monitor the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency;

(ii) to administer any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system;

(iii) to monitor and evaluate the Minnesota family investment program or the child care assistance program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L; and

(iv) to analyze public assistance employment services and program utilization, cost, effectiveness, and outcomes as implemented under the authority established in Title II, Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Health records governed by sections 144.291 to 144.298 and "protected health information" as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code of Federal Regulations, title 45, parts 160-164, including health care claims utilization information, must not be exchanged under this clause;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1 (c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced-price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions;

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education; or

(30) child support data on the parents and the child may be disclosed to agencies administering programs under titles IV-B and IV-E of the Social Security Act, as provided by federal law. Data may be disclosed only to the extent necessary for the purpose of establishing parentage or for determining who has or may have parental rights with respect to a child, which could be related to permanency planning.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2010, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare system in an investigation, authorized by statute, and relating to the enforcement of rules or law is confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense; or

(4) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon its submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.556 or 626.557, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence and status of an investigation by the commissioner of possible overpayments of public funds to a service provider are public data during an investigation.

Sec. 3. Minnesota Statutes 2010, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" means all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" means Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1) (i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) When a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions. ~~If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that the license holder or applicant is responsible for maltreatment or is disqualified under chapter 245C, the identity of the license holder or applicant as the individual responsible for maltreatment or as the disqualified individual is public data at the time of the issuance of the licensing sanction or denial.~~

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant or license holder as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is disqualified under chapter 245C, the identity of the license holder or applicant as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant or license holder requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections, except as provided under clause (1).

(3) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(4) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04, subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study. If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that an individual subject to disqualification under chapter 245C is disqualified, the disqualification as a basis for the licensing sanction or denial is public data. As specified in clause (1), item (iv), if the disqualified individual is the license holder or applicant, the identity of the license holder or applicant ~~is~~ and the reason for the disqualification are public data; and, if the license holder or applicant requested reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data. If the disqualified individual is an individual other than the license holder or applicant, the identity of the disqualified individual shall remain private data.

(6) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(7) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, ~~and~~ data on individuals collected by the commissioner of human services according to ~~maltreatment~~ investigations under chapters 245A and 245C, and sections 626.556 and 626.557~~,~~ may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated~~.~~ or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 4. Minnesota Statutes 2010, section 13.82, subdivision 1, is amended to read:

Subdivision 1. **Application.** This section shall apply to agencies which carry on a law enforcement function, including but not limited to municipal police departments, county sheriff departments, fire departments, the Bureau of Criminal Apprehension, the Minnesota State Patrol, the Board of Peace Officer Standards and Training, the Department of Commerce, ~~and the program integrity section of, and~~ county human service agency client and provider fraud investigation, prevention, and control units operated or supervised by the Department of Human Services.

ARTICLE 2
LICENSING

Section 1. Minnesota Statutes 2010, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, corporation, partnership, voluntary association, other organization or controlling individual that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within the state.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the information required under section 245C.05.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

(b) An application for licensure must ~~specify one or more~~ identify all controlling individuals ~~as~~ and must specify an agent who is responsible for dealing with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made. The agent must be authorized to accept service on behalf of all of the controlling individuals of the program. Service on the agent is service on all of the controlling individuals of the program. It is not a defense to any action arising under this chapter that service was not made on each controlling individual of the program. The designation of one or more controlling individuals as agents under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) The applicant must be able to demonstrate competent knowledge of the applicable requirements of this chapter and chapter 245C, and the requirements of other licensing statutes and rules applicable to the program or services for which the applicant is seeking to be licensed. Effective January 1, 2013, the commissioner may require the applicant, except for child foster care, to demonstrate competence in the applicable licensing requirements by successfully completing a written examination. The commissioner may develop a prescribed written examination format.

(f) When an applicant is an individual, the individual must provide the applicant's Social Security number and a photocopy of a Minnesota driver's license, Minnesota identification card, or valid United States passport.

(g) When an applicant is a nonindividual, the applicant must provide the applicant's Minnesota tax identification number, the name, address, and Social Security number of all individuals who will be controlling individuals, including all officers, owners, and managerial officials as defined in section 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant for each controlling individual, and:

(1) if the agent authorized to accept service on behalf of all the controlling individuals resides in Minnesota, the agent must provide a photocopy of the agent's Minnesota driver's license, Minnesota identification card, or United States passport; or

(2) if the agent authorized to accept service on behalf of all the controlling individuals resides outside Minnesota, the agent must provide a photocopy of the agent's driver's license or identification card from the state where the agent resides or a photocopy of the agent's United States passport.

Sec. 2. Minnesota Statutes 2010, section 245A.04, subdivision 5, is amended to read:

Subd. 5. **Commissioner's right of access.** (a) When the commissioner is exercising the powers conferred by this chapter and sections 245.69, 626.556, and 626.557, the commissioner must be given access to:

(1) the physical plant and grounds where the program is provided~~,~~;

(2) documents and records, including records maintained in electronic format~~,~~;

(3) persons served by the program~~,~~; and

(4) staff whenever the program is in operation and the information is relevant to inspections or investigations conducted by the commissioner. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. In conducting inspections, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or license holder shall allow the commissioner to photocopy, photograph, and make audio and video tape recordings during the inspection of the program at the commissioner's expense. The commissioner shall obtain a court order or the consent of the subject of the records or the parents or legal guardian of the subject before photocopying hospital medical records.

(b) For programs with a government entity as license holder, the commissioner's data access provisions of this chapter supersede the otherwise applicable provisions of chapter 13. Persons served by the program have the right to refuse to consent to be interviewed, photographed, or audio or videotaped. Failure or refusal of an applicant or license holder to fully comply with this subdivision is reasonable cause for the commissioner to deny the application or immediately suspend or revoke the license.

Sec. 3. Minnesota Statutes 2010, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue an initial license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.

(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).

(e) Except as provided in paragraphs (g) and (h), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) ~~has~~ been denied a license within the past two years;

(3) had a license revoked within the past five years; ~~or~~

(4) ~~has~~ an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent~~.~~; or

(5) failed to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A or 245B for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

(f) The commissioner shall not issue or reissue a license if an individual living in the household where the licensed services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

(g) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

(h) Notwithstanding paragraph (g), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

(i) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

(j) Unless otherwise specified by statute, all licenses expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

(k) The commissioner shall not issue or reissue a license if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

Sec. 4. Minnesota Statutes 2010, section 245A.04, subdivision 11, is amended to read:

Subd. 11. **Education program; permitted ages, additional requirement.** (a) ~~The education program offered in a residential or nonresidential program, except for child care, foster care, or services for adults, must be approved by the commissioner of education before the commissioner of human services may grant a license to the program.~~ Except for foster care, the commissioner of human services may not grant a license to a residential facility for the placement of children before the commissioner has received documentation of approval of the educational program from the commissioner of education according to section 125A.515.

~~(b) A residential program licensed by the commissioner of human services under Minnesota Rules, parts 2960.0010 to 2960.0710, may serve persons through the age of 19 when:~~

~~(1) the admission or continued stay is necessary for a person to complete a secondary school program or its equivalent, or it is necessary to facilitate a transition period after completing the secondary school program or its equivalent for up to four months in order for the resident to obtain other living arrangements;~~

~~(2) the facility develops policies, procedures, and plans required under section 245A.65;~~

~~(3) the facility documents an assessment of the 18- or 19-year-old person's risk of victimizing children residing in the facility, and develops necessary risk reduction measures, including sleeping arrangements, to minimize any risk of harm to children; and~~

~~(4) notwithstanding the license holder's target population age range, whenever persons age 18 or 19 years old are receiving residential services, the age difference among residents may not exceed five years.~~

~~(c)~~ (b) A ~~child foster care~~ program licensed by the commissioner under Minnesota Rules, chapter 2960, may serve persons who are over the age of 18 but under the age of 21 when the person is:

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

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

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

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

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

(c) In addition to the requirements in paragraph (b), a residential program licensed by the commissioner of human services under Minnesota Rules, parts 2960.0010 to 2960.0710, may serve persons under the age of 21 provided the facility complies with the following requirements:

(1) for each person age 18 and older served at the program, the program must assess and document the person's risk of victimizing other residents residing in the facility, and based on the assessment, the facility must develop and implement necessary measures to minimize any risk of harm to other residents, including making arrangements for appropriate sleeping arrangements; and

(2) the program must assure that the services and living arrangements provided to all residents are suitable to the age and functioning of the residents, including separation of services, staff supervision, and other program operations as appropriate.

(d) Nothing in this ~~paragraph~~ subdivision precludes the license holder from seeking other variances under subdivision 9.

Sec. 5. Minnesota Statutes 2010, section 245A.04, is amended by adding a subdivision to read:

Subd. 16. **Program policy; reporting a death in the program.** Unless such reporting is otherwise already required under statute or rule, programs licensed under this chapter must have a written policy for reporting the death of an individual served by the program to the commissioner of human services. Within 24 hours of receiving knowledge of the death of an individual served by the program, the license holder shall notify the commissioner of the death. If the license holder has reason to know that the death has been reported to the commissioner, a subsequent report is not required.

Sec. 6. Minnesota Statutes 2010, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

~~(1)~~ (2) fails to comply with applicable laws or rules;

~~(2)~~ (3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

~~(3)~~ (4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

~~(4)~~ (5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted; ~~or~~

~~(5)~~ (6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted~~.~~; or

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g).

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial. Notice must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 7. Minnesota Statutes 2010, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules~~, if~~;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification which has not been set aside under section 245C.22~~, or if~~;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules~~.~~; or

(4) after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).

A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and (h), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide the residential-based habilitation services, as defined under section 245B.02, subdivision 20, and a license to provide foster care, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study

violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 8. Minnesota Statutes 2010, section 245A.14, subdivision 11, is amended to read:

Subd. 11. **Swimming pools; family day care and group family day care providers.** (a) This subdivision governs swimming pools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. This subdivision does not apply to portable wading pools or whirlpools located at family day care or group family day care homes licensed under Minnesota Rules, chapter 9502. For a provider to be eligible to allow a child cared for at the family day care or group family day care home to use the swimming pool located at the home, the provider must not have had a licensing sanction under section 245A.07 or a correction order or conditional license under section 245A.06 relating to the supervision or health and safety of children during the prior 24 months, and must satisfy the following requirements:

(1) notify the county agency before initial use of the swimming pool and annually, thereafter;

(2) obtain written consent from a child's parent or legal guardian allowing the child to use the swimming pool and renew the parent or legal guardian's written consent at least annually. The written consent must include a statement that the parent or legal guardian has received and read materials provided by the Department of Health to the Department of Human Services for distribution to all family day care or group family day care homes and the general public on the human services Internet Web site related to the risk of disease transmission as well as other health risks associated with swimming pools. The written consent must also include a statement that the Department of Health, Department of Human Services, and county agency will not monitor or inspect the provider's swimming pool to ensure compliance with the requirements in this subdivision;

(3) enter into a written contract with a child's parent or legal guardian and renew the written contract annually. The terms of the written contract must specify that the provider agrees to perform all of the requirements in this subdivision;

(4) attend and successfully complete a swimming pool operator training course once every five years. Acceptable training courses are:

(i) the National Swimming Pool Foundation Certified Pool Operator course;

(ii) the National Spa and Pool Institute Tech I and Tech II courses (both required); or

(iii) the National Recreation and Park Association Aquatic Facility Operator course;

(5) require a caregiver trained in first aid and adult and child cardiopulmonary resuscitation to supervise and be present at the swimming pool with any children in the pool;

(6) toilet all potty-trained children before they enter the swimming pool;

(7) require all children who are not potty-trained to wear swim diapers while in the swimming pool;

(8) if fecal material enters the swimming pool water, add three times the normal shock treatment to the pool water to raise the chlorine level to at least 20 parts per million, and close the pool to swimming for the 24 hours following the entrance of fecal material into the water or until the water pH and disinfectant concentration levels have returned to the standards specified in clause (10), whichever is later;

(9) prevent any person from entering the swimming pool who has an open wound or any person who has or is suspected of having a communicable disease;

(10) maintain the swimming pool water at a pH of not less than 7.2 and not more than 8.0, maintain the disinfectant concentration between two and five parts per million for chlorine or between 2.3 and 4.5 parts per million for bromine, and maintain a daily record of the swimming pool's operation with pH and disinfectant concentration readings on days when children cared for at the family day care or group family day care home are present;

(11) have a disinfectant feeder or feeders;

(12) have a recirculation system that will clarify and disinfect the swimming pool volume of water in ten hours or less;

(13) maintain the swimming pool's water clarity so that an object on the pool floor at the pool's deepest point is easily visible;

(14) ~~have two or more suction lines in the swimming pool~~ comply with the provisions of the Abigail Taylor Pool Safety Act in section 144.1222, subdivisions 1c and 1d;

(15) have in place and enforce written safety rules and swimming pool policies;

(16) have in place at all times a safety rope that divides the shallow and deep portions of the swimming pool;

(17) satisfy any existing local ordinances regarding swimming pool installation, decks, and fencing;

(18) maintain a water temperature of not more than 104 degrees Fahrenheit and not less than 70 degrees Fahrenheit; and

(19) for lifesaving equipment, have a United States Coast Guard-approved life ring attached to a rope, an exit ladder, and a shepherd's hook available at all times to the caregiver supervising the swimming pool.

The requirements of clauses (5), (16), and (18) only apply at times when children cared for at the family day care or group family day care home are present.

(b) A violation of paragraph (a), clauses (1) to (3), is grounds for a sanction under section 245A.07 or a correction order or conditional license under section 245A.06.

(c) If a provider under this subdivision receives a licensing sanction under section 245A.07 or a correction order or a conditional license under section 245A.06 relating to the supervision or health and safety of children, the provider is prohibited from allowing a child cared for at the family day care or group family day care home to continue to use the swimming pool located at the home.

Sec. 9. Minnesota Statutes 2010, section 245A.146, subdivision 2, is amended to read:

Subd. 2. **Documentation requirement for license holders.** (a) ~~Effective January 1, 2006,~~ All licensed child care providers, children's residential facilities, chemical dependency treatment programs with children in care, and residential habilitation programs serving children with developmental disabilities must maintain the following documentation for every crib used by or that is accessible to any child in care:

(1) the crib's brand name; and

(2) the crib's model number.

(b) Any crib for which the license holder does not have the documentation required under paragraph (a) must not be used by or be accessible to children in care.

(c) Effective December 28, 2012, the licensed program must maintain documentation to show that every full-size and non-full-size crib that is used by or is accessible to any child in care is compliant with federal crib standards under Code of Federal Regulations, title 16, part 1219, for full-size baby cribs, or Code of Federal Regulations, title 16, part 1220, for non-full-size baby cribs. Documentation must include verification that each crib was either purchased from a retailer on or after June 28, 2011, or a certificate from the manufacturer or retailer verifying compliance with Code of Federal Regulations, title 16, part 1219 or part 1220 for each crib purchased before June 28, 2011.

Sec. 10. Minnesota Statutes 2010, section 245A.146, subdivision 3, is amended to read:

Subd. 3. **License holder documentation of cribs.** (a) Annually, from the date printed on the license, all license holders shall check all their cribs' brand names and model numbers against the United States Consumer Product Safety Commission Web site listing of unsafe cribs.

(b) The license holder shall maintain written documentation to be reviewed on site for each crib showing that the review required in paragraph (a) has been completed, and which of the following conditions applies:

(1) the crib was not identified as unsafe on the United States Consumer Product Safety Commission Web site;

(2) the crib was identified as unsafe on the United States Consumer Product Safety Commission Web site, but the license holder has taken the action directed by the United States Consumer Product Safety Commission to make the crib safe; or

(3) the crib was identified as unsafe on the United States Consumer Product Safety Commission Web site, and the license holder has removed the crib so that it is no longer used by or accessible to children in care.

(c) Documentation of the review completed under this subdivision shall be maintained by the license holder on site and made available to parents or guardians of children in care and the commissioner.

(d) Notwithstanding Minnesota Rules, part 9502.0425, a family child care provider that complies with this section may use a mesh-sided playpen or crib that has not been identified as unsafe on the United States Consumer Product Safety Commission Web site for the care or sleeping of infants.

Sec. 11. Minnesota Statutes 2010, section 245A.18, subdivision 1, is amended to read:

Subdivision 1. **Seat belt and child passenger restraint system use.** When a child is transported, a license holder must comply with all seat belt and child passenger restraint system requirements under ~~section~~ sections 169.685 and 169.686.

Sec. 12. **[245A.191] PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL DEPENDENCY CONSOLIDATED TREATMENT FUND.**

(a) When a chemical dependency treatment provider licensed under Minnesota Rules, parts 2960.0430 to 2960.0490 or 9530.6405 to 9530.6505, agrees to meet the applicable requirements under section 254B.05, subdivision 5, paragraphs (b), clauses (1) to (4) and (6), (c), and (d), to be eligible for enhanced funding from the chemical dependency consolidated treatment fund, the applicable requirements under section 254B.05 are also licensing requirements that may be monitored for compliance through licensing investigations and licensing inspections.

(b) Noncompliance with the requirements identified under paragraph (a) may result in:

(1) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(2) nonpayment of claims submitted by the license holder for public program reimbursement;

(3) recovery of payments made for the service;

(4) disenrollment in the public payment program; or

(5) other administrative, civil, or criminal penalties as provided by law.

Sec. 13. Minnesota Statutes 2010, section 245A.22, subdivision 2, is amended to read:

Subd. 2. **Admission.** (a) The license holder shall accept as clients in the independent living assistance program only youth ages 16 to 21 who are in out-of-home placement, leaving out-of-home placement, at risk of becoming homeless, or homeless.

(b) Youth who have current drug or alcohol problems, a recent history of violent behaviors, or a mental health disorder or issue that is not being resolved through counseling or treatment are not eligible to receive the services described in subdivision 1.

(c) Youth who are not employed, participating in employment training, or enrolled in an academic program are not eligible to receive transitional housing or independent living assistance.

(d) The commissioner may grant a variance under section 245A.04, subdivision 9, to requirements in this section.

Sec. 14. Minnesota Statutes 2010, section 245A.66, subdivision 2, is amended to read:

Subd. 2. **Child care centers; risk reduction plan.** (a) Child care centers licensed under this chapter and Minnesota Rules, chapter 9503, must develop a risk reduction plan that ~~assesses~~ identifies the general risks to children served by the child care center. The license holder must establish procedures to minimize identified risks, train staff on the procedures, and annually review the procedures.

(b) The risk reduction plan must include an assessment of risk to children the center serves or intends to serve and identify specific risks based on the outcome of the assessment. The assessment of risk must be based on the following:

(1) ~~an assessment of the risk presented by the vulnerability of the children served, including an evaluation of the following factors: age, developmental functioning, and the physical and emotional health of children the program serves or intends to serve;~~

~~(2)~~ an assessment of the risks presented by the physical plant where the licensed services are provided, including an evaluation of the following factors: the condition and design of the facility and its outdoor space, bathrooms, storage areas, and accessibility of medications and cleaning products that are harmful to children when children are not supervised~~, doors where finger pinching may occur,~~ and the existence of areas that are difficult to supervise; and

~~(3)~~ (2) an assessment of the risks presented by the environment for each facility and for each site, including an evaluation of the following factors: the type of grounds and terrain surrounding the building and the proximity to hazards, busy roads, and publicly accessed businesses.

(c) The risk reduction plan must include a statement of measures that will be taken to minimize the risk of harm presented to children for each risk identified in the assessment required under paragraph (b) related to the physical plan and environment. At a minimum, the ~~risk reduction plan~~ stated measures must ~~address the following:~~ include

~~(1) a general description of supervision, programming, and~~ the development and implementation of specific policies and procedures or reference to ~~the~~ existing policies and procedures ~~developed and implemented to address~~ that minimize the risks identified ~~in the assessment required under paragraph (b) related to the general population served, the physical plant, and environment;~~.

~~(2)~~ (d) In addition to any program-specific risks identified in paragraph (b), the plan must include development and implementation of specific policies and procedures or refer to existing policies and procedures ~~developed and implemented to~~ that minimize the risk of harm or injury to children, including:

~~(i)~~ (1) closing children's fingers in doors, including cabinet doors;

~~(ii)~~ (2) leaving children in the community without supervision;

~~(iii)~~ (3) children leaving the facility without supervision;

~~(iv)~~ (4) caregiver dislocation of children's elbows;

~~(v)~~ (5) burns from hot food or beverages, whether served to children or being consumed by caregivers, and the devices used to warm food and beverages;

~~(vi)~~ (6) injuries from equipment, such as scissors and glue guns;

~~(vii)~~ (7) sunburn;

~~(viii)~~ (8) feeding children foods to which they are allergic;

~~(ix)~~ (9) children falling from changing tables; and

~~(x)~~ (10) children accessing dangerous items or chemicals or coming into contact with residue from harmful cleaning products~~; and~~.

~~(3)~~ (e) The plan shall prohibit the accessibility of hazardous items to children.

(f) The plan must include specific policies and procedures to ensure adequate supervision of children at all times as defined under section 245A.02, subdivision 18, with particular emphasis on:

(1) times when children are transitioned from one area within the facility to another;

(2) nap-time supervision, including infant crib rooms as specified under section 245A.02, subdivision 18, which requires that when an infant is placed in a crib to sleep, supervision occurs when a staff person is within sight or hearing of the infant. When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision components;

(3) child drop-off and pick-up times;

(4) supervision during outdoor play and on community activities, including but not limited to field trips and neighborhood walks; and

(5) supervision of children in hallways.

Sec. 15. Minnesota Statutes 2010, section 245A.66, subdivision 3, is amended to read:

Subd. 3. **Orientation to risk reduction plan and annual review of plan.** (a) The license holder shall ensure that all mandated reporters, as defined in section 626.556, subdivision 3, who are under the control of the license holder, receive an orientation to the risk reduction plan prior to first providing unsupervised direct contact services, as defined in section 245C.02, subdivision 11, to children, not to exceed 14 days from the first supervised direct contact, and annually thereafter. The license holder must document the orientation to the risk reduction plan in the mandated reporter's personnel records.

(b) The license holder must review the risk reduction plan annually and document the annual review. When conducting the review, the license holder must consider incidents that have occurred in the center since the last review, including:

(1) the assessment factors in the plan;

(2) the internal reviews conducted under this section, if any;

(3) substantiated maltreatment findings, if any; and

(4) incidents that caused injury or harm to a child, if any, that occurred since the last review.

Following any change to the risk reduction plan, the license holder must inform mandated reporters, under the control of the license holder, of the changes in the risk reduction plan, and document that the mandated reporters were informed of the changes.

Sec. 16. Minnesota Statutes 2010, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause; and

(7) all managerial officials as defined under section 245A.02, subdivision 5a.

(b) For family child foster care settings, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

Sec. 17. Minnesota Statutes 2010, section 245C.04, subdivision 1, is amended to read:

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

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at reapplication for a license for family child care.

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

(1) registered under chapter 144D; or

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

(3) the following conditions are met:

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

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

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

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

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

(f) From January 1, 2010, to December 31, 2012, unless otherwise specified in paragraph (c), the commissioner shall conduct a study of an individual required to be studied under section 245C.03 at the time of reapplication for an adult foster care or family adult day services license: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b), for background studies conducted by the commissioner for all family adult day services and for adult foster care when the adult foster care license holder resides in the adult foster care or family adult day services residence; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for

background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.

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

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

(i) A license holder must ~~provide the commissioner notice~~ initiate a new background study through the commissioner's online background study system ~~or through a letter mailed to the commissioner~~ when:

(1) an individual returns to a position requiring a background study following an absence of ~~45~~ 180 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for ~~45~~ 180 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

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

(k) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

Sec. 18. Minnesota Statutes 2010, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) home address, city, and state of residence;

(3) zip code;

(4) sex;

(5) date of birth; ~~and~~

(6) Minnesota driver's license number or state identification number; and

(7) Social Security number.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints as required in subdivision 5, paragraph (c).

Sec. 19. Minnesota Statutes 2010, section 245C.05, subdivision 2, is amended to read:

Subd. 2. **Applicant, license holder, or other entity.** The applicant, license holder, or other entities as provided in this chapter shall ~~provide~~ verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a format prescribed by the commissioner.

Sec. 20. Minnesota Statutes 2010, section 245C.05, is amended by adding a subdivision to read:

Subd. 2c. **Privacy notice to background study subject.** (a) For every background study, the commissioner's notice to the background study subject required under section 13.04, subdivision 2, that is provided through the commissioner's electronic NETStudy system or through the commissioner's background study forms shall include the information in paragraph (b).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

Sec. 21. Minnesota Statutes 2010, section 245C.05, subdivision 3, is amended to read:

Subd. 3. **Additional information from individual studied.** ~~(a) For purposes of completing the background study, the commissioner may request the individual's Social Security number or race. The individual is not required to provide this information to the commissioner.~~

~~(b)~~ The commissioner may also require additional information if the commissioner determines the information is necessary to complete the background study. Failure to provide the required information may result in a disqualification pursuant to section 245C.09.

Sec. 22. Minnesota Statutes 2010, section 245C.05, subdivision 4, is amended to read:

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

(1) background study information to the commissioner;

(2) background study results to the license holder;

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

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

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as NETStudy to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

Sec. 23. Minnesota Statutes 2010, section 245C.05, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2010, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.

(a) ~~Except for child foster care and adoption agencies,~~ Subject to the conditions in paragraph (d), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the Department of Human Services, Department of Health, or Department of Corrections, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) When a background study is being initiated by a licensed program or service or a foster care provider that is also registered under chapter 144D, a study subject affiliated with multiple licensed programs or services may attach to the background study form a cover letter indicating the additional names of the programs or services, addresses, and background study identification numbers.

When the commissioner receives a notice, the commissioner shall notify each program or service identified by the background study subject of the study results.

The background study notice the commissioner sends to the subsequent agencies shall satisfy those programs' or services' responsibilities for initiating a background study on that individual.

(d) If a background study was conducted on an individual related to child foster care and the requirements under paragraph (a) are met, the background study is transferable across all licensed programs. If a background study was conducted on an individual under a license other than child foster care and the requirements under paragraph (a) are met, the background study is transferable to all licensed programs except child foster care.

(e) The provisions of this section that allow a single background study in one or more licensed programs or services do not apply to background studies submitted by adoption agencies, supplemental nursing services agencies, personnel agencies, educational programs, professional services agencies, and unlicensed personal care provider organizations.

Sec. 25. Minnesota Statutes 2010, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension;

(5) except as provided in clause (6), information from the national crime information system when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5; and

(6) for a background study related to a child foster care application for licensure or adoptions, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) information from national crime information databases, when the background study subject is 18 years of age or older.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner. When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner shall require the subject to provide a set of classifiable fingerprints and may review the subject's national criminal history record information.

Sec. 26. Minnesota Statutes 2010, section 245C.14, subdivision 2, is amended to read:

Subd. 2. **Disqualification from access.** (a) If an individual who is studied under section 245C.03, subdivision 1, paragraph (a), ~~clauses (2), (5), and (6),~~ is disqualified from direct contact under subdivision 1, the commissioner shall also disqualify the individual from access to a person receiving services from the license holder.

(b) No individual who is disqualified following a background study under section 245C.03, subdivision 1, paragraph (a), ~~clauses (2), (5), and (6),~~ or as provided elsewhere in statute who is disqualified as a result of this section, may be allowed access to persons served by the program unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that licensed program or entity identified in section 245C.03 as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

Sec. 27. Minnesota Statutes 2010, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; and

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

(e) This section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

~~(e)~~ (f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 28. Minnesota Statutes 2010, section 245C.17, subdivision 2, is amended to read:

Subd. 2. **Disqualification notice sent to subject.** (a) If the information in the study indicates the individual is disqualified from direct contact with, or from access to, persons served by the program, the commissioner shall disclose to the individual studied:

(1) the information causing disqualification;

(2) instructions on how to request a reconsideration of the disqualification;

(3) an explanation of any restrictions on the commissioner's discretion to set aside the disqualification under section 245C.24, when applicable to the individual;

(4) a statement that, if the individual's disqualification is set aside under section 245C.22, the applicant, license holder, or other entity that initiated the background study will be provided with the reason for the individual's disqualification and an explanation that the factors under section 245C.22, subdivision 4, which were the basis of the decision to set aside the disqualification shall be made available to the license holder upon request without the consent of the subject of the background study;

~~(4)~~ (5) a statement indicating that if the individual's disqualification is set aside or the facility is granted a variance under section 245C.30, the individual's identity and the reason for the individual's disqualification will become public data under section 245C.22, subdivision 7, when applicable to the individual; ~~and~~

(6) a statement that when a subsequent background study is initiated on the individual following a set-aside of the individual's disqualification, and the commissioner makes a determination under section 245C.22, subdivision 5, paragraph (b), that the previous set-aside applies to the subsequent background study, the applicant, license holder, or other entity that initiated the background study will be informed in the notice under section 245C.22, subdivision 5, paragraph (c):

(i) of the reason for the individual's disqualification;

(ii) that the individual's disqualification is set aside for that program or agency; and

(iii) that information about the factors under section 245C.22, subdivision 4, that were the basis of the decision to set aside the disqualification are available to the license holder upon request without the consent of the background study subject; and

~~(5)~~ (7) the commissioner's determination of the individual's immediate risk of harm under section 245C.16.

(b) If the commissioner determines under section 245C.16 that an individual poses an imminent risk of harm to persons served by the program where the individual will have direct contact with, or access to, people receiving services, the commissioner's notice must include an explanation of the basis of this determination.

(c) If the commissioner determines under section 245C.16 that an individual studied does not pose a risk of harm that requires immediate removal, the individual shall be informed of the conditions under which the agency that initiated the background study may allow the individual to have direct contact with, or access to, people receiving services, as provided under subdivision 3.

Sec. 29. Minnesota Statutes 2010, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23~~, unless otherwise specified in the notice~~. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (i), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 30. Minnesota Statutes 2010, section 245C.23, subdivision 2, is amended to read:

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

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

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

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

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

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

(c) If the commissioner does not set aside the disqualification under section 245C.22, and the license holder was not previously ordered to immediately remove the individual from any position allowing direct contact with persons receiving services from the program or to ensure that the individual is under continuous, direct supervision when providing direct contact services, the commissioner shall order the license holder to ensure that the individual remains under continuous, direct supervision when providing direct contact services pending the outcome of a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14.

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

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

Sec. 31. Minnesota Statutes 2010, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as otherwise provided in ~~paragraph (b)~~ this section, the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual ~~in the chemical dependency or corrections field~~ who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(d) For background studies related to an application or license to provide child foster care for a specific child related to the applicant or license holder, the commissioner shall consider granting a variance under section 245C.30 to an individual with a disqualification under section 245C.15, subdivision 1. The variance shall be limited to the specific child related to the applicant or license holder.

(e) When a background study is required on a child foster care provider's former recipient of foster care services because the former recipient of foster care services returns for occasional overnight visits or temporarily resides with the foster parents, the commissioner shall consider granting a variance under section 245C.30 related to the former foster care recipient with a disqualification under section 245C.15, subdivision 1.

Sec. 32. Minnesota Statutes 2010, section 471.709, is amended to read:

471.709 LICENSE; PERMIT.

Notwithstanding any law to the contrary, a municipality shall not require a massage therapist to obtain a license or permit when the therapist is working for or an employee of a medical professional licensed under chapter 147 or 148 or a dental professional licensed under chapter 150A. A massage therapist is not limited to providing treatment to patients of the medical or dental professional.

Sec. 33. **REVISOR'S INSTRUCTION.**

The revisor shall renumber Minnesota Statutes, section 245B.05, subdivision 4, as Minnesota Statutes, section 245A.04, subdivision 2a. The revisor shall make necessary cross-reference changes to effectuate this renumbering.

Sec. 34. **REPEALER.**

Minnesota Rules, part 9503.0150, item E, is repealed.

ARTICLE 3
PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2010, section 171.07, subdivision 1a, is amended to read:

Subd. 1a. **Filing photograph or image; data classification.** The department shall file, or contract to file, all photographs or electronically produced images obtained in the process of issuing drivers' licenses or Minnesota identification cards. The department shall permanently retain all photographs or electronically produced images collected and filed pursuant to this section. The photographs or electronically produced images shall be private data pursuant to section 13.02, subdivision 12. Notwithstanding section 13.04, subdivision 3, the department shall not be required to provide copies of photographs or electronically produced images to data subjects. The use of the files is restricted:

(1) to the issuance and control of drivers' licenses;

(2) to criminal justice agencies, as defined in section 299C.46, subdivision 2, for the investigation and prosecution of crimes, service of process, enforcement of no contact orders, location of missing persons, investigation and preparation of cases for criminal, juvenile, and traffic court, and supervision of offenders;

(3) to public defenders, as defined in section 611.272, for the investigation and preparation of cases for criminal, juvenile, and traffic courts; ~~and~~

(4) to child support enforcement purposes under section 256.978; and

(5) to publicly funded assistance program eligibility under chapter 119B, 256B, 256D, 256I, 256J, 256L, or the supplemental nutrition assistance program; and fraud investigative purposes under sections 256.98, 256.983, 256B.064, and 256J.32.

Sec. 2. Minnesota Statutes 2010, section 245A.04, subdivision 1, is amended to read:

Subdivision 1. **Application for licensure.** (a) An individual, corporation, partnership, voluntary association, other organization or controlling individual that is subject to licensure under section 245A.03 must apply for a license. The application must be made on the forms and in the manner prescribed by the commissioner. The

commissioner shall provide the applicant with instruction in completing the application and provide information about the rules and requirements of other state agencies that affect the applicant. An applicant seeking licensure in Minnesota with headquarters outside of Minnesota must have a program office located within the state.

The commissioner shall act on the application within 90 working days after a complete application and any required reports have been received from other state agencies or departments, counties, municipalities, or other political subdivisions. The commissioner shall not consider an application to be complete until the commissioner receives all of the information required under section 245C.05.

(b) An application for licensure must specify one or more controlling individuals as an agent who is responsible for dealing with the commissioner of human services on all matters provided for in this chapter and on whom service of all notices and orders must be made. The agent must be authorized to accept service on behalf of all of the controlling individuals of the program. Service on the agent is service on all of the controlling individuals of the program. It is not a defense to any action arising under this chapter that service was not made on each controlling individual of the program. The designation of one or more controlling individuals as agents under this paragraph does not affect the legal responsibility of any other controlling individual under this chapter.

(c) An applicant or license holder must have a policy that prohibits license holders, employees, subcontractors, and volunteers, when directly responsible for persons served by the program, from abusing prescription medication or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care. The license holder must train employees, subcontractors, and volunteers about the program's drug and alcohol policy.

(d) An applicant and license holder must have a program grievance procedure that permits persons served by the program and their authorized representatives to bring a grievance to the highest level of authority in the program.

(e) At the time of application for licensure or renewal of a license, the applicant or license holder must acknowledge on the form provided by the commissioner if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license that:

(1) the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored by the commissioner as part of a licensing investigation or licensing inspection; and

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement;

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

(v) other administrative, civil, or criminal penalties as provided by law.

Sec. 3. Minnesota Statutes 2010, section 245A.14, is amended by adding a subdivision to read:

Subd. 14. **Attendance records for publicly funded services.** (a) A child care center licensed under this chapter and according to Minnesota Rules, chapter 9503, must maintain documentation of actual attendance for each child receiving care for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(b) A family child care provider licensed under this chapter and according to Minnesota Rules, chapter 9502, must maintain documentation of actual attendance for each child receiving care for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

(c) An adult day services program licensed under this chapter and according to Minnesota Rules, parts 9555.5105 to 9555.6265, must maintain documentation of actual attendance for each adult day service recipient for which the license holder is reimbursed by a governmental program. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

(1) the first, middle, and last name of the recipient;

(2) the time of day that the recipient was dropped off; and

(3) the time of day that the recipient was picked up.

(d) The commissioner shall not issue a correction for attendance record errors that occur before August 1, 2013.

Sec. 4. **[245A.167] PUBLIC FUNDS PROGRAM INTEGRITY MONITORING.**

(a) An applicant or a license holder that has enrolled to receive public funding reimbursement for services is required to comply with the registration or enrollment requirements as licensing standards.

(b) Compliance with the licensing standards established under paragraph (a) may be monitored during a licensing investigation or inspection. Noncompliance with these licensure standards may result in:

(i) a correction order or a conditional license under section 245A.06, or sanctions under section 245A.07;

(ii) nonpayment of claims submitted by the license holder for public program reimbursement according to the statute applicable to that program;

(iii) recovery of payments made for the service according to the statute applicable to that program;

(iv) disenrollment in the public payment program according to the statute applicable to that program; or

(v) a referral for other administrative, civil, or criminal penalties as provided by law.

Sec. 5. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18c. **Verification of legal presence.** The commissioner of public safety shall, upon request of the commissioner, provide the dates of a person's established legal presence as provided to the commissioner of public safety, to the commissioner of human services. The commissioner of human services must determine whether the data newly indicates that the established legal presence has expired for any individuals who receive publicly funded assistance under chapter 119B, 256B, 256D, 256I, 256J, 256L, or the supplemental nutrition assistance program. The commissioner shall terminate publicly funded assistance to persons whose established legal presence has expired and who are not otherwise eligible to receive publicly funded assistance under chapter 119B, 256B, 256D, 256I, 256J, 256L, or the supplemental nutrition assistance program. The commissioner shall notify the county attorney when it confirms that a person whose established legal presence has expired was receiving publicly funded assistance under chapter 119B, 256B, 256D, 256I, 256J, 256L, or the supplemental nutrition assistance program.

Sec. 6. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

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

(b) The commissioner shall determine at the time of initial application, recertification, and at any other time the commissioner is made aware of any felony drug conviction if any of the persons in the report is applying for or receiving publicly funded assistance in violation of section 256J.26, or any other law or rule.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the Minnesota Department of Human Services permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

Sec. 8. Minnesota Statutes 2010, section 256J.32, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** The county agency shall verify the following at application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of a minor child to caregivers in the assistance unit;

(4) age, if necessary to determine MFIP eligibility;

(5) immigration status;

(6) Social Security number according to the requirements of section 256J.30, subdivision 12;

(7) income;

(8) self-employment expenses used as a deduction;

(9) source and purpose of deposits and withdrawals from business accounts;

(10) spousal support and child support payments made to persons outside the household;

(11) real property;

(12) vehicles;

(13) checking and savings accounts;

(14) savings certificates, savings bonds, stocks, and individual retirement accounts;

(15) pregnancy, if related to eligibility;

(16) inconsistent information, if related to eligibility;

(17) burial accounts;

(18) school attendance, if related to eligibility;

(19) residence;

(20) a claim of family violence if used as a basis to qualify for the family violence waiver;

(21) disability if used as the basis for reducing the hourly participation requirements under section 256J.55, subdivision 1, or the type of activity included in an employment plan under section 256J.521, subdivision 2; ~~and~~

(22) information needed to establish an exception under section 256J.24, subdivision 9; and

(23) the validity and status of Minnesota drivers' licenses or identification cards, if provided as documentation of identity.

Sec. 9. **AGREEMENT FOR DATA SHARING BETWEEN DEPARTMENT OF PUBLIC SAFETY AND DEPARTMENT OF HUMAN SERVICES OF FACIAL RECOGNITION VERIFICATION PROJECT DIGITAL IMAGES.**

The commissioner of public safety shall enter into an agreement with the commissioner of human services to provide digital images of suspected fraudulent driver's license or identification card applicants and the status of the applicant's driver's license or identification after review by the commissioner of public safety from the Facial Recognition Verification Project of the Division of Driver and Vehicle Services for purposes of investigating fraud under Minnesota Statutes, sections 256.98, 256.983, and 256B.064. The commissioner of public safety shall provide the data for use only by those employees with investigative responsibility under Minnesota Statutes, sections 256.98, 256.983, and 256B.064. The agreement must be certified annually and the use of data is subject to audit by the commissioner of public safety. An audit that results in confirmed misuse of data that is provided by the commissioner of public safety under this section by an employee or agent of the Department of Human Services is cause for the commissioner of public safety to terminate the agreement.

Sec. 10. **AGREEMENT FOR DATA SHARING BETWEEN DEPARTMENT OF PUBLIC SAFETY AND DEPARTMENT OF HUMAN SERVICES FOR DRIVER'S LICENSE AND IDENTIFICATION CARD DATA.**

The commissioner of public safety shall enter into an agreement with the commissioner of human services to provide driver's license and identification card data under Minnesota Statutes, section 171.06, for purposes of investigating fraud under Minnesota Statutes, sections 256.98, 256.983, and 256B.064. The commissioner of public

safety shall provide data to the commissioner of human services for use only by those employees with investigative responsibility under Minnesota Statutes, sections 256.98, 256.983, and 256B.064. The agreement must be certified annually and the use of data is subject to audit by the commissioner of public safety. An audit that results in confirmed misuse of data that is provided by the commissioner of public safety under this section by an employee or agent of the Department of Human Services is cause for the commissioner of public safety to terminate the agreement.

Sec. 11. **DIRECTION TO THE COMMISSIONER.**

The commissioner of human services, in consultation with the commissioner of public safety, shall report to the legislative committees with jurisdiction over health and human services policy and finance regarding the implementation of sections 1, 5, 6, 8, 9, and 10 and the number of persons affected by February 1, 2013.

Sec. 12. **INSTRUCTIONS TO THE COMMISSIONER.**

(a) The commissioner of human services shall convene a work group to evaluate the length of time between license holder submission of appeals and the dates of the resulting administrative hearings under Minnesota Statutes, section 256.045, and Minnesota Statutes, chapter 14, for background study, maltreatment, and licensing decision appeals. The work group shall evaluate license holder appeals for the departments of health and human services and affiliated agencies or providers.

(b) The work group must include representatives from the Departments of Health and Human Services, legal aid, the attorney general's office, the Office of Administrative Hearings, and at least five affected provider organizations.

(c) The commissioner must issue a report to the legislature of the work group's recommendations to improve the timeliness for resolution of appeals by February 1, 2013."

Delete the title and insert:

"A bill for an act relating to human services; changing human services legal provisions; modifying provisions related to human services licensing, licensing data, and the Office of Inspector General; amending the Human Services Background Studies Act; modifying municipal license provisions; providing for program integrity monitoring; requiring a report; amending Minnesota Statutes 2010, sections 13.46, subdivisions 2, 3, 4; 13.82, subdivision 1; 171.07, subdivision 1a; 245A.04, subdivisions 1, 5, 7, 11, by adding a subdivision; 245A.05; 245A.07, subdivision 3; 245A.14, subdivision 11, by adding a subdivision; 245A.146, subdivisions 2, 3; 245A.18, subdivision 1; 245A.22, subdivision 2; 245A.66, subdivisions 2, 3; 245C.03, subdivision 1; 245C.04, subdivision 1; 245C.05, subdivisions 1, 2, 3, 4, 7, by adding a subdivision; 245C.07; 245C.08, subdivision 1; 245C.14, subdivision 2; 245C.16, subdivision 1; 245C.17, subdivision 2; 245C.22, subdivision 5; 245C.23, subdivision 2; 245C.24, subdivision 2; 256.01, by adding subdivisions; 256J.32, subdivision 4; 471.709; Minnesota Statutes 2011 Supplement, section 256B.04, subdivision 21; proposing coding for new law in Minnesota Statutes, chapter 245A; repealing Minnesota Rules, part 9503.0150, item E."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Civil Law.

The report was adopted.

Peppin from the Committee on Government Operations and Elections to which was referred:

H. F. No. 2244, A bill for an act relating to the permanent school fund; changing the Permanent School Fund Advisory Committee into a legislative commission; granting the commission authority to employ a director to oversee, manage, and administer school trust lands; amending Minnesota Statutes 2010, sections 16A.06, subdivision 11; 16A.125, subdivision 5; 84.027, subdivision 18; 84.085, subdivision 1; 92.12, subdivision 1; 92.121; 92.13; 93.2236; 94.342, subdivision 5; 127A.30; proposing coding for new law in Minnesota Statutes, chapter 127A.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2010, section 16A.06, subdivision 11, is amended to read:

Subd. 11. **Permanent school fund reporting.** The commissioner shall annually report to the Permanent School Fund ~~Advisory Committee~~ Board, and the legislature the amount of the permanent school fund transfer and information about the investment of the permanent school fund provided by the State Board of Investment. The State Board of Investment shall provide information about how they maximized the long-term economic return of the permanent school fund.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 2. Minnesota Statutes 2010, section 16A.125, subdivision 5, is amended to read:

Subd. 5. **Forest trust lands.** (a) The term "state forest trust fund lands" as used in this subdivision, means public land in trust under the Constitution set apart as "forest lands under the authority of the commissioner" of natural resources as defined by section 89.001, subdivision 13, but excludes school trust lands as defined in section 92.025.

(b) The commissioner of management and budget shall credit the revenue from the forest trust fund lands, excluding school trust lands defined under section 92.025, to the forest suspense account. The account must specify the trust funds interested in the lands and the respective receipts of the lands.

(c) After a fiscal year, the commissioner of management and budget shall certify the total costs incurred for forestry during that year under appropriations for the protection, improvement, administration, and management of state forest trust fund lands and construction and improvement of forest roads to enhance the forest value of the lands. The certificate must specify the trust funds interested in the lands. The commissioner of natural resources shall supply the commissioner of management and budget with the information needed for the certificate.

(d) After a fiscal year, the commissioner shall distribute the receipts credited to the suspense account during that fiscal year as follows:

(1) the amount of the certified costs incurred by the ~~state~~ Department of Natural Resources for forest management, forest improvement, and road improvement during the fiscal year shall be transferred to the forest management investment account established under section 89.039;

(2) the balance of the certified costs incurred by the ~~state~~ Department of Natural Resources during the fiscal year shall be transferred to the general fund; and

(3) the balance of the receipts shall then be returned prorated to the trust funds in proportion to their respective interests in the lands which produced the receipts.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 3. Minnesota Statutes 2010, section 84.027, subdivision 18, is amended to read:

Subd. 18. **Permanent school fund authority; reporting.** The ~~commissioner of natural resources~~ Permanent School Fund Board has the authority and responsibility for the administration of school trust lands under sections 92.121 and 127A.31. The ~~commissioner~~ board shall biannually report to the Legislative Permanent School Fund ~~Advisory Committee~~ Commission and the legislature on the management of the school trust lands that shows how the ~~commissioner~~ board has and will continue to achieve the following goals:

(1) manage the school trust lands efficiently;

(2) reduce the management expenditures of school trust lands and maximize the revenues deposited in the permanent school trust fund;

(3) manage the sale, exchange, and commercial leasing of school trust lands to maximize the revenues deposited in the permanent school trust fund and retain the value from the long-term appreciation of the school trust lands; and

(4) manage the school trust lands to maximize the long-term economic return for the permanent school trust fund while maintaining sound natural resource conservation and management principles.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 4. Minnesota Statutes 2010, section 84.085, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner of natural resources may accept for and on behalf of the state any gift, bequest, devise, or grants of lands or interest in lands or personal property of any kind or of money tendered to the state for any purpose pertaining to the activities of the department or any of its divisions. Any money so received is hereby appropriated and dedicated for the purpose for which it is granted. Lands and interests in lands so received may be sold or exchanged as provided in chapter 94.

(b) When the commissioner of natural resources accepts lands or interests in land, the commissioner may reimburse the donor for costs incurred to obtain an appraisal needed for tax reporting purposes. If the state pays the donor for a portion of the value of the lands or interests in lands that are donated, the reimbursement for appraisal costs shall not exceed $1,500. If the donor receives no payment from the state for the lands or interests in lands that are donated, the reimbursement for appraisal costs shall not exceed $5,000.

(c) The commissioner of natural resources, on behalf of the state, may accept and use grants of money or property from the United States or other grantors for conservation purposes not inconsistent with the laws of this state. Any money or property so received is hereby appropriated and dedicated for the purposes for which it is granted, and shall be expended or used solely for such purposes in accordance with the federal laws and regulations pertaining thereto, subject to applicable state laws and rules as to manner of expenditure or use providing that the commissioner may make subgrants of any money received to other agencies, units of local government, private individuals, private organizations, and private nonprofit corporations. Appropriate funds and accounts shall be maintained by the commissioner of management and budget to secure compliance with this section.

~~(d) The commissioner may accept for and on behalf of the permanent school fund a donation of lands, interest in lands, or improvements on lands. A donation so received shall become state property, be classified as school trust land as defined in section 92.025, and be managed consistent with section 127A.31.~~

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 5. Minnesota Statutes 2010, section 92.12, subdivision 1, is amended to read:

Subdivision 1. **Appraisers.** The Permanent School Fund Board may have any school trust land appraised. The commissioner may have any ~~school trust or~~ other state lands appraised. The appraisals must be made by regularly appointed and qualified state appraisers. To be qualified, an appraiser must hold a state appraiser license issued by the Department of Commerce. The appraisal must be in conformity with the Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 6. Minnesota Statutes 2010, section 92.121, is amended to read:

92.121 PERMANENT SCHOOL FUND LANDS.

The Permanent School Fund Board and the commissioner of natural resources shall exchange permanent school fund land as defined in the Minnesota Constitution, article XI, section 8, located in state parks, state recreation areas, wildlife management areas, scientific and natural areas, or state waysides or on lands managed by the commissioner as old growth stands, for other lands as allowed by the Minnesota Constitution, article XI, section 10, and section 94.343, subdivision 1, that are compatible with the goal of the permanent school fund lands in section 127A.31 when, as a result of management practices applied to the permanent school fund lands and associated resources, revenue generation has been diminished or is prohibited and no alternative has been put into effect to compensate the permanent school fund for the income losses.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 7. Minnesota Statutes 2010, section 92.13, is amended to read:

92.13 STATE LANDS, DATE OF SALE.

The commissioner shall hold public sales of ~~school and other~~ state lands other than school trust lands when it is advantageous to the state and to intending buyers and settlers.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 8. Minnesota Statutes 2010, section 93.2236, is amended to read:

93.2236 MINERALS MANAGEMENT ACCOUNT.

(a) The minerals management account is created as an account in the natural resources fund. Interest earned on money in the account accrues to the account. Money in the account may be spent or distributed only as provided in paragraphs (b) and (c).

(b) If the balance in the minerals management account exceeds $3,000,000 on June 30, the amount exceeding $3,000,000 must be distributed to ~~the permanent school fund and~~ the permanent university fund. ~~The amount distributed to each fund must be in the same proportion as the total mineral lease revenue received in the previous biennium from school trust lands and university lands.~~

(c) Subject to appropriation by the legislature, money in the minerals management account may be spent by the commissioner of natural resources for mineral resource management and projects to enhance future mineral income and promote new mineral resource opportunities.

(d) Beginning July 1, 2014, no revenue from school trust lands, including revenue from severed minerals interests, shall be deposited in the minerals management account.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 9. Minnesota Statutes 2010, section 94.342, subdivision 5, is amended to read:

Subd. 5. **Additional restrictions on school trust land.** School trust land may be exchanged with other Class A land only if the ~~Permanent School Fund Advisory Committee is appointed as temporary~~ Permanent School Fund Board is serving as trustee of the school trust land for purposes of the exchange. The ~~committee~~ director shall provide independent legal counsel to review the exchanges.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 10. Minnesota Statutes 2010, section 127A.30, is amended to read:

127A.30 LEGISLATIVE PERMANENT SCHOOL FUND ~~ADVISORY COMMITTEE~~ COMMISSION.

Subdivision 1. **Commission established; membership.** ~~A state~~ (a) The Legislative Permanent School Fund ~~Advisory Committee~~ Commission of 12 members is established to advise ~~the Department of Natural Resources~~ the Permanent School Fund Board on the management of permanent school fund land, which is held in trust for the school districts of the state and to review legislation affecting permanent school fund land. The ~~advisory committee must consist~~ commission consists of the following persons ~~or their designees~~: ~~the chairs of the education committees of the legislature, the chairs of the legislative committees with jurisdiction over the K-12 education budget, the chairs of the legislative committees with jurisdiction over the environment and natural resources policy and budget, the chair of the senate Committee on Finance and the chair of the house of representatives Committee on Ways and Means, the commissioner of education, one superintendent from a nonmetropolitan district, one superintendent from a metropolitan area district, one person with an expertise in forestry, one person with an expertise in minerals and mining, one person with an expertise in real estate development, one person with an expertise in renewable energy, one person with an expertise in finance and land management, and one person with an expertise in natural resource conservation. The school district superintendents shall be appointed by the commissioner of education. The committee members with areas of expertise in forestry, minerals and mining, real estate development, renewable energy, finance and land management, and natural resource conservation shall be appointed by the commissioner of natural resources. Members of the legislature shall be given the opportunity to recommend candidates for vacancies on the committee to the commissioners of education and natural resources. The advisory committee must also include a nonvoting member appointed by the commissioner of natural resources. The commissioner of natural resources shall provide administrative support to the committee. The members of the committee shall serve without compensation. The members of the Permanent School Fund Advisory Committee shall elect their chair and are bound by the provisions of sections 43A.38 and 116P.09, subdivision 6.~~

(1) six members of the senate, including three members from the majority party and three members from the minority party, appointed by the senate Subcommittee on Committees of the Committee on Rules and Administration; and

(2) six members of the house of representatives, including three majority party members appointed by the speaker of the house and three minority party members appointed by the minority leader.

(b) Appointed legislative members serve at the pleasure of the appointing authority and continue to serve until their successors are appointed.

(c) The first meeting of the commission shall be convened by the chair of the Legislative Coordinating Commission. Members shall elect a chair, vice-chair, secretary, and other officers as determined by the commission. The chair may convene meetings as necessary to conduct the duties prescribed by this section.

(d) The Legislative Coordinating Commission shall provide administrative support for the commission.

Subd. 2. **Duties.** The ~~advisory committee~~ commission shall review ~~the policies of the Department of Natural Resources and~~ current statutes on management of school trust fund lands at least annually and shall recommend necessary changes in statutes, policy, and implementation in order to ensure provident utilization of the permanent school fund lands. By January 15 of each year, the ~~advisory committee~~ commission shall submit a report to the legislature with recommendations for the management of school trust lands to secure long-term economic return for the permanent school fund, consistent with sections 92.121 and 127A.31. The ~~committee's~~ commission's annual report may include recommendations to:

(1) manage the school trust lands efficiently;

(2) reduce the management expenditures of school trust lands and maximize the revenues deposited in the permanent school trust fund;

(3) manage the sale, exchange, and commercial leasing of school trust lands to maximize the revenues deposited in the permanent school trust fund and retain the value from the long-term appreciation of the school trust lands; ~~and~~

(4) manage the school trust lands to maximize the long-term economic return for the permanent school trust fund while maintaining sound natural resource conservation and management principles; and

(5) make recommendations concerning the asset allocation of the school endowment fund.

~~Subd. 3. **Duration.** Notwithstanding section 15.059, subdivision 5, the advisory committee is permanent and does not expire.~~

EFFECTIVE DATE. This section is effective January 2, 2013.

Sec. 11. **[127A.3011] POLICY AND PURPOSE.**

(a) The purpose of sections 127A.3011 to 127A.3020 is to establish a board and a director to oversee, manage, and administer Minnesota's school trust lands in accordance with the provisions of the Minnesota Constitution, article XI, section 8.

(b) As trustee, the state must manage the lands and revenues generated from the lands in the most prudent and profitable manner possible, and not for any purpose inconsistent with the best interests of the trust beneficiaries as defined in the Minnesota Constitution, article XI, section 8.

(c) The trustee must be concerned with both income for the current beneficiaries and the preservation of trust assets for future beneficiaries, which requires a balancing of short-term and long-term interests so that long-term benefits are not lost in an effort to maximize short-term gains.

(d) Sections 127A.3011 to 127A.3020 shall be liberally construed to enable the board and the director to faithfully fulfill the state's obligations to the trust beneficiaries.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 12. **[127A.3012] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 127A.3011 to 127A.3020, the definitions have the meanings given.

Subd. 2. **Board.** "Board" means the Permanent School Fund Board.

Subd. 3. **Director.** "Director" means the director of trust lands and mineral assets.

Subd. 4. **School trust land.** "School trust land" means land granted by the United States for use of schools within each township, swampland granted to the state, and internal improvement land that are reserved for permanent school fund purposes under the Minnesota Constitution, article XI, section 8, and land exchanged, purchased, or granted for the benefit of the permanent school fund.

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

Sec. 13. **[127A.3013] PERMANENT SCHOOL FUND BOARD.**

Subdivision 1. **Membership.** The Permanent School Fund Board is composed of five members. The governor must appoint the members with the advice and consent of both the senate and the house of representatives acting separately. If either house fails to confirm the appointment of a board member within 45 legislative days after appointment or by adjournment sine die, whichever occurs first, the appointment terminates on the day following the 45th legislative day or on adjournment sine die, whichever occurs first. If either house votes not to confirm an appointment, the appointment terminates on the day following the vote not to confirm.

Subd. 2. **Qualifications.** In making appointments, the governor shall consider geographic balance, gender, age, ethnicity, and varying interests. Members must have practical experience or expertise or demonstrated knowledge in renewable or nonrenewable resource management or development, real estate, business, finance, trust administration, asset management, environmental science, or the practice of law in the areas of natural resources or real estate. Registered lobbyists must not be members of the board.

Subd. 3. **Terms, compensation, removal.** Membership terms, compensation, removal of members and filling of vacancies are as provided in section 15.0575.

Subd. 4. **Conflict of interest.** (a) A board member may not be an advocate for or against a board action or vote on any action that may be a conflict of interest. A conflict of interest must be disclosed as soon as it is discovered. The commission shall follow the policies and requirements related to conflicts of interest developed by the Office of Grants Management under section 16B.98.

(b) For the purposes of this section, a "conflict of interest" exists when a person has an organizational conflict of interest or direct financial interests and those interests present the appearance that it will be difficult for the person to impartially fulfill the person's duty. An "organizational conflict of interest" exists when a person has an affiliation with an organization that is subject to commission activities, which presents the appearance of a conflict between organizational interests and commission member duties. An "organizational conflict of interest" does not exist if the person's only affiliation with an organization is being a member of the organization.

Subd. 5. **No transfers.** The commissioner of administration may not use section 16B.37 to transfer duties of the board.

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

Sec. 14. **[127A.3014] DUTIES.**

Subdivision 1. **Management.** (a) The board shall manage all school trust lands within the state, and shall provide policies for the director and for the management of trust lands and assets.

(b) The board may enter into an agreement with the commissioner of natural resources for administration and management of trust lands. This agreement must specify the services that the Department of Natural Resources will provide to the board and the fees the department will charge for providing these services. If the board and the commissioner of natural resources cannot reach an agreement satisfactory to both parties, the board may contract with an outside entity for these services.

(c) If, after July 1, 2014, the board determines that receiving administrative and management services from the commissioner of natural resources is not the best way to manage lands in the most prudent and profitable manner, the board may move these services to another agency or outside entity.

Subd. 2. **Joint ventures.** The board may enter into joint ventures to develop trust lands and minerals.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 15. **[127A.3015] POLICIES.**

Subdivision 1. **Management.** The board shall establish policies for the director of trust lands and mineral assets. The policies shall:

(1) be consistent with the Minnesota Constitution and state law;

(2) reflect undivided loyalty to the beneficiaries consistent with fiduciary duties;

(3) require the return of not less than fair market value for the use, sale, or exchange of school trust assets;

(4) seek to optimize trust land revenues and increase the value of trust land holdings consistent with the balancing of short-term and long-term interests, so that long-term benefits are not lost in an effort to maximize short-term gains; and

(5) maintain the integrity of the trust and prevent the misapplication of its lands and its revenues.

Subd. 2. **Duties.** The board and the director shall recommend to the governor and the legislature any necessary or desirable changes in statutes relating to the trust or their trust responsibilities. The board shall develop policies for the long-term benefit of the trust utilizing the broad discretion and power granted to it in sections 127A.3011 to 127A.3015.

Subd. 3. **Policies continued unless changed.** Policies adopted by the Department of Natural Resources prior to the effective date of this act regarding school trust lands shall remain in effect until amended or repealed by the board. The board shall be the named party in substitution of the Department of Natural Resources or its predecessor agencies with respect to all documents affecting trust lands with respect to duties transferred to the board.

Subd. 4. **Accept land and property.** The board may accept for and on behalf of the permanent school fund a donation of lands, interest in lands, or improvements on lands. A donation so received shall become state property, be classified as school trust land as defined in section 92.025, and be managed consistent with section 127A.31.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 16. **[127A.3016] DIRECTOR.**

Subdivision 1. **Term.** The board shall select a director on the basis of outstanding professional qualifications pertinent to the purposes and activities of the trust. The director serves in the unclassified service at the pleasure of the board.

Subd. 2. **Compensation.** The board shall establish the compensation of the director. The compensation and performance of the director shall be examined each year as part of the board's budget review process.

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

Sec. 17. **[127A.3017] RESPONSIBILITIES OF DIRECTOR.**

Subdivision 1. **Duties and budget review.** In carrying out the policies of the board and in establishing procedures and rules, the director shall:

(1) take an oath of office before assuming any duties as the director;

(2) adopt procedures necessary for the proper administration of matters entrusted to the director by state law and commission policy;

(3) faithfully manage the administration under the policies established by the board;

(4) submit to the board and for public inspection an annual management budget and financial plan for operations of the administration and, after approval by the board, submit the budget to the governor;

(5) direct and control the budget expenditures as finally authorized and appropriated;

(6) establish job descriptions and employ, within the limitation of the budget, staff necessary to accomplish the purposes of the director's office;

(7) maintain appropriate records of trust activities to enable the legislative auditor to conduct periodic audits of trust activities;

(8) provide that all leases, contracts, and agreements be submitted to legal counsel for review of compliance with applicable law and fiduciary duties prior to execution and utilize the services of the attorney general as provided in section 127A.3018;

(9) keep the board, beneficiaries, governor, legislature, and the public informed about the work of the director and board by reporting to the board in a public meeting at least once during each calendar quarter; and

(10) respond in writing within a reasonable time to a request by the board for responses to questions on policies and practices affecting the management of the trust.

Subd. 2. **Additional responsibilities.** The director may:

(1) contract with other public agencies or other public or private entities for personnel management services; and

(2) with the approval of the board, enter into joint ventures and other business arrangements consistent with the purposes of the trust.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 18. **[127A.3018] ATTORNEY GENERAL.**

The attorney general shall: represent the board, director, or administration in any legal action relating to trust lands; review leases, contracts, and agreements submitted for review prior to execution; and undertake suits for the collection of royalties, rental, and other damages in the name of the state.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 19. **[127A.3019] LAND EXCHANGE.**

The board may enter into land exchange agreements with the commissioner of natural resources according to the provisions of section 92.121.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 20. **[127A.3020] FOREST AND MINERALS MANAGEMENT.**

Subdivision 1. **Control.** All forest and minerals management on school trust lands is vested with the board according to the provisions of sections 127A.3011 to 127A.3020.

Subd. 2. **May contract.** The board may contract with any public or private entity to make improvements to or upon trust lands and to carry out any of the responsibilities of the office, so long as the contract requires strict adherence to trust management principles and applicable law.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 21. **[127A.3021] SCHOOL TRUST LANDS SUSPENSE ACCOUNT.**

A school trust lands suspense account is established as an account in the special revenue fund. The director shall credit all revenue from the school trust lands to the school trust lands suspense account. After a fiscal year, the director shall certify that year's costs for oversight, protection, improvement, administration, and management of school trust lands against the account and distribute the balance of the revenue to the permanent school fund.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 22. Minnesota Statutes 2010, section 477A.11, is amended by adding a subdivision to read:

Subd. 1a. **Board.** "Board" means the Permanent School Fund Board established under section 127A.3013.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 23. Minnesota Statutes 2010, section 477A.11, subdivision 3, is amended to read:

Subd. 3. **Acquired natural resources land.** "Acquired natural resources land" means:

(1) any land presently administered by the commissioner or the board in which the state acquired by purchase, condemnation, or gift, a fee title interest in lands which were previously privately owned; and

(2) lands acquired by the state under chapter 84A that are designated as state parks, state recreation areas, scientific and natural areas, or wildlife management areas.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 24. Minnesota Statutes 2010, section 477A.11, subdivision 4, is amended to read:

Subd. 4. **Other natural resources land.** "Other natural resources land" means any other land presently owned in fee title by the state and administered by the commissioner or the board, or any tax-forfeited land, other than platted lots within a city or those lands described under subdivision 3, clause (2), which is owned by the state and administered by the commissioner or the board or by the county in which it is located.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 25. Minnesota Statutes 2011 Supplement, section 477A.12, subdivision 1, is amended to read:

Subdivision 1. **Types of land; payments.** (a) As an offset for expenses incurred by counties and towns in support of natural resources lands, the following amounts are annually appropriated to the commissioner of natural resources from the general fund for transfer to the commissioner of revenue. The commissioner of revenue shall pay the transferred funds to counties as required by sections 477A.11 to 477A.14. The amounts are:

(1) for acquired natural resources land, $5.133 multiplied by the total number of acres of acquired natural resources land or, at the county's option three-fourths of one percent of the appraised value of all acquired natural resources land in the county, whichever is greater;

(2) $1.283 multiplied by the number of acres of county-administered other natural resources land;

(3) $1.283 multiplied by the total number of acres of land utilization project land; and

(4) 64.2 cents multiplied by the number of acres of ~~commissioner-administered~~ noncounty-administered other natural resources land located in each county as of July 1 of each year prior to the payment year.

(b) The amount determined under paragraph (a), clause (1), is payable for land that is acquired from a private owner and owned by the Department of Transportation for the purpose of replacing wetland losses caused by transportation projects, but only if the county contains more than 500 acres of such land at the time the certification is made under subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 26. Minnesota Statutes 2010, section 477A.12, subdivision 2, is amended to read:

Subd. 2. **Procedure.** Lands for which payments in lieu are made pursuant to section 97A.061, subdivision 3, and Laws 1973, chapter 567, shall not be eligible for payments under this section. Each county auditor shall certify to the Department of Natural Resources during July of each year prior to the payment year the number of acres of county-administered other natural resources land within the county. The Department of Natural resources may, in addition to the certification of acreage, require descriptive lists of land so certified. The commissioner of natural resources shall determine and certify to the commissioner of revenue by March 1 of the payment year:

(1) the number of acres and most recent appraised value of acquired natural resources land, excluding any administered by the board within each county;

(2) the number of acres of commissioner-administered natural resources land within each county;

(3) the number of acres of county-administered other natural resources land within each county, based on the reports filed by each county auditor with the commissioner of natural resources; and

(4) the number of acres of land utilization project land within each county.

The Permanent School Fund Board shall determine and certify to the commissioner of revenue by March 1 of the payment year the number of acres of land and the appraised value of the land administered by the board subject to payments under this section.

The commissioner of transportation shall determine and certify to the commissioner of revenue by March 1 of the payment year the number of acres of land and the appraised value of the land described in subdivision 1, paragraph (b), but only if it exceeds 500 acres.

The commissioner of revenue shall determine the distributions provided for in this section using the number of acres and appraised values certified by the commissioner of natural resources and the commissioner of transportation by March 1 of the payment year.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 27. Minnesota Statutes 2010, section 477A.12, subdivision 3, is amended to read:

Subd. 3. **Determination of appraised value.** For the purposes of this section, the appraised value of acquired natural resources land is the purchase price for the first five years after acquisition. The appraised value of acquired natural resources land received as a donation is the value determined for the commissioner of natural resources or the board by a licensed appraiser, or the county assessor's estimated market value if no appraisal is done. The appraised value must be determined by the county assessor every five years after the land is acquired.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 28. **TRANSFER OF ASSETS AND BUDGET RESPONSIBILITY.**

Unless otherwise provided by statute, the responsibilities of the Department of Natural Resources and any other state agency with respect to the permanent school fund lands are transferred to the Permanent School Fund Board. Minnesota Statutes, section 15.039, subdivisions 1 to 6, apply to this transfer.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 29. **REPORT.**

The Permanent School Fund Board must meet with the commissioner of natural resources to discuss potential agreements with the commissioner for administration and management of trust lands, including services that the Department of Natural Resources will provide to the board and the fees the department will charge for these services. The board must report to the legislature by January 15, 2014, on the result of these discussions, including any statutory changes needed to implement agreements between the board and the commissioner.

Sec. 30. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall recode Minnesota Statutes, section 84.027, subdivision 18, as section 127A.3014, subdivision 3.

(b) By January 15, 2013, the revisor of statutes, in consultation with the commissioner of natural resources shall identify and report to the legislature on statutes related to management of school trust fund lands and transfer of functions in this act."

Amend the title as follows:

Page 1, line 3, after the semicolon, insert "establishing a permanent school fund board;" and delete the second "commission" and insert "board"

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Ways and Means.

The report was adopted.

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 2251, A bill for an act relating to insurance; shifting regulatory authority over health maintenance organizations from the commissioner of health to the commissioner of commerce; amending Minnesota Statutes 2010, sections 62D.02, subdivision 3; 62D.05, subdivision 6; 62D.12, subdivision 1.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Gottwalt from the Committee on Health and Human Services Reform to which was referred:

H. F. No. 2258, A bill for an act relating to human services; creating a chemical health navigation program; limiting residential chemical dependency treatment; requiring a report; amending Minnesota Statutes 2010, sections 254B.03, subdivision 1; 254B.04, subdivision 1; 256B.69, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 254B.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2010, section 254A.19, is amended by adding a subdivision to read:

Subd. 4. **Civil commitments.** A Rule 25 assessment, under Minnesota Rules, part 9530.6615, does not need to be completed for civil commitments and for the duration of a civil commitment under section 253B.065, 253B.09, or 253B.095 in order for a county to access state funding for chemical dependency treatment. Nothing in this subdivision shall prohibit placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655. The commissioner of human services shall adopt rules to comply with this subdivision.

Sec. 2. **[254B.14] CHEMICAL HEALTH NAVIGATION PROGRAM.**

Subdivision 1. **Establishment; purpose.** (a) There is established a state-county chemical health navigation program. The Department of Human Services and interested counties shall work in partnership to augment the current chemical health service delivery system to promote better outcomes for eligible individuals and greater accountability and productivity in the delivery of state and county funded chemical dependency services.

(b) The navigation program shall allow flexibility for eligible individuals to timely access needed services as well as to align systems and services to offer the most appropriate level of chemical health services to eligible individuals.

(c) Chemical health navigation programs must maintain eligibility requirements for the consolidated chemical dependency treatment fund, continue to meet the requirements of Minnesota Rules, parts 9530.6405 to 9530.6505 and 9530.6600 to 9530.6655, and must not put current and future federal funding of chemical health services at risk.

Subd. 2. **Program implementation.** (a) Each county's participation in the chemical health navigation program is voluntary.

(b) The commissioner and each county participating in the chemical health navigation program shall enter into an agreement governing the operation of the county's navigation program. Each county shall implement its program within 60 days of the final agreement with the commissioner.

Subd. 3. **Notice of program discontinuation.** Each county's participation in the chemical health navigation program may be discontinued for any reason by the county or the commissioner after 30 days' written notice to the other party. Any unspent funds held for the exiting county's pro rata share in the special revenue fund under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated chemical dependency treatment fund following discontinuation of the program.

Subd. 4. **Eligibility for navigator program.** To be considered for participation in a navigator program, an individual must:

(1) be a resident of a county with an approved navigator program;

(2) be eligible for chemical dependency fund services;

(3) have a score of at least three in two or more dimensions of the placement criteria in a Rule 25 assessment under Minnesota Rules, parts 9530.6600 to 9530.6655;

(4) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds; and

(5) be a voluntary participant in the navigator program.

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize chemical health navigator programs to use chemical dependency treatment funds to pay for nontreatment services:

(1) in addition to those authorized under section 254B.03, subdivision 2, paragraph (a); and

(2) by vendors in addition to those authorized under section 254B.05 when not providing chemical dependency treatment services.

(b) Participating counties may contract with providers to provide nontreatment services pursuant to section 256B.69, subdivision 6, paragraph (c).

(c) For the purposes of this section, "nontreatment services" include community-based navigator services, peer support, family engagement and support, housing support and rent subsidy for up to 90 days, supported employment, and independent living skills.

(d) State expenditures for chemical dependency services and nontreatment services provided through the navigator programs must not be greater than the chemical dependency treatment fund expected share of forecasted expenditures in the absence of the navigator programs. The commissioner may restructure the schedule of payments between the state and participating counties under the local agency share and division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the navigation programs.

(e) To the extent that state fiscal year expenditures within a county's navigator program are less than the expected share of forecasted expenditures in the absence of the navigator program, the commissioner shall deposit the unexpended funds in a separate account within the consolidated chemical dependency treatment fund, and make these funds available for expenditure by the county for the following year. To the extent that treatment and nontreatment services expenditures within a county's navigator program exceed the amount expected in the absence of the navigator program, the county shall be responsible for the portion of costs for nontreatment services expended in excess of the otherwise expected share of forecasted expenditures.

(f) The commissioner may waive administrative rule requirements that are incompatible with the implementation of navigator programs, except that any chemical dependency treatment funded under this section must continue to be provided by a licensed treatment provider.

(g) The commissioner shall not approve or enter into any agreement related to navigator programs authorized under this section that puts current or future federal funding at risk.

(h) The commissioner shall provide participating counties with transactional data, reports, provider data, and other data generated by county activity to assess and measure outcomes. This information must be transmitted to participating counties at least once every six months.

Subd. 6. **Duties of county board.** The county board, or other county entity that is approved to administer a navigator program, shall:

(1) administer the program in a manner consistent with this section;

(2) ensure that no one is denied chemical dependency treatment services for which they would otherwise be eligible under section 254A.03, subdivision 3; and

(3) provide the commissioner with timely and pertinent information as negotiated in the agreement governing operation of the county's navigator program.

Subd. 7. **Report.** The commissioner, in partnership with participating counties, shall provide an annual report on the achievement of navigator program outcomes to the legislative committees with jurisdiction over chemical health. The report shall address qualitative and quantitative outcomes.

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

Sec. 3. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Demonstration providers may contract with counties participating in the chemical health navigation program established under section 254B.14, to provide chemical dependency nontreatment services as defined in section 254B.14, subdivision 5, paragraph (b), using capitation payments received under this section and section 256B.692.

Sec. 4. **INSTRUCTIONS TO THE COMMISSIONER; CHEMICAL HEALTH.**

(a) With broad stakeholder input, the commissioner of human services shall develop a plan to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals. The plan shall identify methods to reduce duplication of efforts, promote scientifically supported practices, and improve efficiency. This plan shall consider the potential for geographically or demographically disparate impact on individuals who need chemical dependency services.

(b) The commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over chemical dependency a report detailing necessary statutory and rule changes and a proposal for a pilot project to implement the plan no later than March 15, 2013."

Delete the title and insert:

"A bill for an act relating to human services; modifying chemical use assessment requirements for civil commitments; creating a chemical health navigation program; requiring reports on chemical health services; providing rulemaking authority; amending Minnesota Statutes 2010, sections 254A.19, by adding a subdivision; 256B.69, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 254B."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health and Human Services Finance.

The report was adopted.

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 2280, A bill for an act relating to taxation; liquor; modifying the definition of a qualified brewer; amending Minnesota Statutes 2010, section 297G.04, subdivision 2.

Reported the same back with the recommendation that the bill pass and be re-referred to the Committee on Taxes.

The report was adopted.

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 2356, A bill for an act relating to insurance; requiring the Workers' Compensation Reinsurance Association to comply with the open meeting law and the Data Practices Act; amending Minnesota Statutes 2010, section 79.34, subdivision 1.

Reported the same back with the following amendments:

Page 2, after line 25, insert:

"Sec. 2. Minnesota Statutes 2010, section 79.37, is amended to read:

79.37 BOARD OF DIRECTORS.

A board of directors of the reinsurance association is created and is responsible for the operation of the reinsurance association consistent with the plan of operation and sections 79.34 to 79.40. The board consists of ~~13~~ 14 directors. Four directors shall represent insurers~~,~~; two directors shall represent employers~~,~~; two directors shall represent individual self-insurers; one director shall represent group self-insurers; two directors shall represent employees; the commissioner of management and budget and the executive director of the state Board of Investment or their designees shall serve as directors; and one director shall represent the public. Insurer members of the reinsurance association shall elect the directors who represent insurers; self-insurer members of the reinsurance association shall elect the directors who represent self-insurers; and the commissioner of labor and industry shall appoint the remaining directors for the terms authorized in the plan of operation. Each director is entitled to one vote. Terms of the directors shall be staggered so that the terms of all the directors do not expire at the same time and so that a director does not serve a term of more than four years. The board shall select a chair and other officers it deems appropriate.

A majority of the directors currently holding office constitutes a quorum. Action may be taken by a majority vote of the directors present.

The board shall take reasonable and prudent action regarding the management of the reinsurance association including but not limited to determining the entity who shall manage the daily affairs of the reinsurance association. The board shall report to the governor of its actions regarding the entity selected to manage the reinsurance association and the reasons for the selection."

Amend the title as follows:

Page 1, line 3, after the semicolon, insert "modifying board membership;"

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Civil Law.

The report was adopted.

Gottwalt from the Committee on Health and Human Services Reform to which was referred:

H. F. No. 2456, A bill for an act relating to human services; amending continuing care policy provisions; making changes to disability services and licensing provisions; establishing home and community-based services standards; establishing payment methodologies; requiring a report; amending Minnesota Statutes 2010, sections 245A.03,

subdivision 2; 245A.041, by adding subdivisions; 245A.085; 245B.02, subdivision 10, by adding a subdivision; 245B.04, subdivisions 1, 2, 3; 245B.05, subdivision 1; 245B.06, subdivision 2; 245B.07, subdivisions 5, 9, 10, by adding a subdivision; 252.40; 252.41, subdivision 3; 252.42; 252.43; 252.44; 252.45; 252.451, subdivisions 2, 5; 252.46, subdivision 1a; 256B.0916, subdivision 2; 256B.49, subdivision 17; 256B.4912; 256B.501, subdivision 4b; 256B.5013, subdivision 1; Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 16a; proposing coding for new law in Minnesota Statutes, chapters 245A; 256B; proposing coding for new law as Minnesota Statutes, chapter 245D; repealing Minnesota Statutes 2010, sections 252.46, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21; 256B.501, subdivision 8.

Reported the same back with the following amendments:

Page 1, after line 17, insert:

"ARTICLE 1
STATEWIDE PROVIDER ENROLLMENT, PERFORMANCE
STANDARDS, AND RATE-SETTING METHODOLOGY"

Page 3, strike lines 5 to 10

Page 3, line 11, strike "(23)" and insert "(21)"

Page 3, line 13, strike "(24)" and insert "(22)"

Page 3, line 15, strike "(25)" and insert "(23)"

Page 3, line 17, strike "(26)" and insert "(24)"

Page 3, line 21, strike "(27)" and insert "(25)"

Page 3, line 28, strike "(28)" and insert "(26)"

Page 6, delete lines 8 to 15

Page 6, line 16, delete "3" and insert "2"

Page 6, line 17, delete "phased in upon receipt of an" and insert "implemented upon authorization for the commissioner to collect fees according to section 245A.10, subdivisions 3 and 4, necessary to support licensing functions. License applications will be received on a phased in schedule as determined by the commissioner. Licenses will be issued on or after January 1, 2013, according to section 245A.04."

Page 6, delete lines 18 and 19

Page 8, line 13, after "information" insert "about the person in accordance with applicable state and federal law, regulation, or rule"

Page 9, line 11, delete "(13) to (15)" and insert "(14) to (19)"

Page 11, line 1, delete "well-being" and insert "status"

Page 16, line 9, after "provide" insert "waiver"

Page 19, line 15, delete everything after "means" and insert "physical or mechanical limiting of the free and normal movement of body or limbs."

Page 19, delete lines 16 and 17

Page 19, line 18, delete everything after ""Seclusion"" and insert "means separating a recipient from others in a way that prevents social contact and prevents the recipient from leaving the situation if he or she chooses."

Page 19, delete line 19

Page 20, line 14, after "CADI" insert ", BI, CAC, DD, and EW" and delete everything after "waiver" and insert "plans or successor plans when the provider is an individual who is not an employee of a residential or nonresidential program licensed by the Department of Human Services or the Department of Health that is otherwise providing the respite service;"

Page 20, delete line 15

Page 20, line 23, delete "and excluding providers serving only" and insert a semicolon

Page 20, delete line 24

Page 20, line 26, delete everything before the semicolon

Page 20, line 29, after "waiver" insert "plan or successor plans"

Page 20, line 30, after "CADI" insert ", BI, CAC, DD, and EW" and delete "plan" and insert "plans"

Page 20, line 31, delete the second comma and insert "and"

Page 20, line 32, delete ", and providers serving only one family"

Page 21, line 16, delete "(2),"

Page 21, line 19, after "(e)" insert "Notwithstanding section 245D.06, subdivision 5,"

Page 21, line 24, after the period, insert "The license holder is subject to the prohibitions identified under section 245D.06, subdivision 5, for all persons without developmental disabilities receiving structured day, prevocational, or supported services."

Page 24, line 9, delete "and (14)" and insert "to (15)"

Page 24, line 30, after the second period, insert "(a)"

Page 25, line 1, after the period, insert:

"(b)"

Page 28, line 31, delete ", restraints, or seclusion"

Page 28, line 32, after the period, insert "The license holder is prohibited from using restraints or seclusion under any circumstance."

Page 30, line 6, delete "license holders" and insert "service providers"

Page 30, line 7, delete "license holders" and insert "service providers"

Page 33, line 21, delete "(5)" and insert "(6)"

Page 36, line 1, delete "24 hours" and insert "five working days" and delete ", or if requested by the person," and insert a period

Page 36, delete line 2

Page 46, line 31, after "a" insert "provider is enrolled or"

Page 47, line 17, after "living" insert "or 24-hour customized living"

Page 47, line 18, delete "treatment" and insert "training"

Page 49, line 28, after the second period, insert "For bathing services provided in conjunction with adult day care services, the payment rate is $7.01 per 15-minute unit per bath."

Page 51, line 4, after "use" insert "service planning"

Page 51, line 22, delete "a shared" and insert "an individual"

Page 51, line 29, delete "individual" and insert "shared"

Page 52, line 4, after "section" insert "as revised to reflect the results of staffing and service utilization findings under subdivision 11"

Page 52, line 7, delete "that" and insert "the prior"

Page 52, line 11, delete "county and tribal allocation changes"

Page 52, line 25, after "2012" insert "to inform factor values for payments to be made in 2013"

Page 53, line 5, delete "reduce" and insert "increase" and delete "as follows:" and insert "to five percent below the historic rate."

Page 53, delete lines 6 to 10

Page 53, line 13, delete "increase" and insert "decrease" and delete "as follows:" and insert "to five percent above the historic rate."

Page 53, delete lines 14 to 18

Page 55, delete section 44

Page 55, after line 26, insert:

"ARTICLE 2
PAYMENT RATE-SETTING METHODOLOGIES

Section 1. Minnesota Statutes 2010, section 256B.0911, is amended by adding a subdivision to read:

Subd. 10. **Disability waivered services assessment requirements.** The commissioner of human services shall establish an assessment methodology to determine reimbursement classifications based upon each individual's assessed needs for services reimbursed under section 256B.4913.

(a) For purposes of this subdivision, the following terms have the meanings given them:

(1) "high medical needs" means complex health-related needs that require on-site medical attention and are specified in the coordinated service and support plan;

(2) "high behavioral needs" means a history of observable behavior that deviates from social norms as defined and counted in the assessment that require comprehensive training in behavior management, behavior programming, de-escalation techniques, or medication management training for behavior medications. Examples of participant needs include, but are not limited to, a participant at risk of or with a history of:

(i) elopement, defined as when a patient or resident who is cognitively, physically, mentally, emotionally, or chemically impaired wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, or prior to their scheduled discharge; or

(ii) serious harm to self or others;

(3) "high mental health needs" means a history of a mental disorder, diagnosed by a physician and confirmed in the assessment, that requires constant staff oversight without which the consequences of the participant's behaviors are severe. The management of these needs requires comprehensive training in mental health issues, dual diagnosis, and medication management training. This means a current diagnosis of severe and persistent mental illness or severe emotional disturbance that manifests itself through one of the following:

(i) serious harm to self or others; or

(ii) other extreme behaviors that interfere with major life activities; and

(4) "deaf or hard-of-hearing" means a loss of hearing diagnosed by a physician and confirmed in the assessment that requires staff proficient in one or more of the following to communicate:

(i) American sign language;

(ii) tactile interpretation; or

(iii) other sign language.

(b) The commissioner shall ensure that:

(1) the assessment includes a full and accurate accounting of each individual's need for supports;

(2) the results of the methodology for each individual are statistically valid and reliable, and for each individual's result, there is a statistically significant level of interrated reliability; and

(3) the assessment determines if an individual fits the definitions of high medical needs, high behavioral needs, high mental health needs, or deaf or hard-of-hearing.

(c) The assessment methodology must be completed prior to the implementation of any changes to rates determined under section 246B.4913.

(d) Any individual may appeal the results of the individual's assessment as outlined in section 256.045.

(e) The commissioner shall adopt rules under section 14.05 to implement this methodology.

Sec. 2. Minnesota Statutes 2010, section 256B.0916, subdivision 2, is amended to read:

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) Upon implementation of rate methodologies developed under section 256B.4913, the commissioner shall adjust allocations to local agencies for home and community-based waivered service allocations to reflect the total amount of spending for all recipients with disabilities in their respective counties in need of the level of care provided in an intermediate care facility for individuals with developmental disabilities, a nursing facility, or a hospital as determined by the methodology in section 256B.4913.

Sec. 3. Minnesota Statutes 2010, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with

developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community-based resources for all recipients shall be managed by ~~the county of financial responsibility within an allowable reimbursement average established for~~ each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

(d) Resources and payment rates for all recipients of home and community-based services shall remain as negotiated by each county of fiscal responsibility as of January 1, 2012.

(e) Resources and payment rates for recipients of home and community-based services enrolled prior to January 1, 2012, may be adjusted for changes in needs using processes by county agencies established as of January 1, 2012.

(f) Any new recipients of home and community-based services after January 1, 2012, shall have resources managed by the county using the process in place in each county as of January 1, 2012.

(g) Counties may not implement changes to resources for individuals under section 256B.4913, until the implementation of a statistically valid and reliable process for assessing each individual's needs under section 256B.0911, subdivision 10.

Sec. 4. Minnesota Statutes 2010, section 256B.49, subdivision 17, is amended to read:

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

(b) ~~The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital.~~ Upon implementation of rate methodologies developed under section 256B.4913, the commissioner shall adjust allocations to local agencies for home and community-based waivered service allocations to reflect the total amount of spending for all recipients with disabilities in their respective counties in need of the level of care provided in an intermediate care facility for individuals with developmental disabilities, a nursing facility, or a hospital as determined by the methodology in section 256B.4913:

(1) the commissioner shall set each county's allocation to include resources for the total amount of spending for each respective county based on the total number of individuals estimated to be served multiplied by each individual's service rate determined under section 256B.4913; and

(2) if an individual relocates from one county to another within a calendar year, the commissioner shall adjust county allocations to reflect where the individual is receiving services.

(c) Until the allocation method described in paragraph (b) is implemented, the commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

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

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

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

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0656 and 256B.0659. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

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

Sec. 5. Minnesota Statutes 2010, section 256B.4912, is amended to read:

256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS AND PAYMENT.

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet ~~qualifications defined in the waiver plans~~ Minnesota health care program requirements;

(2) regular reviews of provider qualifications, including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

~~By July 2010~~ (b) Beginning July 2011, staff that provide direct contact~~, as defined in section 245C.02, subdivision 11, that are employees of waiver service providers~~ for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Upon enactment of section 256B.4913, providers of waiver services must reenroll with the state. County and tribal agency contracts existing prior to January 1, 2013, are not effective beginning January 1, 2013.

Subd. 2. **Rate-setting methodologies.** (a) The commissioner shall establish statewide prospective rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The rate-setting methodologies must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

(b) No changes in existing provider rates are effective until the development and implementation of an assessment methodology for individuals assessed under section 256B.0911, subdivision 10, that provides a statistically reliable and valid means for assessing each individual's support needs.

Subd. 3. **Payment rate criteria.** (a) The payment structures and methodologies under this section shall reflect the payment rate criteria in paragraphs (b) and (c).

(b) Payment rates shall be determined according to reasonable, ordinary, and necessary costs that accurately reflect the actual cost of service delivery.

(c) Payment rates shall be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area as required by section 1902(a)(30)(A) of the Social Security Act.

(d) The commissioner must not reimburse:

(1) unauthorized service delivery;

(2) services provided under a receipt of a special grant;

(3) services provided under contract to a local school district;

(4) extended employment services under Minnesota Rules, parts 3300.2005 to 3300.3100; or vocational rehabilitation services provided under the federal Rehabilitation Act, United States Code, title I, section 110, as amended; or United States Code, title VI, part C, and not through use of medical assistance or county social service funds; or

(5) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner, or any other vendor of medical care that are billed separately on a fee-for-service basis.

(e) Payment rates are set prospectively and may not be enforced retroactively.

Sec. 6. **[256B.4913] HOME AND COMMUNITY-BASED WAIVERS; RATE-SETTING METHODOLOGIES.**

Subdivision 1. **Applicable services.** "Applicable services" are those authorized under the state's home and community-based waivers under sections 256B.092 and 256B.49, including those defined in the federally approved home and community-based services plan, as follows:

(1) adult day care;

(2) family adult day services;

(3) day training and habilitation;

(4) prevocational services;

(5) structured day services;

(6) supported employment services;

(7) behavioral programming;

(8) housing access coordination;

(9) independent living services;

(10) in-home family supports;

(11) night supervision;

(12) personal support;

(13) supported living services;

(14) transportation services;

(15) respite services;

(16) residential services; or

(17) any other services approved as part of the state's home and community-based services plan.

Subd. 2. **Base wage index.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services.

(b) The base wage shall be calculated using a composite of wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics, as defined in the most recent edition of the Occupational Outlook Handbook. The base wage index shall be calculated as follows:

(1) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services workers (SOC code 21-1093);

(2) for residential direct care staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential awake overnight staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep overnight staff, the wage will be $7.66 per hour, adjusted annually by the Consumer Price Index for urban wage earners;

(5) for supported living services hourly staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(6) for behavior programming aide staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(7) for behavioral programming professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(8) for supported employment job coach staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for supported employment job developer staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(10) for in-home family support, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(11) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(12) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(13) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(14) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(15) for transportation staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(16) for independent living skills staff, ten percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012); 30 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093); and

(17) for supervisory staff, 55 percent of the median wage for medical and health services managers (SOC code 11-9111).

(c) The commissioner shall update the base wage index on an annual basis upon the release of the December 31 data of the most recent year from the Bureau of Labor Statistics and publish the base wage index on July 1 of the beginning of the next fiscal year.

(d) The commissioner shall adjust payment rates for changes in the base wage index on an annual basis for each individual receiving waivered services.

(e) The commissioner shall determine the staffing component of each individual's payment rate receiving services under sections 256B.092 and 256B.49 using the base wage index.

Subd. 3. **Payments for residential services.** (a) Payments for services in residential settings include supported living services, foster care, residential care, customized living, and 24-hour customized living.

(b) The separate components of each individual's payment rate for residential services shall be calculated as follows:

(1) for direct supervision, the commissioner shall determine the number of units of service to be delivered utilizing the assessment process in section 256B.0911, subdivision 10. The provider may deliver services using direct staffing or supervision technology:

(i) for direct staff cost:

(A) the commissioner shall determine staff wages for shared staff, individual staffing, and supervision staffing using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of direct staff hours specified by each individual's support team;

(B) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(C) multiply the number of direct staff hours by the staff wage; and

(D) multiply the result of the previous calculation by one plus 9.4 percent;

(ii) for supervision technology cost:

(A) the commissioner shall determine supervision technology wages using the base wage index in subdivision 2. The supervision technology cost is the staff wage multiplied by the number of supervision technology hours specified by each individual's support team;

(B) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the supervision technology cost;

(C) multiply the number of supervision technology hours by the staff wage; and

(D) add the amounts under subitems (B) and (C) to obtain the direct staffing cost;

(iii) add the amounts from items (i) and (ii) to obtain the direct supervision cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the two percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for transportation:

(i) the commissioner shall include an amount for the costs of acquiring and maintaining vehicles for the transportation of individuals, as follows: $1,875 for a standard vehicle; $3,803 for a full-size adapted van; and $2,208 for a minivan;

(ii) for individuals requiring individualized customization, the commissioner shall include the number of miles multiplied by $0.51 per mile for a standard vehicle, $1.43 for a full-size adapted van, and $0.61 for a minivan. The amount of miles for customization shall be determined by each individual's support team under section 245A.11, subdivision 8; and

(iii) the total under items (i) and (ii) is the total for transportation;

(4) for client programming and supports:

(i) the commissioner shall add $2,179 for the cost of client programming and supports; and

(ii) for individuals that had previously received an adjustment to rates under section 256B.501, subdivision 4, the commissioner shall add an amount to reflect the costs of providing services allowable under title XIX of the Social Security Act to obtain the total for client programming and supports;

(5) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for support costs; and

(6) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct supervision cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the total for transportation;

(3) plus the total for client programming and supports;

(4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for support costs;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for administrative overhead; and

(6) divide the total of clause (5) by 365 to obtain the daily rate.

Subd. 4. **Payment for day program services.** (a) Payments for services with day programs include adult day care, family adult day care, day training and habilitation, prevocational services, and structured day services.

(b) The separate components of each individual's payment rate for day program services shall be calculated as follows:

(1) for direct staffing:

(i) the commissioner shall determine the number of units of service to be used and each individual's support ratio utilizing the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine staff wages using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of units of service. The commissioner shall include 4.5 supervisory hours per week for each individual at a staffing ratio of 1:1. Supervisory hours will reduce as ratios increase, but shall not be less than 2.5 hours per week. The number of hours shall be prorated for less than full-day participation;

(iii) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(iv) multiply the units of service by the staff wage;

(v) multiply the result of the calculation in item (iv) by 9.4 percent; and

(vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the two percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for transportation:

(i) the commissioner shall determine the number of trips required, as determined under the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine the total distance transported from the person's residence to the initial day service destination and whether an individual requires the use of a lift;

(iii) for each trip to and from each individual's residence, the commissioner shall add a value of:

(A) for distances of zero to ten miles, the commissioner shall pay $7.77 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $7 for those who are transported in other vehicles;

(B) for individuals who are transported 11 to 20 miles, the commissioner shall pay $10.27 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $7.87 for those who are transported in other vehicles;

(C) for individuals who are transported 21 to 50 miles, the commissioner shall pay $15.04 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $9.53 for those who are transported in other vehicles; and

(D) for individuals transported 51 or more miles, the commissioner shall pay $18.74 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $10.80 for those who are transported in other vehicles;

(iv) these rates shall apply regardless of whether the person is being transported alone or with others;

(v) the rates identified in paragraph (c) shall be adjusted within 30 days by the commissioner using the same percentage as used by the Internal Revenue Service when adjusting standard mileage rates for business purposes; and

(vi) the rates determined in this clause are the total for transportation;

(4) for program plan and supports, the commissioner shall add 16.6 percent for the cost of program plan and supports;

(5) the commissioner shall include an adjustment of ten percent for the cost of client programming and supports;

(6) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support;

(iii) the commissioner shall add $31.69 per week for the facility reasonable-use rate; and

(iv) the total of the adjustments under items (i) to (iii) is the total percentage for support costs; and

(7) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct staffing cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the total for transportation;

(3) plus the cost for program plan and supports;

(4) plus the cost for client programming and supports;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for support costs;

(6) the subtotal of clauses (1) to (5), multiplied by one plus the total percentage for administrative overhead; and

(7) divide the total in clause (6) by 365 to obtain the daily rate.

Subd. 5. **Payment for individualized services.** (a) Payments for individualized services include supported employment, behavioral programming, housing access coordination, independent living services, in-home family supports, night supervision, personal support, and respite services.

(b) The separate components of each individual's payment rate for individualized services shall be calculated as follows:

(1) for direct staffing:

(i) the commissioner shall determine the number of units of service to be used utilizing the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine staff wages for shared staff, individual staffing, and supervision staffing using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of units of service;

(iii) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(iv) multiply the units of service by the staff wage;

(v) multiply the result of the calculation in item (iv) by 9.4 percent; and

(vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for program plan and supports, the commissioner shall add 16.6 percent for the cost of program plan supports;

(4) for client programming and supports, the commissioner shall include an adjustment of ten percent for the cost of client programming and supports; and

(5) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support; and

(iii) the total of the adjustments under the two previous items is the total percentage for support costs; and

(6) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct staffing cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the cost for program plan supports;

(3) plus the cost for client programming and supports;

(4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for support costs;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for administrative overhead; and

(6) adjust the total in clause (5) to reflect the hourly units of service that will be provided to the individual per year, and divide by four to obtain the 15-minute rate.

Subd. 6. **Customization of rates for individuals.** For persons determined to have higher needs based on their assessed needs, as determined by the process in section 256B.0911, subdivision 10, those individuals will receive an increase in staffing wages. The customization add-on shall be:

(1) for individuals assessed as having high medical needs, $1.79 per authorized hour;

(2) for individuals assessed as having high behavioral needs, $2.01 per authorized hour;

(3) for individuals assessed as having high mental health needs, $2.01 per authorized hour; and

(4) for individuals assessed as being deaf or hard-of-hearing, $1.79 per authorized hour.

Subd. 7. **Rate exception process.** (a) A variance from rates determined in subdivisions 3, 4, and 5 may be granted by the lead agency when:

(1) an individual is set to be discharged; and

(2) the rate determined is inadequate to meet the health and safety needs of that individual.

(b) The lead agency shall have 30 calendar days from the date of the receipt of the complete request from the vendor for a rate variance to accept or reject it, or the request shall be deemed to have been granted. The lead agency shall state in writing the specific objections to the request and the reasons for its rejection.

(c) If the lead agency rejects the request from the vendor for a rate variance, the vendor may appeal the decision to the commissioner of human services. The commissioner shall have 30 calendar days to consider the appeal. The commissioner shall state in writing the specific objections to the request and the reasons for its rejection of the appeal.

(d) The commissioner shall collect information annually and report on the number of exceptions granted under this subdivision.

Subd. 8. **Cost neutrality adjustment.** (a) The commissioner shall calculate the spending for all long-term care waivered services under the payments as defined in subdivisions 3, 4, and 5 for each group of service. These groups are defined as:

(1) residential services, including corporate foster care, family foster care, residential care, supported living services, customized living, and 24-hour customized living;

(2) day program services, including adult day care, day training and habilitation, prevocational services, and structured day services;

(3) hourly services with programming, including in-home family support, independent living services, supported living services, supported employment, behavior programming, and housing access coordination;

(4) hourly services without programming, including respite, personal support, and night supervision; and

(5) individualized services, including 24-hour emergency assistance, assistive technology, caregiver training and education, consumer education and training, crisis respite, family counseling and training, independent living service therapies, live-in caregiver expenses, modification and adaptations, specialist services, specialized supplies and equipment, transitional, and transportation services.

(b) If spending for each group of service does not equal the total spending under current law, the commissioner shall apply an across-the-board adjustment to payment rates to align the levels of overall spending under current law.

Subd. 9. **Budget neutrality adjustment.** (a) The commissioner shall calculate the total spending for all long-term care waivered services under the payments as defined in subdivisions 3, 4, and 5, and total spending under current law for the fiscal year beginning July 1, 2013. If total spending under subdivisions 3, 4, and 5 is projected to be higher than under current law, the commissioner shall adjust the rate by whatever percentage is needed to reduce aggregate spending to the same level as projected under current law.

(b) The commissioner shall make any future across-the-board adjustment to provider rates in this portion of the rate calculation.

Subd. 10. **Individual rate notification.** Upon request, the commissioner shall make available the rate calculation for each individual to any member of the individual's support team under subdivisions 3, 4, and 5, and section 245A.11, subdivision 8, prior to any cost or budget neutrality adjustments.

Subd. 11. **Rulemaking authority.** The commissioner shall adopt rules under section 14.05 to address the implementation of the payment methodology system. These rules will address processes for detailing the implementation of this payment methodology system, including the roles and responsibilities of the department, lead agencies, and service providers.

Subd. 12. **Rate review and adjustments.** (a) If an individual's needs change, the commissioner shall reassess that individual's needs under the process as outlined in section 256B.0911, subdivision 10.

(b) If there is a material change to an individual's existing services, the commissioner shall reassess that individual's needs under the assessment process outlined in section 256B.0911, subdivision 10.

Subd. 13. **Reports and data.** Twelve months prior to final implementation, the commissioner shall:

(1) generate and publish provider rates calculated under this section;

(2) provide an analysis of the impact of the rate methodology system to the legislature that includes:

(i) the average individual rate for residential services and day training and habilitation services under the new and previous methodologies; and

(ii) the projected supply of service providers prior to and after implementation.

Sec. 7. **EFFECTIVE DATE; APPLICATION.**

Sections 1 to 6 are effective the day following final enactment. The rate-setting methodologies in section 6 apply on January 1, 2013, following the implementation of the assessment methodology under Minnesota Statutes, section 256B.0911, subdivision 10."

Correct the internal references

Amend the title as follows:

Page 1, line 5, after the semicolon, insert "providing rulemaking authority;"

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Civil Law.

The report was adopted.

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 2500, A bill for an act relating to commerce; changing laws relating to debt settlement services agreements; amending Minnesota Statutes 2010, sections 332B.06, subdivisions 2, 5, 8; 332B.07, subdivisions 1, 4; 332B.09, subdivision 1; 332B.10; 332B.13, subdivision 3; repealing Minnesota Statutes 2010, section 332B.09, subdivisions 2, 3.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Hoppe from the Committee on Commerce and Regulatory Reform to which was referred:

H. F. No. 2553, A bill for an act relating to insurance; regulating certain wealth-related claims practices; amending Minnesota Statutes 2010, sections 65A.29, subdivisions 8, 11; 326B.081, subdivision 3; Minnesota Statutes 2011 Supplement, section 325E.66, subdivisions 1, 2, by adding a subdivision.

Reported the same back with the following amendments:

Page 1, delete section 1

Page 2, line 15, reinstate the stricken language

Page 2, line 16, reinstate the stricken "experience unless the insurer has"

Page 2, line 17, after the stricken period, insert "provided the insured with a copy of the insured's nonrenewal plan at the time of policy issuance and each renewal."

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 2, delete "wealth-related"

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass.

The report was adopted.

Gottwalt from the Committee on Health and Human Services Reform to which was referred:

H. F. No. 2555, A bill for an act relating to state government; implementing changes to the sunset review; changing certain agency requirements; requiring posting of convictions of felonies or gross misdemeanors and malpractice settlements or judgments for a regulated practitioner; requiring certain information on regulated practitioners; requiring a study; prohibiting transfer of certain funds; requiring reports; setting fees; appropriating money; amending Minnesota Statutes 2010, sections 3.922, by adding a subdivision; 3.9223, subdivision 7; 3.9225, subdivision 7; 3.9226, subdivision 7; 147.01, subdivision 4; 147.111, by adding a subdivision; Minnesota Statutes

2011 Supplement, sections 3D.06; 3D.21, subdivisions 1, 2; proposing coding for new law in Minnesota Statutes, chapters 3D; 16B; 214; repealing Minnesota Statutes 2010, sections 138A.01; 138A.02; 138A.03; 138A.04; 138A.05; 138A.06.

Reported the same back with the following amendments:

Page 6, delete line 5 and insert:

"**EFFECTIVE DATE.** This section is effective for all corrective action taken on or after August 1, 2012."

Page 6, delete section 10 and insert:

"Sec. 10. Minnesota Statutes 2010, section 147.111, is amended by adding a subdivision to read:

Subd. 10. **Failure to report.** On or after August 1, 2012, any person, health care facility, business, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 11. Minnesota Statutes 2010, section 148.102, is amended by adding a subdivision to read:

Subd. 8. **Failure to report.** On or after August 1, 2012, any person or insurer that fails to report as required under subdivisions 2 to 4 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 12. Minnesota Statutes 2010, section 148.263, is amended by adding a subdivision to read:

Subd. 7. **Failure to report.** On or after August 1, 2012, any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 5 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 13. Minnesota Statutes 2010, section 148B.07, is amended by adding a subdivision to read:

Subd. 10. **Failure to report.** On or after August 1, 2012, any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 14. Minnesota Statutes 2010, section 148C.095, is amended by adding a subdivision to read:

Subd. 8. **Failure to report.** On or after August 1, 2012, any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 5 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 15. Minnesota Statutes 2010, section 148E.285, is amended by adding a subdivision to read:

Subd. 4. **Failure to report.** On or after August 1, 2012, any person, institution, or organization that fails to report as required under subdivisions 1 and 2 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 16. Minnesota Statutes 2010, section 150A.13, is amended by adding a subdivision to read:

Subd. 10. **Failure to report.** On or after August 1, 2012, any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 shall be subject to civil penalties for failing to report as required by law.

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

Sec. 17. Minnesota Statutes 2010, section 153.24, is amended by adding a subdivision to read:

Subd. 8. **Failure to report.** On or after August 1, 2012, any person, institution, or insurer that fails to report as required under subdivisions 2 to 5 shall be subject to civil penalties for failing to report as required by law.

EFFECTIVE DATE. This section is effective August 1, 2012."

Page 6, after line 16, insert:

"Sec. 19. Minnesota Statutes 2010, section 214.06, subdivision 1, is amended to read:

Subdivision 1. **Fee adjustment.** Notwithstanding any law to the contrary, the commissioner of health as authorized by section 214.13, all health-related licensing boards and all non-health-related licensing boards shall by rule, with the approval of the commissioner of management and budget, adjust, as needed, any fee which the commissioner of health or the board is empowered to assess. As provided in section 16A.1285, the adjustment shall be an amount sufficient so that the total fees collected by each board will be based on anticipated expenditures, including expenditures for the programs authorized by sections 214.10, 214.103, 214.11, 214.17 to 214.24, 214.28 to 214.37, and 214.40, except that a health-related licensing board may have anticipated expenditures in excess of anticipated revenues in a biennium by using accumulated surplus revenues from fees collected by that board in previous bienniums. A health-related licensing board may accumulate up to one year of operating funds, and then must reduce fees. A health-related licensing board shall not spend more money than the amount appropriated by the legislature for a biennium. For members of an occupation registered after July 1, 1984, by the commissioner of health under the provisions of section 214.13, the fee established must include an amount necessary to recover, over a five-year period, the commissioner's direct expenditures for adoption of the rules providing for registration of members of the occupation. All fees received shall be deposited in the state treasury.

Sec. 20. Minnesota Statutes 2010, section 214.06, is amended by adding a subdivision to read:

Subd. 1b. **Health-related licensing boards; surcharges.** When a health-related licensing board imposes a surcharge, the surcharge must not be incorporated as a fee increase, but must be made as a separate assessment to be paid by the individuals regulated by the board."

Page 6, line 18, before "Each" insert "(a)"

Page 6, line 28, delete "settlement or"

Page 6, line 29, delete "settlements"

Page 6, line 30, delete the first "and"

Page 7, after line 5, insert:

"(b) Each board and the commissioner of health must post in-state information required in paragraph (a) no later than January 1, 2013. Information from other states and jurisdictions must be posted no later than July 1, 2013."

Page 7, line 11, after "applicant" insert "on or after August 1, 2012,"

Page 9, line 11, delete "shall be" and insert "are"

Renumber the sections in sequence and correct the internal references

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Civil Law.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 1416, 2500 and 2553 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House Files were introduced:

Mariani introduced:

H. F. No. 2743, A bill for an act relating to education; improving the academic achievement of all students; amending Minnesota Statutes 2010, sections 120A.22, subdivision 5; 120B.35, by adding a subdivision; 121A.03; 121A.17, subdivisions 3, 5; 122A.50; 122A.60, subdivision 1a; 123B.41, subdivision 7; 124D.02, subdivision 1, by adding a subdivision; 126C.05, subdivision 15; 126C.12, subdivisions 1, 5; 145A.17, subdivision 1; Minnesota Statutes 2011 Supplement, sections 121A.55; 123B.92, subdivision 1; 124D.10, subdivision 8; 126C.05, subdivision 1; 126C.126; proposing coding for new law in Minnesota Statutes, chapter 120B; repealing Minnesota Statutes 2010, section 121A.0695.

The bill was read for the first time and referred to the Committee on Education Reform.

Cornish introduced:

H. F. No. 2744, A bill for an act relating to public safety; clarifying the community notification law by adding cross-references; amending Minnesota Statutes 2010, section 244.052, subdivision 4.

The bill was read for the first time and referred to the Committee on Public Safety and Crime Prevention Policy and Finance.

Loon, Lohmer, Gruenhagen, Barrett, Kriesel, Nelson, Allen, Moran, Laine, Gunther, Liebling, Kieffer, Mack, Kiel, Sanders and Carlson introduced:

H. F. No. 2745, A bill for an act relating to adoption; modifying provisions governing access to adoption records and original birth certificates; amending Minnesota Statutes 2010, sections 13.465, subdivision 8; 144.218, subdivision 1; 144.225, subdivision 2; 144.2252; 144.226, subdivision 1; 259.89, subdivision 1; 260C.317, subdivision 4; proposing coding for new law in Minnesota Statutes, chapter 144; repealing Minnesota Statutes 2010, sections 259.83, subdivision 3; 259.89, subdivisions 2, 3, 4.

The bill was read for the first time and referred to the Committee on Health and Human Services Reform.

Abeler and Fritz introduced:

H. F. No. 2746, A bill for an act relating to human services; modifying medical assistance payment procedures for multiple services provided on the same day; modifying the health care home certification process for federally qualified health centers; amending Minnesota Statutes 2010, section 256B.0625, by adding a subdivision; Minnesota Statutes 2011 Supplement, section 256B.0751, subdivision 4.

The bill was read for the first time and referred to the Committee on Health and Human Services Finance.

Murray introduced:

H. F. No. 2747, A bill for an act relating to utilities; modifying the reporting obligations of certain cooperative utilities under the integrated resource planning process; amending Minnesota Statutes 2010, section 216B.2422, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Environment, Energy and Natural Resources Policy and Finance.

Atkins introduced:

H. F. No. 2748, A bill for an act relating to taxation; sales and use; modifying definition of sale and purchase relating to amusement devices; amending Minnesota Statutes 2011 Supplement, section 297A.61, subdivision 3.

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

Abeler introduced:

H. F. No. 2749, A bill for an act relating to commerce; regulating auto insurance claims practices; amending Minnesota Statutes 2010, sections 65B.54, subdivision 6; 609.612, subdivision 1.

The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform.

Abeler and Murphy, E., introduced:

H. F. No. 2750, A bill for an act relating to nursing; authorizing criminal history records check; proposing coding for new law in Minnesota Statutes, chapter 148.

The bill was read for the first time and referred to the Committee on Health and Human Services Reform.

Dettmer introduced:

H. F. No. 2751, A bill for an act relating to natural resources; providing for repayment when gifts of land are sold; amending Minnesota Statutes 2010, section 84.085, subdivision 1.

The bill was read for the first time and referred to the Committee on Environment, Energy and Natural Resources Policy and Finance.

Daudt and Barrett introduced:

H. F. No. 2752, A bill for an act relating to property taxation; eliminating the Department of Revenue's role in setting property valuations for green acres and rural preserves; amending Minnesota Statutes 2010, sections 273.111, subdivision 4; 273.114, subdivision 3.

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

Hornstein introduced:

H. F. No. 2753, A bill for an act relating to transportation; public safety; traffic regulations; regulating electric-assisted bicycle as bicycle rather than motorized bicycle; amending Minnesota Statutes 2010, sections 169.011, subdivisions 4, 45; 169.222, subdivision 6; 169.223, subdivisions 1, 5.

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

Howes, Hausman, Scalze, Nornes, Lanning and Urdahl introduced:

H. F. No. 2754, A bill for an act relating to capital investment; appropriating money for repair and restoration improvements of the State Capitol; authorizing the sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Capital Investment.

Loeffler, Kahn, Gottwalt, Norton, Clark, Dittrich, Kieffer and Hosch introduced:

H. F. No. 2755, A bill for an act relating to motor vehicles; requiring that motorcycle owners bear the economic costs of their injuries not caused by others; requiring motorcycle owners to comply with the motor vehicle insurance requirements that apply to other motor vehicles; requiring motorcycle riders to wear helmets subject to an exception; amending Minnesota Statutes 2010, sections 65B.43, subdivision 2; 65B.46, subdivisions 1, 2; 65B.48, subdivision 5; 168.013, subdivision 1b; 169.974, subdivision 4; repealing Minnesota Statutes 2010, section 65B.46, subdivision 3.

The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform.

Hamilton introduced:

H. F. No. 2756, A bill for an act relating to agriculture; appropriating money for grants for 4-H and Future Farmers of America.

The bill was read for the first time and referred to the Committee on Agriculture and Rural Development Policy and Finance.

Abeler, Gunther, Paymar, Clark, Kelly, McFarlane, LeMieur, Huntley, Dill, Howes, Mahoney, Sanders, Kieffer and Murray introduced:

H. F. No. 2757, A bill for an act relating to jobs; establishing a jobs innovation for hard-to-employ Minnesotans grant program; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 116J.

The bill was read for the first time and referred to the Committee on Jobs and Economic Development Finance.

Downey and Holberg introduced:

H. F. No. 2758, A bill for an act relating to state government; establishing general fund spending limits for fiscal years 2014 and 2015 that freezes state spending at fiscal years 2012 and 2013 spending levels.

The bill was read for the first time and referred to the Committee on Ways and Means.

MESSAGES FROM THE SENATE

The following message was received from the Senate:

Mr. Speaker:

I hereby announce that the Senate accedes to the request of the House for the appointment of a Conference Committee on the amendments adopted by the Senate to the following House File:

H. F. No. 1870, A bill for an act relating to education; allowing school districts to base unrequested leave of absence and certain discharge and demotion decisions on teacher evaluation outcomes; amending Minnesota Statutes 2010, sections 122A.40, subdivisions 10, 11, 19; 122A.41, subdivisions 14, 15; 123A.75, subdivision 1; Minnesota Statutes 2011 Supplement, sections 122A.245, subdivision 1; 122A.41, subdivision 6.

The Senate has appointed as such committee:

Senators Wolf, Daley, Kruse, Olson and Bonoff.

Said House File is herewith returned to the House.

CAL R. LUDEMAN, Secretary of the Senate

CALENDAR FOR THE DAY

H. F. No. 2152, A bill for an act relating to commerce; specifying the extent of responsibility of real estate licensees for property management activities on real property owned by the licensee or by an entity in which the licensee has an ownership interest; amending Minnesota Statutes 2010, section 82.73, subdivision 3.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Hancock	Lanning	Mullery	Scott
Allen	Davnie	Hansen	Leidiger	Murphy, E.	Shimanski
Anderson, B.	Dean	Hausman	LeMieur	Murphy, M.	Simon
Anderson, D.	Dettmer	Hilstrom	Lenczewski	Murray	Slawik
Anderson, P.	Dill	Holberg	Lesch	Myhra	Slocum
Anderson, S.	Dittrich	Hoppe	Liebling	Nelson	Smith
Anzelc	Doepke	Hornstein	Lillie	Nornes	Stensrud
Atkins	Downey	Hortman	Loeffler	Norton	Swedzinski
Banaian	Drazkowski	Hosch	Lohmer	O'Driscoll	Thissen
Barrett	Eken	Howes	Loon	Paymar	Tillberry
Beard	Erickson	Huntley	Mack	Pelowski	Torkelson
Benson, J.	Falk	Johnson	Mahoney	Peppin	Urdahl
Benson, M.	Franson	Kahn	Mariani	Persell	Vogel
Bills	Fritz	Kath	Marquart	Petersen, B.	Wagenius
Brynaert	Garofalo	Kelly	Mazorol	Peterson, S.	Ward
Buesgens	Gottwalt	Kieffer	McDonald	Poppe	Wardlow
Carlson	Greene	Kiel	McElfatrick	Quam	Westrom
Champion	Greiling	Kiffmeyer	McFarlane	Rukavina	Winkler
Clark	Gruenhagen	Knuth	McNamara	Runbeck	Woodard
Cornish	Gunther	Koenen	Melin	Sanders	Spk. Zellers
Crawford	Hackbarth	Kriesel	Moran	Scalze	
Daudt	Hamilton	Laine	Morrow	Schomacker	

The bill was passed and its title agreed to.

H. F. No. 2455, A bill for an act relating to the city of Montgomery; authorizing the city to convey property for less than market value.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Anderson, D.	Anzelc	Barrett	Benson, M.	Buesgens
Allen	Anderson, P.	Atkins	Beard	Bills	Carlson
Anderson, B.	Anderson, S.	Banaian	Benson, J.	Brynaert	Champion

Clark	Gottwalt	Kahn	Loon	Nornes	Slawik
Cornish	Greene	Kath	Mack	Norton	Slocum
Crawford	Greiling	Kelly	Mahoney	O'Driscoll	Smith
Daudt	Gruenhagen	Kieffer	Mariani	Paymar	Stensrud
Davids	Gunther	Kiel	Marquart	Pelowski	Swedzinski
Davnie	Hackbarth	Kiffmeyer	Mazorol	Peppin	Thissen
Dean	Hamilton	Knuth	McDonald	Persell	Tillberry
Dettmer	Hancock	Koenen	McElfatrick	Petersen, B.	Torkelson
Dill	Hansen	Kriesel	McFarlane	Peterson, S.	Urdahl
Dittrich	Hausman	Laine	McNamara	Poppe	Vogel
Doepke	Hilstrom	Lanning	Melin	Quam	Wagenius
Downey	Holberg	Leidiger	Moran	Rukavina	Ward
Drazkowski	Hoppe	LeMieur	Morrow	Runbeck	Wardlow
Eken	Hornstein	Lenczewski	Mullery	Sanders	Westrom
Erickson	Hortman	Lesch	Murphy, E.	Scalze	Winkler
Falk	Hosch	Liebling	Murphy, M.	Schomacker	Woodard
Franson	Howes	Lillie	Murray	Scott	Spk. Zellers
Fritz	Huntley	Loeffler	Myhra	Shimanski	
Garofalo	Johnson	Lohmer	Nelson	Simon	

The bill was passed and its title agreed to.

H. F. No. 2376, A bill for an act relating to education finance; simplifying the approval process for food service equipment purchased from the food service fund; amending Minnesota Statutes 2010, section 124D.111, subdivision 3.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Hancock	Lanning	Mullery	Scott
Allen	Davnie	Hansen	Leidiger	Murphy, E.	Shimanski
Anderson, B.	Dean	Hausman	LeMieur	Murphy, M.	Simon
Anderson, D.	Dettmer	Hilstrom	Lenczewski	Murray	Slawik
Anderson, P.	Dill	Holberg	Lesch	Myhra	Slocum
Anderson, S.	Dittrich	Hoppe	Liebling	Nelson	Smith
Anzelc	Doepke	Hornstein	Lillie	Nornes	Stensrud
Atkins	Downey	Hortman	Loeffler	Norton	Swedzinski
Banaian	Drazkowski	Hosch	Lohmer	O'Driscoll	Thissen
Barrett	Eken	Howes	Loon	Paymar	Tillberry
Beard	Erickson	Huntley	Mack	Pelowski	Torkelson
Benson, J.	Falk	Johnson	Mahoney	Peppin	Urdahl
Benson, M.	Franson	Kahn	Mariani	Persell	Vogel
Bills	Fritz	Kath	Marquart	Petersen, B.	Wagenius
Brynaert	Garofalo	Kelly	Mazorol	Peterson, S.	Ward
Buesgens	Gottwalt	Kieffer	McDonald	Poppe	Wardlow
Carlson	Greene	Kiel	McElfatrick	Quam	Westrom
Champion	Greiling	Kiffmeyer	McFarlane	Rukavina	Winkler
Clark	Gruenhagen	Knuth	McNamara	Runbeck	Woodard
Cornish	Gunther	Koenen	Melin	Sanders	Spk. Zellers
Crawford	Hackbarth	Kriesel	Moran	Scalze	
Daudt	Hamilton	Laine	Morrow	Schomacker	

The bill was passed and its title agreed to.

H. F. No. 2132, A bill for an act relating to the Washington County Housing and Redevelopment Authority; clarifying the jurisdiction of the authority; amending Laws 1974, chapter 475, sections 1; 2, subdivision 1; 3.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Hancock	Lanning	Mullery	Scott
Allen	Davnie	Hansen	Leidiger	Murphy, E.	Shimanski
Anderson, B.	Dean	Hausman	LeMieur	Murphy, M.	Simon
Anderson, D.	Dettmer	Hilstrom	Lenczewski	Murray	Slawik
Anderson, P.	Dill	Holberg	Lesch	Myhra	Slocum
Anderson, S.	Dittrich	Hoppe	Liebling	Nelson	Smith
Anzelc	Doepke	Hornstein	Lillie	Nornes	Stensrud
Atkins	Downey	Hortman	Loeffler	Norton	Swedzinski
Banaian	Drazkowski	Hosch	Lohmer	O'Driscoll	Thissen
Barrett	Eken	Howes	Loon	Paymar	Tillberry
Beard	Erickson	Huntley	Mack	Pelowski	Torkelson
Benson, J.	Falk	Johnson	Mahoney	Peppin	Urdahl
Benson, M.	Franson	Kahn	Mariani	Persell	Vogel
Bills	Fritz	Kath	Marquart	Petersen, B.	Wagenius
Brynaert	Garofalo	Kelly	Mazorol	Peterson, S.	Ward
Buesgens	Gottwalt	Kieffer	McDonald	Poppe	Wardlow
Carlson	Greene	Kiel	McElfatrick	Quam	Westrom
Champion	Greiling	Kiffmeyer	McFarlane	Rukavina	Winkler
Clark	Gruenhagen	Knuth	McNamara	Runbeck	Woodard
Cornish	Gunther	Koenen	Melin	Sanders	Spk. Zellers
Crawford	Hackbarth	Kriesel	Moran	Scalze	
Daudt	Hamilton	Laine	Morrow	Schomacker	

The bill was passed and its title agreed to.

H. F. No. 2392, A bill for an act relating to Anoka County; providing for powers and jurisdiction of the Anoka County Housing and Redevelopment Authority; amending Minnesota Statutes 2010, sections 383E.17; 383E.18.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 129 yeas and 1 nay as follows:

Those who voted in the affirmative were:

Abeler	Atkins	Brynaert	Davids	Downey	Garofalo
Allen	Banaian	Carlson	Davnie	Drazkowski	Gottwalt
Anderson, B.	Barrett	Champion	Dean	Eken	Greene
Anderson, D.	Beard	Clark	Dettmer	Erickson	Greiling
Anderson, P.	Benson, J.	Cornish	Dill	Falk	Gruenhagen
Anderson, S.	Benson, M.	Crawford	Dittrich	Franson	Gunther
Anzelc	Bills	Daudt	Doepke	Fritz	Hackbarth

Hamilton	Kelly	Loeffler	Mullery	Poppe	Thissen
Hancock	Kieffer	Lohmer	Murphy, E.	Quam	Tillberry
Hansen	Kiel	Loon	Murphy, M.	Rukavina	Torkelson
Hausman	Kiffmeyer	Mack	Murray	Runbeck	Urdahl
Hilstrom	Knuth	Mahoney	Myhra	Sanders	Vogel
Holberg	Koenen	Mariani	Nelson	Scalze	Wagenius
Hoppe	Kriesel	Marquart	Nornes	Schomacker	Ward
Hornstein	Laine	Mazorol	Norton	Scott	Wardlow
Hortman	Lanning	McDonald	O'Driscoll	Shimanski	Westrom
Hosch	Leidiger	McElfatrick	Paymar	Simon	Winkler
Howes	LeMieur	McFarlane	Pelowski	Slawik	Woodard
Huntley	Lenczewski	McNamara	Peppin	Slocum	Spk. Zellers
Johnson	Lesch	Melin	Persell	Smith	
Kahn	Liebling	Moran	Petersen, B.	Stensrud	
Kath	Lillie	Morrow	Peterson, S.	Swedzinski	

Those who voted in the negative were:

Buesgens

The bill was passed and its title agreed to.

H. F. No. 2022, A bill for an act relating to St. Louis County; authorizing the private sale of certain real and personal property.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 129 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Hancock	Leidiger	Murphy, E.	Shimanski
Allen	Davnie	Hansen	LeMieur	Murphy, M.	Simon
Anderson, B.	Dean	Hilstrom	Lenczewski	Murray	Slawik
Anderson, D.	Dettmer	Holberg	Lesch	Myhra	Slocum
Anderson, P.	Dill	Hoppe	Liebling	Nelson	Smith
Anderson, S.	Dittrich	Hornstein	Lillie	Nornes	Stensrud
Anzelc	Doepke	Hortman	Loeffler	Norton	Swedzinski
Atkins	Downey	Hosch	Lohmer	O'Driscoll	Thissen
Banaian	Drazkowski	Howes	Loon	Paymar	Tillberry
Barrett	Eken	Huntley	Mack	Pelowski	Torkelson
Beard	Erickson	Johnson	Mahoney	Peppin	Urdahl
Benson, J.	Falk	Kahn	Mariani	Persell	Vogel
Benson, M.	Franson	Kath	Marquart	Petersen, B.	Wagenius
Bills	Fritz	Kelly	Mazorol	Peterson, S.	Ward
Brynaert	Garofalo	Kieffer	McDonald	Poppe	Wardlow
Buesgens	Gottwalt	Kiel	McElfatrick	Quam	Westrom
Carlson	Greene	Kiffmeyer	McFarlane	Rukavina	Winkler
Champion	Greiling	Knuth	McNamara	Runbeck	Woodard
Clark	Gruenhagen	Koenen	Melin	Sanders	Spk. Zellers
Cornish	Gunther	Kriesel	Moran	Scalze	
Crawford	Hackbarth	Laine	Morrow	Schomacker	
Daudt	Hamilton	Lanning	Mullery	Scott	

The bill was passed and its title agreed to.

H. F. No. 1738, A bill for an act relating to local government; providing for detachment from a municipality; amending Minnesota Statutes 2010, section 414.06, subdivisions 1, 2, 3, by adding subdivisions.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 130 yeas and 0 nays as follows:

Those who voted in the affirmative were:

Abeler	Davids	Hancock	Lanning	Mullery	Scott
Allen	Davnie	Hansen	Leidiger	Murphy, E.	Shimanski
Anderson, B.	Dean	Hausman	LeMieur	Murphy, M.	Simon
Anderson, D.	Dettmer	Hilstrom	Lenczewski	Murray	Slawik
Anderson, P.	Dill	Holberg	Lesch	Myhra	Slocum
Anderson, S.	Dittrich	Hoppe	Liebling	Nelson	Smith
Anzelc	Doepke	Hornstein	Lillie	Nornes	Stensrud
Atkins	Downey	Hortman	Loeffler	Norton	Swedzinski
Banaian	Drazkowski	Hosch	Lohmer	O'Driscoll	Thissen
Barrett	Eken	Howes	Loon	Paymar	Tillberry
Beard	Erickson	Huntley	Mack	Pelowski	Torkelson
Benson, J.	Falk	Johnson	Mahoney	Peppin	Urdahl
Benson, M.	Franson	Kahn	Mariani	Persell	Vogel
Bills	Fritz	Kath	Marquart	Petersen, B.	Wagenius
Brynaert	Garofalo	Kelly	Mazorol	Peterson, S.	Ward
Buesgens	Gottwalt	Kieffer	McDonald	Poppe	Wardlow
Carlson	Greene	Kiel	McElfatrick	Quam	Westrom
Champion	Greiling	Kiffmeyer	McFarlane	Rukavina	Winkler
Clark	Gruenhagen	Knuth	McNamara	Runbeck	Woodard
Cornish	Gunther	Koenen	Melin	Sanders	Spk. Zellers
Crawford	Hackbarth	Kriesel	Moran	Scalze	
Daudt	Hamilton	Laine	Morrow	Schomacker	

The bill was passed and its title agreed to.

S. F. No. 1183, A bill for an act relating to civil law; restoring state and local government tort liability limits to pre-2008 levels in certain instances; prohibiting state and local government contracts that require contractors to provide liability insurance or other security in excess of those limits; amending Minnesota Statutes 2010, sections 3.736, subdivision 4; 466.04, subdivisions 1, 3.

The bill was read for the third time and placed upon its final passage.

The question was taken on the passage of the bill and the roll was called. There were 129 yeas and 1 nay as follows:

Those who voted in the affirmative were:

Abeler	Anderson, P.	Banaian	Benson, M.	Champion	Daudt
Allen	Anderson, S.	Barrett	Bills	Clark	Davids
Anderson, B.	Anzelc	Beard	Brynaert	Cornish	Davnie
Anderson, D.	Atkins	Benson, J.	Carlson	Crawford	Dean

Dettmer	Hamilton	Kiffmeyer	Marquart	Paymar	Smith
Dill	Hancock	Knuth	Mazorol	Pelowski	Stensrud
Dittrich	Hansen	Koenen	McDonald	Peppin	Swedzinski
Doepke	Hausman	Kriesel	McElfatrick	Persell	Thissen
Downey	Hilstrom	Laine	McFarlane	Petersen, B.	Tillberry
Drazkowski	Holberg	Lanning	McNamara	Peterson, S.	Torkelson
Eken	Hoppe	Leidiger	Melin	Poppe	Urdahl
Erickson	Hornstein	LeMieur	Moran	Quam	Vogel
Falk	Hortman	Lenczewski	Morrow	Rukavina	Wagenius
Franson	Hosch	Lesch	Mullery	Runbeck	Ward
Fritz	Howes	Liebling	Murphy, E.	Sanders	Wardlow
Garofalo	Huntley	Lillie	Murphy, M.	Scalze	Westrom
Gottwalt	Johnson	Loeffler	Murray	Schomacker	Winkler
Greene	Kahn	Lohmer	Myhra	Scott	Woodard
Greiling	Kath	Loon	Nelson	Shimanski	Spk. Zellers
Gruenhagen	Kelly	Mack	Nornes	Simon	
Gunther	Kieffer	Mahoney	Norton	Slawik	
Hackbarth	Kiel	Mariani	O'Driscoll	Slocum	

Those who voted in the negative were:

Buesgens

The bill was passed and its title agreed to.

Peterson, S., was excused for the remainder of today's session.

H. F. No. 389 was reported to the House.

H. F. No. 389 was read for the third time.

Beard moved that H. F. No. 389 be continued on the Calendar for the Day. The motion prevailed.

Dean moved that the remaining bills on the Calendar for the Day be continued. The motion prevailed.

ANNOUNCEMENT BY THE SPEAKER

The Speaker announced the following change in the membership of the Conference Committee on H. F. No. 1870:

Delete the name of Kelly and add the name of Erickson.

MOTIONS AND RESOLUTIONS

Loeffler moved that the name of Norton be added as an author on H. F. No. 248. The motion prevailed.

Ward moved that the name of Norton be added as an author on H. F. No. 253. The motion prevailed.

Clark moved that the name of Allen be shown as chief author on H. F. No. 647. The motion prevailed.

Downey moved that the name of Carlson be added as an author on H. F. No. 1069. The motion prevailed.

Hortman moved that the name of Norton be added as an author on H. F. No. 1429. The motion prevailed.

Lohmer moved that the names of Hausman; Murphy, E., and Mariani be added as authors on H. F. No. 1492. The motion prevailed.

Torkelson moved that the name of Kieffer be added as an author on H. F. No. 1596. The motion prevailed.

Dettmer moved that the name of Norton be added as an author on H. F. No. 1821. The motion prevailed.

Downey moved that the name of Norton be added as an author on H. F. No. 1823. The motion prevailed.

Ward moved that the name of Norton be added as an author on H. F. No. 1827. The motion prevailed.

Fabian moved that the name of Norton be added as an author on H. F. No. 1842. The motion prevailed.

Fabian moved that the name of Norton be added as an author on H. F. No. 2095. The motion prevailed.

Drazkowski moved that the name of Myhra be added as an author on H. F. No. 2140. The motion prevailed.

Atkins moved that his name be stricken as an author on H. F. No. 2216. The motion prevailed.

Benson, M., moved that the name of Mariani be added as an author on H. F. No. 2327. The motion prevailed.

Gottwalt moved that the name of Dettmer be added as an author on H. F. No. 2412. The motion prevailed.

Myhra moved that the name of Dittrich be added as an author on H. F. No. 2647. The motion prevailed.

McElfatrick moved that the name of Erickson be added as an author on H. F. No. 2710. The motion prevailed.

Loon moved that the name of Mariani be added as an author on H. F. No. 2729. The motion prevailed.

Kiffmeyer moved that the name of Dettmer be added as an author on H. F. No. 2738. The motion prevailed.

Drazkowski moved that H. F. No. 2232 be recalled from the Committee on Health and Human Services Reform and be re-referred to the Committee on Transportation Policy and Finance. The motion prevailed.

Gruenhagen moved that H. F. No. 2346 be recalled from the Committee on Health and Human Services Reform and be re-referred to the Committee on Civil Law. The motion prevailed.

ADJOURNMENT

Dean moved that when the House adjourns today it adjourn until 3:00 p.m., Monday, March 12, 2012. The motion prevailed.

Dean moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 3:00 p.m., Monday, March 12, 2012.

ALBIN A. MATHIOWETZ, Chief Clerk, House of Representatives