FORTY-SECOND DAY

St. Paul, Minnesota, Monday, April 27, 2009

The Senate met at 11:00 a.m. and was called to order by the President.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rev. David D. Colby.

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

The roll was called, and the following Senators answered to their names:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

REPORTS FILED WITH THE SECRETARY OF THE SENATE

The following reports were received and filed with the Secretary of the Senate: Minnesota Revenue, Limited Market Value Report, 2008 Assessment Year, Taxes Payable 2009; Minnesota Revenue, 2009 Property Values and Assessment Practices Report, (Assessment Year 2008); Minnesota Department of Transportation, 2008 Transit Report, A Guide to Minnesota's Public Transit Systems; Minnesota Department of Transportation Construction Impacts, February 2009; Minnesota Department of Transportation, 2009 Biannual Report; Office of Enterprise Technology, Enterprise Information Technology Portfolio Report 2009; Minnesota Department of Corrections,

Interstate Compact for Adult Offender Supervision, 2009 Report to the Legislature; Minnesota Department of Corrections, Review of Guidelines for Revocation of Parole and Supervised Release; Minnesota Management and Budget, February 2009 Debt Capacity Report; Minnesota Department of Revenue, This Old House, Assessment Year 2008; Minnesota Department of Health, Eliminating Health Disparities Initiative, January 2009; Office of Enterprise Technology, Master Plan 2009 for Information and Telecommunications Technology Systems and Services; Minnesota Department of Human Services, Financial Management of Health Care Programs, February 2009; University of Minnesota, Center for Transportation Studies, Multiuse, High Accuracy, High Density Geospatial Database, CTS 09-05; Department of Public Safety, 2008 Permit to Carry Report, March 1, 2009; Minnesota Department of Human Services, Governor's Report on Compulsive Gambling, February 2009; University of Minnesota, Center for Transportation Studies, In-Situ Vehicle Classification Using an ILD and a Magnetoresistive Sensor Array, CTS 09-06; University of Minnesota, Transportation Data Research Laboratory: Data Acquisition and Archiving of Large Scaled Transportation Data, Analysis Tool Developments, and On-Line Data Support, CTS 09-07; University of Minnesota, Center for Transportation Studies, Impending Box Impact Warning System for Prevention of Snowplow-Bridge Impacts: A Final Report of Investigations, CTS 09-08; Minnesota Department of Education, Special Education Cross-Subsidies Fiscal Year 2008; Minnesota Department of Health, Administrative Expenses and Investment Income for Health Plans and County-Based Purchasers: Guidelines and Recommendations, March 2009; Minnesota Department of Health, Personal Care Assistants: Recommendations for Provider Standards, February 2009; Minnesota Board of Pardons, Annual Report to the Legislature, 2008 Activity; Minnesota Department of Education, Interagency Coordinating Council on Early Childhood Intervention, March 2009; Minnesota Board on Judicial Standards, Annual Report 2008; University of Minnesota, Postsecondary Planning: A Joint Report to the Minnesota Legislature, February 2009; Minnesota Department of Public Safety, ARMER System Biennial Report to the Legislature, March 2009; Minnesota Department of Public Safety, The Minnesota Child Passenger Restraint and Education Account, January 29, 2009; Minnesota Department of Public Safety, Annual Report Fiscal Year 2008, Minnesota Crime Victims Reparations Board; Office of Enterprise Technology, IT Planning Assistance at OET; Minnesota Job Skills Partnership Special Incumbent Worker Training Program, FY 2008 Performance Report; Minnesota Department of Human Services, Helping Older Adults Select and Purchase Long Term Care, March 23, 2009; Department of Employment and Economic Development, Positively Minnesota, Growth Acceleration Program; Minnesota Department of Employment and Economic Development, Minnesota Technology Incorporated, Annual Report Period Ending December, 2008; Department of Employment and Economic Development, Positively Minnesota, 2008 Annual Report, Urban Initiative Loan Program; University of Minnesota, Center for Transportation Studies, Advanced BRT Volume I: Innovative Technologies for Dedicated Roadways, CTS 08-06 and Advanced BRT Volume II: Innovative Technologies for Dedicated Roadways, CTS 08-07; Minnesota Department of Natural Resources, Mississippi River Corridor Critical Area Report, Corrections to Report Submitted in February 2008; Minnesota Department of Human Resources, Ombudsman for Managed Care Study, March 2009; Minnesota Department of Natural Resources, Division of Forestry, State Forest Nursery Program, Fiscal Year 2007; Minnesota Department of Natural Resources, Aquatic Plant Management Permit Fees; Minnesota Department of Education, Report on the Schools Mentoring Schools Regional Sites Program for 2008-09, March 2009; Minnesota Department of Health, Naturopathy Work Group, March 2009; Minnesota Department of Education, Status of K-12 World Language Education in Minnesota, February 2009 (March 2009 Revision); Minnesota Department of Natural Resources, Correction to Letter Dated March 9, 2009 to Attachments DNR Proposed

Aquatic Plant Management Permit Fee Rules; Minnesota Department of Health, Minnesota's Lead Poisoning Prevention Programs, Biennial Report to the Legislature, February 2009; Minnesota Department of Human Resources, Compliance by County Attorneys With 120 Day Requirement to Determine "Good Cause" and File Petitions To Civilly Commit Certain Individuals As A Sexually Dangerous Person and/or A Sexual Psychopathic Personality (SDP/SPP); Minnesota Department of Human Services, Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services; Minnesota Department of Human Services, Mental Health Acute Care Needs Report, March 2009; Minnesota Department of Human Services, Recommendations for Services for Children and Youth with Disabilities, January 2009; Minnesota Department of Transportation, Research Services 2008 Annual Report; University of Minnesota, Center for Transportation Studies, Automatic Detection of RWIS Sensor Malfunctions (Phase I), Automatic Detection of RWIS Sensor Malfunctions (Phase II); Minnesota Racing Commission, 2008 Annual Report; Minnesota Department of Human Services, Defining the Direct Care Worker in Nursing Facilities; Minnesota Pollution Control Agency, Annual Pollution Report, March 2009; Department of Employment and Economic Development, Report on Funding for Centers for Independent Living; Minnesota Department of Natural Resources, State Forest Nursery Program, Fiscal Year 2008; Minnesota Department of Human Services, Managed Care Performance Data, April 2009; Minnesota Housing Finance Agency, Minnesota Families Affordable Rental Investment Fund Report, April 2009; Department of Natural Resources, Division of Fish and Wildlife, Investigational Report 552, Can Minimum Length Limits Improve Size Structure in Minnesota Black Crappie Populations? March 2009; Department of Natural Resources, Fisheries Management Section Investigational Report No. 553, Evaluation of an 11-in Maximum Length Limit for Smallmouth Bass Populations in Northeastern Minnesota, March 2009; Minnesota Department of Human Services, Evaluation of the Extent Pension Costs Lead to Funding Shortfalls for Privatizing Nursing Facilities, April 2009.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate Files, herewith returned: S.F. Nos. 462 and 261.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned April 25, 2009

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 5 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2081: A bill for an act relating to economic development and housing; establishing and modifying certain programs; providing for regulation of certain activities and practices; amending certain unemployment insurance provisions; providing for accounts, assessments, and fees; changing codes and licensing provisions; amending Iron Range resources provisions; regulating debt management and debt settlement services; increasing certain occupation license fees; making technical changes; providing penalties; appropriating money; amending Minnesota Statutes 2008,

sections 15.75, subdivision 5; 16B.54, subdivision 2; 45.011, subdivision 1; 45.027, subdivision 1; 46.04, subdivision 1; 46.05; 46.131, subdivision 2; 84.94, subdivision 3; 115C.08, subdivision 4; 116J.035, subdivisions 1, 6; 116J.401, subdivision 2; 116J.424; 116J.435, subdivisions 2, 3; 116J.68, subdivision 2; 116J.8731, subdivisions 2, 3; 116L.03, subdivision 5; 116L.05, subdivision 5; 116L.871, subdivision 1; 116L.96; 123A.08, subdivision 1; 124D.49, subdivision 3; 129D.13, subdivisions 1, 2, 3; 129D.14, subdivisions 4, 5, 6; 129D.155; 154.44, subdivision 1; 160.16, by adding a subdivision; 160.276, subdivision 8; 241.27, subdivision 1; 248.061, subdivision 3; 248.07, subdivisions 7, 8; 256J.626, subdivision 4; 256J.66, subdivision 1; 268.031; 268.035, subdivisions 2, 17, by adding subdivisions; 268.042, subdivision 3; 268.043; 268.044, subdivision 2; 268.047, subdivisions 1, 2; 268.051, subdivisions 1, 4; 268.052, subdivision 2; 268.053, subdivision 1; 268.057, subdivisions 4, 5; 268.0625, subdivision 1; 268.066; 268.067; 268.069, subdivision 1; 268.07, subdivisions 1, 2, 3, 3b; 268.084; 268.085, subdivisions 1, 2, 3, 3a, 4, 5, 6, 15; 268.095, subdivisions 1, 2, 4, 10, 11; 268.101, subdivisions 1, 2; 268.103, subdivision 1, by adding a subdivision; 268.105, subdivisions 1, 2, 3a, 4; 268.115, subdivision 5; 268.125, subdivision 5; 268.135, subdivision 4; 268.145, subdivision 1; 268.18, subdivisions 1, 2, 4a; 268.186; 268.196, subdivisions 1, 2; 268.199; 268.211; 268A.06, subdivision 1; 270.97; 298.22, subdivisions 2, 5a, 6, 7, 8, 10, 11; 298.221; 298.2211, subdivision 3; 298.2213, subdivision 4; 298.2214, by adding a subdivision; 298.223; 298.227; 298.28, subdivision 9d; 298.292, subdivision 2; 298.294; 298.296, subdivision 2; 298.2961; 325E.115, subdivision 1; 325E.1151, subdivisions 1, 3, 4; 325E.311, subdivision 6; 326B.33, subdivisions 13, 19; 326B.46, subdivision 4; 326B.475, subdivisions 4, 7; 326B.49, subdivision 1; 326B.56, subdivision 4; 326B.58; 326B.815, subdivision 1; 326B.821, subdivision 2; 326B.86, subdivision 1; 326B.885, subdivision 2; 326B.89, subdivisions 3, 16; 326B.94, subdivision 4; 326B.972; 326B.986, subdivisions 2, 5, 8; 327B.04, subdivisions 7, 8, by adding a subdivision; 327C.03, by adding a subdivision; 327C.095, subdivision 12; 332A.02, subdivisions 5, 8, 9, 10, 13, by adding subdivisions; 332A.04, subdivision 6; 332A.08; 332A.10; 332A.11, subdivision 2; 332A.14; 469.169, subdivision 3; Laws 1998, chapter 404, section 23, subdivision 6, as amended; proposing coding for new law in Minnesota Statutes, chapters 1; 116J; 137; 161; 268; 298; 326B; proposing coding for new law as Minnesota Statutes, chapter 332B; repealing Minnesota Statutes 2008, sections 116J.402; 116J.413; 116J.58, subdivision 1; 116J.59; 116J.61; 116J.656; 116L.16; 116L.88; 116U.65; 129D.13, subdivision 4; 176.135, subdivision 1b; 268.085, subdivision 14; 268.086; Minnesota Rules, part 1350.8300.

There has been appointed as such committee on the part of the House:

Rukavina; Murphy, M; Clark; Mahoney and Gunther.

Senate File No. 2081 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned April 25, 2009

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 5 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2083: A bill for an act relating to higher education; classifying data; amending

postsecondary education provisions; setting deadlines; allowing certain advertising; establishing the Minnesota P-20 education partnership; regulating course equivalency guides; requiring notice to prospective students; requiring lists of enrolled students; amending Minnesota Office of Higher Education responsibilities; establishing programs; defining terms; regulating grants, scholarships, and work-study; requiring an annual certificate; regulating certain board membership provisions; requiring job placement impact reviews; regulating oral health care practitioner provisions; establishing fees; providing criminal penalties; requiring reports; appropriating money; amending Minnesota Statutes 2008, sections 13.3215; 124D.09, subdivision 9; 135A.08, subdivision 1; 135A.17, subdivision 2; 135A.25, subdivision 4; 136A.08, subdivision 1, by adding a subdivision; 136A.101, subdivision 5a; 136A.121, by adding subdivisions; 136A.127, subdivisions 2, 4, 9, 10, 12, 14, by adding a subdivision; 136A.1701, subdivision 10; 136A.87; 136F.02, subdivision 1; 136F.03, subdivision 4; 136F.04, subdivision 4; 136F.045; 136F.19, subdivision 1; 136F.31; 137.0245, subdivision 2; 137.0246, subdivision 2; 137.025, subdivision 1; 150A.01, by adding subdivisions; 150A.05, subdivision 2, by adding subdivisions; 150A.06, subdivisions 2d, 5, 6, by adding subdivisions; 150A.08, subdivisions 1, 3a, 5; 150A.09, subdivisions 1, 3; 150A.091, subdivisions 2, 3, 5, 8, 10; 150A.10, subdivisions 1, 2, 3, 4; 150A.11, subdivision 4; 150A.12; 150A.21, subdivisions 1, 4; 151.01, subdivision 23; 151.37, subdivision 2; 201.061, subdivision 3; 299A.45, subdivision 1; Laws 2007, chapter 144, article 1, section 4, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 127A; 135A; 136A; 136F; 150A; repealing Minnesota Statutes 2008, sections 136A.127, subdivisions 8, 13; 150A.061.

There has been appointed as such committee on the part of the House:

Rukavina, Slocum, Haws, Bly and McFarlane.

Senate File No. 2083 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned April 25, 2009

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 2:

H.F. No. 2: A bill for an act relating to education; providing for policy and funding for family, adult, and prekindergarten through grade 12 education including general education, education excellence, special programs, facilities and technology, libraries, nutrition, accounting, self-sufficiency and lifelong learning, state agencies, pupil transportation, school finance system changes, forecast adjustments, and technical corrections; providing for advisory groups; requiring reports; appropriating money; amending Minnesota Statutes 2008, sections 6.74; 13.32, by adding a subdivision; 16A.06, subdivision 11; 120A.22, subdivision 7; 120A.40; 120B.02; 120B.021, subdivision 1; 120B.022, subdivision 1; 120B.023, subdivision 2; 120B.11, subdivision 5; 120B.13; 120B.132; 120B.30; 120B.31; 120B.35; 120B.36; 121A.15, subdivision 8; 121A.41, subdivisions 7, 10; 121A.43; 122A.07, subdivisions 2, 3; 122A.18, subdivision 4; 122A.31, subdivision 4; 122A.40, subdivisions 6, 8; 122A.41, subdivisions 3, 5; 122A.413, subdivision 2; 122A.414, subdivisions 2, 2b; 122A.60, subdivisions 1a, 2; 122A.61, subdivision 1; 123A.05; 123A.06; 123A.08; 123B.02, subdivision 21; 123B.03, subdivisions 1, 1a; 123B.10, subdivision 1;

123B.14, subdivision 7; 123B.143, subdivision 1; 123B.36, subdivision 1; 123B.49, subdivision 4; 123B.51, by adding a subdivision; 123B.53, subdivision 5; 123B.57, subdivision 1; 123B.59, subdivisions 2, 3, 3a; 123B.70, subdivision 1; 123B.71, subdivisions 8, 9, 12; 123B.75, subdivision 5; 123B.76, subdivision 3; 123B.77, subdivision 3; 123B.79, subdivision 7; 123B.81, subdivisions 3, 4, 5; 123B.83, subdivision 3; 123B.92, subdivisions 1, 5; 124D.095, subdivisions 2, 3, 4, 7, 10; 124D.10; 124D.11, subdivisions 4, 9; 124D.111, subdivision 3; 124D.128, subdivisions 2, 3; 124D.42, subdivision 6, by adding a subdivision; 124D.4531; 124D.59, subdivision 2; 124D.65, subdivision 5; 124D.68, subdivisions 2, 3, 4, 5; 124D.83, subdivision 4; 124D.86, subdivisions 1, 1a, 1b; 125A.02; 125A.07; 125A.08; 125A.091; 125A.11, subdivision 1; 125A.15; 125A.28; 125A.51; 125A.56; 125A.57, subdivision 2; 125A.62, subdivision 8; 125A.63, subdivisions 2, 4; 125A.76, subdivisions 1, 5; 125A.79, subdivision 7; 125B.26; 126C.01, by adding subdivisions; 126C.05, subdivisions 1, 2, 3, 5, 6, 8, 15, 16, 17, 20; 126C.10, subdivisions 1, 2, 2a, 3, 4, 6, 13, 14, 18, 24, 34, by adding subdivisions; 126C.13, subdivisions 4, 5; 126C.15, subdivisions 2, 4; 126C.17, subdivisions 1, 5, 6, 9; 126C.20; 126C.40, subdivisions 1, 6; 126C.41, subdivision 2; 126C.44; 127A.08, by adding a subdivision; 127A.441; 127A.45, subdivisions 2, 3, 13, by adding a subdivision; 127A.47, subdivisions 5, 7; 127A.51; 134.31, subdivision 4a, by adding a subdivision; 169.011, subdivision 71; 169.443, subdivision 9; 169.4501, subdivision 1; 169.4503, subdivision 20, by adding a subdivision; 169.454, subdivision 13; 169A.03, subdivision 23; 171.01, subdivision 22; 171.02, subdivisions 2, 2a, 2b; 171.05, subdivision 2; 171.17, subdivision 1; 171.22, subdivision 1; 171.321, subdivisions 1, 4, 5; 181A.05, subdivision 1; 275.065, subdivisions 3, 6; 299A.297; 471.975; 475.58, subdivision 1; Laws 2007, chapter 146, article 1, section 24, subdivisions 2, as amended, 6, as amended, 8, as amended; article 2, section 46, subdivision 6, as amended; article 3, section 24, subdivision 4, as amended; article 4, section 16, subdivisions 2, as amended, 6, as amended; article 5, section 13, subdivisions 2, as amended, 3, as amended; article 9, section 17, subdivisions 2, as amended, 13, as amended; Laws 2008, chapter 363, article 2, section 46, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 120B; 123B; 125A; 126C; 127A; repealing Minnesota Statutes 2008, sections 120B.362; 120B.39; 121A.27; 121A.66; 121A.67, subdivision 1; 122A.628; 122A.75; 123B.54; 123B.57, subdivisions 3, 4, 5; 123B.591; 124D.091; 125A.03; 125A.05; 125A.18; 125A.76, subdivision 4; 125A.79, subdivision 6; 126C.10, subdivisions 2b, 13a, 13b, 24, 25, 26, 27, 28, 29, 30, 31, 31a, 31b, 32, 33, 34, 35, 36; 126C.12; 126C.126; 127A.50; 275.065, subdivisions 5a, 6b, 6c, 8, 9, 10; Minnesota Rules, parts 3525.0210, subparts 5, 6, 9, 13, 17, 29, 30, 34, 43, 46, 47; 3525.0400; 3525.1100, subpart 2, item F; 3525.2445; 3525.2900, subpart 5; 3525.4220.

The House respectfully requests that a Conference Committee of 5 members be appointed thereon.

Greiling, Mariani, Slawik, Ward and Garofalo have been appointed as such committee on the part of the House.

House File No. 2 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted April 25, 2009

Senator Stumpf moved that the Senate accede to the request of the House for a Conference

Committee on H.F. No. 2, and that a Conference Committee of 5 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 936:

H.F. No. 936: A bill for an act relating to human services; specifying criteria for communities for a lifetime; requiring the Minnesota Board on Aging to study and report on communities for a lifetime; amending Minnesota Statutes 2008, section 256.975, by adding a subdivision.

The House respectfully requests that a Conference Committee of 3 members be appointed thereon.

Thissen, Hosch and Beard have been appointed as such committee on the part of the House.

House File No. 936 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted April 25, 2009

Senator Sheran moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 936, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 2123:

H.F. No. 2123: A bill for an act relating to state government; environment, natural resources, and energy finance; appropriating money for environment and natural resources; authorizing sale of gift cards and certificates; establishing composting competitive grant program; modifying regulation of storm water discharges; modifying waste management reporting requirements and creating a work group; requiring nonresident all-terrain vehicle state trail pass; modifying horse trail and state park pass requirements; requiring disclosure of certain chemicals in children's products by manufacturers; requiring plastic yard waste bags to be compostable and establishing labeling standards; authorizing uses of the Hennepin County solid and hazardous waste fund; modifying greenhouse gas emissions provisions and requiring a registry; establishing and authorizing fees; providing for disposition of certain fees; modifying and establishing assessments for certain regulatory expenses; providing for fish consumption advisories in different languages; limiting use of certain funds; requiring reports; appropriating money to Department of Commerce and Public Utilities Commission to finance activities related to commerce and energy; modifying provisions related to Telecommunications Access Minnesota assessments, insurance audits, insurers and insurance products, certain financial institutions, regulated activities related to certain mortgage

transactions and professionals, and debt management and debt settlement services; providing penalties and remedies; appropriating and allocating federal stimulus money for various energy programs; amending Minnesota Statutes 2008, sections 45.011, subdivision 1; 45.027, subdivision 1; 46.04, subdivision 1; 46.05; 46.131, subdivision 2; 47.58, subdivision 1; 47.60, subdivisions 1, 3, 6; 48.21; 58.05, subdivision 3; 58.06, subdivision 2; 58.126; 58.13, subdivision 1; 60A.124; 60A.14, subdivision 1; 60B.03, subdivision 15; 60L.02, subdivision 3; 61B.19, subdivision 4; 61B.28, subdivisions 4, 8; 67A.01; 67A.06; 67A.07; 67A.14, subdivisions 1, 7; 67A.18, subdivision 1; 84.0835, subdivision 3; 84.415, subdivision 5, by adding a subdivision; 84.63; 84.631; 84.632; 84.788, subdivision 3; 84.922, subdivision 1a; 85.015, subdivision 1b; 85.053, subdivision 10; 85.46, subdivisions 3, 4, 7; 93.481, subdivisions 1, 3, 5, 7; 97A.075, subdivision 1; 103G.301, subdivisions 2, 3; 115.03, subdivision 5c; 115.073; 115.56, subdivision 4; 115.77, subdivision 1; 115A.1314, subdivision 2; 115A.557, subdivision 3; 115A.931; 116.07, subdivision 4d; 116.41, subdivision 2; 116C.834, subdivision 1; 116D.045; 216B.62, subdivisions 3, 4, 5, by adding a subdivision; 216H.10, subdivision 7; 216H.11; 325E.311, subdivision 6; 332A.02, subdivisions 5, 8, 9, 10, 13, by adding a subdivision; 332A.04, subdivision 6; 332A.08; 332A.10; 332A.11, subdivision 2; 332A.14; Laws 2002, chapter 220, article 8, section 15; Laws 2007, chapter 57, article 1, section 4, subdivision 2; Laws 2008, chapter 363, article 5, section 4, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 60A; 61A; 67A; 84; 93; 115A; 116; 216H; 325E; 383B; proposing coding for new law as Minnesota Statutes, chapter 332B; repealing Minnesota Statutes 2008, sections 60A.129; 61B.19, subdivision 6; 67A.14, subdivision 5; 67A.17; 67A.19; Laws 2008, chapter 363, article 5, section 30; Minnesota Rules, parts 2675.2180; 2675.7100; 2675.7110; 2675.7120; 2675.7130; 2675.7140.

The House respectfully requests that a Conference Committee of 5 members be appointed thereon.

Wagenius, Hilty, Knuth, Hansen and Loon have been appointed as such committee on the part of the House.

House File No. 2123 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted April 25, 2009

Senator Pogemiller, for Senator Anderson, moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 2123, and that a Conference Committee of 5 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 111, 1309 and 2323.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted April 25, 2009

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 111: A bill for an act relating to the State Board of Investment; requiring divestment from certain investments relating to Iran; requiring a report; proposing coding for new law in Minnesota Statutes, chapter 11A.

Referred to the Committee on Finance.

H.F. No. 1309: A bill for an act relating to transportation finance; appropriating money for transportation, Metropolitan Council, and public safety activities and programs; providing for fund transfers and tort claims; authorizing an account and certain contingent appropriations; modifying previous appropriations provisions; modifying various provisions related to transportation finance and policy; modifying provisions related to speed limits, fracture-critical bridges, transit, passenger rail, motor vehicle lease sales tax revenue allocations, transit services, and the Buffalo Ridge Regional Rail Authority; requiring reports; amending Minnesota Statutes 2008, sections 16A.152, subdivision 2; 161.081, by adding a subdivision; 161.36, subdivision 7, as added; 162.12, subdivision 2; 169.14, by adding a subdivision; 174.24, subdivision 1a, by adding a subdivision; 174.50, by adding a subdivision; 297A.815, subdivision 3; 473.408, by adding a subdivision; Laws 2007, chapter 143, article 1, section 3, subdivision 2, as amended; Laws 2008, chapter 152, article 1, section 5; proposing coding for new law in Minnesota Statutes, chapters 161; 174.

Senator Pogemiller moved that H.F. No. 1309 be laid on the table. The motion prevailed.

H.F. No. 2323: A bill for an act relating to the financing and operation of state and local government; making policy, technical, administrative, enforcement, collection, refund, clarifying, and other changes to income, franchise, property, sales and use, estate, gift, cigarette, tobacco, liquor, motor vehicle, gross receipts, minerals, tax increment financing and other taxes and tax-related provisions; requiring certain additions; conforming to federal section 179 expensing allowances; adding Minnesota development subsidies to corporate taxable income; disallowing certain subtractions; allowing certain nonrefundable credits; allowing a refundable Minnesota child credit; repealing various credits; conforming to certain federal tax provisions; expanding definition of domestic corporation to include tax havens; modifying income tax rates; expanding and increasing credit for research activities; accelerating single sales apportionment; modifying minimum fees; allowing county local sales tax; eliminating certain existing local sales taxes; adjusting county program aid; modifying levy limits; making changes to residential homestead market value credit; providing flexibility and mandate reduction provisions; making changes to various property tax and local government aid-related provisions; providing temporary suspension of new or increased maintenance of effort and matching fund requirements; modifying county support of libraries; establishing the Council on Local Results and Innovation; providing property tax system benchmarks, critical indicators, and principles; establishing a property tax work group; creating the Legislative Commission on Mandate Reform; making changes to certain administrative procedures; modifying mortgage registry tax payments; modifying truth in taxation provisions; providing clarification for eligibility for property tax exemption for institutions of purely public charity; making changes to property tax refund and senior citizen property tax deferral programs; providing property tax exemptions; providing a property valuation reduction for certain land constituting a riparian buffer; providing a partial valuation exclusion for disaster damaged homes; extending deadline for special service district and housing improvement districts; requiring a

fiscal disparity study; extending emergency medical service special taxing district; providing emergency debt certificates; providing and modifying local taxes; expanding county authorization to abate certain improvements; providing municipal street improvement districts; establishing a seasonal recreational property tax deferral program; expanding sales and use tax base; defining solicitor for purposes of nexus; providing a bovine tuberculosis testing grant; modifying tax preparation services law; modifying authority of municipalities to issue bonds for certain other postemployment benefits; allowing use of increment to offset state aid reductions; allowing additional authority to spend increments for housing replacement district plans; modifying and authorizing certain tax increment financing districts; providing equitable funding health and human services reform; modifying JOBZ provisions; repealing international economic development and biotechnology and health science industry zones; modifying basic sliding fee program funding; providing appointments; requiring reports; appropriating money; amending Minnesota Statutes 2008, sections 3.842, subdivision 4a; 3.843; 16C.28, subdivision 1a; 40A.09; 84.82, subdivision 10; 84.922, subdivision 11; 86B.401, subdivision 12; 123B.10, subdivision 1; 134.34, subdivisions 1, 4; 245.4932, subdivision 1; 253B.045, subdivision 2; 254B.04, subdivision 1; 270C.12, by adding a subdivision; 270C.445; 270C.56, subdivision 3; 272.02, subdivision 7, by adding subdivisions; 272.029, subdivision 6; 273.111, by adding a subdivision; 273.1231, subdivision 1; 273.1232, subdivision 1; 273.124, subdivision 1; 273.13, subdivisions 25, 34; 273.1384, subdivisions 1, 4, by adding a subdivision; 273.1393; 275.025, subdivisions 1, 2; 275.065, subdivisions 1, 1a, 1c, 3, 6; 275.07, subdivisions 1, 4, by adding a subdivision; 275.70, subdivisions 3, 5; 275.71, subdivisions 2, 4, 5; 276.04, subdivision 2; 279.10; 282.08; 287.08; 289A.02, subdivision 7, as amended; 289A.11, subdivision 1; 289A.20, subdivision 4; 289A.31, subdivision 5; 290.01, subdivisions 5, 19, as amended, 19a, as amended, 19b, 19c, as amended, 19d, as amended, 29, 31, as amended, by adding subdivisions; 290.014, subdivision 2; 290.06, subdivisions 2c, 2d, by adding subdivisions; 290.0671, subdivision 1; 290.068, subdivisions 1, 3, 4; 290.091, subdivision 2; 290.0921, subdivision 3; 290.0922, subdivisions 1, 3, by adding a subdivision; 290.17, subdivisions 2, 4; 290.191, subdivisions 2, 3; 290A.03, subdivision 15, as amended; 290A.04, subdivision 2; 290B.03, subdivision 1; 290B.04, subdivisions 3, 4; 290B.05, subdivision 1; 291.005, subdivision 1, as amended; 291.03, subdivision 1; 295.75, subdivision 2; 297A.61, subdivisions 3, 4, 5, 6, 10, 14a, 17a, 21, 38, by adding subdivisions; 297A.62, by adding a subdivision; 297A.63; 297A.64, subdivision 2; 297A.66, subdivision 1, by adding a subdivision; 297A.67, subdivisions 15, 23; 297A.815, subdivision 3; 297A.83, subdivision 3; 297A.94; 297A.99, subdivisions 1, 6; 297B.02, subdivision 1; 297F.01, by adding a subdivision; 297F.05, subdivisions 1, 3, 4, by adding a subdivision; 297G.03, subdivision 1; 297G.04; 298.001, by adding a subdivision; 298.018, subdivisions 1, 2, by adding a subdivision; 298.227; 298.24, subdivision 1; 298.28, subdivisions 2, 11, by adding a subdivision; 306.243, by adding a subdivision; 344.18; 365.28; 375.194, subdivision 5; 383A.75, subdivision 3; 428A.101; 428A.21; 429.011, subdivision 2a; 429.021, subdivision 1; 429.041, subdivisions 1, 2; 446A.086, subdivision 8; 465.719, subdivision 9; 469.015; 469.174, subdivision 22; 469.175, subdivisions 1, 6; 469.176, subdivisions 3, 6, by adding a subdivision; 469.1763, subdivisions 2, 3; 469.178, subdivision 7; 469.315; 469.3192; 473.13, subdivision 1; 473H.04, by adding a subdivision; 473H.05, subdivision 1; 475.51, subdivision 4; 475.52, subdivision 6; 475.58, subdivision 1; 477A.011, subdivision 36; 477A.0124, by adding a subdivision; 477A.013, subdivision 9, by adding a subdivision; 477A.03, subdivisions 2a, 2b; 641.12, subdivision 1; Laws 1986, chapter 396, section 4, subdivision 3; by adding a subdivision; Laws 1986, chapter 400, section 44, as amended; Laws 1991, chapter 291, article 8, section 27, subdivision 3, as amended; Laws 1993, chapter 375, article 9, section 46, subdivision 2, as amended, by adding a subdivision; Laws 1995, chapter 264, article 5, sections 44, subdivision 4,

as amended; 45, subdivision 1, as amended; Laws 1996, chapter 471, article 2, section 30; Laws 1998, chapter 389, article 8, section 37, subdivision 1; Laws 2001, First Special Session chapter 5, article 3, section 8, as amended; Laws 2002, chapter 377, article 3, section 25; Laws 2006, chapter 259, article 3, section 12, subdivision 3; Laws 2008, chapter 366, article 5, section 34; article 6, sections 9; 10; article 7, section 16, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 3; 6; 14; 17; 256E; 270C; 272; 273; 275; 290; 292; 297A; 435; 475; 477A; proposing coding for new law as Minnesota Statutes, chapter 290D; repealing Minnesota Statutes 2008, sections 245.4835; 245.714; 246.54; 254B.02, subdivision 3; 256B.19, subdivision 1; 256I.08; 272.02, subdivision 83; 273.113; 275.065, subdivisions 5a, 6b, 6c, 8, 9, 10; 289A.50, subdivision 10; 290.01, subdivision 6b; 290.06, subdivisions 24, 28, 30, 31, 32, 33, 34; 290.067, subdivisions 1, 2, 2a, 2b, 3, 4; 290.0672; 290.0674; 290.0679; 290.0802; 290.0921, subdivision 7; 290.191, subdivision 4; 290.491; 297A.61, subdivision 45; 297A.68, subdivisions 38, 41; 469.316; 469.317; 469.321; 469.3215; 469.322; 469.323; 469.324; 469.325; 469.326; 469.327; 469.328; 469.329; 469.330; 469.331; 469.332; 469.333; 469.334; 469.335; 469.336; 469.337; 469.338; 469.339; 469.340; 469.341; 477A.0124, subdivisions 3, 4, 5; 477A.03, subdivision 5; Laws 2009, chapter 3, section 1; Laws 2009, chapter 12, article 1, section 8.

Senator Pogemiller moved that H.F. No. 2323 be laid on the table. The motion prevailed.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time.

Senators Sheran, Dibble, Pappas, Frederickson and Dille introduced–

S.F. No. 2119: A bill for an act relating to arts and cultural heritage; establishing a grant program for historic sites; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 138.

Referred to the Committee on State and Local Government Operations and Oversight.

Senators Marty, Dibble and Lourey introduced–

S.F. No. 2120: A bill for an act relating to employment; enabling low-income workers to meet basic needs; providing child care assistance to low-income workers; increasing working family credit; increasing minimum wage; amending Minnesota Statutes 2008, sections 119B.02, subdivisions 1, 2; 119B.03, subdivisions 3, 9, 10; 119B.035, subdivisions 1, 2, 4, 5; 119B.05, subdivision 5; 119B.08; 119B.09, subdivisions 4a, 7; 119B.10; 119B.11, subdivision 1; 119B.12, subdivision 2; 119B.15; 119B.24; 290.0671, subdivisions 1, 7; repealing Minnesota Statutes 2008, sections 119B.011, subdivisions 20, 20a; 119B.03, subdivisions 1, 2, 4, 5, 6, 6a, 6b, 8; 119B.05, subdivision 1; 119B.07; 119B.09, subdivision 3; 119B.11, subdivision 4.

Referred to the Committee on Business, Industry and Jobs.

MOTIONS AND RESOLUTIONS

Senator Kelash moved that the name of Senator Gerlach be added as a co-author to S.F. No. 640.

The motion prevailed.

Senator Sieben moved that the name of Senator Bonoff be added as a co-author to S.F. No. 1331. The motion prevailed.

Senator Pogemiller moved that the name of Senator Clark be added as a co-author to S.F. No. 1417. The motion prevailed.

Senator Senjem moved that the name of Senator Ingebrigtsen be added as a co-author to S.F. No. 1551. The motion prevailed.

Senator Clark moved that the name of Senator Tomassoni be added as a co-author to S.F. No. 1569. The motion prevailed.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

MOTIONS AND RESOLUTIONS - CONTINUED

Remaining on the Order of Business of Motions and Resolutions, Senator Pogemiller moved that the Senate take up the Calendar. The motion prevailed.

CALENDAR

S.F. No. 1117: A bill for an act relating to the legislature; modifying the definition of a legislative day; amending Minnesota Statutes 2008, section 3.012.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 50 and nays 15, as follows:

Those who voted in the affirmative were:

Anderson	Dille	Kubly	Olson, G.	Scheid
Bakk	Doll	Langseth	Olson, M.	Sheran
Berglin	Erickson Ropes	Latz	Pappas	Sieben
Betzold	Fischbach	Lourey	Pariseau	Skoe
Carlson	Fobbe	Lynch	Pogemiller	Skogen
Chaudhary	Foley	Marty	Prettner Solon	Stumpf
Clark	Frederickson	Metzen	Rest	Tomassoni
Cohen	Higgins	Moua	Rummel	Torres Ray
Dahle	Kelash	Murphy	Saltzman	Vickerman
Dibble	Koering	Olseen	Saxhaug	Wiger

Those who voted in the negative were:

Day	Hann	Jungbauer	Michel	Rosen
Gerlach	Ingebrigtsen	Koch	Ortman	Senjem
Gimse	Johnson	Limmer	Robling	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 484: A bill for an act relating to agriculture; changing duties of the Food Safety and Defense Task Force; changing membership and procedures of the Minnesota Organic Advisory Task Force; eliminating language requiring two annual reports; amending Minnesota Statutes 2008, sections 28A.21, subdivision 5; 31.94.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 713: A bill for an act relating to state government; establishing a state employee suggestion system for making state government less costly or more efficient; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 16A.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 64 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koering	Olson, G.	Scheid
Bakk	Fischbach	Kubly	Olson, M.	Senjem
Berglin	Fobbe	Langseth	Ortman	Sheran
Betzold	Foley	Latz	Pappas	Sieben
Carlson	Frederickson	Limmer	Pariseau	Skoe
Chaudhary	Gerlach	Lourey	Pogemiller	Skogen
Clark	Gimse	Lynch	Prettner Solon	Stumpf
Cohen	Hann	Marty	Rest	Tomassoni
Dahle	Ingebrigtsen	Metzen	Robling	Torres Ray
Day	Johnson	Michel	Rosen	Vandeveer
Dibble	Jungbauer	Moua	Rummel	Vickerman
Dille	Kelash	Murphy	Saltzman	Wiger
Doll	Koch	Olseen	Saxhaug	

So the bill passed and its title was agreed to.

H.F. No. 523: A bill for an act relating to education; modifying school background check requirements relating to disciplinary actions; amending Minnesota Statutes 2008, section 123B.03, subdivision 1a.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 1431: A bill for an act relating to employment; regulating the deduction from wages of unreimbursed expenses; amending Minnesota Statutes 2008, section 177.24, subdivisions 4, 5.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 666: A bill for an act relating to human services; modifying provisions related to children aging out of foster care; amending Minnesota Statutes 2008, section 260C.212, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 260C.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 60 and nays 5, as follows:

Those who voted in the affirmative were:

Anderson	Doll	Koering	Olson, G.	Saxhaug
Bakk	Erickson Ropes	Kubly	Olson, M.	Scheid
Berglin	Fischbach	Langseth	Ortman	Senjem
Betzold	Fobbe	Latz	Pappas	Sheran
Carlson	Foley	Lourey	Pariseau	Sieben
Chaudhary	Frederickson	Lynch	Pogemiller	Skoe
Clark	Gimse	Marty	Prettner Solon	Skogen
Cohen	Higgins	Metzen	Rest	Stumpf
Dahle	Johnson	Michel	Robling	Tomassoni
Day	Jungbauer	Moua	Rosen	Torres Ray
Dibble	Kelash	Murphy	Rummel	Vickerman
Dille	Koch	Olseen	Saltzman	Wiger

Those who voted in the negative were:

Gerlach	Hann	Ingebrigtsen	Limmer	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 537: A bill for an act relating to higher education; requiring postsecondary institutions to notify prospective students of the potential effects of a criminal conviction on future employment; proposing coding for new law in Minnesota Statutes, chapter 135A.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 412: A bill for an act relating to probate; enacting the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act; proposing coding for new law in Minnesota Statutes, chapter 524.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 3, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olson, G.	Senjem
Bakk	Fischbach	Koering	Olson, M.	Sheran
Berglin	Fobbe	Kubly	Ortman	Sieben
Betzold	Foley	Langseth	Pappas	Skoe
Carlson	Frederickson	Latz	Pogemiller	Skogen
Chaudhary	Gerlach	Lourey	Prettner Solon	Stumpf
Clark	Gimse	Lynch	Rest	Tomassoni
Cohen	Hann	Marty	Robling	Torres Ray
Dahle	Higgins	Metzen	Rosen	Vickerman
Day	Ingebrigtsen	Michel	Rummel	Wiger
Dibble	Johnson	Moua	Saltzman	
Dille	Jungbauer	Murphy	Saxhaug	
Doll	Kelash	Olseen	Scheid	

Those who voted in the negative were:

Limmer	Pariseau	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 1810: A bill for an act relating to property; enacting the Uniform Disclaimer of Property Interests Act; proposing coding for new law in Minnesota Statutes, chapter 524; repealing Minnesota Statutes 2008, sections 501B.86; 525.532.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 63 and nays 2, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olson, G.	Scheid
Bakk	Fischbach	Koering	Olson, M.	Senjem
Berglin	Fobbe	Kubly	Ortman	Sheran
Betzold	Foley	Langseth	Pappas	Sieben
Carlson	Frederickson	Latz	Pariseau	Skoe
Chaudhary	Gerlach	Lourey	Pogemiller	Skogen
Clark	Gimse	Lynch	Prettner Solon	Stumpf
Cohen	Hann	Marty	Rest	Tomassoni
Dahle	Higgins	Metzen	Robling	Torres Ray
Day	Ingebrigtsen	Michel	Rosen	Vickerman
Dibble	Johnson	Moua	Rummel	Wiger
Dille	Jungbauer	Murphy	Saltzman	
Doll	Kelash	Olseen	Saxhaug	

Those who voted in the negative were:

Limmer	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 1876: A bill for an act relating to transportation; modifying and updating provisions relating to motor carriers, highways, and the Department of Transportation; making clarifying and technical changes; amending Minnesota Statutes 2008, sections 168.013, subdivision 1e; 168.185; 169.025; 169.801, subdivision 10; 169.823, subdivision 1; 169.824; 169.8261; 169.827; 169.85, subdivision 2; 169.862, subdivision 2; 169.864, subdivisions 1, 2; 169.865, subdivisions 1, 2, 3,

4; 169.866, subdivision 1; 169.87, subdivision 2, by adding a subdivision; 174.64, subdivision 4; 174.66; 221.012, subdivisions 19, 29; 221.021, subdivision 1; 221.022; 221.025; 221.026, subdivisions 2, 5; 221.0269, subdivision 3; 221.031, subdivisions 1, 3, 3c, 6; 221.0314, subdivisions 2, 3a, 9; 221.033, subdivisions 1, 2; 221.121, subdivisions 1, 7; 221.122, subdivision 1; 221.123; 221.132; 221.151, subdivision 1; 221.161, subdivisions 1, 4; 221.171; 221.172, subdivision 3; 221.185, subdivisions 2, 4, 5a, 9; 221.605, subdivision 1; 221.68; 221.81, subdivision 3d; repealing Minnesota Statutes 2008, sections 169.67, subdivision 6; 169.826, subdivisions 1b, 5; 169.832, subdivisions 11, 11a; 221.012, subdivisions 2, 3, 6, 7, 11, 12, 21, 23, 24, 30, 32, 39, 40, 41; 221.031, subdivision 2b; 221.072; 221.101; 221.111; 221.121, subdivisions 2, 3, 5, 6, 6a, 6c, 6d, 6e, 6f; 221.131, subdivision 2a; 221.141, subdivision 6; 221.151, subdivisions 2, 3; 221.153; 221.172, subdivisions 4, 5, 6, 7, 8; 221.296, subdivisions 3, 4, 5, 6, 7, 8.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 62 and nays 3, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olson, M.	Senjem
Bakk	Fischbach	Kubly	Ortman	Sheran
Berglin	Fobbe	Langseth	Pappas	Sieben
Betzold	Foley	Latz	Pariseau	Skoe
Carlson	Frederickson	Lourey	Pogemiller	Skogen
Chaudhary	Gerlach	Lynch	Prettner Solon	Stumpf
Clark	Gimse	Marty	Rest	Tomassoni
Cohen	Hann	Metzen	Robling	Torres Ray
Dahle	Higgins	Michel	Rosen	Vickerman
Day	Ingebrigtsen	Moua	Rummel	Wiger
Dibble	Johnson	Murphy	Saltzman	
Dille	Jungbauer	Olseen	Saxhaug	
Doll	Kelash	Olson, G.	Scheid	

Those who voted in the negative were:

Koering	Limmer	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 532: A bill for an act relating to rulemaking; authorizing notice by electronic mail; amending Minnesota Statutes 2008, sections 14.07, subdivision 6; 14.14, subdivision 1a; 14.22, subdivision 1; 14.389, subdivision 2; 14.3895, subdivision 3.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Cohen	Fischbach	Higgins	Kubly
Bakk	Dahle	Fobbe	Ingebrigtsen	Langseth
Berglin	Day	Foley	Johnson	Latz
Betzold	Dibble	Frederickson	Jungbauer	Limmer
Carlson	Dille	Gerlach	Kelash	Lourey
Chaudhary	Doll	Gimse	Koch	Lynch
Clark	Erickson Ropes	Hann	Koering	Marty

Metzen	Olson, M.	Rest	Scheid	Stumpf
Michel	Ortman	Robling	Senjem	Tomassoni
Moua	Pappas	Rosen	Sheran	Torres Ray
Murphy	Pariseau	Rummel	Sieben	Vandeveer
Olseen	Pogemiller	Saltzman	Skoe	Vickerman
Olson, G.	Prettner Solon	Saxhaug	Skogen	Wiger

So the bill passed and its title was agreed to.

S.F. No. 122: A bill for an act relating to pet animals; requiring a notice for retail sales of unprocessed cocoa bean shell mulch; proposing coding for new law in Minnesota Statutes, chapter 325E.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 54 and nays 11, as follows:

Those who voted in the affirmative were:

Anderson	Doll	Kubly	Olseen	Saxhaug
Bakk	Erickson Ropes	Langseth	Olson, G.	Scheid
Berglin	Fischbach	Latz	Olson, M.	Senjem
Betzold	Fobbe	Limmer	Pappas	Sheran
Carlson	Foley	Lourey	Pariseau	Sieben
Chaudhary	Frederickson	Lynch	Pogemiller	Skoe
Clark	Gimse	Marty	Prettner Solon	Skogen
Cohen	Higgins	Metzen	Rest	Torres Ray
Dahle	Johnson	Michel	Rosen	Vickerman
Dibble	Kelash	Moua	Rummel	Wiger
Dille	Koering	Murphy	Saltzman	

Those who voted in the negative were:

Day	Ingebrigtsen	Ortman	Tomassoni
Gerlach	Jungbauer	Robling	Vandeveer
Hann	Koch	Stumpf	

So the bill passed and its title was agreed to.

S.F. No. 545: A bill for an act relating to health occupations; authorizing licensed doctoral-level psychologists to provide a final determination not to certify; adding a member appointed by the Minnesota Psychological Association to the Health Care Reform Review Council; amending Minnesota Statutes 2008, sections 62M.09, subdivision 3a; 62U.09, subdivision 2; 148.89, subdivision 5.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 63 and nays 2, as follows:

Those who voted in the affirmative were:

Anderson	Clark	Doll	Gerlach	Jungbauer
Bakk	Cohen	Erickson Ropes	Gimse	Kelash
Berglin	Dahle	Fischbach	Hann	Koch
Betzold	Day	Fobbe	Higgins	Koering
Carlson	Dibble	Foley	Ingebrigtsen	Kubly
Chaudhary	Dille	Frederickson	Johnson	Langseth

Latz	Murphy	Pogemiller	Saxhaug	Stumpf
Lourey	Olseen	Prettner Solon	Scheid	Tomassoni
Lynch	Olson, G.	Rest	Senjem	Torres Ray
Marty	Olson, M.	Robling	Sheran	Vickerman
Metzen	Ortman	Rosen	Sieben	Wiger
Michel	Pappas	Rummel	Skoe	
Moua	Pariseau	Saltzman	Skogen	

Those who voted in the negative were:

Limmer	Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 1408: A bill for an act relating to public safety; securing aircraft cockpits against lasers; proposing coding for new law in Minnesota Statutes, chapter 609.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 707: A bill for an act relating to public safety; allowing emergency 911 systems to include referral to mental health crisis teams; amending Minnesota Statutes 2008, section 403.03.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Dille	Ingebrigtsen	Lynch	Pariseau
Bakk	Doll	Johnson	Marty	Pogemiller
Berglin	Erickson Ropes	Jungbauer	Metzen	Prettner Solon
Betzold	Fischbach	Kelash	Michel	Rest
Carlson	Fobbe	Koch	Moua	Robling
Chaudhary	Foley	Koering	Murphy	Rosen
Clark	Frederickson	Kubly	Olseen	Rummel
Cohen	Gerlach	Langseth	Olson, G.	Saltzman
Dahle	Gimse	Latz	Olson, M.	Saxhaug
Day	Hann	Limmer	Ortman	Scheid
Dibble	Higgins	Lourey	Pappas	Senjem

Sheran	Skoe	Stumpf	Torres Ray	Vickerman
Sieben	Skogen	Tomassoni	Vandeveer	Wiger

So the bill passed and its title was agreed to.

S.F. No. 474: A bill for an act relating to consumer protection; prohibiting retail sales of toys that have been recalled for safety reasons; proposing coding for new law in Minnesota Statutes, chapter 325F.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 64 and nays 1, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koering	Olson, G.	Scheid
Bakk	Fischbach	Kubly	Olson, M.	Senjem
Berglin	Fobbe	Langseth	Ortman	Sheran
Betzold	Foley	Latz	Pappas	Sieben
Carlson	Frederickson	Limmer	Pariseau	Skoe
Chaudhary	Gerlach	Lourey	Pogemiller	Skogen
Clark	Gimse	Lynch	Prettner Solon	Stumpf
Cohen	Hann	Marty	Rest	Tomassoni
Dahle	Higgins	Metzen	Robling	Torres Ray
Day	Ingebrigtsen	Michel	Rosen	Vandeveer
Dibble	Johnson	Moua	Rummel	Vickerman
Dille	Kelash	Murphy	Saltzman	Wiger
Doll	Koch	Olseen	Saxhaug	

Those who voted in the negative were:

Jungbauer

So the bill passed and its title was agreed to.

S.F. No. 1096: A bill for an act relating to legislation; correcting erroneous, ambiguous, and omitted text and obsolete references; eliminating redundant, conflicting, and superseded provisions; making miscellaneous technical corrections to laws and statutes; amending Minnesota Statutes 2008, sections 2.031, subdivision 2; 3.7393, subdivision 10; 6.67; 13.202, subdivision 3; 13.4967, by adding subdivisions; 13.681, by adding a subdivision; 13.871, subdivision 6; 16A.152, subdivision 2; 16A.19, subdivision 1; 16B.284; 16B.85, subdivision 1; 17.4986, subdivision 2; 58.05, subdivision 3; 62S.01, subdivision 24; 62S.292, subdivision 4; 66A.07, subdivision 4; 116V.01, subdivision 3; 122A.31, subdivision 1; 125A.63, subdivision 5; 128B.03, subdivision 7; 144.6501, subdivision 6; 144.966, subdivision 2; 148.01, subdivision 1a; 148.71, subdivision 2; 148.725, subdivision 5; 148C.11, subdivision 3; 160.80, subdivision 1a; 161.125, subdivision 1; 168.09, subdivision 3; 168.27, subdivision 1; 169.18, subdivision 5; 181.985, subdivision 1; 201.081; 206.82, subdivision 2; 216B.241, subdivision 9; 216C.19, subdivision 17; 216H.07, subdivision 1; 221.84, subdivision 4; 243.166, subdivisions 1b, 6, 9; 244.052, subdivision 3a; 244.18, subdivision 1; 245.8261, subdivisions 3, 6, 7; 253B.08, subdivision 1; 256B.0571, subdivision 8; 260.105; 260C.446; 270.45; 270.47; 270.80, subdivision 1; 273.05, subdivision 1; 273.061, subdivision 2; 275.065, subdivision 6c; 289A.08, subdivision 16; 289A.40, subdivision 6; 298.34, subdivision 2; 309.745; 325E.317, subdivision 5; 326B.082, subdivision 8; 326B.121, subdivision 3; 327B.041; 336.10-105; 347.542, subdivision 1; 349.31, subdivision 1; 352.017, subdivision 1; 357.18, subdivision 1; 360.0426, subdivision 5; 365A.08, subdivision

2; 401.025, subdivision 3; 414.02, subdivision 4; 423A.01, subdivision 2; 473.167, subdivision 2; 473.384, subdivision 6; 473.388, subdivision 2; 507.24, subdivision 2; 508.82, subdivision 1; 508A.82, subdivision 1; 524.3-303; 524.3-308; 524.8-103; 541.023, subdivision 6; 600.24; 609.75, subdivision 1; 609.76, subdivision 1; 609.762, subdivision 1; 624.731, subdivision 3; 626.556, subdivision 2; Laws 2001, First Special Session chapter 5, article 3, section 50; Laws 2008, chapter 344, section 56; repealing Laws 2003, chapter 26; Laws 2005, chapter 152, article 1, section 18; Laws 2005, chapter 163, section 2; Laws 2006, chapter 260, article 5, section 11; Laws 2008, chapter 204, section 41; Laws 2008, chapter 281, sections 6; 12; Laws 2008, chapter 287, article 1, section 21; Laws 2008, chapter 366, article 9, section 7; article 12, section 2.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 1794: A bill for an act relating to veterans; clarifying the circumstances under which pay differential applies for deployed National Guard and reserve members who are teachers; amending Minnesota Statutes 2008, section 471.975.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vandeveer
Dille	Jungbauer	Moua	Rummel	Vickerman
Doll	Kelash	Murphy	Saltzman	Wiger

So the bill passed and its title was agreed to.

S.F. No. 729: A bill for an act relating to Hennepin County; modifying personnel rules and procedures; amending Minnesota Statutes 2008, sections 383B.27, subdivision 16; 383B.29, subdivision 2; 383B.31.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 64 and nays 1, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Koch	Olseen	Saxhaug
Bakk	Fischbach	Koering	Olson, G.	Scheid
Berglin	Fobbe	Kubly	Olson, M.	Senjem
Betzold	Foley	Langseth	Ortman	Sheran
Carlson	Frederickson	Latz	Pappas	Sieben
Chaudhary	Gerlach	Limmer	Pariseau	Skoe
Clark	Gimse	Lourey	Pogemiller	Skogen
Cohen	Hann	Lynch	Prettner Solon	Stumpf
Dahle	Higgins	Marty	Rest	Tomassoni
Day	Ingebrigtsen	Metzen	Robling	Torres Ray
Dibble	Johnson	Michel	Rosen	Vickerman
Dille	Jungbauer	Moua	Rummel	Wiger
Doll	Kelash	Murphy	Saltzman	

Those who voted in the negative were:

Vandeveer

So the bill passed and its title was agreed to.

S.F. No. 1910: A bill for an act relating to commerce; providing for the licensing and regulation of certain persons; establishing prelicense and continuing education requirements; amending Minnesota Statutes 2008, sections 45.22; 45.23; 60K.31, by adding a subdivision; 60K.36, subdivision 4, by adding a subdivision; 60K.37, by adding a subdivision; 60K.55, subdivision 2; 60K.56; 72B.02, subdivisions 2, 5, 6, 11, by adding subdivisions; 72B.03; 72B.05; 72B.06; 72B.08, subdivisions 1, 2, 4; 72B.135, subdivisions 1, 2, 3; 82.32; 82B.05, subdivision 1; 82B.08, by adding subdivisions; 82B.09, by adding a subdivision; 82B.10; 82B.13, subdivisions 4, 5, 6; 82B.19, subdivisions 1, 2; 82B.20, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 45; 60K; 72B; 82; 82B; repealing Minnesota Statutes 2008, sections 72B.02, subdivision 12; 72B.04; 82B.02; Minnesota Rules, parts 2808.0100; 2808.1000; 2808.1100; 2808.1200; 2808.1300; 2808.1400; 2808.1500; 2808.1600; 2808.1700; 2808.2000; 2808.2100; 2808.6000; 2808.7000; 2808.7100; 2809.0010; 2809.0020; 2809.0030; 2809.0040; 2809.0050; 2809.0060; 2809.0070; 2809.0080; 2809.0090; 2809.0100; 2809.0110; 2809.0120; 2809.0130; 2809.0140; 2809.0150; 2809.0160; 2809.0170; 2809.0180; 2809.0190; 2809.0200; 2809.0210; 2809.0220.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 65 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Bakk	Berglin	Betzold	Carlson

Chaudhary	Frederickson	Langseth	Olson, M.	Scheid
Clark	Gerlach	Latz	Ortman	Senjem
Cohen	Gimse	Limmer	Pappas	Sheran
Dahle	Hann	Lourey	Pariseau	Sieben
Day	Higgins	Lynch	Pogemiller	Skoe
Dibble	Ingebrigtsen	Marty	Prettner Solon	Skogen
Dille	Johnson	Metzen	Rest	Stumpf
Doll	Jungbauer	Michel	Robling	Tomassoni
Erickson Ropes	Kelash	Moua	Rosen	Torres Ray
Fischbach	Koch	Murphy	Rummel	Vandeveer
Fobbe	Koering	Olseen	Saltzman	Vickerman
Foley	Kubly	Olson, G.	Saxhaug	Wiger

So the bill passed and its title was agreed to.

S.F. No. 1033: A bill for an act relating to housing; modifying municipality rent control provisions; amending Minnesota Statutes 2008, section 471.9996, subdivision 1.

Was read the third time and placed on its final passage.

The question was taken on the passage of the bill.

The roll was called, and there were yeas 57 and nays 8, as follows:

Those who voted in the affirmative were:

Anderson	Doll	Koering	Pappas	Sheran
Bakk	Erickson Ropes	Kubly	Pariseau	Sieben
Berglin	Fischbach	Langseth	Pogemiller	Skoe
Betzold	Fobbe	Latz	Prettner Solon	Skogen
Carlson	Foley	Lourey	Rest	Stumpf
Chaudhary	Frederickson	Lynch	Robling	Tomassoni
Clark	Gerlach	Marty	Rosen	Torres Ray
Cohen	Gimse	Metzen	Rummel	Vickerman
Dahle	Higgins	Moua	Saltzman	Wiger
Day	Ingebrigtsen	Murphy	Saxhaug	
Dibble	Johnson	Olseen	Scheid	
Dille	Kelash	Olson, M.	Senjem	

Those who voted in the negative were:

Hann	Koch	Michel	Ortman
Jungbauer	Limmer	Olson, G.	Vandeveer

So the bill passed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Senator Pogemiller moved that H.F. No. 1309 be taken from the table. The motion prevailed.

H.F. No. 1309: A bill for an act relating to transportation finance; appropriating money for transportation, Metropolitan Council, and public safety activities and programs; providing for fund transfers and tort claims; authorizing an account and certain contingent appropriations; modifying previous appropriations provisions; modifying various provisions related to transportation finance and policy; modifying provisions related to speed limits, fracture-critical bridges, transit, passenger rail, motor vehicle lease sales tax revenue allocations, transit services, and the Buffalo Ridge Regional Rail Authority; requiring reports; amending Minnesota Statutes 2008, sections 16A.152, subdivision 2; 161.081, by adding a subdivision; 161.36, subdivision 7, as added; 162.12, subdivision 2; 169.14, by adding a subdivision; 174.24, subdivision 1a, by adding a subdivision;

174.50, by adding a subdivision; 297A.815, subdivision 3; 473.408, by adding a subdivision; Laws 2007, chapter 143, article 1, section 3, subdivision 2, as amended; Laws 2008, chapter 152, article 1, section 5; proposing coding for new law in Minnesota Statutes, chapters 161; 174.

SUSPENSION OF RULES

Senator Pogemiller moved that an urgency be declared within the meaning of Article IV, Section 19, of the Constitution of Minnesota, with respect to H.F. No. 1309 and that the rules of the Senate be so far suspended as to give H.F. No. 1309 its second and third reading and place it on its final passage. The motion prevailed.

H.F. No. 1309 was read the second time.

Senator Murphy moved to amend H.F. No. 1309 as follows:

Delete everything after the enacting clause, and delete the title, of H.F. No. 1309, and insert the language after the enacting clause, and the title, of S.F. No. 1276, the third engrossment.

The motion prevailed. So the amendment was adopted.

H.F. No. 1309 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 48 and nays 16, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Kelash	Olseen	Sheran
Bakk	Dille	Kubly	Olson, M.	Sieben
Berglin	Erickson Ropes	Langseth	Pappas	Skoe
Betzold	Fobbe	Latz	Pogemiller	Skogen
Carlson	Foley	Lourey	Prettner Solon	Stumpf
Chaudhary	Frederickson	Lynch	Rest	Torres Ray
Clark	Gimse	Marty	Rosen	Vickerman
Cohen	Higgins	Metzen	Rummel	Wiger
Dahle	Ingebrigtsen	Moua	Saxhaug	
Day	Jungbauer	Murphy	Scheid	

Those who voted in the negative were:

Doll	Koch	Olson, G.	Saltzman
Fischbach	Koering	Ortman	Senjem
Gerlach	Limmer	Pariseau	Tomassoni
Hann	Michel	Robling	Vandeveer

So the bill, as amended, was passed and its title was agreed to.

MOTIONS AND RESOLUTIONS - CONTINUED

Pursuant to Rule 26, Senator Pogemiller, Chair of the Committee on Rules and Administration, designated S.F. No. 695 a Special Order to be heard immediately.

SPECIAL ORDER

S.F. No. 695: A bill for an act relating to state government; making changes to health and human services; amending provisions related to continuing care, child care, Minnesota family investment program, adult supports, program integrity, health care programs including MinnesotaCare, medical assistance, and general assistance medical care, state-operated services, the sex offender program, the Department of Health, chemical and mental health, health-related fees; establishing licensing for body art technicians and establishments; establishing and increasing fees; requiring reports; appropriating money; amending Minnesota Statutes 2008, sections 60A.092, subdivision 2; 62D.03, subdivision 4; 62D.05, subdivision 3; 62J.692, subdivision 7; 62Q.19, subdivision 1; 103I.208, subdivision 2; 119B.09, subdivision 7; 119B.13, subdivision 6; 125A.744, subdivision 3; 144.0724, subdivisions 2, 4, 8, by adding subdivisions; 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision 1a; 144.1501, subdivision 2; 144.226, subdivision 4; 144.72, subdivisions 1, 3; 144.9501, subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions 1g, 4; 144.9508, subdivisions 2, 3, 4; 144.97, subdivisions 2, 4, 6, by adding subdivisions; 144.98, subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision 1; 144A.073, by adding a subdivision; 144A.44, subdivision 2; 144A.46, subdivision 1; 144D.03, by adding a subdivision; 148.108; 148.6445, by adding a subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180, subdivisions 1, 2, 3, 5; 152.126, subdivisions 1, 2; 153A.17; 156.015; 157.15, by adding a subdivision; 157.16; 157.22; 176.011, subdivision 9; 198.003, by adding subdivisions; 245A.03, by adding a subdivision; 245A.10, subdivision 3; 245A.11, by adding subdivisions; 245A.16, subdivision 3; 245C.03, subdivision 2; 245C.04, subdivisions 1, 3; 245C.05, subdivision 4; 245C.08, subdivision 2; 245C.10, subdivision 3, by adding a subdivision; 245C.17, by adding a subdivision; 245C.20; 245C.21, subdivision 1a; 245C.23, subdivision 2; 246.50, subdivision 5, by adding subdivisions; 246.51, by adding subdivisions; 246.511; 246.52; 246.54, subdivision 2; 246B.01, by adding subdivisions; 252.025, subdivision 7; 252.46, by adding a subdivision; 256.01, subdivision 2b, by adding subdivisions; 256.476, subdivisions 5, 11; 256.9657, subdivision 1; 256.969, subdivisions 2b, 3a, by adding subdivisions; 256.975, subdivision 7; 256.983, subdivision 1; 256B.04, subdivision 16; 256B.055, subdivisions 7, 12; 256B.056, subdivisions 3, 3b, 3c, 3d; 256B.057, subdivision 9, by adding a subdivision; 256B.0575; 256B.0595, subdivisions 1, 2; 256B.06, subdivisions 4, 5; 256B.0621, subdivision 2; 256B.0625, subdivisions 3, 6a, 7, 8, 8a, 11, 13, 13e, 13h, 17, 17a, 19a, 19c, 26, 47, by adding subdivisions; 256B.0651; 256B.0652; 256B.0653; 256B.0654; 256B.0655, subdivisions 1b, 4; 256B.0657, subdivisions 2, 6, 8; 256B.0751, subdivision 7; 256B.08, by adding a subdivision; 256B.0911, subdivisions 1, 1a, 3, 3a, 3b, 3c, 4a, 5, 6, 7, by adding subdivisions; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3e, 3h, 5, by adding a subdivision; 256B.0917, by adding a subdivision; 256B.092, subdivision 8a, by adding a subdivision; 256B.0943, subdivision 12; 256B.15, subdivisions 1, 1a, 1h, 2, by adding subdivisions; 256B.199; 256B.37, subdivisions 1, 5; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.441, subdivisions 51a, 53, by adding subdivisions; 256B.49, subdivisions 12, 13, 14, 17, by adding a subdivision; 256B.501, subdivision 4a; 256B.5011, subdivision 2; 256B.5012, by adding a subdivision; 256B.69, subdivisions 5a, 5c, 5f, 6, 23, by adding a subdivision; 256B.76, subdivision 1; 256D.03, subdivision 4; 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivision 1a; 256J.24, subdivision 5; 256J.42, by adding a subdivision; 256J.425, subdivisions 2, 3, 4, by adding a subdivision; 256J.45, subdivision 3; 256J.46, subdivision 1; 256J.49, subdivision 1; 256J.521, subdivision 2; 256J.53, subdivision 1; 256J.545; 256J.561, subdivisions 2, 3; 256J.57, subdivision 1; 256J.575, subdivisions 3, 4, 6, 7; 256J.621; 256J.626, subdivision 7; 256J.95, subdivisions 3, 11, 13; 256L.03, subdivision 1; 256L.04, subdivisions 1, 7a, 10a, by adding a subdivision; 256L.05, subdivisions 3, 3a, by adding

a subdivision; 256L.07, subdivisions 1, 2, 3, by adding a subdivision; 256L.11, subdivision 1; 256L.12, subdivisions 7, 9; 256L.15, subdivisions 2, 3; 256L.17, subdivision 5; 327.14, by adding a subdivision; 327.15; 327.16; 327.20, subdivision 1, by adding a subdivision; 501B.89, by adding a subdivision; 519.05; 604A.33, subdivision 1; 609.232, subdivision 11; 626.556, subdivision 3c; 626.5572, subdivisions 6, 13, 21; Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 1, as amended; Laws 2008, chapter 358, article 3, section 8; proposing coding for new law in Minnesota Statutes, chapters 144; 156; 246B; 256; 256B; proposing coding for new law as Minnesota Statutes, chapter 146B; repealing Minnesota Statutes 2008, sections 62Q.80, subdivision 1a; 103I.112; 144.9501, subdivision 17b; 148D.180, subdivision 8; 246.51, subdivision 1; 246.53, subdivision 3; 256.962, subdivision 7; 256B.037; 256B.0625, subdivision 9; 256B.0655, subdivisions 1, 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.0951; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256B.69, subdivision 6c; 256I.06, subdivision 9; 256L.17, subdivision 6; 327.14, subdivisions 5, 6; Minnesota Rules, parts 4626.2015, subpart 9; 9100.0400, subparts 1, 3; 9100.0500; 9100.0600.

Senator Berglin moved to amend S.F. No. 695 as follows:

Page 11, line 26, delete "and" and insert "or"

Page 13, line 21, strike "program's overall ratio of actual payments to service authorizations" and insert "programs"

Page 14, after line 11, insert:

"(e) Effective July l1, 2009, the surcharge in paragraph (d) shall be increased to $3,165."

Page 14, line 12, strike "(e)" and insert "(f)"

Page 14, line 13, strike "(d)" and insert "(e)"

Page 14, line 14, strike "(f)" and insert "(g)" and strike "April 1, 2002, and August 15, 2004" and insert "July 1, 2009, and June 30, 2010"

Page 14, line 19, strike everything after the period

Page 14, strike lines 20 to 26

Page 14, delete line 27

Page 14, before line 28, insert:

"(h) For a facility assuming full participation in the medical assistance program under paragraph (g), payment rates shall be determined in accordance with clauses (1) to (3):

(1) initial operating payment rates shall be equal to those of the facility in the same peer group and facility type with the median operating payment rate at a RUGs weight of 1.00. After the facility submits it first statistical and cost report under section 256B.441, for a period of at least six months, the commissioner shall determine rates using section 256B.441, applying the phase-in blending in subdivision 55 specified for October 1, 2008;

(2) an external fixed rate component shall be determined in accordance with section 256B.441, subdivision 53; and

(3) a property payment rate shall be determined in accordance with section 256B.431 and Minnesota Rules, chapter 9549."

Page 16, line 21, after the period, insert "In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:"

Page 16, delete lines 22 to 27

Page 17, line 6, reinstate the stricken language and before "sections" insert "and"

Page 18, delete sections 21 and 22

Page 20, line 12, delete everything after "under"

Page 20, line 13, delete "483.430" and insert "245B.07, subdivision 4"

Page 27, line 31, reinstate the stricken language and delete "50"

Page 27, line 32, delete the new language

Page 31, line 8, delete "section 148.6402" and insert "Minnesota Rules, part 9505.0390"

Page 31, line 9, delete "section 148.65" and insert "Minnesota Rules, part 9505.0390"

Page 39, line 14, after the first comma, insert "family foster parents,"

Page 41, line 26, delete "256B.0652" and insert "256B.0651"

Page 44, after line 24, insert:

"Sec. 29. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to read:

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be ~~equal to the greater of either~~ established based on:

(1) th~~e annual amount of personal care assistant services under section 256B.0655 that the recipient has used in the most recent 12-month period; or~~ personal care assistance unit rate:

(i) with a reduction to the unit rate to pay for a program administrator as defined in subdivision 10 of this section; and

(ii) an additional adjustment to the unit rate as needed to assure cost neutrality for the state; and

(2) ~~the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs~~ assessed personal care assistance units, not to exceed the maximum number of personal care assistance units available within each home care rating.

Sec. 30. Minnesota Statutes 2008, section 256B.0657, is amended by adding a subdivision to read:

Subd. 32. **Enrollment and evaluations.** Enrollment in the self-directed supports option is

available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of 1,000 people in the first fiscal year of implementation and an additional 1,000 people in the second fiscal year. The commissioner shall evaluate the self-directed supports option during the first two years of implementation and make any necessary changes prior to the option becoming available statewide."

Page 51, line 30, delete everything after "(c)" and insert "A responsible party must not be the:"

Page 51, delete line 31

Page 54, line 12, after the third comma, insert "family"

Page 60, line 21, after the second comma, insert "schedule,"

Page 63, line 31, delete "services" and insert "providers"

Page 65, line 34, delete "and"

Page 65, line 36, delete the period and insert "; and"

Page 65, after line 36, insert:

"(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner."

Page 74, line 15, after the second comma, insert "verifying"

Page 75, line 13, delete "moved" and insert "moving"

Page 81, line 30, delete everything after the period

Page 81, delete line 31

Page 104, line 22, delete "1b,"

Page 187, line 9, strike everything after "256B.0911"

Page 187, line 10, delete "256B.0659"

Page 187, line 11, strike ", pursuant to section" and delete "256B.0659"

Page 230, line 8, delete everything after "shall"

Page 230, delete line 9 and insert "ensure that each provider who is currently using e-prescribing software receives"

Page 230, line 15, delete "by the commissioner" and insert "in paragraph (b)"

Page 236, delete lines 3 and 4

Page 236, line 21, after "contains" insert "personal"

Page 237, line 1, delete "clauses (1) to (4)" and insert "clause (2)"

Page 238, line 25, delete "clauses (1) to (7)" and insert "clause (2)"

Page 241, delete lines 32 and 33

Page 242, line 10, delete "other" and insert "covered under"

Page 243, line 19, after "expenses" insert a comma

Page 248, delete line 5

Page 252, line 25, before "and" insert "and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 451.310,"

Page 255, line 24, delete "nondirected"

Page 255, line 25, delete "an anesthesiologist" and insert "a physician"

Page 260, line 28, before "The" insert "Effective January 1, 2010,"

Page 261, line 8, delete "Strattera" and insert "atomoxetine"

Page 294, after line 5, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 294, after line 8, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 295, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 296, after line 18, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 296, line 23, after "application" insert ", or according to section 256L.05, subdivision 3, if 90 percent of the child's family gross income is greater than 200 percent of federal poverty guidelines"

Page 297, after line 30, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 298, after line 15, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 299, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 299, after line 28, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 303, after line 22, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 303, after line 26, insert:

"**EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal approval, whichever is later."

Page 316, line 3, delete "Medicine" and insert "Physicians"

Page 319, delete line 18 and insert:

"General	$ 4,463,730,000	$ 5,254,130,000	$ 9,717,860,000"

Page 319, delete line 24 and insert:

"**Total**	**$ 5,302,701,000**	**$ 6,157,303,000**	**$ 11,460,004,000**"

Page 320, line 9, delete "4,345,752,000" and insert "4,346,589,000" and delete "5,139,485,000" and insert "5,140,321,000"

Page 320, line 32, after the period, insert "The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers."

Page 321, line 4, delete "**HealthMatch Systems Account.**" and insert "**HealthMatch Systems Project.**"

Page 321, line 5, delete "$3,053,000" and insert "$6,106,000"

Page 321, line 6, delete "systems" and after "in" insert "the state systems account in"

Page 334, after line 23, insert:

"**Federal Stimulus Money.** (a) $1,500,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for emergency food and shelter programs.

(b) $18,200,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for homelessness prevention. The commissioner shall conduct

a request for proposals process to allocate money for grants in accordance with federal requirements.

(c) $1,500,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for commodity assistance programs.

(d) $1,700,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for senior nutrition programs.

(e) $12,000,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for community services block grant programs."

Page 334, line 25, delete "the commissioner" and insert "$500,000 is appropriated to the commissioner from the increased federal economic stimulus funding for senior nutrition programs. The commissioner shall expend this economic stimulus funding and other available federal funding for senior nutrition programs before expending state appropriations."

Page 334, delete lines 26 to 28

Page 336, line 1, delete "Of"

Page 336, line 2, delete "this appropriation,"

Page 336, line 3, after "is" insert "appropriated"

Page 338, line 24, delete the second "940,000" and insert "190,000"

Page 340, line 30, delete "848,065,000" and insert "845,836,000" and delete "1,025,510,000" and insert "1,018,049,000"

Page 342, delete lines 28 to 35

Page 343, delete lines 1 to 4 and insert:

"**Chemical Dependency Maximum Rates.** For services provided in fiscal years 2010 to 2013, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed rates charged for services in excess of those in effect on January 1, 2009. If statutes authorize a cost-of-living increase, then notwithstanding any law to the contrary, rates must not exceed those in effect on January 1, plus any authorized cost-of-living adjustments."

Page 345, line 33, delete "Of"

Page 345, line 34, delete "this appropriation,"

Page 345, line 35, after "is" insert "appropriated"

Page 346, line 6, delete "46,008,000" and insert "49,074,000" and delete "59,436,000" and insert "67,733,000"

Page 346, delete lines 7 to 9

Page 346, line 12, delete "$836,500 each" and insert "$836,000 the first year and $837,000 the second"

Page 347, after line 21, insert:

"**Federal Stimulus Money.** $3,300,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for WIC program management information systems."

Page 348, line 35, delete "14,173,000" and insert "14,303,000" and delete "14,214,000" and insert "14,333,000"

Page 350, line 26, delete "30,339,000" and insert "30,209,000" and delete "30,328,000" and insert "30,209,000"

Page 350, after line 26, insert:

"**Federal Stimulus Money.** $1,000,000 in fiscal year 2010 is appropriated from the federal stimulus money to the commissioner for immunization program operations activities."

Page 350, line 29, delete "68,425,000" and insert "43,397,000" and delete "70,584,000" and insert "45,556,000"

Page 350, line 30, delete "68,425,000" and insert "43,397,000" and delete "70,584,000" and insert "45,556,000"

Page 352, line 4, delete "$3,000,000" and insert "$6,066,000"

Page 354, line 17, delete "$11,839,000" and insert "$5,839,000"

Correct the subdivision and section totals and the appropriations by fund

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Berglin moved to amend S.F. No. 695 as follows:

Page 91, after line 11, insert:

"Sec. 57. Minnesota Statutes 2008, section 256B.434, is amended by adding a subdivision to read:

Subd. 21. **Payment of post-PERA pension benefit costs.** Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percent of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 256B.431, 256B.434, 256B.441, and any other law enacted after the base rate year and prior to the year for which rates are being determined shall be applied to the allowable amount. The adjusted allowable amount shall be added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate."

Page 106, after line 9, insert:

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

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

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

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

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

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

Page 340, line 15, delete "$240,000" and insert "$259,000"

Page 340, line 16, delete everything after "2011" and insert "and $25,000 in fiscal year 2012 and $25,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014."

Page 340, delete line 17

Correct the subdivision and section totals and the appropriations by fund

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Ingebrigtsen moved to amend S.F. No. 695 as follows:

Page 20, after line 16, insert:

"Sec. 25. Minnesota Statutes 2008, section 256B.0641, subdivision 3, is amended to read:

Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of ownership of a facility to a nonrelated organization while the facility to be sold, transferred or reorganized is in receivership under section 144A.14, 144A.15, 245A.12, or 245A.13, and the commissioner during the receivership has not determined the need to place residents of the facility into a newly constructed or newly established facility. Nothing in this subdivision limits the liability of a former owner."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Limmer moved to amend S.F. No. 695 as follows:

Page 106, after line 18, insert:

"Sec. 4. Minnesota Statutes 2008, section 256D.024, is amended by adding a subdivision to read:

Subd. 5. **Persons convicted of crimes of violence.** An individual convicted of a crime of violence, as defined in section 624.712, subdivision 5, or as defined under the laws of the jurisdiction in which the crime was committed, is disqualified from receiving general assistance.

Sec. 5. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including

eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.

(e) Applicants and recipients eligible under paragraph (a), clause (1), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social

Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (j);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(f) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).

(h) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

(i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal

hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(p) Effective July 1, 2003, general assistance medical care emergency services end.

(q) An individual convicted of a crime of violence, as defined in section 624.712, subdivision 5, or as defined under the laws of the jurisdiction in which the crime was committed, is not eligible for general assistance medical care.

EFFECTIVE DATE. This section is effective July 1, 2009."

Page 107, after line 16, insert:

"Sec. 8. Minnesota Statutes 2008, section 256J.26, is amended by adding a subdivision to read:

Subd. 5. **Persons convicted of crimes of violence.** An individual convicted of a crime of violence, as defined in section 624.712, subdivision 5, or as defined under the laws of the jurisdiction in which the crime was committed, is disqualified from receiving MFIP."

Page 294, after line 24, insert:

"Sec. 69. Minnesota Statutes 2008, section 256L.04, is amended by adding a subdivision to read:

Subd. 14. **Persons convicted of crimes of violence.** An individual convicted of a crime of violence, as defined in section 624.712, subdivision 5, or as defined under the laws of the jurisdiction in which the crime was committed, who is or would be covered under subdivision 7, is not eligible for MinnesotaCare.

EFFECTIVE DATE. This section is effective July 1, 2009."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 13 and nays 46, as follows:

Those who voted in the affirmative were:

Fischbach	Hann	Jungbauer	Michel	Vandeveer
Gerlach	Ingebrigtsen	Koch	Ortman	
Gimse	Johnson	Limmer	Senjem	

Those who voted in the negative were:

Anderson	Dille	Latz	Prettner Solon	Skogen
Bakk	Doll	Lourey	Rest	Stumpf
Berglin	Erickson Ropes	Lynch	Rosen	Tomassoni
Betzold	Fobbe	Marty	Rummel	Torres Ray
Carlson	Foley	Metzen	Saltzman	Vickerman
Chaudhary	Frederickson	Moua	Saxhaug	Wiger
Clark	Higgins	Murphy	Scheid	
Cohen	Kelash	Olseen	Sheran	
Dahle	Kubly	Olson, M.	Sieben	
Dibble	Langseth	Pogemiller	Skoe	

The motion did not prevail. So the amendment was not adopted.

Senator Rosen moved to amend S.F. No. 695 as follows:

Page 126, after line 27, insert:

"Sec. 28. **[402A.01] CITATION.**

Sections 402A.01 to 402A.30 may be cited as the "Human Service Authority Act."

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

Sec. 29. **[402A.10] DESIGNATION OF HUMAN SERVICE AUTHORITY.**

Subdivision 1. **Establishment.** (a) There is established in each county or a consortium of counties of the state a human service authority.

(b) The duties of each human service authority are to:

(1) carry out the responsibilities required of local social services agencies under chapter 393 and human service boards under chapter 402;

(2) manage the public resources devoted to human services delivered or purchased by the counties, which are subsidized or regulated by the Department of Human Services under chapters 245 to 267;

(3) employ staff to carry out the purposes of this chapter;

(4) plan and deliver services directly or through contract with other governmental or nongovernmental providers;

(5) develop and maintain a continuity of operations plan to ensure the continued operation or resumption of essential human service functions in the event of any business interruption according to local, state, and federal emergency planning requirements;

(6) receive and expend funds for the purposes of this chapter;

(7) rent, purchase, sell, or otherwise dispose of real and personal property and equipment; and

(8) carry out any other human service duties currently under the purview of counties.

(c) Each human service authority certified under subdivision 2 shall have a single administrator that has authority over all the duties assigned to the human service authority under this chapter effective January 1, 2012.

Subd. 2. **Certification of human service authority.** The commissioner of human services or the commissioner's designee shall certify a county or consortium of counties as a human service authority if:

(1) the condition in subdivision 5, paragraph (a), clause (1), has been met;

(2) the approvals in subdivision 5, paragraph (a), clauses (2) and (3), have been received from the commissioner of human services; and

(3) the county or consortium of counties is either:

(i) a single county has a population of 250,000 people or more; or

(ii) for a consortium of counties:

(A) the population when combined totals approximately 100,000 people or more; and

(B) the counties comprising the consortium are in close geographic proximity; or

(iii) the commissioner determines that the best interests of the state warrant certification of a county or consortium of counties that does not meet the conditions of item (i) or (ii).

Subd. 3. **Multicounty human service authority.** Two or more counties meeting the criteria

in subdivision 2 may, by resolution of their county boards of commissioners and by execution of a joint powers agreement under section 471.59, designate a human service authority having the composition, powers, and duties agreed upon. These counties shall, by agreement entered into through action of their bodies, jointly or cooperatively exercise any power common to the contracting parties in carrying out their duties under current law, including, but not limited to, chapters 245 to 267, 393, and 402. The counties shall notify the commissioner of human services of these resolutions and agreements.

Subd. 4. **Single county human service authority.** For counties with populations over 250,000, the board of county commissioners may be the human service authority and retain existing authority under current law. Counties with populations over 250,000 that serve as their own human service authority shall enter into shared services arrangements with other human service authorities or smaller counties. These shared services arrangements may include, but are not limited to: planning, human resources, program development and operations, training, technical systems, joint purchasing, consultative services, or services to transient, special needs, or low-incidence populations. These services must be provided at cost plus no more than five percent. Shared services arrangements under this subdivision must be approved by the commissioner of human services for purposes of receiving state aid under this chapter.

Subd. 5. **County duties.** (a) A county shall:

(1) by November 1, 2009, indicate to the commissioner of human services through a board resolution the county's intent to form or join a human service authority;

(2) by June 1, 2010, submit for approval to the commissioner of human services a board resolution forming the human service authority, including the names of other counties anticipated to be members of the human service authority, if any;

(3) by June 1, 2011, submit for approval to the commissioner of human services a plan that includes a joint powers agreement for the human service authority, or, in the case of a county with a population over 250,000 serving as its own human service authority, identify what shared services are available to be provided to other human service authorities or smaller counties effective January 1, 2012; and

(4) by June 1, 2012, and each June 1 thereafter, meet performance standards as defined by the commissioner of human services.

(b) If a county has not met the requirements in paragraph (a) by June 1, 2012, a county board may join an established human service authority at a later time by submitting to the commissioner:

(1) a county board resolution indicating the county's intent to join a human service authority; and

(2) an amended joint powers agreement of the accepting human service authority.

Subd. 6. **Agreement.** Any agreement under subdivision 3 or 4 must be governed by this chapter and section 471.59. The county boards of commissioners must be party to the agreement and shall determine the proportional financial responsibility of each county to support the programs and services of the human service authority. This subdivision does not limit the authority of a county board to enter into contractual agreements for services not covered by this chapter with other agencies or with other units of government.

Subd. 7. **Assignment.** (a) For purposes of this section, "assign" or "assignment" means the process by which the commissioner of human services may add to or create a consortium of counties to enlarge or form a human service authority. In this process, the commissioner of human services has the authority to require that county boards submit for approval new or amended joint powers agreements to effectuate the creation of a human service authority.

(b) If any county with a population of less than 250,000 timely submits a resolution of intent to join a human service authority, but is unable to secure a joint powers agreement described in subdivision 5, paragraph (a), clause (2), then the commissioner of human services may, in consultation with the affected counties, assign the county to a human service authority.

(c) If a county has not created or joined a human service authority and that county fails to meet the performance standards established under subdivision 5, paragraph (a), clause (4), then the commissioner of human services may assign the county to a human service authority.

(d) The commissioner of human services retains the authority to make the assignments described in this subdivision beyond the year in which initial human service authorities are created.

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

Sec. 30. **[402A.20] AIDS TO COUNTIES.**

Subdivision 1. **Payments.** The commissioner of human services shall annually notify the commissioner of revenue of counties meeting the requirements of this chapter for purposes of aid adjustments under chapter 477A.

Subd. 2. **Transfer of payment.** For a county meeting the requirements of section 402A.10, subdivision 5, paragraph (b), the commissioner of human services shall notify the commissioner of revenue to transfer the amount of the next available year's aid payments under this section for the qualifying county to the accepting human service authority. Subsequent aid payments available under this chapter to the qualifying county must revert back to the county.

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

Sec. 31. **[402A.30] WORKGROUP.**

Subdivision 1. **Composition.** The commissioner of human services shall form a workgroup comprised of representatives from the following entities: Association of Minnesota Counties, Minnesota Association of County Social Service Administrators, Minnesota County Attorneys Association, unions representing county employees, and the Departments of Health, Corrections, and Human Services.

Subd. 2. **Duties.** The commissioner shall, with the advice of the workgroup, develop and draft legislation for the next legislative session that will recodify language found in chapters 393 and 402 and other relevant statutes that direct and authorize county powers and duties regarding the delivery of human services under this chapter.

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Berglin questioned whether the amendment was germane.

The President ruled that the amendment was not germane.

Senator Senjem moved to amend S.F. No. 695 as follows:

Page 315, line 22, delete "15" and insert "21"

Page 315, delete lines 29 to 33 and insert:

"(3) seven public members appointed by the legislature, with regard to geographic diversity in the state, with the senate Subcommittee on Committees of the Committee on Rules and Administration making the appointments for the senate, and the speaker of the house making the appointments for the house:

(i) two members who are parents of children with autism spectrum disorder (ASD), one member appointed by the senate, and one member appointed by the house;

(ii) two members who have ASD, one member appointed by the senate, and one member appointed by the house;

(iii) one member representing an agency that provides residential housing services to individuals with ASD, appointed by the house;

(iv) one member representing an agency that provides employment services to individuals with ASD, appointed by the senate; and

(v) one member who is a provider of ASD therapy appointed by the house;"

Page 316, after line 6, insert:

"(7) one member appointed by the Minnesota Academy of Family Practice;"

Page 316, line 7, delete "(7)" and insert "(8)"

Page 316, line 8, delete "(8)" and insert "(9)"

Page 316, line 9, delete "(9)" and insert "(10)"

Page 316, line 10, delete "(10)" and insert "(11)"

Page 316, line 11, delete "(11)" and insert "(12)"

Page 316, line 13, delete "(12)" and insert "(13)"

Page 316, delete lines 18 to 20 and insert:

"(b) If federal or state funding is available, the commissioners of education, employment and economic development, health, and human services shall provide assistance to the task force. The commissioner of education shall provide the task force with a count of children who have ASD with an individual education program or an individual family service plan and children with ASD who have a 504 plan. Additionally, the commissioner of human services shall submit a count of the adults with ASD enrolled in social service programs and the number of individuals with ASD who are enrolled in medical assistance and other waiver programs."

Page 316, line 21, delete "develop recommendations and report on" and insert "examine"

Page 316, line 23, delete "and private"

Page 316, line 26, delete ", and to address any geographic" and insert a semicolon

Page 316, delete line 27

Page 316, line 29, delete the second "and"

Page 316, after line 29, insert:

"(5) increasing the availability of and the training for educators who identify and educate individuals with ASD;

(6) ways to enhance Minnesota's role in ASD research and delivery of service;

(7) methods to educate parents, family members, and the public on ASD and the required services; and

(8) treatment options for individuals with ASD."

Page 316, delete lines 30 to 34 and insert:

"(d) The task force shall:

(1) coordinate with existing efforts at the Departments of Education, Health, Human Services, and Employment and Economic Development related to ASD; and

(2) apply peer-reviewed, established scientific research to their recommendations concerning the most effective treatment methods."

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 29 and nays 34, as follows:

Those who voted in the affirmative were:

Day	Frederickson	Jungbauer	Metzen	Robling
Dibble	Gerlach	Koch	Michel	Rosen
Dille	Gimse	Koering	Moua	Scheid
Erickson Ropes	Hann	Latz	Olson, G.	Senjem
Fischbach	Ingebrigtsen	Limmer	Ortman	Vandeveer
Fobbe	Johnson	Lynch	Pariseau	

Those who voted in the negative were:

Anderson	Cohen	Langseth	Prettner Solon	Skoe
Bakk	Dahle	Lourey	Rest	Skogen
Berglin	Doll	Marty	Rummel	Stumpf
Betzold	Foley	Murphy	Saltzman	Torres Ray
Carlson	Higgins	Olseen	Saxhaug	Vickerman
Chaudhary	Kelash	Olson, M.	Sheran	Wiger
Clark	Kubly	Pogemiller	Sieben	

The motion did not prevail. So the amendment was not adopted.

Senator Olson, M. moved to amend S.F. No. 695 as follows:

Page 94, lines 26 and 32, delete "peer group and"

Page 94, line 33, delete "64th" and insert "76th"

Page 95, lines 1 and 3, delete "64th" and insert "76th"

CALL OF THE SENATE

Senator Berglin imposed a call of the Senate for the balance of the proceedings on S.F. No. 695. The Sergeant at Arms was instructed to bring in the absent members.

The question was taken on the adoption of the Olson, M. amendment.

The roll was called, and there were yeas 20 and nays 45, as follows:

Those who voted in the affirmative were:

Bakk	Frederickson	Kubly	Rosen	Skoe
Day	Gimse	Langseth	Saxhaug	Skogen
Dille	Ingebrigtsen	Metzen	Senjem	Stumpf
Erickson Ropes	Jungbauer	Olson, M.	Sheran	Vickerman

Those who voted in the negative were:

Anderson	Doll	Koch	Murphy	Robling
Berglin	Fischbach	Koering	Olseen	Rummel
Betzold	Fobbe	Latz	Olson, G.	Saltzman
Carlson	Foley	Limmer	Ortman	Scheid
Chaudhary	Gerlach	Lourey	Pappas	Sieben
Clark	Hann	Lynch	Pariseau	Tomassoni
Cohen	Higgins	Marty	Pogemiller	Torres Ray
Dahle	Johnson	Michel	Prettner Solon	Vandeveer
Dibble	Kelash	Moua	Rest	Wiger

The motion did not prevail. So the amendment was not adopted.

Senator Robling moved to amend S.F. No. 695 as follows:

Page 336, after line 9, insert:

"**Use of Funds.** Funding for state-sponsored health programs shall not be used for funding abortions, except to the extent necessary for continued participation in a federal program. For purposes of this section, abortion has the meaning given in Minnesota Statutes, section 144.343, subdivision 3. The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of this paragraph and shall expedite the resolution of the action. Notwithstanding any contrary provision in this article, this paragraph does not expire."

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 26 and nays 39, as follows:

Those who voted in the affirmative were:

Day	Gimse	Koering	Pariseau	Vandeveer
Dille	Hann	Kubly	Robling	Vickerman
Fischbach	Ingebrigtsen	Limmer	Rosen	
Fobbe	Johnson	Olson, G.	Senjem	
Frederickson	Jungbauer	Olson, M.	Skogen	
Gerlach	Koch	Ortman	Stumpf	

Those who voted in the negative were:

Anderson	Dahle	Latz	Olseen	Scheid
Bakk	Dibble	Lourey	Pappas	Sheran
Berglin	Doll	Lynch	Pogemiller	Sieben
Betzold	Erickson Ropes	Marty	Prettner Solon	Skoe
Carlson	Foley	Metzen	Rest	Tomassoni
Chaudhary	Higgins	Michel	Rummel	Torres Ray
Clark	Kelash	Moua	Saltzman	Wiger
Cohen	Langseth	Murphy	Saxhaug	

The motion did not prevail. So the amendment was not adopted.

Senator Hann moved to amend S.F. No. 695 as follows:

Page 321, delete lines 8 to 13

Correct the subdivision and section totals and the appropriations by fund

Amend the title accordingly

Pursuant to Rule 7, Senator Berglin questioned whether the Hann amendment was in order. The President ruled the amendment was not in order.

Senator Hann appealed the decision of the President.

The question was taken on "Shall the decision of the President be the judgment of the Senate?"

Senator Berglin moved that those not voting be excused from voting. The motion prevailed.

The roll was called, and there were yeas 41 and nays 17, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Langseth	Pappas	Sieben
Bakk	Dille	Latz	Pogemiller	Skogen
Berglin	Doll	Lourey	Prettner Solon	Tomassoni
Betzold	Fobbe	Lynch	Rest	Torres Ray
Carlson	Foley	Marty	Rummel	Wiger
Chaudhary	Frederickson	Metzen	Saltzman	
Clark	Higgins	Murphy	Saxhaug	
Cohen	Kelash	Olseen	Scheid	
Dahle	Kubly	Olson, M.	Sheran	

Those who voted in the negative were:

Day	Hann	Koch	Ortman	Vandeveer
Fischbach	Ingebrigtsen	Limmer	Pariseau	
Gerlach	Johnson	Michel	Robling	
Gimse	Jungbauer	Olson, G.	Senjem	

So the decision of the President was sustained.

Senator Pogemiller moved to amend S.F. No. 695 as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

CONTINUING CARE

Section 1. Minnesota Statutes 2008, section 144.0724, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" means the last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.

(b) "Case mix index" means the weighting factors assigned to the RUG-III classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum data set" means the assessment instrument specified by the Centers for Medicare and Medicaid Services and designated by the Minnesota Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

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

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or 256B.441;

(2) elderly waiver services under section 256B.0915;

(3) CADI and TBI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit

to the commissioner of health case mix assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 2.0, October 1995, and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment must be completed by day 14 following admission;

(2) an annual assessment must be completed within 366 days of the last comprehensive assessment;

(3) a significant change assessment must be completed within 14 days of the identification of a significant change; and

(4) the second quarterly assessment following either a new admission assessment, an annual assessment, or a significant change assessment, and all quarterly assessments beginning October 1, 2006. Each quarterly assessment must be completed within 92 days of the previous assessment.

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256B.0911, subdivision 4a, by a county, tribe, or managed care organization under contract with the Department of Human Services; and

(2) a face-to-face long-term care consultation assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 3. Minnesota Statutes 2008, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of

health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs or assessment characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 4. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of

long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person needs the assistance of another person or constant supervision to begin and complete at least four activities of daily living;

(2) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(3) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(4) the person has had a previous qualifying nursing facility stay of at least 90 days; or

(5) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone upon discharge and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance financial eligibility determination. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for services provided under sections 256B.0915 and 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under subdivision 4, paragraph (c), clause (2), that occurred no more than 60 calendar days before the effective date of financial eligibility determination.

Sec. 5. Minnesota Statutes 2008, section 144.0724, is amended by adding a subdivision to read:

Subd. 12. **Appeal of nursing facility level of care determination.** A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (7).

Sec. 6. Minnesota Statutes 2008, section 245A.03, is amended by adding a subdivision 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 the effective date of this section 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;

(4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level of 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 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) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011.

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

Sec. 7. Minnesota Statutes 2008, section 245A.11, is amended by adding a subdivision 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.

(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. 8. Minnesota Statutes 2008, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

The commissioner shall supervise county boards' provision of day training and habilitation services to adults with developmental disabilities. The commissioner shall:

(1) determine the need for day training and habilitation services under section 252.28;

(2) ~~approve payment rates established by a county under section 252.46, subdivision 1;~~

~~(3)~~ adopt rules for the administration and provision of day training and habilitation services under sections 252.40 to 252.46 and sections 245A.01 to 245A.16 and 252.28, subdivision 2;

~~(4)~~ (3) enter into interagency agreements necessary to ensure effective coordination and provision of day training and habilitation services;

~~(5)~~ (4) monitor and evaluate the costs and effectiveness of day training and habilitation services; and

~~(6)~~ (5) provide information and technical help to county boards and vendors in their administration and provision of day training and habilitation services.

Sec. 9. Minnesota Statutes 2008, section 252.46, is amended by adding a subdivision to read:

Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish a statewide rate-setting methodology for all day training and habilitation services. The rate-setting methodology must abide by the principles of transparency and equitability across the state. The methodology must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

Sec. 10. **[256.0281] INTERAGENCY DATA EXCHANGE.**

The Department of Human Services, the Department of Health, and the Office of the Ombudsman for Mental Health and Developmental Disabilities may establish interagency agreements governing the electronic exchange of data on providers and individuals collected, maintained, or used by each agency when such exchange is outlined by each agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

(1) to improve provider enrollment processes for home and community-based services and state plan home care services;

(2) to improve quality management of providers between state agencies;

(3) to establish and maintain provider eligibility to participate as providers under Minnesota health care programs; and

(4) to meet the quality assurance reporting requirements under federal law under section 1915(c) of the Social Security Act related to home and community-based waiver programs.

Each interagency agreement must include provisions to ensure anonymity of individuals, including mandated reporters, and must outline the specific uses of and access to shared data within each agency. Electronic interfaces between source data systems developed under these interagency agreements must incorporate these provisions as well as other HIPPA provisions related to individual data.

Sec. 11. Minnesota Statutes 2008, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance; senior linkage.** (a) The Minnesota Board on Aging shall operate a statewide information and assistance service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide

toll-free number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

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

(c) The Minnesota Board on Aging shall conduct an evaluation of the effectiveness of the statewide information and assistance, and submit this evaluation to the legislature by December 1, 2002. The evaluation must include an analysis of funding adequacy, gaps in service delivery, continuity in information between the service and identified linkages, and potential use of private funding to enhance the service.

Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **Home health services.** Home health services are those services specified in ~~Minnesota Rules, part 9505.0295~~ sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has ~~prior~~ authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to ~~256B.0656~~ 256B.0653.

Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 7, is amended to read:

Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and ~~256B.0653~~ 256B.0654 to 256B.0656. All private duty nursing services must be provided according to the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private duty nursing services may not be reimbursed if the nurse is the foster care provider of a recipient who is under age 18.

Sec. 14. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy, as described in section 148.65, and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Sec. 15. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy, as described in section 148.6404, and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational

therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Sec. 16. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistant services.** Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, a recipient must require assistance and be determined dependent in two activities of daily living as defined in section 256B.0659. Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting according to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care assistant services must be provided according to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or ~~legal~~ paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider ~~of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services, if they are granted a waiver under sections 256B.0651 and 256B.0653 to 256B.0656~~. Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause (4)~~ 256B.0659, the ~~noncorporate legal~~ unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be ~~granted a hardship waiver under sections 256B.0651 and 256B.0653 to 256B.0656, to be~~ reimbursed to provide personal care assistant services to the recipient if the guardian or conservator meet all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 17. Minnesota Statutes 2008, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistant services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 ~~and 256B.0653~~ to 256B.0656, ~~where the services have a statement of need by a physician,~~ provided in accordance with a plan, and ~~are~~ supervised by ~~the recipient or~~ a qualified professional. ~~The physician's statement of need for personal care assistant services shall be documented on a form approved by the commissioner and include the diagnosis or condition of the person that results in a need for personal care assistant services and be updated when the person's medical condition requires a change, but at least annually if the need for personal care assistant~~

~~services is ongoing.~~

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, or 245.4871, subdivision 27; or a registered nurse as defined in sections 148.171 to 148.285, or a licensed social worker as defined in section 148B.21. ~~As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant.~~ The qualified professional shall perform the duties ~~described~~ required in ~~Minnesota Rules, part 9505.0335, subpart 4~~ section 256B.0659.

Sec. 18. Minnesota Statutes 2008, section 256B.0651, is amended to read:

256B.0651 HOME CARE SERVICES.

Subdivision 1. **Definitions.** (a) ~~"Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning~~ For the purposes of sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g) have the meanings given.

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

~~(b)~~ (c) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person as required in section 256B.0911. ~~Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for medical assistance home care services for developmental disability and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments 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.~~

~~(c)~~ (d) "Home care services" ~~means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625~~ means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy; private duty nursing; and personal care assistance.

(e) "Home residence" means a residence owned or rented by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient.

~~(d)~~ (f) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

~~(e) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site where the practitioner is located.~~

(g) "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.

Subd. 2. **Services covered.** Home care services covered under this section and sections ~~256B.0653~~ 256B.0652 to 256B.0656 and 256B.0659 include:

(1) nursing services under ~~section~~ sections 256B.0625, subdivision 6a, and 256B.0653;

(2) private duty nursing services under ~~section~~ sections 256B.0625, subdivision 7, and 256B.0654;

(3) home health services under ~~section~~ sections 256B.0625, subdivision 6a, and 256B.0653;

(4) personal care assistant services under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659;

(5) supervision of personal care assistant services provided by a qualified professional under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659;

~~(6) qualified professional of personal care assistant services under the fiscal intermediary option as specified in section 256B.0655, subdivision 7;~~

~~(7)~~ (6) face-to-face assessments by county public health nurses for services under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659; and

~~(8)~~ (7) service updates and review of temporary increases for personal care assistant services by the county public health nurse for services under ~~section~~ sections 256B.0625, subdivision 19a, and 256B.0659.

Subd. 3. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

~~(1) skilled nurse visits for the sole purpose of supervision of the home health aide;~~

~~(2) a skilled nursing visit:~~

~~(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or~~

~~(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;~~

~~(3) home care services to a recipient who is eligible for covered services under the Medicare program or any other insurance held by the recipient;~~

~~(4) services to other members of the recipient's household;~~

~~(5) a visit made by a skilled nurse solely to train other home health agency workers;~~

~~(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;~~

~~(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistant care;~~

~~(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and~~

~~(9) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.~~

(1) services provided in a nursing facility, hospital, or intermediate care facility with exceptions in section 256B.0653;

(2) services for the sole purpose of monitoring medication compliance with an established medication program for a recipient;

(3) home care services for covered services under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(6) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal assistance care; or

(7) Medicare evaluation or administrative nursing visits on dual-eligible recipients that do not qualify for Medicare visit billing.

Subd. 4. **~~Prior~~ Authorization; exceptions.** All home care services above the limits in subdivision 11 must receive the commissioner's ~~prior~~ authorization before services begin, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) ~~the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;~~ a recipient's eligibility lapse from medical assistance has been retroactively reinstated and an authorization for home care services is completed based on the date of a current assessment, eligibility, and request for authorization;

(3) a third-party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) ~~the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.~~ if a recipient enrolled in managed care experiences a temporary disenrollment from a health plan, the commissioner shall accept the current health plan authorization for personal care assistance services for up to 60 days. The request must be received within the first 30 days of the disenrollment. If the recipient's reenrollment in managed care is after the 60 days and before 90 days, the provider shall request an additional 30-day extension of the current health plan authorization, for a total limit of 90 days from the time of disenrollment.

~~Subd. 5. **Retroactive authorization.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.~~

Subd. 6. **~~Prior~~ Authorization.** (a) The commissioner, or the commissioner's designee, shall review the assessment, ~~service update,~~ request for temporary services, ~~request for flexible use option,~~ service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as ~~follows:~~ provided in this section.

~~(a) **Home health services.**~~ (b) ~~All~~ Home health services ~~provided by a home health aide~~ including skilled nurse visits and home health aide visits must be ~~prior~~ authorized by the commissioner or the commissioner's designee. ~~Prior~~ Authorization must be based on medical necessity and cost-effectiveness when compared with other care options. The commissioner must receive the request for authorization of skilled nurse visits and home health aide visits within 20 working days of the start of service. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. ~~The commissioner shall limit home health aide visits to no more than one visit each per day. The commissioner, or the commissioner's designee, may authorize up to two skilled nurse visits per day.~~

~~(b) **Ventilator-dependent recipients.**~~ (c) If the recipient is ventilator-dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this paragraph, home care services means all direct care services provided in the home that would be included in the payment for care at the long-term hospital. ~~"Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.~~ Recipients who meet the definition of ventilator dependent and the EN home care rating and utilize a combination of home care services are limited up to a total of 24 hours of home care services per day. Additional hours may be authorized when a recipient's assessment indicates a need for two staff to perform activities. Additional time is limited to four hours per day.

Subd. 7. **~~Prior~~ Authorization; time limits.** (a) The commissioner or the commissioner's designee shall determine the time period for which ~~a prior~~ an authorization shall be effective ~~and, if flexible use has been requested, whether to allow the flexible use option~~. If the recipient continues to require home care services beyond the duration of the ~~prior~~ authorization, the home care

provider must request a new ~~prior~~ authorization. A personal care provider agency must request a new personal care assistant services assessment, or service update if allowed, at least 60 days prior to the end of the current ~~prior~~ authorization time period. The request for the assessment must be made on a form approved by the commissioner. ~~Under no circumstances, other than the exceptions in subdivision 4, shall a prior~~ An authorization must be valid ~~prior to the date the commissioner receives the request or~~ for no more than 12 months.

(b) A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under subdivision 8, pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced~~ in amount from those requested by the home care provider~~.

Subd. 8. **~~Prior~~ Authorization requests; temporary services.** The agency nurse, ~~the~~ independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services ~~by telephone~~. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days~~, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made~~. The level of services authorized under this provision shall have no bearing on a future ~~prior~~ authorization.

Subd. 9. **~~Prior~~ Authorization for foster care setting.** (a) Home care services provided in an adult or child foster care setting must receive ~~prior~~ authorization by the ~~department~~ commissioner according to the limits established in subdivision 11.

(b) The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules;

(2) personal care assistant services when the foster care license holder is also the personal care provider or personal care assistant ~~unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a~~; or

~~(3) personal care assistant services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a; or~~

~~(4)~~ (3) personal care assistant and private duty nursing services when the ~~number of foster care residents~~ licensed capacity is greater than four ~~unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that personal care assistant and private duty nursing services be provided, and case management is provided as required in section 256B.0625, subdivision 19a~~.

~~Subd. 10. **Limitation on payments.** Medical assistance payments for home care services shall be limited according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and 256B.0655, subdivisions 3 and 4.~~

Subd. 11. **Limits on services without ~~prior~~ authorization.** A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistant services;

(2) one service update done to determine a recipient's need for personal care assistant services; and

(3) up to nine face-to-face skilled nurse visits.

Subd. 12. **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to subdivisions 4 to 12 and sections 256B.0654, subdivision 2, and ~~256B.0655, subdivisions 3 and 4~~ 256B.0659, the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

Subd. 13. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section and sections 256B.0653 to 256B.0656. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

Subd. 14. **Referrals to Medicare providers required.** Home care providers that do not participate in or accept Medicare assignment must refer and document the referral of dual-eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment. Providers must be terminated from participation in the medical assistance program for failure to make these referrals.

Subd. 15. **Quality assurance for program integrity.** The commissioner shall maintain processes for monitoring ongoing program integrity including provider standards and training, consumer surveys, and random reviews of documentation.

Subd. 16. **Oversight of enrolled providers.** The commissioner shall establish an ongoing quality assurance process for home care services. The commissioner has the authority to request proof of documentation of meeting provider standards, quality standards of care, correct billing practices, and other information. Failure to provide access and information to demonstrate compliance with laws, rules, or policies must result in suspension, denial, or termination of the provider agency's enrollment with the department.

Sec. 19. Minnesota Statutes 2008, section 256B.0652, is amended to read:

256B.0652 ~~PRIOR~~ AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

Subdivision 1. **State coordination.** The commissioner shall supervise the coordination of the ~~prior~~ authorization and review of home care services that are reimbursed by medical assistance.

Subd. 2. **Duties.** (a) The commissioner may contract with or employ ~~qualified registered nurses and~~ necessary ~~support~~ staff, or contract with qualified agencies, to provide home care ~~prior~~ authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the ~~prior~~ authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The functions will be to:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a ~~service~~ care plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost-effectiveness and nonduplication of medical assistance home care services;

(4) recommend the approval or denial of the use of medical assistance funds to pay for home care services;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner; and

(6) conduct on-site assessments when determined necessary by the commissioner and recommend changes to care plans that will provide more efficient and appropriate home care.

(c) In addition, the commissioner or the commissioner's designee may:

(1) review care service plans and reimbursement data for utilization of services that exceed community-based standards for home care, inappropriate home care services, medical necessity, home care services that do not meet quality of care standards, or unauthorized services and make appropriate referrals within the department or to other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

(3) coordinate home care services with other medical assistance services under section 256B.0625;

(4) assist the recipient with problems related to the provision of home care services;

(5) assure the quality of home care services; and

(6) assure that all liable third-party payers including, but not limited to, Medicare have been used prior to medical assistance for home care services~~, including but not limited to, home health agency, elected hospice benefit, waivered services, alternative care program services, and personal care services~~.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

Subd. 3. **Assessment and ~~prior~~ authorization process for persons receiving personal care assistance and developmental disabilities services.** ~~Effective January 1, 1996,~~ For

purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and ~~prior~~ authorization process for persons receiving both home care and home and community-based waivered services for persons with developmental disabilities shall meet the requirements of sections 256B.0651 and 256B.0653 to 256B.0656 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under sections 256B.0651 and 256B.0653 to 256B.0656, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community-based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give ~~prior~~ authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community-based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community-based waivered services for persons with developmental disabilities.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and ~~prior~~ authorization process will be held separate and distinct from the provision of services.

Sec. 20. Minnesota Statutes 2008, section 256B.0653, is amended to read:

256B.0653 HOME HEALTH AGENCY ~~COVERED~~ SERVICES.

Subdivision 1. **~~Homecare; skilled nurse visits~~ Scope.** ~~"Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:~~

~~(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;~~

~~(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;~~

~~(3) assessments performed only by a registered nurse; and~~

~~(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.~~ This section applies to home health agency services including, home health aide, skilled nursing visits, physical therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.

Subd. 2. ~~**Telehomecare; skilled nurse visits**~~ **Definitions.** ~~Medical assistance covers skilled nurse visits according to section 256B.0625, subdivision 6a, provided via telehomecare, for services which do not require hands-on care between the home care nurse and recipient. The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Store-and-forward technology includes telehomecare services that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the recipient for all or any part of any such telehomecare visit. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed. A communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners, is not to be considered a telehomecare visit. Multiple daily skilled nurse visits provided via telehomecare are allowed. Coverage of telehomecare is limited to two visits per day. All skilled nurse visits provided via telehomecare must be prior authorized by the commissioner or the commissioner's designee and will be covered at the same allowable rate as skilled nurse visits provided in person.~~ For the purposes of this section, the following terms have the meanings given.

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request and as specified Code of Federal Regulations, title 42, section 484.1 to 494.55.

(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.

(c) "Home health agency services" means services delivered in the recipient's home residence, except as specified in section 256B.0625, by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions.

(d) "Home health aide" means an employee of a home health agency who meets the requirements of Code of Federal Regulations, title 42, sections 484.1 to 494.55, and completes medically oriented tasks written in the plan of care for a recipient.

(e) "Home health agency" means a home care provider agency who is Medicare-certified satisfying the requirements of Code of Federal Regulations, title 42, sections 484.1 to 494.55.

(f) "Occupational therapy services" mean the services defined in section 148.6402.

(g) "Physical therapy services" mean the services defined in section 148.65.

(h) "Respiratory therapy services" mean the services defined in chapter 147C and Minnesota Rules, part 4668.0003, subpart 37.

(i) "Speech-language pathology services" mean the services defined in section 148.512.

(j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

(k) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

(l) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

(m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Subd. 3. **~~Therapies through home health agencies~~ Home health aide visits.** ~~(a) Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate. Direction of the physical therapy assistant must be provided by the physical therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The physical therapist and physical therapist assistant may not both bill for services provided to a recipient on the same day.~~

~~(b) Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate. Direction of the occupational therapy assistant must be provided by the occupational therapist as described in Minnesota Rules, part 9505.0390, subpart 1, item B. The occupational therapist and occupational therapist assistant may not both bill for services provided to a recipient on the same day.~~

(a) Home health aide visits must be provided by a certified home health aide using a written plan of care that is updated in compliance with Medicare regulations. A home health aide shall provide hands-on personal care, perform simple procedures as an extension of therapy or nursing services, and assist in instrumental activities of daily living as defined in section 256B.0659. Home health aide visits must be provided in the recipient's home.

(b) All home health aide visits must have authorization under section 256B.0652. The commissioner shall limit home health aide visits to no more than one visit per day per recipient.

(c) Home health aides must be supervised by a registered nurse or an appropriate therapist when providing services that are an extension of therapy.

Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice according to chapter 148. Skilled nurse visit services must be ordered by a physician and documented in a plan of care that is reviewed and approved by the ordering physician at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence

except as allowed under section 256B.0625, subdivision 6a.

(b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. All visits must be based on assessed needs.

(c) Telehomecare skilled nurse visits are allowed when the recipient's health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter. All telehomecare skilled nurse visits must have authorization and are paid at the same allowable rates as face-to-face skilled nurse visits.

(d) The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed.

(e) Authorization for skilled nurse visits must be completed under section 256B.0652. A total of nine face-to-face skilled nurses visits per calendar year do not require authorization. All telehomecare skilled nurse visits require authorization.

Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

(b) Home care therapies must be:

(1) provided in the recipient's residence after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician and documented in a plan of care and reviewed, according to Minnesota Rules, part 9505.0390;

(3) assessed by an appropriate therapist; and

(4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider agency.

(c) Restorative and specialized maintenance therapies must be provided according to Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

(d) For both physical and occupational therapies, the therapist and the therapist's assistant may not both bill for services provided to a recipient on the same day.

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program

for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw or Synagis injections when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; and

(4) home care therapies provided in other settings such as a clinic, day program, or as an inpatient or when the recipient can access therapy outside of the recipient's residence.

Sec. 21. Minnesota Statutes 2008, section 256B.0654, is amended to read:

256B.0654 PRIVATE DUTY NURSING.

Subdivision 1. **Definitions.** ~~(a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for medical assistance home care services for developmental disabilities and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication.~~

~~(b)~~ (a) "Complex ~~and regular~~ private duty nursing care" means~~:~~

~~(1) complex care is private duty~~ nursing services provided to recipients who are ventilator dependent or for whom a physician has certified that ~~were it not for private duty nursing~~ the recipient ~~would meet~~ meets the criteria for inpatient hospital intensive care unit (ICU) level of care~~; and~~

~~(2) regular care is private duty nursing provided to all other recipients~~.

(b) "Private duty nursing" means ongoing professional nursing services by a registered or licensed practical nurse including assessment, professional nursing tasks, and education, based on an assessment and physician orders to maintain or restore optimal health of the recipient.

(c) "Private duty nursing agency" means a medical assistance enrolled provider licensed under chapter 144A to provide private duty nursing services.

(d) "Regular private duty nursing" means nursing services provided to a recipient who is considered stable and not at an inpatient hospital intensive care unit level of care, but may have episodes of instability that are not life threatening.

(e) "Shared private duty nursing" means the provision of nursing services by a private duty nurse to two recipients at the same time and in the same setting.

Subd. 2. **Authorization; private duty nursing services.** (a) All private duty nursing services shall be ~~prior~~ authorized by the commissioner or the commissioner's designee. ~~Prior~~ Authorization for private duty nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter-hour units when:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) The commissioner may authorize:

(1) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(2) private duty nursing in combination with other home care services up to the total cost allowed under section 256B.0655, subdivision 4;

(3) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in clause (1) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0501 to 9505.0540.

(c) The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section and sections 256B.0651, 256B.0653, ~~256B.0655, and~~ 256B.0656, and 256B.0659 than would otherwise be authorized under section 256B.49.

Subd. 2a. **Private duty nursing services.** (a) Private duty nursing services must be used:

(1) in the recipient's home or outside the home when normal life activities require;

(2) when the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; and

(3) when the care required is outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) Private duty nursing services must be:

(1) assessed by a registered nurse on a form approved by the commissioner;

(2) ordered by a physician and documented in a plan of care that is reviewed by the physician at least once every 60 days; and

(3) authorized by the commissioner under section 256B.0652.

Subd. 2b. **Noncovered private duty nursing services.** Private duty nursing services do not cover the following:

(1) nursing services by a nurse who is the foster care provider of a person who has not reached 18 years of age;

(2) nursing services to more than two persons receiving shared private duty nursing services from a private duty nurse in a single setting; and

(3) nursing services provided by a registered nurse or licensed practical nurse who is the recipient's legal guardian or related to the recipient as spouse, parent, or child whether by blood, marriage, or adoption except as specified in section 256B.0652, subdivision 4.

Subd. 3. **Shared private duty nursing ~~care~~ option.** (a) Medical assistance payments for shared private duty nursing services by a private duty nurse shall be limited according to this subdivision. ~~For the purposes of this section and sections 256B.0651, 256B.0653, 256B.0655, and 256B.0656, "private duty nursing agency" means an agency licensed under chapter 144A to provide private duty nursing services.~~ Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services. Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient.

~~(b) Recipients of private duty nursing services may share nursing staff and the commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider shall not exceed 1.5 times the regular private duty nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed. No more than two persons may receive shared private duty nursing services from a private duty nurse in a single setting.~~

~~(c)~~ (b) Shared private duty nursing ~~care~~ is the provision of nursing services by a private duty nurse to two medical assistance eligible recipients at the same time and in the same setting. This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or foster care home of one of the individual recipients as defined in section 256B.0651; ~~or~~

(2) a child care program licensed under chapter 245A or operated by a local school district or private school; ~~or~~

(3) an adult day care service licensed under chapter 245A; or

(4) outside the home residence or foster care home of one of the recipients when normal life activities take the recipients outside the home.

~~This subdivision does not apply when a private duty nurse is caring for multiple recipients in more than one setting.~~

(d) The private duty nursing agency must offer the recipient the option of shared or one-on-one private duty nursing services. The recipient may withdraw from participating in a shared service arrangement at any time.

~~(d)~~ (e) The recipient or the recipient's legal representative, and the recipient's physician, in conjunction with the ~~home health care~~ private duty nursing agency, shall determine:

(1) whether shared private duty nursing care is an appropriate option based on the individual needs and preferences of the recipient; and

(2) the amount of shared private duty nursing services authorized as part of the overall authorization of nursing services.

~~(e)~~ (f) The recipient or the recipient's legal representative, in conjunction with the private duty nursing agency, shall approve the setting, grouping, and arrangement of shared private duty nursing care based on the individual needs and preferences of the recipients. Decisions on the selection of recipients to share services must be based on the ages of the recipients, compatibility, and coordination of their care needs.

~~(f)~~ (g) The following items must be considered by the recipient or the recipient's legal representative and the private duty nursing agency, and documented in the recipient's health service record:

(1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are met appropriately and safely;

(2) the setting in which the shared private duty nursing care will be provided;

(3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

(4) a contingency plan which accounts for absence of the recipient in a shared private duty nursing setting due to illness or other circumstances;

(5) staffing backup contingencies in the event of employee illness or absence; and

(6) arrangements for additional assistance to respond to urgent or emergency care needs of the recipients.

~~(g) The provider must offer the recipient or responsible party the option of shared or one-on-one private duty nursing services. The recipient or responsible party can withdraw from participating in a shared service arrangement at any time.~~

(h) ~~The private duty nursing agency must document the following in the health service record for each individual recipient sharing private duty nursing care~~ The documentation for shared private duty nursing must be on a form approved by the commissioner for each individual recipient sharing private duty nursing. The documentation must be part of the recipient's health service record and include:

(1) permission by the recipient or the recipient's legal representative for the maximum number of shared nursing ~~care~~ hours per week chosen by the recipient and permission for shared private duty nursing services provided in and outside the recipient's home residence;

~~(2) permission by the recipient or the recipient's legal representative for shared private duty nursing services provided outside the recipient's residence;~~

~~(3) permission by the recipient or the recipient's legal representative for others to receive shared private duty nursing services in the recipient's residence;~~

~~(4)~~ (2) revocation by the recipient or the recipient's legal representative ~~of~~ for the shared private duty nursing ~~care authorization, or the shared care to be provided to others in the recipient's residence, or the shared private duty nursing services to be provided outside~~ permission, or services provided to others in and outside the recipient's residence; and

~~(5)~~ (3) daily documentation of the shared private duty nursing services provided by each identified private duty nurse, including:

(i) the names of each recipient receiving shared private duty nursing services ~~together~~;

(ii) the setting for the shared services, including the starting and ending times that the recipient received shared private duty nursing care; and

(iii) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of private duty nursing services, and scheduling and care issues.

~~(i) Unless otherwise provided in this subdivision, all other statutory and regulatory provisions relating to private duty nursing services apply to shared private duty nursing services.~~

~~Nothing in this subdivision shall be construed to reduce the total number of private duty nursing hours authorized for an individual recipient under subdivision 2.~~

(i) The commissioner shall provide a rate methodology for shared private duty nursing. For two persons sharing nursing care, the rate paid to a provider must not exceed 1.5 times the regular private duty nursing rates paid for serving a single individual by a registered nurse or licensed practical nurse. These rates apply only to situations in which both recipients are present and receive shared private duty nursing care on the date for which the service is billed.

Subd. 4. **Hardship criteria; private duty nursing.** (a) Payment is allowed for extraordinary services that require specialized nursing skills and are provided by parents of minor children, spouses, and legal guardians who are providing private duty nursing care under the following conditions:

(1) the provision of these services is not legally required of the parents, spouses, or legal guardians;

(2) the services are necessary to prevent hospitalization of the recipient; and

(3) the recipient is eligible for state plan home care or a home and community-based waiver and one of the following hardship criteria are met:

(i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide

nursing care for the recipient; ~~or~~

(ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide nursing care for the recipient; ~~or~~

(iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide nursing care for the recipient; or

(iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to provide adequate private duty nursing services to meet the medical needs of the recipient.

(b) Private duty nursing may be provided by a parent, spouse, or legal guardian who is a nurse licensed in Minnesota. Private duty nursing services provided by a parent, spouse, or legal guardian cannot be used in lieu of nursing services covered and available under liable third-party payors, including Medicare. The private duty nursing provided by a parent, spouse, or legal guardian must be included in the service plan. Authorized ~~skilled~~ nursing services for a single recipient or recipients with the same residence and provided by the parent, spouse, or legal guardian may not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. A parent or parents, spouse, or legal guardian shall not provide more than 40 hours of services in a seven-day period. For parents and legal guardians, 40 hours is the total amount allowed regardless of the number of children or adults who receive services. Nothing in this subdivision precludes the parent's, spouse's, or legal guardian's obligation of assuming the nonreimbursed family responsibilities of emergency backup caregiver and primary caregiver.

(c) A parent or a spouse may not be paid to provide private duty nursing care if:

(1) the parent or spouse fails to pass a criminal background check according to chapter 245C~~, or if~~;

(2) it has been determined by the home ~~health~~ care agency, the case manager, or the physician that the private duty nursing ~~care~~ provided by the parent, spouse, or legal guardian is unsafe; or

(3) the parent, spouse, or legal guardian do not follow physician orders.

(d) For purposes of this section, "assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing must be conducted by a registered nurse.

Sec. 22. Minnesota Statutes 2008, section 256B.0655, subdivision 4, is amended to read:

Subd. 4. **~~Prior~~ Authorization; personal care assistance and qualified professional.** ~~The commissioner, or the commissioner's designee, shall review the assessment, service update, request for temporary services, request for flexible use option, service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:~~

~~(1)~~ (a) All personal care assistant services ~~and~~, supervision by a qualified professional, ~~if requested by the recipient,~~ and additional services beyond the limits established in section 256B.0652, subdivision 11, must be ~~prior~~ authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in ~~section~~ sections

256B.0651, subdivision 11, and 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistant services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) number of complex health-related functions as defined in section 256B.0659; and

(3) number of behavior descriptions as defined in section 256B.0659.

(c) The methodology to determine total time for personal care assistance services for each home care rating is based on fiscal year 2007 data from the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes for each behavior issue as defined in section 256B.0659.

(d) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

~~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 and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:~~

~~(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or~~

~~(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or~~

~~(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or~~

~~(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation~~

~~team. For purposes of this clause, home care services means all services provided in the home or community that would be included in the payment to a regional treatment center; or~~

~~(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and~~

~~(F) a reasonable amount of time for the provision of supervision by a qualified professional of personal care assistant services, if a qualified professional is requested by the recipient or responsible party.~~

~~(2) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.~~

~~(3) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656 and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.~~

~~(4) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community-based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:~~

~~(A) daily tube feedings;~~

~~(B) daily parenteral therapy;~~

~~(C) wound or decubiti care;~~

~~(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;~~

~~(E) catheterization;~~

~~(F) ostomy care;~~

~~(G) quadriplegia; or~~

~~(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.~~

~~(5) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one~~

~~or more of the following behaviors that cause, or have the potential to cause:~~

~~(A) injury to the recipient's own body;~~

~~(B) physical injury to other people; or~~

~~(C) destruction of property.~~

~~(6) Time authorized for personal care relating to Level I behavior in paragraph (5), clauses (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.~~

~~(7) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care assistant services under subdivision 2, paragraph (a):~~

~~(A) unusual or repetitive habits;~~

~~(B) withdrawn behavior; or~~

~~(C) offensive behavior.~~

~~(8) A recipient with a home care rating of Level II behavior in paragraph (7), clauses (A) to (C), shall be rated as comparable to a recipient with complex medical needs under paragraph (4). If a recipient has both complex medical needs and Level II behavior, the home care rating shall be the next complex category up to the maximum rating under paragraph (1), clause (B).~~

Sec. 23. **[256B.0659] PERSONAL CARE ASSISTANCE PROGRAM.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (p) 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" means a category to determine the home care rating and is based on the criteria found in this section.

(d) "Complex health-related functions" 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" 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) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(h) "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 and participating in the community.

(i) "Managerial official" has the same definition as Code of Federal Regulations, title 42, section

455.

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

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

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

(m) "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.

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

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

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

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 functions;

(3) assistance with behavior needs; 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 functions 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;

(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 functions under this section.

(d) A personal care assistant may provide health-related functions associated with the complex health-related function needs of a recipient if the tasks meet the definition of health-related functions under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the task. Delegation of health-related functions and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files.

(e) For a personal care assistant to provide the health-related functions 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 functions 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) 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 (h), include accompanying a recipient to obtain medical diagnosis or treatment when assistance is required by

the recipient during the appointment.

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, or responsible party;

(2) in lieu of other staffing options 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) 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) instrumental activities of daily living without a dependency in at least two activities of daily living;

(4) home maintenance or chore services;

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

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

(7) instrumental activities of daily living for children under the age of 18; and

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

Subd. 4. **Assessment for personal care assistance services.** (a) An assessment as defined in section 256B.0911 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 need, on a daily basis, for:

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

(ii) hands-on assistance to complete the task.

(2) an adult may not be found to be dependent in an activity of daily living because of individual choices; and

(3) 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 functions must meet the criteria in this paragraph. During the assessment process, a recipient qualifies as having complex health-related functions if the recipient has one or more of the interventions that are ordered by a physician, specified in a personal care assistance care plan, and found in the following:

(1) tube feedings requiring:

(i) a gastro/jejunostomy 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 devises 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 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, others, or property that requires immediate response of another;

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

(3) verbally aggressive and resistive to care.

Subd. 5. **Service and support planning.** (a) The assessor, with the recipient or responsible party, shall review the assessment information and determine referrals for other payers, services, and community supports as appropriate.

(b) The recipient must be referred for evaluation, services, or supports that are appropriate to help meet the recipient's needs including, but not limited to, the following circumstances:

(1) when there is another payer who is responsible to provide the service to meet the recipient's needs;

(2) when the recipient qualifies for assistance with behaviors under this section, a referral into the mental health system for a mental health diagnostic and functional assessment must be completed;

(3) when the recipient is eligible for medical assistance and meets medical assistance eligibility for a home health aide or skilled nurse visit;

(4) when the recipient would benefit from an evaluation for another service; and

(5) when there is a more appropriate service to meet the assessed needs.

(c) The reimbursement rates for public health nurse visits that relate to the provision of personal care assistance services under this section and section 256B.0625, subdivision 19a, are:

(1) $210.50 for a face-to-face assessment visit;

(2) $105.25 for each service update; and

(3) $105.25 for each request for a temporary service increase.

(d) The rates specified in paragraph (c) must be adjusted to reflect provider rate increases for personal care assistance services that are approved by the legislature for the fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied by the legislature to provider rate increases for personal care assistance services also apply to adjustments under this paragraph.

(e) Effective July 1, 2008, the payment rate for an assessment under this section and section 256B.0651 shall be reduced by 25 percent when the assessment is not completed on time and the service agreement documentation is not submitted in time to continue services. The commissioner shall reduce the amount of the claim for those assessments that are not submitted on time.

Subd. 6. **Service plan.** The service plan must be completed by the assessor with the recipient and responsible party on a form determined by the commissioner and include a summary of the assessment with a description of the need, authorized amount, and expected outcomes and goals of personal care assistance services. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan. The recipient or responsible party must be given information by the assessor about the options in the personal care assistance program to allow for review and decision making.

Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current personal care assistance care plan based on the service plan in subdivision 21 that is developed by the qualified professional with the recipient and responsible party. A copy of the most current personal care assistance care plan is required to be in the recipient's home and in the recipient's file at the provider agency.

(b) The personal care assistance care plan must have the following components:

(1) start and end date of the care plan;

(2) recipient demographic information, including name and telephone number;

(3) emergency numbers and procedures, including a backup plan;

(4) name of responsible party and instructions for contact;

(5) description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

(6) dated signatures of recipient or responsible party and qualified professional.

(c) The personal care assistance care plan must have instructions and comments about the recipient's needs for assistance and any special instructions or procedures required. The month-to-month plan for the use of personal care assistance services is part of the personal care assistance care plan. The personal care assistance care plan must be completed within the first week after start of services with a personal care provider agency and must be updated as needed when there is a change in need for personal care assistance services. A new personal care assistance care plan is required annually at the time of the reassessment.

Subd. 8. **Communication with recipient's physician.** The personal care assistance program

requires communication with the recipient's physician about a recipient's assessed needs for personal care assistance services. The commissioner shall work with the state medical director to develop options for communication with the recipient's physician.

Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an individual who lives with and 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 have a direct or indirect financial interest in care provided to the recipient and must not be the:

(1) personal care assistant;

(2) home care provider agency staff; or

(3) 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 foster parent does not also have a direct or indirect financial interest in the provision of personal care assistant services.

(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 section 256B.0911 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 including living with the recipient at the time they are serving as the responsible party.

(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.

Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party with a personal care assistance provider agency shall enter into a written agreement, on a form determined by the commissioner, to perform the following duties:

(1) live with the individual who is receiving personal care assistance services;

(2) be available while care is provided in a method agreed upon by the individual or the individual's legal representative and documented in the recipient's personal care assistance care plan;

(3) monitor personal care assistance services to ensure the recipient's personal care assistance care plan is being followed; and

(4) review and sign personal care assistance time sheets after services are provided to provide verification of the personal care assistance services.

Failure to provide the support required by the recipient must result in a referral to the county common entry point.

(b) Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of the responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The responsible party must ensure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the personal care assistance care plan. The responsible party must communicate to the personal care assistance provider agency about the need for a delegate responsible party, including the name of the delegated responsible party, dates the delegated responsible party will be living with the recipient, and contact numbers.

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 non-pay-to provider after clearing a background study. 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) complete standardized training as determined by the commissioner before completing enrollment. 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, fraud issues, and completion of time sheets. Included with the basic training is a need for the personal care assistant to demonstrate competency of ability to understand and provide assistance. Personal care assistant training and orientation must be completed within the first seven days after the services begin and be directed to the needs of the recipient and the recipient's personal care assistance care plan; and

(9) be limited to providing and being paid for up to an amount of hours per month of personal care assistance services that is determined by the commissioner regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with.

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

(c) Persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, foster care providers, staff of a residential setting, or anyone who has a direct or indirect financial interest in the service delivery.

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily, on a form approved by the commissioner by each personal care assistant, and kept in the recipient's home for the current month of service. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient;

(4) consecutive dates, including month, day, and year, and arrival and departure time with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must be employed by 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) The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required trainings as an employee with a personal care assistance provider agency do not need to repeat the required trainings if they are hired by another agency, if they have completed the training within the last three years.

Subd. 14. **Qualified professional; duties.** (a) All personal care assistants must be supervised by a qualified professional or in a joint supervision relationship with the recipient or the responsible party.

(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 services for a recipient. The qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work:

(1) at least every 90 days thereafter for the first year of services; and

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

(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.

(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) agency administrative activities;

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

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

Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized hours of personal care assistance services, which vary within a service authorization period covering no more than six months, in order to more effectively meet the needs and schedule of the recipient. Each 12-month service agreement is divided into two six-month authorization date spans. No more than 75 percent of the total authorized units for a 12-month service agreement may be used in a six-month date span.

(b) Authorization of flexible use occurs during the authorization process under section 256B.0652. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient. The commissioner shall not authorize additional personal care assistance services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the assessor determines a change in condition and a need for increased services is established. Authorized hours not used within the six-month period must not be carried over to another time period.

(c) A recipient who has terminated personal care assistance services before the end of the 12-month authorization period must not receive additional hours upon reapplying during the same 12-month authorization period, except if a change in condition is documented. Services must be prorated for the remainder of the 12-month authorization period based on the first six-month assessment.

(d) The recipient, responsible party, and qualified professional must develop a written month-to-month plan of the projected use of personal care assistance services that is part of the personal care assistance care plan and ensures:

(1) that the health and safety needs of the recipient are met throughout both date spans of the authorization period; and

(2) that the total authorized amount of personal care assistance services for each date span must not be used before the end of each date span in the authorization period.

(e) The personal care assistance provider agency shall monitor the use of personal care assistance services to ensure health and safety needs of the recipient are met throughout both date spans of the authorization period. The commissioner or the commissioner's designee shall provide written notice to the provider and the recipient or responsible party when a recipient is at risk of exceeding

the personal care assistance services prior to the end of the six-month period.

(f) Misuse and abuse of the flexible use of personal care assistance services resulting in the overuse of units in a manner where the recipient will not have enough units to meet their needs for assistance and ensure health and safety for the entire six-month date span may lead to an action by the commissioner. The commissioner may take action including, but not limited to: (1) restricting recipients to service authorizations of no more than one month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring a qualified professional to monitor and report services on a monthly basis.

Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal care assistance services are limited according to this subdivision.

(b) Shared service is the provision of personal care assistance services by a personal care assistant to two or three recipients, eligible for medical assistance, who voluntarily enter into an agreement to receive services at the same time and in the same setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or family foster care home of one or more of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) Shared personal care assistance services follow the same criteria for covered services as subdivision 2.

(e) Noncovered shared personal care assistance services include the following:

(1) services for more than three recipients by one personal care assistant at one time;

(2) staff requirements for child care programs under chapter 245C;

(3) caring for multiple recipients in more than one setting;

(4) additional units of personal care assistance based on the selection of the option; and

(5) use of more than one personal care assistance provider agency for the shared care services.

(f) The option of shared personal care assistance is elected by the recipient or the responsible party with the assistance of the assessor. The option must be determined appropriate based on the ages of the recipients, compatibility, and coordination of their assessed care needs. The recipient or the responsible party, in conjunction with the qualified professional, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. The personal care assistance provider agency shall offer the recipient or the responsible party the option of shared or one-on-one personal care assistance services or a combination of both. The recipient or the responsible party may withdraw from participating in a shared services arrangement at any time.

(g) Authorization for the shared service option must be determined by the commissioner based on the criteria that the shared service is appropriate to meet all of the recipients' needs and their health and safety is maintained. The authorization of shared services is part of the overall authorization of personal care assistance services. Nothing in this subdivision must be construed to reduce the total

number of hours authorized for an individual recipient.

(h) A personal care assistant providing shared personal care assistance services must:

(1) receive training specific for each recipient served; and

(2) follow all required documentation requirements for time and services provided.

(i) A qualified professional shall:

(1) evaluate the ability of the personal care assistant to provide services for all of the recipients in a shared setting;

(2) visit the shared setting as services are being provided at least once every six months or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff;

(3) provide ongoing monitoring and evaluation of the effectiveness and appropriateness of the shared services;

(4) develop a contingency plan with each of the recipients which accounts for absence of the recipient in a share services setting due to illness or other circumstances;

(5) obtain permission from each of the recipients who are sharing a personal care assistant for number of shared hours for services provided inside and outside the home residence; and

(6) document the training completed by the personal care assistants specific to the shared setting and recipients sharing services.

Subd. 17. **Shared services; rates.** The commissioner shall provide a rate system for shared personal care assistance services. For two persons sharing services, the rate paid to a provider must not exceed one and one-half times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed twice the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared care personal care assistance service have been met.

Subd. 18. **Personal care assistance choice option; generally.** (a) The commissioner may allow a recipient of personal care assistance services to use a fiscal intermediary to assist the recipient in paying and account for medically necessary covered personal care assistance services. Unless otherwise provided in this section, all other statutory and regulatory provisions relating to personal care assistance services apply to a recipient using the personal care assistance choice option.

(b) Personal care assistance choice is an option of the personal care assistance program that allows the recipient who receives personal care assistance services to be responsible for the hiring, training, and firing of personal care assistants. This program offers greater control and choice for the recipient in who provides the personal care assistance service and when the service is scheduled. The recipient or the recipient's responsible party must choose a personal care assistance choice provider agency as a fiscal intermediary. This personal care assistance choice provider agency manages payroll, invoices the state, is responsible for all payroll related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's personal care assistance services.

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

(1) recruit, hire, and terminate personal care assistants and a qualified professional;

(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) supervise and evaluate the personal care assistant with the qualified professional;

(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 to the recipient, qualified professional, or the personal care assistant; and

(4) ensure arm's-length transactions 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.

Subd. 20. **Personal care assistance choice option; administration.** (a) Before services commence under the personal care assistance choice option, and annually thereafter, the personal care assistance choice provider agency, recipient, or responsible party, each personal care assistant, and the qualified professional shall enter into a written agreement. The agreement must include at a minimum:

(1) duties of the recipient, qualified professional, personal care assistant, and personal care assistance choice provider agency;

(2) salary and benefits for the personal care assistant and the qualified professional;

(3) administrative fee of the personal care assistance choice provider agency and services paid for with that fee, including background study fees;

(4) grievance procedures to respond to complaints;

(5) procedures for hiring and terminating the personal care assistant; and

(6) documentation requirements including, but not limited to, time sheets, activity records, and the personal care assistance care plan.

(b) Except for the administrative fee of the personal care assistance choice provider agency as reported on the written agreement, the remainder of the rates paid to the personal care assistance choice provider agency must be used to pay for the salary and benefits for the personal care assistant or the qualified professional.

(c) The commissioner shall deny, revoke, or suspend the authorization to use the personal care assistance choice option if:

(1) it has been determined by the qualified professional or public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in subdivision 20;

(3) the use of the option has led to abusive or fraudulent billing for personal care assistance services; or

(4) the department terminates the personal care assistance choice option.

(d) The recipient or responsible party may appeal the commissioner's decision in paragraph (c) according to section 256.045. The denial, revocation, or suspension to use the personal care assistance choice option must not affect the recipient's authorized level of personal care assistance services.

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

(6) 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;

(7) 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 and the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

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

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

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

(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 upon enactment of this section.

(c) All personal care assistance provider agencies shall complete mandatory training as

determined by the commissioner before enrollment as a provider. Personal care assistance provider agencies are required to send all owners, qualified professionals employed by the agency, and all other managerial officials to the initial and subsequent trainings. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective upon enactment of this section. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of the effective date of this section. Any new owners, new qualified professionals, and new managerial officials are required to complete mandatory training as a requisite of hiring.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under Minnesota Rules, part 4668.0012, as a class A provider or currently certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

Subd. 23. **Enrollment requirements following termination.** (a) A terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination.

(b) After the two-year period in paragraph (a), if the provider seeks to reenroll as a personal care assistance provider agency, the personal care assistance provider agency must be placed on a one-year probation period, beginning after completion of the following:

(1) the department's provider trainings under this section; and

(2) initial enrollment requirements under subdivision 21.

(c) During the probationary period the commissioner shall complete site visits and request submission of documentation to review compliance with program policy.

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

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

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

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

(8) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(9) enter into a written agreement under subdivision 21 before services are provided;

(10) report suspected neglect and abuse to the common entry point according to section 256B.0651; and

(11) provide the recipient with a copy of the home care bill of rights at start of service.

Subd. 25. **Personal care assistance provider agency; background studies.** Personal care assistance provider agencies enrolled to provide personal care assistance services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care assistance provider agencies and those agencies seeking enrollment as a personal care assistance provider agency. Managerial official has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners and managerial officials; or

(ii) the organization has initiated background studies on owners and managerial officials, but the commissioner has sent the organization a notice that an owner or managerial official of the organization has been disqualified under section 245C.14, and the owner or managerial official has not received a set aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all qualified professionals; and

(3) a background study must be initiated and completed for all personal care assistants.

Subd. 26. **Personal care assistance provider agency; communicable disease prevention.** A personal care assistance provider agency shall establish and implement policies and procedures

for prevention, control, and investigation of infections and communicable diseases according to current nationally recognized infection control practices or guidelines established by the United States Centers for Disease Control and Prevention, as well as applicable regulations of other federal or state agencies.

Subd. 27. **Personal care assistance provider agency; ventilator training.** The personal care assistance provider agency is required to provide training for the personal care assistant responsible for working with a recipient who is ventilator dependent. All training must be administered by a respiratory therapist, nurse, or physician. Qualified professional supervision by a nurse must be completed and documented on file in the personal care assistant's employment record and the recipient's health record. If offering personal care services to a ventilator-dependent recipient, the personal care assistance provider agency shall demonstrate the ability to:

(1) train the personal care assistant;

(2) supervise the personal care assistant in ventilator operation and maintenance; and

(3) supervise the recipient and responsible party in ventilator operation and maintenance.

Subd. 28. **Personal care assistance provider agency; required documentation.** Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) medical assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances; and

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served.

Subd. 29. **Transitional assistance.** Notwithstanding any contrary provision in this section, the commissioner, counties, and personal care assistance providers shall work together to provide transitional assistance for recipients and families to come into compliance with the new live-in responsible party requirements of this section, and ensure that services are prohibited from being provided by the housing provider. The commissioner and counties shall provide this assistance until July 1, 2010.

Sec. 24. Minnesota Statutes 2008, 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 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 placements and to provide transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary certified nursing facility admissions. Long-term consultation services must be available to any person regardless of public program eligibility. The ~~commissioners~~ commissioner of human services ~~and health~~ 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 ~~services~~ long-term care options counseling provided under section 256.975, subdivision 7, and ~~with services provided by other public and private agencies in the community~~ 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 agency 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. 25. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, is amended to read:

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

(a) "Long-term care consultation services" means:

~~(1) providing information and education to the general public regarding availability of the services authorized under this section;~~

~~(2) an intake process that provides access to the services described in this section;~~

~~(3) assessment of the health, psychological, and social needs of referred individuals;~~

~~(4)~~ (1) assistance in identifying services needed to maintain an individual in the ~~least restrictive~~ most inclusive environment;

~~(5)~~ (2) providing recommendations on cost-effective community services that are available to the individual;

~~(6)~~ (3) development of an individual's person-centered community support plan;

~~(7)~~ (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;

~~(8) preadmission~~ (6) federally mandated screening to determine the need for a ~~nursing facility~~ institutional level of care under section 256B.0911, subdivision 4, paragraph (a);

~~(9) preliminary~~ (7) determination of ~~Minnesota health care programs~~ home and community-based waiver service eligibility including level of care determination for individuals who need ~~a nursing facility~~ an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), based on assessment and support plan development with appropriate referrals ~~for final determination~~;

~~(10)~~ (8) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

~~(11)~~ (9) assistance to transition people back to community settings after facility admission.

(b) "Long-term 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. Long-term care options counselors shall:

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

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

(3) provide long-term care futures planning defined as providing assistance to individuals who

anticipate having long-term care needs to develop a plan for the more distant future; and

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

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

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

Sec. 26. Minnesota Statutes 2008, section 256B.0911, is amended by adding a subdivision to read:

Subd. 2b. **Certified assessors.** (a) Beginning January 1, 2011, each lead agency shall have certified assessors who have completed training and certification process 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.

(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 with at least three years of home and community-based experience that have received training and certification specific to assessment and consultation for long-term care services in the state.

Sec. 27. Minnesota Statutes 2008, section 256B.0911, is amended by adding a subdivision to read:

Subd. 2c. **Assessor training and certification.** The commissioner shall develop curriculum and a 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. 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. 28. Minnesota Statutes 2008, 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) 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 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 section 256B.0911, subdivision 1, paragraph (b).

Sec. 29. Minnesota Statutes 2008, 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 personal care assistance services, private duty nursing services, home health agency services, waiver or alternative care program eligibility, must be visited by a long-term care consultation team on or after January 1, 2011, a certified assessor within ~~ten working~~ 15 calendar days after the date on which an assessment was requested or recommended. Face-to-face assessments must be conducted according to paragraphs (b) to ~~(i)~~ (k).

(b) The county may utilize a team of either the social worker or public health nurse, or both, after January 1, 2011, lead agencies shall use a certified assessor to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The ~~long-term care consultation team must assess the health and social needs of the person~~ 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 support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The ~~team must conduct the~~ assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, ~~if applicable~~ 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 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 ~~team must provide the~~ person, or the person's legal representative, must be provided with written recommendations for ~~facility- or~~ community-based services~~. The team must document~~ or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than ~~nursing facility~~ institutional care.

(f) If the person chooses to use community-based services, the ~~team must provide the~~ person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. ~~The~~ A person may request assistance in ~~developing a community support plan~~ 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 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 ~~nursing facility~~ institutional placement and community placement after the ~~screening team's recommendation~~ recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

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

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

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

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

(6) the long-term care consultant's decision regarding the person's need for ~~nursing facility~~ institutional level of care as determined under criteria established in section 144.0724, subdivision 11, or 256B.092; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county'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.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs 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). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 30. Minnesota Statutes 2008, 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 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 established in section 144.0724, subdivision 11, and 256B.092, using forms developed by the commissioner. 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.

Sec. 31. Minnesota Statutes 2008, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** The commissioner shall minimize the number of ~~forms required in the provision of long-term care consultation services and shall limit the screening document to items necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development~~ business processes required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

Sec. 32. Minnesota Statutes 2008, 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).

(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) 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 federal funding for this activity.

Sec. 33. Minnesota Statutes 2008, section 256B.0911, subdivision 7, is amended to read:

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987 completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

Sec. 34. Minnesota Statutes 2008, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility according to the criteria established in section 144.0724, subdivision 11, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 35. Minnesota Statutes 2008, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate ~~negotiated and~~ authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the ~~services that have been customized for each recipient and specify the~~ amount of each component service included in the recipient's customized living service ~~to be provided~~ plan. The lead agency shall ensure that there is a documented need ~~for all~~ within the parameters established by the commissioner for all component customized living services authorized. ~~Customized living services must not include rent or raw food costs.~~

(b) The ~~negotiated~~ payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

~~Negotiated~~ (c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

~~(b)~~ (d) The individualized monthly ~~negotiated~~ authorized payment for the customized living

~~services~~ service plan shall not exceed ~~the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated,~~ 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly ~~negotiated~~ authorized payment for the services described in this clause shall not exceed the limit ~~described in this clause~~ which was in effect on June 30 of the previous state fiscal year ~~and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities~~ updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

~~(c)~~ (e) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D.

Sec. 36. Minnesota Statutes 2008, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rates for 24-hour customized living services ~~is~~ are a monthly rate ~~negotiated and~~ authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the ~~services that have been customized for each recipient and specify the~~ amount of each component service included in each recipient's customized living service ~~to be provided~~ plan. The lead agency shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) other conditions or needs as defined by the commissioner of human services. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient. ~~Customized living services must not include rent or raw food costs.~~

(c) The ~~negotiated~~ payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

~~Negotiated~~ (d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually ~~negotiated~~ authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish an alternative payment rate system for 24-hour customized living services by applying a single hourly rate for direct services provided in establishments, which meet the following criteria:

(1) 24-hour customized living services must be provided in a shared living unit; and

(2) the unit is licensed as an adult foster care for no more than five residents or licensed as a board and lodge facility with no more than ten residents.

Sec. 37. Minnesota Statutes 2008, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital. There must be a determination that the client requires nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) 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 and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

Sec. 38. Minnesota Statutes 2008, section 256B.0915, is amended by adding a subdivision 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 and 23, to reflect the maximum service rate limits for customized

living services and 24-hour customized living services under subdivisions 3e and 3h for the contract period beginning January 1, 2010. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits determined by the commissioner under subdivisions 3e and 3h.

Sec. 39. Minnesota Statutes 2008, section 256B.0917, is amended by adding a subdivision to read:

Subd. 14. **Essential community supports grants.** (a) The purpose of the essential community supports grant program is to provide targeted services to persons 65 years and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Within the limits of the appropriation and not to exceed $400 per person per month, funding must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) would otherwise be financially eligible for the alternative care program under section 256B.0913, subdivision 4;

(4) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) caregiver support;

(ii) homemaker;

(iii) chore; or

(iv) a personal emergency response device or system.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination as part of their community support plan.

(d) A person who has been determined to be eligible for an essential community support grant must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for an essential community support grant.

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

Sec. 40. Minnesota Statutes 2008, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County concurrence.** (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 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 plan. The county where services are provided may not make changes in the person's service 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 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~~; or~~.

~~(3) in the case of home and community-based services for persons with developmental disabilities, the county of service can demonstrate that the prospective provider has failed to substantially comply with the terms of a past contract or has had a prior contract terminated within the last 12 months for failure to provide adequate services, or has received a notice of intent to terminate the contract.~~

(c) The county of service shall notify the county of financial responsibility of concurrence or refusal to concur no later than 20 working days following receipt of the written request. 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.

Sec. 41. Minnesota Statutes 2008, section 256B.092, is amended by adding a subdivision 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 CAC, CADI, DD, and TBI 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 under category 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.

Sec. 42. Minnesota Statutes 2008, section 256B.37, subdivision 1, is amended to read:

Subdivision 1. **Subrogation.** Upon furnishing medical assistance or alternative care services under section 256B.0913 to any person who has private accident or health care coverage, or receives or has a right to receive health or medical care from any type of organization or entity, or has a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency or the state agency's agent shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of the coverage, or against the organization or entity providing or liable to provide health or medical care, or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Sec. 43. Minnesota Statutes 2008, section 256B.37, subdivision 5, is amended to read:

Subd. 5. **Private benefits to be used first.** Private accident and health care coverage including Medicare for medical services is primary coverage and must be exhausted before medical assistance ~~is~~ or alternative care services are paid for medical services including home health care, personal care assistant services, hospice, supplies and equipment, or services covered under a Centers for Medicare and Medicaid Services waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent.

Sec. 44. Minnesota Statutes 2008, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's total operating payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an operating payment rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(g) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

Sec. 45. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 59. **Single-bed payments for medical assistance recipients.** Notwithstanding Minnesota Rules, part 9549.0070, subpart 3, beginning on October 1, 2009, the commissioner shall allow a single-bed payment rate for any medical assistance recipient residing in a single-bed room regardless of having physician's orders for a single-bed room. The amount of the single-bed payment shall be 110 percent of the payment rate for the individual recipient. This subdivision does not affect the use of the single-bed election under Minnesota Rules, part 9549.0060, subpart 11.

Sec. 46. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 60. **Rebasing not to be implemented.** Notwithstanding subdivisions 53 and 55, for rate years beginning on October 1, 2009, and after, no rate adjustments shall be implemented under this section. For rate years beginning October 1, 2009, and after, nursing facility rates shall be determined under section 256B.434.

Sec. 47. Minnesota Statutes 2008, section 256B.49, subdivision 12, is amended to read:

Subd. 12. **Informed choice.** Persons who are determined likely to require the level of care provided in a nursing facility as determined under sections 256B.0911 and 144.0724, subdivision 11,

or hospital shall be informed of the home and community-based support alternatives to the provision of inpatient hospital services or nursing facility services. Each person must be given the choice of either institutional or home and community-based services using the provisions described in section 256B.77, subdivision 2, paragraph (p).

Sec. 48. Minnesota Statutes 2008, 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 include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) developing the written individual service plan within ten working days after the assessment is completed;

(3) informing the recipient or the recipient's legal guardian or conservator of service options;

(4) assisting the recipient in the identification of potential service providers;

(5) assisting the recipient to access services;

(6) 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.

Sec. 49. Minnesota Statutes 2008, 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. 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.

(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 144.0724, subdivision 11, 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.

~~(c)~~ (e) 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.

Sec. 50. Minnesota Statutes 2008, section 256B.49, is amended by adding a subdivision to read:

Subd. 22. **Residential support services.** For the purposes of this section, the provisions of section 256B.092, subdivision 11, are controlling.

Sec. 51. **[256B.4912] HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS AND PAYMENT.**

Subdivision 1. **Provider qualifications.** 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;

(2) regular reviews of provider qualifications; and

(3) processes to gather the necessary information to determine provider qualifications.

By July 2010, staff that provide direct contact, as defined in section 245C.02, subdivision 11, that are employees of waiver service providers 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.

Subd. 2. **Rate-setting methodologies.** The commissioner shall establish statewide 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.

Sec. 52. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 8. **ICF/MR rate decreases effective July 1, 2009.** The commissioner shall decrease each facility reimbursed under this section operating payment adjustments equal to 3.0 percent of the operating payment rates in effect on June 30, 2009. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.502, subdivision 7.

Sec. 53. **COLA COMPENSATION REQUIREMENTS.**

Effective July 1, 2009, providers who received rate increases under Laws 2007, chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15, section 17, and Minnesota Statutes, section 256B.5012, subdivision 7, for state fiscal years 2008 and 2009 are no longer required to continue or retain employee compensation or wage-related increases required by those sections.

Sec. 54. **AGING AND DISABILITY SERVICES FOR ADULTS.**

(a) The commissioner of human services shall form a work group with counties, in consultation with other stakeholders, to develop recommendations and priorities for the portion of funding to be allocated to counties for aging and disability services for adults. This funding must be transferred from the Children and Community Services Act (CCSA) distribution beginning July 1, 2011, and the CCSA distribution of county social services block grant funds beginning January 1, 2011.

(b) Starting January 1, 2011, funding for aging and disability services for adults must be governed under the CCSA under Minnesota Statutes, chapter 256M, pending final enactment of the legislation in paragraph (d).

(c) The work group's recommendations must include:

(1) identification of the priorities and targeted activities for this funding; and

(2) the funding allocation method to counties that must be effective January 1, 2011.

(d) The commissioner shall draft legislation for the 2010 legislative session that is necessary for the implementation of this funding allocation method. This allocation shall thereafter be referred to as the "Protecting Adults Act."

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

Sec. 55. **PROVIDER RATE AND GRANT REDUCTIONS.**

(a) The commissioner of human services shall decrease grants, allocations, reimbursement rates, or rate limits, as applicable, by 3.0 percent effective July 1, 2009, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease and must be retroactive from the effective date of the rate decrease.

(b) The annual rate decreases described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(13) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233 and 256C.25; Laws 1985, chapter 9; and Laws 1997, First Special Session chapter 5, section 20;

(14) physical therapy services under Minnesota Statutes, sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;

(15) occupational therapy services under Minnesota Statutes, sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4;

(16) speech-language therapy services under Minnesota Statutes, section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390;

(17) respiratory therapy services under Minnesota Statutes, section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295;

(18) consumer support grants under Minnesota Statutes, section 256.476;

(19) family support grants under Minnesota Statutes, section 252.32;

(20) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928;

(21) disability linkage line grants under Minnesota Statutes, section 256.01, subdivision 24; and

(22) housing access grants under Minnesota Statutes, section 256B.0658.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers effective on January 1 following the effective date of the rate decrease.

Sec. 56. **REVISOR'S INSTRUCTION.**

Subdivision 1. **Renumbering of Minnesota Statutes, section 256B.0652, authorization and review of home care services.** (a) The revisor of statutes shall renumber each section of Minnesota Statutes listed in column A with the number in column B.

Column A	Column B
256B.0652, subdivision 3	256B.0652, subdivision 14
256B.0651, subdivision 6, paragraph (a)	256B.0652, subdivision 3
256B.0651, subdivision 6, paragraph (b)	256B.0652, subdivision 4
256B.0651, subdivision 6, paragraph (c)	256B.0652, subdivision 7
256B.0651, subdivision 7, paragraph (a)	256B.0652, subdivision 8
256B.0651, subdivision 7, paragraph (b)	256B.0652, subdivision 14
256B.0651, subdivision 8	256B.0652, subdivision 9
256B.0651, subdivision 9	256B.0652, subdivision 10
256B.0651, subdivision 11	256B.0652, subdivision 11
256B.0654, subdivision 2	256B.0652, subdivision 5
256B.0655, subdivision 4	256B.0652, subdivision 6

(b) The revisor of statutes shall make necessary cross-reference changes in statutes and rules consistent with the renumbering in paragraph (a). The Department of Human Services shall assist the revisor with any cross-reference changes. The revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text to conform with the intent of the renumbering in paragraph (a).

Subd. 2. **Renumbering personal care assistance services.** The revisor of statutes shall replace any reference to Minnesota Statutes, section 256B.0655 with section 256B.0659, wherever it appears in statutes or rules. The revisor shall correct any cross reference changes that are necessary as a result of this section. The Department of Human Services shall assist the revisor in making these changes, and if necessary, shall draft a corrections bill with changes for introduction in the 2010 legislative session. The revisor may make changes to punctuation, grammar, or sentence structure to preserve the integrity of statutes and effectuate the intention of this section.

Sec. 57. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256B.19, subdivision 1d; and 256B.431, subdivision 23, are repealed effective May 1, 2009.

(b) Laws 1988, chapter 689, section 251, is repealed effective July 1, 2009.

(c) Minnesota Statutes 2008, section 256B.0951, is repealed effective July 1, 2009.

(d) Minnesota Statutes 2008, sections 256B.0655, subdivisions 1, 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13; and 256B.071, subdivisions 1, 2, 3, and 4, are repealed.

ARTICLE 2

MFIP/CHILD CARE

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

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

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

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

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

Sec. 2. Minnesota Statutes 2008, section 119B.12, subdivision 1, is amended to read:

Subdivision 1. **Fee schedule.** In setting the sliding fee schedule, the commissioner shall exclude from the amount of income used to determine eligibility an amount for federal and state income and Social Security taxes attributable to that income level according to federal and state standardized tax tables. The commissioner shall base the parent fee on the ability of the family to pay for child care. The fee schedule must be designed to use any available tax credits.

PARENT FEE SCHEDULE. The parent fee schedule is as follows, except as noted in subdivision 2:

Income Range (as a percent of the state median income, except at the start of the first tier)	Co-payment (as a percentage of adjusted gross income)
0-74.99% of federal poverty guidelines	$0/month
75.00-99.99% of federal poverty guidelines	$5/month
100.00% of federal poverty guidelines-27.72%	~~2.61%~~ 2.69%
27.73-29.04%	~~2.61%~~ 2.69%
29.05-30.36%	~~2.61%~~ 2.69%
30.37-31.68%	~~2.61%~~ 2.69%

31.69-33.00%	~~2.91%~~ 3.00%
33.01-34.32%	~~2.91%~~ 3.00%
34.33-35.65%	~~2.91%~~ 3.00%
35.66-36.96%	~~2.91%~~ 3.00%
36.97-38.29%	~~3.21%~~ 3.31%
38.30-39.61%	~~3.21%~~ 3.31%
39.62-40.93%	~~3.21%~~ 3.31%
40.94-42.25%	~~3.84%~~ 3.96%
42.26-43.57%	~~3.84%~~ 3.96%
43.58-44.89%	~~4.46%~~ 4.59%
44.90-46.21%	~~4.76%~~ 4.90%
46.22-47.53%	~~5.05%~~ 5.20%
47.54-48.85%	~~5.65%~~ 5.82%
48.86-50.17%	~~5.95%~~ 6.13%
50.18-51.49%	~~6.24%~~ 6.43%
51.50-52.81%	~~6.84%~~ 7.05%
52.82-54.13%	~~7.58%~~ 7.81%
54.14-55.45%	~~8.33%~~ 8.58%
55.46-56.77%	~~9.20%~~ 9.48%
56.78-58.09%	~~10.07%~~ 10.37%
58.10-59.41%	~~10.94%~~ 11.27%
59.42-60.73%	~~11.55%~~ 11.90%
60.74-62.06%	~~12.16%~~ 12.52%
62.07-63.38%	~~12.77%~~ 13.15%
63.39-64.70%	~~13.38%~~ 13.78%
64.71-66.99%	~~14.00%~~ 14.42%
67.00%	ineligible

A family's monthly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

Sec. 3. Minnesota Statutes 2008, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning July 1, ~~2006~~ 2009, the maximum rate paid for child care assistance in any county or multicounty region under the child care fund shall be the rate for like-care arrangements in the county effective ~~January 1, 2006, increased~~ July 1, 2008, decreased by ~~six~~ three percent.

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

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

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

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

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

~~(e)~~ (d) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

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

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

Sec. 4. Minnesota Statutes 2008, section 119B.13, subdivision 6, is amended to read:

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

(b) If payments for child care assistance are made to providers, the provider shall bill the county for services provided within ten days of the end of the service period. If bills are submitted within ten days of the end of the service period, a county or the state shall issue payment to the provider of child care under the child care fund within 30 days of receiving a bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

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

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

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. To establish the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

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

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

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2008, section 256J.24, subdivision 5a, is amended to read:

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

Sec. 7. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

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

Sec. 8. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

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

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

(1) age 60 or older;

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

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

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

(d) Prior to implementing this provision, the commissioner must identify the MFIP participants subject to this provision and provide written notice to these participants at least 30 days before the first grant reduction. The notice must inform the participant of the basis for the potential grant reduction, the exceptions to the provision, if any, and inform the participant of the steps necessary to claim an exception. A person who is found not to meet one of the exceptions to the provision must be notified and informed of the right to a fair hearing under section 256J.40. The notice must

also inform the participant that the participant may be eligible for a rent reduction resulting from a reduction in the MFIP grant and encourage the participant to contact the local housing authority.

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

Sec. 9. Minnesota Statutes 2008, section 256J.37, is amended by adding a subdivision to read:

Subd. 11. **Treatment of Supplemental Security Income.** Effective March 1, 2010, the county shall reduce the cash portion of the MFIP grant by up to $125 for an MFIP assistance unit that includes one or more Supplemental Security Income (SSI) recipients who reside in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but are excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient or recipients receive less than $125 of SSI, only the amount received must be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

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

Sec. 10. Minnesota Statutes 2008, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the ~~plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35~~ participant must be working in unsubsidized employment at least 20 hours per week.

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

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

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

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

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

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

(c) The hourly unsubsidized employment requirement may be reduced for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

(d) Participants with an approved employment plan in place on July 1, 2009, which includes more than 12 months of postsecondary education or training, must be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, are met.

Sec. 11. Minnesota Statutes 2008, section 256J.575, subdivision 3, is amended to read:

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

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

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

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

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

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

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

Sec. 12. Minnesota Statutes 2008, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION CASH BENEFITS.

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

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

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

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

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

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

(c) Expenditures on the program are maintenance of effort state funds under a separate state program for participants under paragraph (b), clauses (1) and (2). Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort funds. Months in which a participant

receives work participation cash benefits under this section do not count toward the participant's MFIP 60-month time limit.

Sec. 13. Minnesota Statutes 2008, section 256J.626, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall~~:~~

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

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

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

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

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

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2008, section 256J.751, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2008, section 256J.95, subdivision 12, is amended to read:

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

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

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

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

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

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

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

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

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

(e) The county shall not request a combined application form for a participant who has exhausted the four months of the diversionary work program, has continued need for cash and food assistance, and has completed, signed, and submitted a program change request form within 30 days of the fourth month of the diversionary work program. The county must process the program change request according to section 256J.32, subdivision 1, except that the county agency shall not require additional verification of information in the case file unless the information is inaccurate, questionable, or no longer current. When a participant does not request MFIP within 30 days of the diversionary work program benefits being exhausted, a new combined application form must be completed for any subsequent request for MFIP.

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

Sec. 16. **REPEALER.**

Minnesota Statutes 2008, section 256J.626, subdivision 7, is repealed.

ARTICLE 3

ADULT SUPPORTS

Section 1. Minnesota Statutes 2008, section 256D.06, subdivision 2, is amended to read:

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

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

reallocate any unspent amounts to other counties.

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

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

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

Sec. 2. Minnesota Statutes 2008, section 256D.09, subdivision 6, is amended to read:

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2008, section 256D.46, is amended to read:

256D.46 EMERGENCY ~~MINNESOTA SUPPLEMENTAL~~ AID.

Subdivision 1. **Eligibility.** ~~A county agency must grant emergency Minnesota supplemental aid, to the extent funds are available, if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is~~

~~being paid under sections 256I.01 to 256I.06.~~ Recipients of Minnesota supplemental aid who have emergent need may apply for emergency general assistance medical care under section 256D.06, subdivision 2.

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

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

Sec. 4. Minnesota Statutes 2008, section 256D.49, subdivision 3, is amended to read:

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** "Countable income" means all income received by an applicant or recipient less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is in a GRH ~~setting less $20~~, less the medical assistance personal needs allowance. If the SSI limit has

been reduced for a person due to events occurring prior to the persons entering the GRH setting, countable income means actual income less any applicable exclusions and disregards.

Sec. 6. Minnesota Statutes 2008, section 256J.38, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 7. Minnesota Statutes 2008, section 393.07, subdivision 10, is amended to read:

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

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

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

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willful statement or misrepresentation, or intentional concealment of a material fact, food stamps or

vouchers issued according to sections 145.891 to 145.897 to which the person is not entitled or in an amount greater than that to which that person is entitled or which specify nutritional supplements to which that person is not entitled; or

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

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

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

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

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

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

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

(h) The commissioner of human services may seek a waiver from the United States Department of Agriculture to allow the state to specify foods that may and may not be purchased in Minnesota with benefits funded by the federal Food Stamp Program. The commissioner shall consult with the members of the house of representatives and senate policy committees having jurisdiction over food support issues in developing the waiver. The commissioner, in consultation with the commissioners of health and education, shall develop a broad public health policy related to improved nutrition and health status. The commissioner must seek legislative approval prior to implementing the waiver.

Sec. 8. **REPEALER.**

(a) Minnesota Statutes 2008, section 256I.06, subdivision 9, is repealed.

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

ARTICLE 4

PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2008, section 119B.02, subdivision 5, is amended to read:

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and ~~256.983~~ 256.9832.

Sec. 2. Minnesota Statutes 2008, section 256.045, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556,

subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been set aside under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit~~.~~; or

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

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

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

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

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

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

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

Sec. 3. **[256.9832] STATE WELFARE FRAUD INVESTIGATIONS.**

Subdivision 1. **Program established.** Effective July 1, 2009, the commissioner of human services shall establish a welfare fraud investigative unit to investigate allegations of recipient fraud in welfare programs with a state or federal funding component and quickly terminate benefits to ineligible recipients. Counties that received grants under Minnesota Statutes 2008, section 256.983, for the fraud prevention investigation project must use state investigators to investigate possible welfare fraud effective with termination of their grants. The commissioner shall develop a process for counties that did not participate in the former fraud prevention investigation project to begin use of state investigators.

Subd. 2. **Relationship to county criminal welfare fraud investigative units.** An investigation resulting in discovery of facts that appear to merit the involvement of the criminal justice system are to be referred to the county human services director or designee for further referral to the county criminal justice system, or may be referred directly to the county criminal justice system. The commissioner of human services must be notified of the disposition of these cases within six months of referral. If the criminal justice system has not acted on the referral or declined to act, the commissioner has the option to pursue further action on those cases.

Subd. 3. **County agency responsibilities.** State welfare fraud investigators shall have unrestricted access to human services records as needed to conduct an investigation. County agencies have 30 days after receipt of investigative findings to notify the commissioner of effect on eligibility. County agencies shall calculate overpayments identified through an investigation and establish a formal claim for repayment within 45 days of discovery.

Subd. 4. **Department responsibilities.** The commissioner shall establish training programs for state investigators, county welfare case workers, and supervisory staff. The commissioner shall develop operational guidelines, forms, and reporting mechanisms, which must be used by county agencies. The commissioner shall develop a process to ensure county cooperation with making appropriate referrals for welfare fraud investigations. An individuals's application or redetermination form for public assistance benefits, including child care assistance programs and medical care programs, must include an authorization by the individual for the release and sharing of information and documentation between third parties and investigators who are conducting welfare fraud investigations. The authorization for release and sharing of information is effective for six months after public assistance benefits have ceased.

EFFECTIVE DATE. This section is effective November 1, 2009.

Sec. 4. Minnesota Statutes 2008, section 270A.09, is amended by adding a subdivision to read:

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

Sec. 5. **REPEALER.**

Minnesota Statutes 2008, section 256.983, is repealed effective November 1, 2009.

ARTICLE 5

CHILD SUPPORT

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

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

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

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

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

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

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

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

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

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

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

(e) When a person terminates IV-D services, if an arrearage for public assistance as defined in section 256.741 exists, the public authority may continue income withholding, as well as use any other enforcement remedy for the collection of child support, until all public assistance arrears are paid in full. Income withholding shall be in an amount equal to 20 percent of the support order in effect at the time the services terminated~~.~~, unless the support order includes a specific monthly payback amount. If the support order includes a specific monthly payback amount, income withholding shall be in the specific amount ordered. The provisions of this paragraph apply to

all support orders in effect on or before January 1, 2010, and to all support orders in effect after January 1, 2010.

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

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

Subd. 10. **Arrearage order.** (a) This section does not prevent the court from ordering the payor of funds to withhold amounts to satisfy the obligor's previous arrearage in support order payments. This remedy shall not operate to exclude availability of other remedies to enforce judgments. The employer or payor of funds shall withhold from the obligor's income an additional amount equal to 20 percent of the monthly child support or maintenance obligation until the arrearage is paid~~.~~, unless the support order includes a specific monthly payback amount. If the support order includes a specific monthly payback amount, income withholding shall be in the specific amount ordered. The provisions of this paragraph apply to all support orders in effect on or before January 1, 2010, and to all support orders in effect after January 1, 2010.

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

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

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

Sec. 4. Minnesota Statutes 2008, section 518A.60, is amended to read:

518A.60 COLLECTION; ARREARS ONLY.

(a) Remedies available for the collection and enforcement of support in this chapter and chapters 256, 257, 518, and 518C also apply to cases in which the child or children for whom support is owed are emancipated and the obligor owes past support or has an accumulated arrearage as of the date of the youngest child's emancipation. Child support arrearages under this section include arrearages for child support, medical support, child care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in section 518A.41, subdivision 1, paragraph (h).

(b) This section applies retroactively to any support arrearage that accrued on or before June 3, 1997, and to all arrearages accruing after June 3, 1997.

(c) Past support or pregnancy and confinement expenses ordered for which the obligor has specific court ordered terms for repayment may not be enforced using drivers' and occupational or professional license suspension, and credit bureau reporting, ~~and additional income withholding under section 518A.53, subdivision 10, paragraph (a),~~ unless the obligor fails to comply with the terms of the court order for repayment.

(d) If an arrearage exists at the time a support order would otherwise terminate and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the arrearage shall be repaid in an amount equal to the current support order until all arrears have been paid in full, absent a court

order to the contrary.

(e) If an arrearage exists according to a support order which fails to establish a monthly support obligation in a specific dollar amount, the public authority, if it provides child support services, or the obligee, may establish a payment agreement which shall equal what the obligor would pay for current support after application of section 518A.34, plus an additional 20 percent of the current support obligation, until all arrears have been paid in full. If the obligor fails to enter into or comply with a payment agreement, the public authority, if it provides child support services, or the obligee, may move the district court or child support magistrate, if section 484.702 applies, for an order establishing repayment terms.

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

ARTICLE 6

PROTECTING CHILDREN AND STRENGTHENING FAMILIES ACT

Section 1. **[256N.01] CITATION.**

Sections 256N.01 to 256N.09 may be cited as the "Protecting Children and Strengthening Families Act," hereafter the "act." This act defines public child welfare policy, sets state priorities, creates accountability mechanisms for achieving improved outcomes for children and families, and establishes a fund to address the safety, permanency, and well-being needs of children and adolescents who come to the attention of the county as a result of a report of child maltreatment pursuant to section 626.556 or are otherwise the responsibility of the county.

Sec. 2. **[256N.02] PUBLIC POLICY.**

Subdivision 1. **General.** The legislature hereby declares that the public policy of the state is:

(1) first and foremost, children should be safe from harm and protected from abuse and neglect;

(2) children should be maintained safely in their homes whenever possible and appropriate;

(3) when the ability of parents to keep their children safe is compromised it is in the public interest to intervene early and provide services that promote parents' protective capacities, mitigate risks of harm, and strengthen and support parents in their care giving roles;

(4) children should grow up in safe, permanent and nurturing homes and, when it is not possible for their parents to provide safety and permanency, alternative permanency options must be made available to children as quickly as possible;

(5) whenever possible, alternative permanency options should be with children's relatives or kin in order to maintain family relationships and preserve connections with their communities and culture; and

(6) once permanency is achieved, children and their families should receive the services and supports necessary to maintain safe, stable, and permanent homes.

Subd. 2. **Racial disparities in child welfare.** It is further the policy of the state to reduce racial disparities and disproportionality that exists in the child welfare system by:

(1) identifying and addressing structural factors contributing to inequities in outcomes;

(2) identifying and implementing promising and evidence-based strategies to reduce racial disparities in treatment and outcomes;

(3) using cultural values, beliefs and practices of families, communities and tribes to shape family assessment, case planning, case service design, and case decision making processes;

(4) using placement and reunification strategies that maintain, honor, and support relationships and connections between parents, siblings, children, kin, and significant others, giving priority to kinship placements when placement is necessary; and

(5) supporting families in the context of their communities and tribes so as to safely divert them away from the child welfare system, whenever possible.

Sec. 3. **[256N.03] PUBLIC PRIORITIES.**

A broad continuum of services and a reform of practice are necessary across Minnesota to keep children safe from abuse and neglect, prevent the trauma associated with removing a child from their family home, and provide families with the necessary supports and services to protect and nurture their children. Successful implementation of state policy must result in improved outcomes for children and families and must be measured by:

(1) improved timeliness to initial investigations;

(2) increased monthly caseworker visits;

(3) reduced out-of-home placements;

(4) reduced re-entry;

(5) reduced recidivism;

(6) reduced number of children aging out of foster care without achieving permanency;

(7) improved rate of relative care;

(8) improved stability in foster care; and

(9) reduced racial and ethnic disparities and disproportionality.

Sec. 4. **[256N.04] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 256N.01 to 256N.09, the terms defined in this section have the meanings given them.

Subd. 2. **Adoptive care.** "Adoptive care" means care to an adopted special needs child under section 259.67.

Subd. 3. **Child protection investigation.** "Child protection investigation" means fact gathering by the child welfare agency related to the current safety of the child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed.

Subd. 4. **Children services.** "Children services" means services provided or arranged for by county boards for infants, children, and adolescents and may include, but are not limited to: child

protection investigation, family assessment response, family-based crisis services, family foster care, family preservation services, foster care, independent living services, permanency services, postpermanency support services, reunification services, subsidized guardianship, and support for at-risk families.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designee.

Subd. 6. **County board.** "County board" means the board of county commissioners in each county.

Subd. 7. **Family assessment response.** "Family assessment response" means a comprehensive assessment of child safety, risk of subsequent maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment response includes assessing the need for services and may include the provision of time-limited services.

Subd. 8. **Family-based crisis services.** "Family-based crisis services" means services provided to a family in the home, within 24 hours of referral, to help the family resolve a relationship crisis to prevent placing a child outside of the home.

Subd. 9. **Foster care.** "Foster care" means 24-hour substitute care in a family home or facility licensed under Minnesota Rules, chapter 2960, for children placed away from their parents or guardian and for whom a responsible social services agency has placement and care responsibility pursuant to a court order or voluntary placement agreement. Foster care includes an emergency placement of a child in the home of a relative who has not yet completed the licensure process. Services are provided to children who are in immediate need of out of home placement until a plan of care is established.

Subd. 10. **Family preservation services.** "Family preservation services" means services designed to maintain children in the home or in an outside setting, if needed to help the family resolve personal, family, or situational problems. These services are provided to prevent placement of a child outside of the home or so that a child can be returned home from placement.

Subd. 11. **Guardianship assistance.** "Guardianship assistance" means financial support to relatives who accept permanent and legal custody of a related child as a result of a permanency proceeding under section 260C.317.

Subd. 12. **Human services board.** "Human services board" means a board established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

Subd. 13. **Independent living services.** "Independent living services" means individual or group services designed to assist youth, ages 14 through 20, who are in out-of-home placement, to prepare them for independent living. Eligible youth can receive services until their 21st birthday. Services include an independent living skills assessment and the development of an independent living plan by a case manager. Services may include training in daily living skills, service coordination, educational and career assistance, driver's education or transportation use, and the funding of activities that promote self-reliance and self-esteem.

Subd. 14. **Permanency services.** "Permanency services" means services designed to plan for and finalize a safe and legally permanent alternative home for the child within the timelines

of section 260C.201, subdivision 11, when a child cannot return to the parent or guardian from whom they were removed. It also includes considering other permanent alternative homes for a child, preferably through adoption or transfer of permanent legal and physical custody of the child. Concurrent permanency planning and family group decision-making are included as permanency services.

Subd. 15. **Postpermanency support services.** "Postpermanency support services" means services designed to improve the likelihood that a child who has been in out-of-home placement will be able to remain in their permanency situation, whether that is reunification with their families, transfer of permanent legal and physical custody to a relative, or in a finalized adoption.

Subd. 16. **Reunification services.** "Reunification services" means services, including family group decision-making, provided to a child and their legal caregiver to facilitate the safe return of the child to the home. Specific services are provided by the local agency with legal responsibility pursuant to a court order or voluntary placement agreement, and are in the out-of-home placement plan.

Subd. 17. **Services for at-risk families.** "Services for at-risk families" means voluntary services that are designed to reduce the likelihood of any future maltreatment for families who have a maltreatment report that is not accepted under section 626.556, are self referred or referred by a community provider, or who are on the Minnesota family investment program under chapter 256J.

Sec. 5. **[256N.05] USE OF FUNDS.**

Funds under this act may be used to provide services under this act, or other services needed based on an individualized assessment of the child and family. Funds must be directed in the following order of priority:

(1) family assessment response, time-limited targeted services and child protection investigations;

(2) support for at-risk families;

(3) postpermanency support services;

(4) independent living services;

(5) family support and family preservation services;

(6) family-based crisis services;

(7) reunification services;

(8) permanency services; and

(9) foster care.

Sec. 6. **[256N.06] DUTIES OF COMMISSIONER OF HUMAN SERVICES.**

Subdivision 1. **General supervision.** In order to achieve the goals of this act, the commissioner shall allocate funds, provide assistance, evaluate the performance of counties, and ensure accountability for achieving improved outcomes for children and families.

Subd. 2. **Allocation of funds.** Each year the commissioner shall allocate available funds to each county with an approved plan according to section 256N.07 and meeting the requirements under this act. Funds must be allocated according to section 256N.08.

Subd. 3. **Assistance.** The commissioner shall:

(1) provide training, technical assistance, and other supports to each county to assist in needs assessment, planning, monitoring of outcomes and service quality, and implementation of program improvement plans;

(2) request waivers from federal programs as necessary to implement this act; and

(3) have authority under sections 14.055 and 14.056 to grant a variance to existing state rules as needed to eliminate barriers to achieving desired outcomes.

Subd. 4. **Accountability.** (a) The commissioner shall maintain a quality assurance system that measures county performance on federal and state outcome measures and performance items regarding child safety, permanency, and well being and determine the status of the public priorities identified in 256N.03. Performance measures may include:

(1) timeliness to initial investigation;

(2) monthly caseworker visits;

(3) rate of entry into foster care;

(4) rate of re-entry;

(5) rate of recidivism;

(6) number of children aging out of foster care without achieving permanency;

(7) rate of relative care;

(8) foster care stability; and

(9) other federal or state performance measures.

Performance measures may be modified by the federal Department of Health and Human Services or the commissioner. The quality assurance system must support and measure continuous quality improvement and work with counties to develop and implement program improvement plans in any areas in which the county is not in substantial conformity with federal and state performance standards.

(b) The commissioner shall:

(1) use data collection, evaluation of outcomes, and the review and approval of county plans to supervise county performance in the delivery of services to children and families;

(2) specify requirements for reports, including fiscal reports to account for funds distributed; and

(3) adjust allocations to a county based on the commissioner's determination regarding county performance under the act.

(c) The following steps must be taken when the commissioner has determined that a county has failed to meet performance standards and address the priorities under this act, or failed to develop and implement a program improvement plan:

(1) the commissioner shall notify the county, by mail, of the standards which the county has not achieved;

(2) the county has 60 days from notification to develop a program improvement plan and submit it to the commissioner for approval; and

(3) if the county fails to demonstrate achievement or fails to implement a program improvement plan approved by the commissioner, the commissioner may withhold the county's share of state or federal funds under this act. The commissioner may withhold future allocations until the county has achieved the standards applicable to the program or has developed and implemented a program improvement plan. If a county does not achieve standards to develop and implement a program improvement plan for more than six consecutive months, the commissioner may reallocate the withheld funds to counties that have achieved standards or are working to achieve them.

Sec. 7. **[256N.07] PLAN.**

Subdivision 1. **Plan submitted to commissioner.** Effective January 1, 2011, and each two-year period thereafter, each county shall have a biennial plan approved by the commissioner that addresses the public policy and priorities of this act in order to receive funds. The plan may be combined with other plans required by the commissioner and counties may submit multicounty or regional plans.

Subd. 2. **Contents.** The plan must be completed in a form prescribed by the commissioner. The plan must include:

(1) strategies the county must implement to keep children safe in their own homes and support families in the context of their communities and tribes so as to safely divert them away from the child welfare system, whenever possible;

(2) strategies the county must engage in to address each of the public priorities identified in section 256N.03;

(3) strategies that the county must engage in to maintain connections between family members and significant others, giving priority to kinship placements, when placement is necessary;

(4) strategies that address disparities in out-of-home placement for African-American and American Indian children in their county and other populations of children disproportionately represented, and when placement is necessary the strategies that must be employed to maintain children's familial and cultural connections;

(5) performance targets on state and federal indicators measuring outcomes of child safety, permanency, and well-being;

(6) strategies the county must implement to achieve the performance targets, including specification of how funds under this section and other community resources must be used to achieve desired performance targets; and

(7) a description of the county's process to solicit public input and a summary of that input.

Subd. 3. **Timelines.** The preliminary plan must be submitted to the commissioner by October 15, 2010, and October 15 of every two years thereafter.

Subd. 4. **Public comment.** The county board shall determine how citizens in the county will participate in the development of the plan and provide opportunities for such participation. The county shall allow a period of no less than 30 days prior to the submission of the plan to the commissioner to solicit comments from the public on the contents of the plan.

Subd. 5. **Commissioner's responsibilities.** The commissioner shall, within 60 days of receiving each county plan, inform the county if the plan has been approved. If the plan is not approved, the commissioner shall inform the county of any revisions needed for approval.

Sec. 8. **[256N.08] GRANT ALLOCATION.**

Subdivision 1. **Determination.** The commissioner shall annually determine whether a county has met the requirements under this act. In making this determination, the commissioner shall consider factors addressed by the county in its plan under section 256N.07, whether the county fully participated in the state quality assurance process, and actual county performance on measures of child safety, permanency, and well-being. The commissioner shall continue to measure and monitor performance, and counties shall continue to develop and employ appropriate strategies and procedures to continuously improve their services and outcomes. Performance standards for these measures must be determined by the commissioner in consultation with counties, and must include those prescribed by the federal Department of Human Services and those unique to the state.

Subd. 2. **Grant formula.** (a) Beginning July 10, 2011, counties shall receive the same allocation as was received the previous year under chapter 256M proportionately to state Children and Community Services Act and federal Title XX funds that are attributable to children services as determined by the commissioner. Allocations must be comprised of both state appropriations under this act and federal Title XX funds, except for Title XX funds allocated for administrative purposes and migrant day care. Beginning July 10, 2012, the amount of money allocated to counties must first be allocated in amounts equal to each county's guaranteed floor according to subdivision 3 provided they meet the requirements under subdivision 1, and second, any remaining available funds must be allocated as provided in paragraphs (b) to (f).

(b) Beginning July 10, 2012, ninety percent of remaining funds must be allocated proportionally to counties based on the previous year's allocation and ten percent must be allocated by the following formula:

(1) 50 percent of the funds must be allocated based on the county's performance on the state and federal standards and the public priorities identified in section 256N.03 as determined by the commissioner for that county;

(2) 30 percent of the funds must be allocated based on the county's percentage share of the number of accepted maltreatment reports in the most recent calendar year available as determined by the commissioner;

(3) ten percent of the funds must be allocated based on the county's percentage share of the number of reports of family assessments and services to at-risk families, as defined by section 256N.04, subdivisions 7 and 17, in the most recent calendar year available as determined by the commissioner; and

(4) ten percent of the funds must be allocated based on the average monthly caseloads in each county in the Minnesota family investment program in the most recent calendar year available as determined by the commissioner.

(c) Beginning July 10, 2013, 70 percent of remaining funds must be allocated proportionally to counties based on the previous year's allocation and 30 percent must be allocated by the following formula:

(1) 50 percent of the funds must be allocated based on the county's performance on the state and federal standards and the public priorities identified in section 256N.03 as determined by the commissioner for that county;

(2) 30 percent of the funds must be allocated based on the county's percentage share of the number of accepted maltreatment reports in the most recent calendar year available as determined by the commissioner;

(3) ten percent of the funds must be allocated based on the county's percentage share of the number of reports of family assessments and services to at-risk families, as defined by section 256N.04, subdivisions 7 and 17, in the most recent calendar year available as determined by the commissioner; and

(4) ten percent of the funds must be allocated based on the average monthly caseloads in each county in the Minnesota family investment program in the most recent calendar year available as determined by the commissioner.

(d) Beginning July 10, 2014, 40 percent of remaining funds must be allocated proportionally to counties based on the previous year's allocation and 60 percent must be allocated by the following formula:

(1) 50 percent of the funds must be allocated based on the county's performance on the state and federal standards and the public priorities identified in section 256N.03 as determined by the commissioner for that county;

(2) 30 percent of the funds must be allocated based on the county's percentage share of the number of accepted maltreatment reports in the most recent calendar year available as determined by the commissioner;

(3) ten percent of the funds must be allocated based on the county's percentage share of the number of reports of family assessments and services to at-risk families, as defined by section 256N.04, subdivisions 7 and 17, in the most recent calendar year available as determined by the commissioner; and

(4) ten percent of the funds must be allocated based on the average monthly caseloads in each county in the Minnesota family investment program in the most recent calendar year available as determined by the commissioner.

(e) Beginning July 10, 2014, ten percent of remaining funds must be allocated proportionally to counties based on the previous year's allocation and 90 percent must be allocated by the following formula:

(1) 50 percent of the funds must be allocated based on the county's performance on the state

and federal standards and the public priorities identified in section 256N.03 as determined by the commissioner for that county;

(2) 30 percent of the funds must be allocated based on the county's percentage share of the number of accepted maltreatment reports in the most recent calendar year available as determined by the commissioner;

(3) ten percent of the funds must be allocated based on the county's percentage share of the number of reports of family assessments and services to at-risk families, as defined by section 256N.04, subdivisions 7 and 17, in the most recent calendar year available as determined by the commissioner; and

(4) ten percent of the funds must be allocated based on the average monthly caseloads in each county in the Minnesota family investment program in the most recent calendar year available as determined by the commissioner.

(f) Beginning July 10, 2015, 100 percent of remaining funds must be allocated by the following formula:

(1) 50 percent of the funds must be allocated based on the county's performance on the state and federal standards and the public priorities identified in section 256N.03 as determined by the commissioner for that county;

(2) 30 percent of the funds must be allocated based on the county's percentage share of the number of accepted maltreatment reports in the most recent calendar year available as determined by the commissioner;

(3) ten percent of the funds shall be allocated based on the county's percentage share of the number of reports of family assessments and services to at-risk families, as defined by section 256N.04, subdivisions 7 and 17, in the most recent calendar year available as determined by the commissioner; and

(4) ten percent of the funds must be allocated based on the average monthly caseloads in each county in the Minnesota family investment program in the most recent calendar year available as determined by the commissioner.

Subd. 3. **Guaranteed floor.** The guaranteed floor portion of funds must be 25 percent of the total allocation. Each county must be allocated a guaranteed floor based on the population of the county under age 19 years as compared to the state as a whole as determined by the most recent data from the state demographer's office. When the amount of funds available for allocation is less than the amount available in the previous year, each county's allocation must be reduced in proportion to the reduction in the statewide funding, to establish each county's guaranteed floor.

Subd. 4. **Payments.** Calendar year state allocations under subdivision 1 must be paid to counties on or before July 10 of each year. Federal Title XX funds must be allocated as permissible under federal law and regulations.

Sec. 9. **[256N.09] DUTIES OF COUNTY BOARDS.**

Subdivision 1. **Responsibilities.** The county or human services board of each county are responsible for administration and funding of children services in order to achieve the public policy

and priorities identified in sections 256N.02 and 256N.03. The county board shall use funds under this act to support the strategies identified in its plan under section 256N.07.

Subd. 2. **Reports.** The county shall provide necessary reports and data as required by the commissioner.

Subd. 3. **Exemption from liability.** The state of Minnesota and the county in the implementation and administration of services under this act must not be liable for damages, injuries, or liabilities sustained through the purchase of services by the individual, the individual's family, or the authorized representative under this section.

Subd. 4. **Fees for services.** The county may establish a schedule of fees based upon clients' ability to pay to be charged to recipients of children services. Payment, in whole or in part, for services may be accepted from any person except that no fee may be charged to persons or families whose adjusted gross household income is below the federal poverty level. When services are provided to any person, including a recipient of aid administered by the federal, state, or county government, payment of any charges due may be billed to and accepted from a public assistance agency or from any public or private corporation.

Subd. 5. **Denial, reduction, or termination of services due to fiscal limitations.** Before a county denies, reduces, or terminates services to an individual, the county shall notify the individual and the individual's guardian in writing of the reason for the denial, reduction, or termination of services and their right to a fair hearing under section 256.045 and that the county will, upon request, meet to discuss alternatives before services are terminated or reduced.

Sec. 10. **EFFECTIVE DATE.**

Sections 1 to 9 are effective January 1, 2011.

Sec. 11. **REVISOR'S INSTRUCTION.**

The revisor shall renumber section 256M.20, subdivision 3, as 256.01, subdivision 29, paragraph (a), and section 256M.20, subdivision 4, as section 256.01, subdivision 29, paragraph (b), and correct any internal cross references resulting from this renumbering. The revisor shall make any necessary technical, grammatical, or punctual changes to accomplish this renumbering.

ARTICLE 7

NORTHSTAR CARE FOR CHILDREN

Section 1. Minnesota Statutes 2008, section 256.991, is amended to read:

256.991 RULES.

The commissioner of human services may promulgate rules as necessary to implement sections 256.01, subdivision 2; ~~256.82, subdivision 3;~~ 256.966, subdivision 1; 256D.03, subdivisions 3, 4, 6, and 7; and 261.23. The commissioner shall promulgate rules to establish standards and criteria for deciding which medical assistance services require prior authorization and for deciding whether a second medical opinion is required for an elective surgery. The commissioner shall promulgate rules as necessary to establish the methods and standards for determining inappropriate utilization of medical assistance services.

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

Sec. 2. Minnesota Statutes 2008, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) state adoption assistance payments under section 259.67, adoption assistance payments under chapter 256O, and up to an equal amount of county adoption assistance payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for ~~relative custody~~ guardianship assistance under ~~section 257.85~~ chapter 256O;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment; and

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC.

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

Sec. 3. Minnesota Statutes 2008, section 256J.24, subdivision 3, is amended to read:

Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

(1) individuals who are recipients of Supplemental Security Income or Minnesota supplemental aid;

(2) individuals disqualified from the food stamp or food support program or MFIP, until the disqualification ends; and

(3) children ~~on whose behalf~~ eligible for Northstar Care for Children under chapter 256O when the caregiver receives federal, state or local foster care; guardianship assistance; or adoption assistance payments ~~are made~~ for them, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2~~; and~~.

~~(4) children receiving ongoing monthly adoption assistance payments under section 259.67.~~

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

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

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

Subd. 4. **Individuals who may elect to be included in the assistance unit.** (a) The minor child's eligible caregiver may choose to be in the assistance unit, if the caregiver is not required to be in the assistance unit under subdivision 2. If the eligible caregiver chooses to be in the assistance unit, that person's spouse must also be in the unit.

(b) Any minor child not related as a sibling, stepsibling, or adopted sibling to the minor child in the unit, but for whom there is an eligible caregiver may elect to be in the unit.

(c) A ~~foster care~~ provider ~~of a minor child who is~~ receiving ~~federal, state, or local foster care maintenance payments~~ benefits for a child eligible for Northstar Care for Children under chapter 256O may elect to receive MFIP if the provider meets the definition of caregiver under section 256J.08, subdivision 11. If the provider chooses to receive MFIP, the spouse of the provider must also be included in the assistance unit with the provider. The provider and spouse are eligible for ~~assistance~~ MFIP even if the only minor child living in the provider's home is receiving ~~foster care maintenance payments~~ benefits from Northstar Care for Children.

(d) The adult caregiver or caregivers of a minor parent are eligible to be a separate assistance unit from the minor parent and the minor parent's child when:

(1) the adult caregiver or caregivers have no other minor children in the household;

(2) the minor parent and the minor parent's child are living together with the adult caregiver or caregivers; and

(3) the minor parent and the minor parent's child receive MFIP, or would be eligible to receive

MFIP, if they were not receiving SSI benefits.

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

Sec. 5. **[256O.001] CITATION.**

Sections 256O.001 to 256O.270 may be cited as the "Northstar Care for Children Act." Sections 256O.001 to 256O.270 establish Northstar Care for Children, which authorizes certain benefits to support children in need who are served by the Minnesota child welfare system and who are the responsibility of the state of Minnesota, local county social service agencies, or tribal social service agencies under section 256.01, subdivision 14b. A child eligible for the benefit has experienced a child welfare intervention that has resulted in the child being placed away from the child's parents' care and is receiving foster care services under chapter 260B, 260C, or 260D or is in the permanent care of relatives through a transfer of permanent legal and physical custody, or in the permanent care of adoptive parents.

Sec. 6. **[256O.01] PUBLIC POLICY.**

(a) The legislature hereby declares that the public policy of this state is to keep children safe from harm and to ensure that when children suffer harmful or injurious experiences in their lives, appropriate services are immediately available to keep them safe.

(b) Children do best in permanent, safe, nurturing homes with long-term relationships with adults. Whenever safely possible, children are best served when they can be nurtured and raised by their parents. Where services cannot be provided to allow a child to remain safely at home, an out-of-home placement may be required. When this occurs, reunification should be sought if it can be accomplished safely. When it is not possible for parents to provide safety and permanency for their children, an alternative permanent home must quickly be made available to the child, drawing from kinship sources whenever possible.

(c) Minnesota understands the importance of having a comprehensive approach to temporary out-of-home care and to permanent homes for children who cannot be reunited with their families. It is critical that stable benefits be available to caregivers to ensure that the child's needs can be met whether the child's situation and best interests call for temporary foster care, transfer of permanent legal and physical custody to a relative, or adoption. Northstar Care for Children focuses on the child's needs and strengths, and the actual level of care provided by the caregiver, without consideration for the type of placement setting. In this way, caregivers are not faced with the burden of making specific long-term decisions based upon competing financial incentives.

Sec. 7. **[256O.02] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 256O.001 to 256O.270, the terms defined in this section have the meanings given them.

Subd. 2. **Adoption assistance.** "Adoption assistance" means financial support, medical coverage, or both, provided under agreement with the legally responsible agency and the commissioner to the parents of an adoptive child whose special needs would otherwise make it difficult to place the child for adoption, to assist with the cost of caring for the child.

Subd. 3. **Assessment.** "Assessment" means the process under section 256O.240 by which is determined the benefits an eligible child may receive under section 256O.250.

Subd. 4. **At-risk child.** "At-risk child" means a child who does not have a documented disability but who is at risk of developing a physical, mental, emotional, or behavioral disability based on being related within the first or second degree to persons who have an inheritable physical, mental, emotional, or behavioral disabling condition, or from a background which has the potential to cause the child to develop a physical, mental, emotional, or behavioral disability. The disability that the child is at risk of developing must be likely to manifest during childhood. A high-risk child under section 259.67 is considered an at-risk child.

Subd. 5. **Basic rate.** "Basic rate" means the maintenance payment made on behalf of a child to support the costs caregivers incur to meet a child's needs consistent with the care parents customarily provide, including: food, clothing, shelter, daily supervision, school supplies, child's personal incidentals, reasonable travel to the child's home for visitation, and transportation needs associated with providing the listed items.

Subd. 6. **Caregiver.** "Caregiver" means the foster parent of a child in foster care who meets the requirements of emergency relative placement, a licensed foster parent under chapter 245A, or approved by the tribe; the relative custodian; or the adoptive parent who has legally adopted a child.

Subd. 7. **Child-placing agency.** "Child-placing agency" means an agency licensed under section 245A.03, subdivision 1, clauses (2) and (3).

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 9. **County board.** "County board" means the board of county commissioners in each county.

Subd. 10. **Disability.** "Disability" means a professionally documented physical, mental, emotional, or behavioral impairment that substantially limits one or more major life activity. Major life activities include, but are not limited to: thinking, walking, hearing, breathing, working, seeing, speaking, communicating, learning, developing and maintaining healthy relationships, safely caring for oneself, and performing manual tasks. The nature, duration, and severity of the impairment must be used in determining if the limitation is substantial.

Subd. 11. **Foster care.** "Foster care" means foster care as described either in section 260B.007, subdivision 7, or 260C.007, subdivision 18.

Subd. 12. **Guardianship assistance.** "Guardianship assistance" means financial support, medical coverage, or both, provided under agreement with the legally responsible agency and the commissioner to a relative who has received permanent legal and physical custody of a child, to assist with the cost of caring for the child.

Subd. 13. **Human services board.** "Human services board" means a board established under section 402.02; Laws 1974, chapter 293; or Laws 1976, chapter 340.

Subd. 14. **Legally responsible agency.** "Legally responsible agency" means the Minnesota agency that is assigned responsibility for placement, care, and supervision of the child through a court order, voluntary placement agreement, or voluntary relinquishment. These agencies include both local social service agencies under section 393.07 and tribal social service agencies authorized in section 256.01, subdivision 14b, and Minnesota tribes when legal responsibility is transferred to the tribal social service agency through a Minnesota district court order.

Subd. 15. **Maintenance payments.** "Maintenance payments" means the basic rate plus any supplemental difficulty of care rate under Northstar Care for Children. It specifically does not include the cost of initial clothing allowance, payment for social services, or administrative payments to a child-placing agency.

Subd. 16. **Permanent legal and physical custody.** "Permanent legal and physical custody" means permanent legal and physical custody ordered by a Minnesota juvenile court under section 260C.201, subdivision 11, or for children under tribal court jurisdiction, similar provision under tribal code which means that the individual responsible for the child has responsibility for the protection, education, care, and control of the child and decision making on behalf of the child.

Subd. 17. **Reassessment.** "Reassessment" means an update of the previous assessment through the process under section 256O.240 for a child who has been continuously eligible for this benefit.

Subd. 18. **Relative.** "Relative" as described in section 260C.007, subdivision 27, means a person related to the child by blood, marriage, or adoption, or an individual who is an important friend with whom the child has resided or had significant contact. For an Indian child, relative includes members of the extended family as defined by the law or custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews, or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1903.

Subd. 19. **Relative custodian.** "Relative custodian" means a person to whom permanent legal and physical custody of a child has been transferred under section 260C.201, subdivision 11, or for children under tribal court jurisdiction, a similar provision under tribal code which means that the individual responsible for the child has responsibility for the protection, education, care, and control of the child and decision making on behalf of the child.

Subd. 20. **Supplemental difficulty of care rate.** "Supplemental difficulty of care rate" means the supplemental rating, if any, as determined by the legally responsible agency or the state, based upon an assessment under section 256O.240. The supplemental rate supports activities consistent with the care a parent would provide a child with special needs and not the equivalent of a purchased service. The rate considers the capacity and intensity of the activities associated with parenting duties provided in the home to nurture the child, preserve the child's connections, and support the child's functioning in the home and community.

Sec. 8. **[256O.200] NORTHSTAR CARE FOR CHILDREN.**

Subdivision 1. **Eligibility.** A child is eligible for Northstar Care for Children if the child is eligible for:

(1) foster care under section 256O.210;

(2) guardianship assistance under section 256O.220; or

(3) adoption assistance under section 256O.230.

Subd. 2. **Assessments and agreements.** A child eligible for Northstar Care for Children shall receive an assessment under section 256O.240. For a child eligible for guardianship assistance or adoption assistance, negotiations with caregivers and the development of a written, binding agreement must be conducted under section 256O.240.

Subd. 3. **Benefits and payments.** A child eligible for Northstar Care for Children is entitled to benefits specified in section 256O.250, based primarily on assessments, negotiations, and agreements under section 256O.240. Although paid to the caregiver, these benefits are considered benefits of the child rather than of the caregiver.

Subd. 4. **Shared cost of care.** The cost of Northstar Care for Children must be shared among the federal government, state, counties of financial responsibility, and certain tribes as specified in section 256O.260.

Subd. 5. **Administration and appeals.** The commissioner and legally responsible agency shall administer Northstar Care for Children according to section 256O.270. The notification and fair hearing process is defined in section 256O.270.

Subd. 6. **Transition.** Provisions for the transition to Northstar Care for Children are specified in sections 256O.240, subdivision 13, and 256O.270, subdivisions 2 and 7 to 10. Additional provisions for children in foster care are specified in section 256O.210, subdivision 5; for children in relative custody assistance under section 257.85 are specified in section 256O.220, subdivision 8; and for children in adoption assistance under section 259.67 are specified in section 256O.230, subdivision 14.

Sec. 9. **[256O.210] FOSTER CARE ASSISTANCE ELIGIBILITY.**

Subdivision 1. **General eligibility requirements.** This section establishes the eligibility for benefits when children are placed in foster care.

(a) A child that meets the requirements of subdivision 2 on or after January 1, 2011, is eligible for the benefit.

(b) The benefit to the child under Northstar Care for Children, if any, is determined under sections 256O.240 and 256O.250.

(c) When a child is eligible for additional services, subdivisions 3 and 4 govern the co-occurrence of program eligibility.

(d) The child's benefit is individually assessed and the information assessment is used to determine future eligibility for guardianship assistance and adoption assistance, if needed.

(e) The county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, shall make a title IV-E eligibility determination for all foster children in Northstar Care for Children. To be eligible for title IV-E foster care, a child must also meet any additional criteria specified in section 472 of the Social Security Act.

Subd. 2. **Placement in foster care.** To be eligible for Northstar Care for Children, all of the following criteria must be met:

(1) the child is placed away from the child's legal parents or guardian and a legally responsible agency has placement authority and care responsibility;

(2) the legally responsible agency has authority to place the child with a voluntary placement agreement or a court order, consistent with section 260C.001, 260B.175, or 260D.01, or continued eligibility consistent with section 260C.451; and

(3) the child is placed in an emergency relative placement under section 245A.035, a licensed foster family setting, foster residence setting, or treatment foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or a family foster home approved by a tribal agency.

Subd. 3. **Minor parent.** A child who is a minor parent in placement with the minor parent's child in the same home is eligible for the benefit. The benefit is limited to the minor parent unless the legally responsible agency has separate legal authority for placement of the minor parent's child.

Subd. 4. **Excluded activities.** The basic and supplemental difficulty of care payments represent costs for activities similar in nature to those expected of parents and do not cover services rendered by the licensed foster parent or facility or any administrative cost. The county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, may pay a fee for specific services provided by the licensed foster parent or facility. Any foster parent or residence setting must be able to distinguish the service from the daily care of the child, as assessed in the universal assessment under section 256O.240. Administrative costs or fees are not part of this benefit.

Subd. 5. **Transition from pre-2011.** All children in family foster care who are the financial responsibility of local social service agencies under section 393.07 or tribal social service agencies authorized in section 256.01, subdivision 14b, are eligible for Northstar Care for Children. All eligible foster children must be assessed according to section 256O.240 and then transitioned into Northstar Care for Children according to the process in section 256O.270.

Sec. 10. **[256O.220] GUARDIANSHIP ASSISTANCE ELIGIBILITY.**

Subdivision 1. **General eligibility requirements.** (a) To be eligible for guardianship assistance, there must be a judicial determination under section 260C.201, subdivision 11, paragraph (c), that a transfer of permanent legal and physical custody to a relative or, for a child under tribal jurisdiction, a similar provision under tribal code which means that the individual responsible for the child has responsibility for the protection, education, care, and control of the child and decision making on behalf of the child, is in the child's best interest. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided in foster care for at least six consecutive months in the home of the prospective relative custodian; or

(ii) have received an exemption from the requirement in item (i) from the court based on a determination that an expedited move to permanency is in the child's best interest;

(3) meet the judicial determination regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3; and

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child has attained 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or

custodians must meet the applicable background study requirements in subdivision 4.

(c) The legally responsible agency shall make a title IV-E guardianship assistance eligibility determination for each child. To be eligible for title IV-E guardianship assistance, a child must also meet any additional criteria specified in section 473(d) of the Social Security Act. A child who meets all eligibility criteria, except those specific to title IV-E guardianship assistance, is entitled to guardianship assistance paid through state funds.

Subd. 2. **Judicial determinations regarding permanency.** To be eligible for guardianship assistance, the following judicial determinations regarding permanency must be made for the child prior to the transfer of permanent legal and physical custody:

(1) a judicial determination that reunification and adoption are not appropriate permanency options for the child; and

(2) a judicial determination that the child demonstrates a strong attachment to the prospective relative custodian and the relative custodian has a strong commitment to caring permanently for the child.

Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the United States or otherwise eligible for federal public benefits according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for title IV-E guardianship assistance.

(b) A child must be a citizen of the United States or meet the qualified alien requirements as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for state-funded guardianship assistance.

Subd. 4. **Background study.** (a) A background study must be completed on each prospective relative custodian. If a background study on the prospective relative custodian was previously completed under section 245A.04 for the purposes of foster care licensure, that background study may be used for the purposes of this section, provided that the background study is current at the time of the application for guardianship assistance. If the background study reveals:

(1) a felony conviction at any time for child abuse or neglect;

(2) spousal abuse;

(3) a crime against children, including child pornography;

(4) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(5) a felony conviction within the past five years for physical assault, battery, or a drug-related offense,

the prospective relative custodian is prohibited from receiving title IV-E guardianship assistance payments on behalf of an otherwise eligible child.

(b) An otherwise eligible prospective relative custodian who possesses one of the felony convictions in paragraph (a) may receive state-funded guardianship assistance payments on behalf of an otherwise eligible child if the court has made a judicial determination that:

(1) the legally responsible agency has thoroughly reviewed the felony conviction and has considered the impact, if any, that the conviction may have on the child's safety, well-being, and permanency;

(2) the conviction likely does not pose a current or future safety risk to the child;

(3) there is no other available permanency resource that is appropriate for the child; and

(4) the proposed transfer of permanent legal and physical custody is in the child's best interest.

Subd. 5. **Residency.** A child placed in the state from another state or a tribe outside the state is not eligible for state-funded guardianship assistance through the state. A child placed in the state from another state or a tribe outside of the state may be eligible for title IV-E guardianship assistance through the state if all eligibility factors are met and there is no state agency that has responsibility for placement and care of the child.

Subd. 6. **Exclusions.** A child with a guardianship assistance agreement under Northstar Care for Children is not eligible for the MFIP child-only grant under section 256J.88.

Subd. 7. **Termination.** (a) A guardianship assistance agreement terminates in any of the following circumstances:

(1) the child reaches the age of 18;

(2) the commissioner determines that the relative custodian is no longer legally responsible for support of the child;

(3) the commissioner determines that the relative custodian is no longer providing financial support to the child;

(4) death of the child; or

(5) the relative custodian requests termination of the guardianship assistance agreement in writing.

(b) A relative custodian is considered no longer legally responsible for support of the child in any of the following circumstances:

(1) permanent legal and physical custody of the child is transferred to another individual;

(2) death of the relative custodian;

(3) enlistment of the child in the military;

(4) marriage of the child; or

(5) emancipation of the child through legal action of another state.

Subd. 8. **Transitioning in from pre-2011.** Effective December 31, 2010, all relative custody assistance agreements under section 257.85 must terminate. A child who has a relative custody assistance agreement executed on the child's behalf under section 257.85 on or before November 24, 2010, is eligible for Northstar Care for Children beginning January 1, 2011, provided that all parties have signed the guardianship assistance agreement on or before that date. All eligible children shall be assessed according to section 256O.240 and transitioned into Northstar Care for Children

according to the process in section 256O.270. Effective November 25, 2010, a child who meets the eligibility criteria for guardianship assistance in subdivision 1, may have a guardianship assistance agreement negotiated on the child's behalf according to section 256O.240, and the effective date of the agreement is January 1, 2011, or the date of the court order transferring permanent legal and physical custody, whichever is later.

Sec. 11. **[256O.230] ADOPTION ASSISTANCE ELIGIBILITY.**

Subdivision 1. **General eligibility requirements.** (a) To be eligible for adoption assistance, a child must:

(1) be determined to be a child with special needs, according to subdivision 2;

(2) meet the applicable citizenship and immigration requirements in subdivision 3; and

(3)(i) meet the criteria outlined in section 473 of the Social Security Act; or

(ii) have had foster care payments paid on the child's behalf while in out-of-home placement through the county or tribe, and be either under the guardianship of the commissioner or under the jurisdiction of a Minnesota tribe and adoption according to tribal law is the child's documented permanency plan.

(b) In addition to the requirements in paragraph (a), the child's adoptive parent or parents must meet the applicable background study requirements in subdivision 4.

(c) The legally responsible agency shall make a title IV-E adoption assistance eligibility determination for each child. A child who meets all eligibility criteria, except those specific to title IV-E adoption assistance, shall receive adoption assistance paid through state funds.

Subd. 2. **Special needs determination.** (a) A child is considered a child with special needs under this section if all of the following criteria in paragraphs (b) to (d) are met.

(b) There has been a determination that the child cannot or should not be returned to the home of the child's parents as evidenced by:

(1) a court-ordered termination of parental rights;

(2) a petition to terminate parental rights;

(3) a consent to adopt accepted by the court under sections 260C.201, subdivision 11, and 259.24;

(4) in circumstances when tribal law permits the child to be adopted without a termination of parental rights, a judicial determination by tribal court indicating the valid reason why the child cannot or should not return home;

(5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment occurred in another state, the applicable laws in that state; or

(6) the death of the legal parent.

(c) There exists a specific factor or condition because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance as evidenced by:

(1) a determination by the Social Security Administration that the child meets all medical or disability requirements of title XVI of the Social Security Act with respect to eligibility for Supplemental Security Income benefits;

(2) a documented physical, mental, emotional, or behavioral disability not covered under clause (1);

(3) membership in a sibling group being adopted at the same time by the same parent;

(4) adoptive placement in the home of a parent who previously adopted another child born of the same mother or father for whom they receive adoption assistance; or

(5) documentation that the child is an at-risk child according to subdivision 7.

(d) A reasonable but unsuccessful effort has been made to place the child with adoptive parents without providing adoption assistance as evidenced by:

(1)(i) a documented search for an appropriate adoptive placement; or

(ii) a determination by the commissioner that such a search would not be in the best interests of the child; and

(2) a written statement from the identified prospective adoptive parents that they are either unwilling or unable to adopt the child without adoption assistance.

(e) To meet the requirement of a documented search for an appropriate adoptive placement under paragraph (d), clause (1), item (i), the placing agency minimally shall:

(1) give consideration as required by section 260C.212, subdivision 5, to placement with a relative;

(2) for an Indian child covered by the Indian Child Welfare Act, comply with the placement preferences identified in the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act; and

(3) review all families approved for adoption who are associated with the placing agency.

If the review of families associated with the placing agency results in the identification of an appropriate adoptive placement for the child, the placing agency must provide documentation of the placement decision to the commissioner as part of the application for adoption assistance. If two or more appropriate families are not approved or available within the placing agency, the agency shall locate additional prospective adoptive families by registering the child with the state adoption exchange, as defined in section 259.75. If registration with the state adoption exchange does not result in an appropriate family for the child, the agency shall employ other recruitment methods as outlined in recruitment policies and procedures prescribed by the commissioner, to meet this requirement.

(f) The requirement for a documented search for an appropriate adoptive placement including a review of all families approved for adoption that are associated with the placing agency, registration of the child with the state adoption exchange, and additional recruitment methods must be waived if:

(1) the child is being adopted by a relative;

(2) the child is being adopted by foster parents with whom the child has developed significant emotional ties while in the foster parents' care as a foster child; or

(3) the child is being adopted by a family that previously adopted a child of the same mother or father;

and the court determines that adoption by the identified family is in the child's best interest. For an Indian child covered by the Indian Child Welfare Act, a waiver must not be granted unless the placing agency has complied with the placement preferences identified in the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act.

(g) Once the placing agency has determined that placement with an identified family is in the child's best interest and made full written disclosure about the child's social and medical history, the agency must ask the prospective adoptive parents if they are willing to adopt the child without adoption assistance. If the identified family is either unwilling or unable to adopt the child without adoption assistance, they must provide a written statement to this effect to the placing agency to fulfill the requirement to make a reasonable effort to place the child without adoption assistance, and a copy of this statement shall be included in the adoption assistance application. If the identified family desires to adopt the child without adoption assistance, they must provide a written statement to this effect to the placing agency and the statement shall be maintained in the permanent adoption record of the placing agency. For children under the commissioner's guardianship, the placing agency shall submit a copy of this statement to the commissioner to be maintained in the permanent adoption record.

Subd. 3. **Citizenship and immigration status.** (a) A child must be a citizen of the United States or otherwise eligible for federal public benefits according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for title IV-E adoption assistance.

(b) A child must be a citizen of the United States or meet the qualified alien requirements as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for state-funded adoption assistance.

Subd. 4. **Background study.** (a) A background study under section 259.41 must be completed on each prospective adoptive parent. If the background study reveals:

(1) a felony conviction at any time for child abuse or neglect;

(2) spousal abuse;

(3) a crime against children, including child pornography;

(4) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(5) a felony conviction within the past five years for physical assault, battery, or a drug-related offense,

the adoptive parent is prohibited from receiving title IV-E adoption assistance on behalf of an otherwise eligible child.

(b) A prospective adoptive parent who possesses one of the felony convictions in paragraph (a) may receive state-funded adoption assistance on behalf of an otherwise eligible child if the court has made a judicial determination that:

(1) the legally responsible agency has thoroughly reviewed the felony conviction and has considered the impact, if any, that the conviction may have on the child's safety, well-being, and permanency;

(2) the conviction likely does not pose a current or future safety risk to the child;

(3) there is no other available permanency resource that is appropriate for the child; and

(4) the adoptive placement is in the child's best interest.

Subd. 5. **Residency.** A child placed in the state from another state or a tribe outside the state is not eligible for state-funded adoption assistance through the state. A child placed in the state from another state or a tribe outside of the state may be eligible for title IV-E adoption assistance through the state of Minnesota if all eligibility factors are met and there is no state agency that has responsibility for placement and care of the child.

Subd. 6. **Exceptions and exclusions.** Payments for adoption assistance must not be made to a biological parent of the child or a stepparent who adopts the child. Direct placement adoptions under section 259.47 or the equivalent in tribal code are not eligible for state-funded adoption assistance. A child who is adopted by the child's legal custodian or guardian is not eligible for state-funded adoption assistance. A child who is adopted by the child's legal custodian or guardian may be eligible for title IV-E adoption assistance if all required eligibility factors are met. International adoptions are not eligible for adoption assistance unless the adopted child has been placed into foster care through the public child welfare system subsequent to the failure of the adoption, and all required eligibility factors are met.

Subd. 7. **Documentation.** (a) Documentation must be provided to verify that a child meets the special needs criteria in subdivision 2.

(b) Documentation of the disability is limited to evidence deemed appropriate by the commissioner.

(c) To qualify as being an at-risk child, the placing agency shall provide to the commissioner one or more of the following:

(1) documented information in a county or tribal social service department record or court record that a relative within the first or second degree has a medical diagnosis or medical history, including diagnosis of a significant mental health or chemical dependency issue, which could result in the child's development of a disability during childhood;

(2) documented information that while in the public child welfare system, the child has experienced three or more placements with extended family or different foster homes that could affect the normal attachment process;

(3) documented evidence in a county or tribal social service department record that the child experienced neglect in the first three years of life or sustained physical injury, sexual abuse, or physical disease that could have a long-term effect on physical, emotional or mental development;

or

(4) documented evidence in a medical or hospital record, law enforcement record, county or tribal social service department record, court record, or record of an agency under a contract with a county social service agency or the state to provide child welfare services that the birth mother used drugs or alcohol during pregnancy which could later result in the child's development of a disability.

Subd. 8. **Termination.** (a) An adoption assistance agreement terminates in any of the following circumstances:

(1) the child attains the age of 18, unless an extension according to subdivisions 10 to 13 are applied for by the adoptive parents and granted by the commissioner;

(2) the commissioner determines that the adoptive parents are no longer legally responsible for support of the child;

(3) the commissioner determines that the adoptive parents are no longer providing financial support to the child;

(4) death of the child; or

(5) the adoptive parents request termination of the adoption assistance agreement in writing.

(b) An adoptive parent is considered no longer legally responsible for support of the child in any of the following circumstances:

(1) parental rights to the child are legally terminated;

(2) permanent legal and physical custody or guardianship of the child is transferred to another individual;

(3) death of the adoptive parent;

(4) enlistment of the child in the military;

(5) marriage of the child; or

(6) emancipation of the child through legal action of another state.

Subd. 9. **Death of adoptive parent or adoption dissolution.** (a) The adoption assistance agreement ends upon death or termination of parental rights of both of the adoptive parents, in the case of a two-parent adoption, or the sole adoptive parent, in the case of a single-parent adoption, but the child maintains eligibility for state-funded or title IV-E adoption assistance in a subsequent adoption if the following criteria are met:

(1) the child is determined to be a child with special needs as described in subdivision 2;

(2) the subsequent adoptive parents reside in the state of Minnesota; and

(3) no state agency outside the state has responsibility for placement and care of the child at the time of the subsequent adoption.

(b) According to federal regulations, if the child had a title IV-E adoption assistance agreement prior to the death of the adoptive parents or dissolution of the adoption, and a state agency outside

of the state of Minnesota has responsibility for placement and care of the child at the time of the subsequent adoption, the state of Minnesota is not responsible for determining whether the child meets the definition of special needs, entering into the adoption assistance agreement, and making any adoption assistance payments outlined in the new agreement.

(c) According to federal regulations, if the child had a title IV-E adoption assistance agreement prior to the death of the adoptive parents or dissolution of the adoption, the subsequent adoptive parents reside outside of the state of Minnesota, and no state agency has responsibility for placement and care of the child at the time of the subsequent adoption, the state of Minnesota is not responsible for determining whether the child meets the definition of special needs, entering into the adoption assistance agreement, and making any adoption assistance payments outlined in the new agreement.

Subd. 10. **Extension, past age 18.** Under certain limited circumstances, a child may qualify for extension of the adoption assistance agreement beyond the date the child attains age 18. An application for extension must be completed and submitted by the adoptive parent at least 90 days prior to the date the child attains age 18, unless the child's adoption is scheduled to finalize less than 90 days prior to that date, in which case the application for extension must be completed and submitted with the adoption assistance application. The application for extension shall be made on forms established by the commissioner and shall include documentation of eligibility as specified by the commissioner.

Subd. 11. **Extension based on a continuing physical or mental disability.** (a) Extensions based on a child's continuing physical or mental disability must be applied for prior to the date the child attains age 18. The commissioner must not grant an extension on this basis if an extension based on continued enrollment in a secondary education program or being a child whose adoption finalized after age 16 was previously granted for the child.

(b) A child is eligible for extension of the adoption assistance agreement to the date the child attains age 21 if the following criteria are met:

(1) the child has a mental or physical disability upon which eligibility for adoption assistance was based which warrants the continuation of assistance;

(2) the child is unable to obtain self-sustaining employment due to the aforementioned mental or physical disability; and

(3) the child needs significantly more care and support than what is typical for an individual of the same age.

Subd. 12. **Extension based on continued enrollment in a secondary education program.** (a) If a child does not qualify for extension based on a continuing physical or mental disability, or a parent chooses not to apply for an extension on that basis, the adoptive parents may make an application for continuation of adoption assistance based on enrollment in a secondary education program.

(b) If a child is enrolled full time in a secondary education program or a program leading to an equivalent credential, the child is eligible for extension to the expected graduation date or the date the child attains age 19, whichever is earlier. If a child receives a school-based extension and at any time ceases to be enrolled in a full-time secondary education program or a program leading to an equivalent credential, the adoptive parents must notify the commissioner and the agreement must

terminate.

(c) Extensions based on continuation in a secondary education program must be paid from state funds only, unless the child meets the extension criteria in subdivision 13.

Subd. 13. **Extension for children whose adoption finalized after age 16.** A child who attained the age of 16 prior to finalization of the child's adoption is eligible for extension of the adoption assistance agreement to the date the child attains age 21 if the child is:

(1) completing a secondary education program 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 child.

Subd. 14. **Transitioning in from pre-2011.** A child who has an adoption assistance agreement executed on their behalf under section 259.67 on or before November 24, 2010, is eligible for Northstar Care for Children beginning January 1, 2011, provided that all parties have signed the renegotiated adoption assistance agreement on or before that date. The adoption assistance agreement of eligible children whose adoptive parents decide to opt in to Northstar Care for Children must be renegotiated according to the process in section 256O.270. All eligible children whose adoptive parents decide to renegotiate their adoption assistance agreement under Northstar Care for Children must be assessed according to section 256O.240 and then transitioned into Northstar Care for Children according to the process in section 256O.270. Effective November 25, 2010, a child who meets the eligibility criteria for adoption assistance in subdivision 1 may have an adoption assistance agreement negotiated on their behalf according to section 256O.240, and the effective date of the agreement is January 1, 2011, or the date of the court order finalizing the adoption, whichever is later.

Sec. 12. **[256O.240] ASSESSMENTS AND AGREEMENTS.**

Subdivision 1. **Assessment.** Every child eligible under sections 256O.210, 256O.220, and 256O.230 must be assessed to determine the benefits the child may receive under section 256O.250 according to the tool, process, and requirements specified in subdivision 2. A child eligible for guardianship assistance under section 256O.220 or adoption assistance under section 256O.230 who is determined to be an at-risk child must be assessed at level A under section 256O.250, subdivision 1. All other children shall be assessed at the basic level, level B, or one of ten supplemental difficulty of care levels, levels C to L.

Subd. 2. **Commissioner to establish the assessment tool, process, and requirements.** Consistent with sections 256O.001 to 256O.270, the commissioner shall establish the tool to be used and the process to be followed, including appropriate documentation and other requirements, when conducting the assessment of children entering or continuing in Northstar Care for Children. The assessment tool must take into consideration the needs of the child and the ability of the caregiver to meet the child's needs.

Subd. 3. **Child care component of the assessment.** (a) The assessment tool established under subdivision 2 must include consideration of the caregiver's need for child care according to this subdivision. Prior to including consideration of the caregiver's need for child care on the child's assessment, prospective adoptive parents or relative custodians shall apply to the child care assistance program under chapter 119B. Foster parents are not required to apply to the child care assistance program to have the caregiver's need for child care considered as part of the foster child's assessment.

(b) The child's assessment must include consideration of the caregiver's need for child care if all the following criteria are met:

(1) the child has not attained the age of 13;

(2) all available adult caregivers are employed or attending training or educational programs;

(3) the caregiver has applied for the child care assistance program under paragraph (a); and

(4) child care assistance under chapter 119B is not received for the child.

Consideration of the caregiver's need for child care may be included on the child's assessment for caregivers who are wait-listed for child care assistance or are eligible for child care assistance but choose not to receive it.

(c) The level determined by the balance of the assessment must be adjusted based on the number of hours of child care needed each week due to employment or attending a training or educational program as follows:

(1) less than ten hours or if the caregiver is participating in the child care assistance program under chapter 119B, no adjustment;

(2) ten to 19 hours, increase one level;

(3) 20 to 29 hours, increase two levels;

(4) 30 to 39 hours, increase three levels; and

(5) 40 or more hours, increase four levels.

(d) When the child attains the age of 13, the level shall revert to the level assessed for the child prior to any consideration of the caregiver's need for child care.

Subd. 4. **Timing of initial assessment.** For an eligible child entering Northstar Care for Children who is not part of the transition group under subdivision 13, the initial assessment must be completed within 30 days of placement for children in foster care and prior to the establishment of a guardianship assistance or adoption assistance agreement on behalf of the child, if an initial assessment is required under subdivision 5.

Subd. 5. **Completing the assessment.** (a) The assessment must be completed in consultation with the child's caregiver. Face-to-face contact with the caregiver is not required to complete the assessment.

(b) For foster children eligible under section 256O.210, the initial assessment must be completed by the county of financial responsibility or, for children in the American Indian Child Welfare

Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, within 30 days of the child's placement in foster care. Reassessments must be completed by the legally responsible agency according to subdivision 7. If the foster parent is unable or unwilling to cooperate with the assessment process, the child must be assessed at the basic level, level B under section 256O.250, subdivision 3. Notice to the foster parent must be provided as specified in subdivision 9.

(c) For children eligible for guardianship assistance under section 256O.220, a new assessment is required as part of the negotiation of the guardianship assistance agreement if:

(1) the child is determined to be an at-risk child;

(2) the child was not placed in foster care with the proposed relative custodian immediately prior to the negotiation of the guardianship assistance agreement under subdivision 10; or

(3) any requirement for reassessment under subdivision 7 is met.

If a new assessment is required prior to the effective date of the guardianship assistance agreement, the new assessment must be completed by the county of financial responsibility or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b. If reassessment is required after the effective date of the guardianship assistance agreement, the new assessment must be completed by the commissioner or the commissioner's designee. If the proposed relative custodian is unable or unwilling to cooperate with the assessment process, the child must be assessed at the basic level, level B under section 256O.250, subdivision 3, unless the child is known to be an at-risk child, in which case, the child must be assessed at level A under section 256O.250, subdivision 1. Notice to the proposed relative custodian must be provided as specified in subdivision 9.

(d) For children eligible for adoption assistance under section 256O.230, a new assessment is required as part of the negotiation of the adoption assistance agreement if:

(1) the child is determined to be an at-risk child;

(2) the child was not placed in foster care with the prospective adoptive parent immediately prior to the negotiation of the adoption assistance agreement under subdivision 10; or

(3) any requirement for reassessment under subdivision 7 is met.

If a new assessment is required prior to the effective date of the adoption assistance agreement, it must be completed by the county of financial responsibility or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b. If there is no county of financial responsibility and the child is not in the American Indian Child Welfare Initiative, or the financially responsible agency is not a county social service or tribal agency in the state, the assessment must be completed by the agency designated by the commissioner. If reassessment is required after the effective date of the adoption assistance agreement, it must be completed by the commissioner or the commissioner's designee. If the prospective adoptive parent is unable or unwilling to cooperate with the assessment process, the child must be assessed at the basic level, level B under section 256O.250, subdivision 3, unless the child is known to be an at-risk child, in which case, the child shall be assessed at level A under section 256O.250, subdivision 1. Notice to the prospective adoptive parent must be provided as specified in subdivision 9.

Subd. 6. **Approval of assessments and reassessments.** Each legally responsible agency shall designate one or more staff to examine and approve completed assessments and reassessments. The staff person approving the assessments and reassessments must not be the case manger or staff member completing the forms. The new rate is effective the calendar month that the assessment is approved or the effective date of the agreement, whichever is later.

Subd. 7. **Timing of reassessments and requests for reassessments.** For an eligible child, reassessments must be completed within 30 days of any of the following events:

(1) for a child in continuous foster care, six months since completion of the last assessment;

(2) for a child in continuous foster care, at a change of placement location;

(3) for a child in foster care, at the request of the legally responsible agency;

(4) at the request of the commissioner; or

(5) at the request of the caregiver under subdivision 8.

Subd. 8. **Caregiver requests for reassessments.** (a) For an eligible child, a caregiver may initiate a reassessment request in writing to the county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, for foster care cases, or the commissioner, or the commissioner's designee for adoption assistance and guardianship assistance cases. The written request must include the reason for the request and the name, address, and contact information of the caregivers. For an eligible child with a guardianship assistance or adoption assistance agreement, the caregiver may request a reassessment if at least six months have elapsed since any previously requested review. A caregiver for a foster child may request reassessment in less than six months with written documentation that there have been significant changes in the child's needs that necessitate an earlier reassessment.

(b) A caregiver may request a reassessment of an at-risk child for whom a guardianship assistance or adoption assistance agreement has been executed if the caregiver has written professional documentation that the potential disability upon which eligibility for the agreement was based has manifested itself.

(c) If the reassessment cannot be completed within 30 days of the caregiver's request, the agency responsible for reassessment shall notify the caregiver of the reason for the delay and a reasonable estimate of when the reassessment can be completed.

(d) If the child's caregiver is unable or unwilling to cooperate with the reassessment, the child must be assessed at level B under section 256O.250, subdivision 3, unless the child has an adoption assistance or guardianship assistance agreement in place and is known to be an at-risk child, in which case, the child shall be assessed at level A under section 256O.250, subdivision 1. Within 60 days of the caregiver demonstrating they are able or willing to cooperate with the assessment or reassessment process, the reassessment for the child must be completed.

Subd. 9. **Notice for caregiver.** (a) The agency responsible for completing the assessment shall provide the child's caregiver with written notice of the initial assessment or reassessment.

(b) Initial assessment notices must be sent within 15 days of completion of the initial assessment

and must minimally include the following:

(1) a summary of the completed child's individual assessment used to determine the rating;

(2) statement of rating and benefit level;

(3) statement of the circumstances under which the agency shall reassess the child;

(4) procedure to seek reassessment;

(5) notice that the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing, consistent with section 256.045, subdivision 3; and

(6) name, telephone number, and, if available, electronic address of a contact person at the responsible agency or state.

(c) Reassessment notices must be sent within 15 days of the completion of the reassessment and must minimally include the following:

(1) a summary of the completed child's individual assessment used to determine the new rating;

(2) any change in rating and its effective date;

(3) procedure to seek reassessment;

(4) notice that if a change in rating results in a reduction of benefits, the caregiver has the right to a fair hearing review of the assessment and how to request a fair hearing consistent with section 256.045, subdivision 3;

(5) notice that a caregiver who requests a fair hearing of the reassessed rating within ten days may continue at the current rate pending the hearing, but the agency may recover any overpayment; and

(6) name, telephone number, and, if available, electronic address of a contact person at the responsible agency or state.

Subd. 10. **Agreements.** (a) In order to receive guardianship assistance or adoption assistance benefits, a written, binding agreement on a form approved by the commissioner must be established prior to finalization of the adoption or a transfer of permanent legal and physical custody. The agreement must be negotiated with the caregivers according to subdivision 11. The caregivers and the commissioner or the commissioner's designee must sign the agreement. A copy of the signed agreement must be given to each party. Termination or disruption of the preadoptive placement or the foster care placement preceding assignment of custody makes the agreement with that family void.

(b) The agreement must specify the following:

(1) duration of the agreement;

(2) the nature and amount of any payment, services, and assistance to be provided under such agreement;

(3) the child's eligibility for Medicaid services;

(4) the terms of the payment;

(5) eligibility for reimbursement of nonrecurring expenses associated with adopting or obtaining permanent legal and physical custody of the child, to the extent that the total cost does not exceed $2,000 per child;

(6) that the agreement must remain in effect regardless of the state of which the adoptive parents or relative custodians are residents at any given time;

(7) provisions for modification of the terms of the agreement; and

(8) the effective date of the agreement.

(c) The effective date of the guardianship assistance agreement is the date of the court order that transfers permanent legal and physical custody to the relative.

(d)(1) For a child who receives Supplementary Security Income (SSI), Retirement, Survivors, and Disability Insurance (RSDI), veteran's benefits, railroad retirement benefits, or black lung benefits, the effective date of the adoption assistance agreement is the date that the adoption is finalized.

(2) For a child who does not receive SSI, RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits, and who has been in the prospective adoptive parents' home as a foster child for at least six consecutive months prior to adoption placement, the effective date of the agreement is the date of adoptive placement or the date that the agreement is signed by all parties, whichever is later.

(3) For a child who does not receive SSI, RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits, and who has been in the prospective adoptive parents' home as a foster child for less than six consecutive months prior to adoptive placement, the effective date of the agreement is the date that the child has resided in the prospective adoptive parents' home as a foster child for at least six consecutive months or the date the adoption is finalized, whichever is earlier.

Subd. 11. **Negotiation of the agreement.** (a) A monthly payment is provided as part of the adoption assistance or guardianship assistance agreement to support the care of children who have manifested special needs. The amount of the payment made on behalf of children eligible for guardianship assistance or adoption assistance is determined through agreement between the relative custodian or the adoptive parent and the commissioner or the commissioner's designee, using the assessment tool established by the commissioner in subdivision 2 and the associated benefit and payments in section 256O.250. The assessment tool establishes the monthly benefit level for a child in foster care. The monthly payment under a guardianship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a guardianship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the child with respect to whom the guardianship assistance or adoption assistance payment is made had been in a foster family home in the state. The income of the relative custodian or adoptive parent must not be taken into consideration when determining eligibility for guardianship assistance or adoption assistance or the amount of the payments under section 256O.250. With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner

in subdivision 2 and the agreement renegotiated under subdivision 12 when there is a change in the child's needs or the family's circumstances.

(b) The guardianship assistance or adoption assistance agreement of a child who is identified as an at-risk child must not include a monthly payment unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly. A relative custodian or adoptive parent of an at-risk child with a guardianship assistance or adoption assistance agreement may request a reassessment of the child under subdivision 8 and renegotiation of the guardianship assistance or adoption assistance agreement under subdivision 12 to include a monthly payment, if the caregiver has written professional documentation that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c)(1) The initial amount of the monthly guardianship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets in section 256O.250, subdivision 8, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless the child is identified as an at-risk child.

(2) An at-risk child must be assigned level A according to section 256O.250 and there shall be no monthly guardianship assistance payment unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly.

(d)(1) For a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets in section 256O.250, subdivision 8, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as an at-risk child.

(2) An at-risk child must be assigned level A according to section 256O.250 and there must be no monthly adoption assistance payment unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly.

(3) For children who are in the guardianship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the guardianship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement.

(4) For children who are not in foster care placement or the guardianship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined using the assessment tool and process in this section and the corresponding payment amount in section 256O.250.

Subd. 12. **Renegotiation of the agreement.** (a) A relative custodian or adoptive parent of a child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests renegotiation of the agreement, a reassessment of

the child must be completed. If the reassessment indicates that the child's level has changed, the commissioner or the commissioner's designee and the caregiver shall renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) A relative custodian or adoptive parent of an at-risk child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement to include a monthly payment, if the caregiver has written professional documentation that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted according to subdivision 8. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement shall not be renegotiated unless the commissioner and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement shall be determined by the commissioner.

Subd. 13. **Transition assessments.** (a) For a child who might transition into Northstar Care for Children under section 256O.210 subdivision 5; 256O.220, subdivision 8; or 256O.230, subdivision 14, initial transition assessments must be completed between May 1, 2010, and December 31, 2010.

(b) Transition assessments for a child in foster care completed between May 1, 2010, and August 31, 2010, must be considered valid under subdivision 7 until April 1, 2011, and those completed between September 1, 2010, and December 31, 2010, must be considered valid under subdivision 7 until July 1, 2011.

(c) Children with relative custody assistance agreements under section 257.85 that are effective prior to May 1, 2010, shall have initial transition assessments completed between May 1 and December 31, 2010. Children with relative custody assistance agreements between May 1, 2010, and November 24, 2010, shall have an initial transition assessment completed as the agreement is being established in conjunction with the supplemental maintenance needs assessment and other required relative custody assistance paperwork under section 257.85.

(d) Children with adoption assistance agreements negotiated under section 259.67 and submitted to the commissioner for review and approval on or before April 30, 2010, who might transition into Northstar Care for Children, shall have initial transition assessments completed by August 31, 2010. Children with adoption assistance agreements negotiated under section 259.67 and submitted to the commissioner for review and approval between May 1, 2010, and November 24, 2010, shall have an initial transition assessment completed in conjunction with the supplemental maintenance needs assessment and other required adoption assistance paperwork under section 259.67.

(e) If the child's caregiver is unable or unwilling to cooperate with the initial transition assessment process, the child shall be assessed at the basic level, level B under section 256O.250, subdivision 3, unless the child is known to be an at-risk child, in which case the child shall be assessed at level A under section 256O.250, subdivision 1. Within 60 days of the caregiver indicating they are able or willing to cooperate with the assessment process, the commissioner or the commissioner's designee shall complete a reassessment for the child.

(f) If the child's caregiver cannot be located to complete the initial transition assessment process according to the time frames outlined in this section, the child shall be assessed at the basic level,

level B under section 256O.250, subdivision 3, unless the child is known to be an at-risk child, in which case the child shall be assessed at level A under section 256O.250, subdivision 1. Within 60 days of locating the caregiver, the commissioner or the commissioner's designee shall complete a reassessment for the child.

Sec. 13. **[256O.250] BENEFITS AND PAYMENTS.**

Subdivision 1. **Benefits.** There are three potential benefits available under Northstar Care for Children: medical assistance, basic payment, and supplemental difficulty of care payment. An eligible child receives medical assistance under subdivision 2. An eligible child receives the basic payment under subdivision 3, except for those assigned level A because they are determined to be at-risk children in guardianship assistance or adoption assistance. An eligible child may receive an additional supplemental difficulty of care payment under subdivision 4, as determined by the assessment under section 256O.240.

Subd. 2. **Medical assistance.** Eligibility for medical assistance under this chapter continues to be determined according to section 256B.055.

Subd. 3. **Basic monthly rate.** For the period January 1, 2011, to June 30, 2012, the basic monthly rate is according to the following schedule:

Ages 0-5	$500 per month
Ages 6-12	$625 per month
Ages 13 and older	$750 per month.

Subd. 4. **Difficulty of care supplemental monthly rate.** For the period January 1, 2011, to June 30, 2012, the difficulty of care supplemental monthly rate is according to the following schedule:

level B	none
level C	$60 per month
level D	$120 per month
level E	$180 per month
level F	$240 per month
level G	$300 per month
level H	$360 per month
level I	$420 per month
level J	$480 per month
level K	$540 per month
level L	$600 per month.

A child assigned level B is still eligible for basic monthly rate under subdivision 3.

Subd. 5. **Daily rates.** The commissioner shall establish prorated daily rates to the nearest cent for the monthly rates under subdivisions 3 and 4. Daily rates must be routinely used when a partial

month is involved for foster care, guardianship assistance, and adoption assistance.

Subd. 6. **Revision.** By April 1, 2013, for fiscal year 2013, and by each subsequent April 1 for each subsequent fiscal year, the commissioner shall review and revise the rates under subdivisions 3, 4, and 5 based on United States Department of Agriculture Estimates of the Cost of Raising a Child, published by the United States Department of Agriculture, Agricultural Resources Service, Publication 1411. The revision must be the average percentage by which costs increase for the age ranges represented in the United States Department of Agriculture Estimates of the Cost of Raising a Child. The monthly rates must be revised to the nearest dollar and the daily rates to the nearest cent.

Subd. 7. **Home and vehicle modifications.** A child who is eligible for an adoption assistance agreement based on the child's physical disability or a child who is eligible for a guardianship assistance agreement who possesses a physical disability must have reimbursement of home and vehicle modifications necessary to accommodate the child's physical disability included as part of the negotiation of the agreement under section 256O.240, subdivision 11. The total of all modifications must not exceed $25,000 and the modifications must be requested during the first six months that the adoption assistance or guardianship assistance agreement is in effect. The type and cost of each modification must be preapproved by the commissioner. The type of home and vehicle modifications is limited to those specified by the commissioner. The commissioner shall ensure that the modifications are necessary to incorporate the child into the family and that the cost is reasonable. Application for and reimbursement of modifications must be completed according to a process specified by the commissioner.

Subd. 8. **Child income or income attributable to the child.** (a) A monthly adoption assistance or guardianship assistance payment must be considered income and resource attributable to the child and must be inalienable by any assignment or transfer and exempt from garnishment under the laws of the state.

(b) When a child is placed into foster care, any income and resources attributable to the child must be handled according to sections 252.27 and 260C.331 or 260B.331, if applicable to the child being placed.

(c) Consideration of income and resources attributable to the child must be part of the negotiation process in section 256O.240, subdivision 11. In some circumstances, the receipt of other income on behalf of the child may impact the amount of the monthly payment received by the adoptive parent or relative custodian on behalf of the child through Northstar Care for Children. Supplemental Security Income (SSI), Retirement, Survivors, and Disability Insurance (RSDI), veteran's benefits, railroad retirement benefits, and black lung benefits are considered income and resources attributable to the child.

Subd. 9. **Treatment of Supplemental Security Income.** If a child placed in foster care receives benefits through Supplemental Security Income (SSI) at the time of foster care placement or subsequent to placement in foster care, the county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, may apply to be the payee for the child for the duration of the child's placement in foster care. If a child continues to be eligible for SSI after finalization of the adoption or transfer of permanent legal and physical custody and is determined to be eligible for a payment under Northstar Care for Children, a permanent caregiver may choose to receive payment

from both programs simultaneously. If the payment under Northstar Care for Children is a title IV-E payment, the permanent caregiver is responsible to report the amount of the payment to the Social Security Administration and the SSI payment will be reduced by the amount of the payment under Northstar Care for Children, as required by the Social Security Administration.

Subd. 10. **Treatment of RSDI, veteran's benefits, railroad retirement benefits, and black lung benefits.** (a) If a child placed in foster care receives RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits at the time of foster care placement or subsequent to placement in foster care, the county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, may apply to be the payee for the child for the duration of the child's placement in foster care. If it is anticipated that a child will be eligible to receive RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits after finalization of the adoption or assignment of permanent legal and physical custody, the permanent caregiver shall apply to be the payee of those benefits on the child's behalf. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.

(b) If a child becomes eligible for RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to renegotiate the payment under Northstar Care for Children. The monthly amount of the other benefits must be considered an offset to the amount of the payment the child is determined eligible for under Northstar Care for Children.

(c) If a child ceases to be eligible for RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits after the initial amount of the payment under Northstar Care for Children is finalized, the permanent caregiver shall contact the commissioner to renegotiate the payment under Northstar Care for Children. The monthly amount of the payment under Northstar Care for Children must be the amount the child was determined to be eligible for prior to consideration of any offset.

(d) If the monthly payment received on behalf of the child under RSDI, veteran's benefits, railroad retirement benefits, or black lung benefits changes after the adoption assistance or guardianship assistance agreement is finalized, the permanent caregiver shall notify the commissioner as to the new monthly payment amount, regardless of the amount of the change in payment. If the monthly payment changes by $75 or more, even if the change occurs incrementally over the duration of the term of the adoption assistance or guardianship assistance agreement, the monthly payment under Northstar Care for Children must be renegotiated to reflect the amount of the increase or decrease in the offset amount. Any subsequent change to the payment must be reported and handled in the same manner. A change of monthly payments of less than $75 is not a permissible reason to renegotiate the adoption assistance or guardianship assistance agreement under section 256O.240, subdivision 12.

Subd. 11. **Treatment of child support and MFIP.** (a) If a child placed in foster care receives child support, the child support payment may be redirected to the county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, for the duration of the child's placement in foster care. In cases where the child qualifies for Northstar Care for Children by meeting the adoption assistance eligibility criteria or the guardianship assistance eligibility criteria, any court-ordered child support must not be considered income attributable to the child and must have no impact on

the monthly payment.

(b) Consistent with section 256J.24, children eligible for and receiving a payment from Northstar Care for Children are excluded from a MFIP assistance unit.

Subd. 12. **Payments.** (a) Payments to caregivers under Northstar Care for Children must be made monthly.

(b) The county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, shall pay foster parents for eligible children in foster care.

(c) The commissioner shall pay caregivers for eligible children in guardianship assistance and adoption assistance. Payments must commence when the commissioner receives the required documentation from the court, the legally responsible agency, or the caregiver. In guardianship assistance or adoption assistance cases, monthly payments must be prorated according to subdivision 5 based on the effective date of the agreement.

Subd. 13. **Effect of benefit on other aid.** Payments received under this section shall not be considered as income for child care assistance under chapter 119B or any other financial benefit. Consistent with section 256J.24, all children receiving a maintenance payment under Northstar Care for Children are excluded from any MFIP assistance unit.

Subd. 14. **Waivered service plans.** A child in foster care may qualify for home and community-based waivered services, consistent with section 256B.092 for developmental disabilities, or section 256B.49 for community alternative care, community alternatives for disabled individuals, or traumatic brain injury waivers. A waiver service must not be substituted for the foster care program. When the child is eligible for waivered services and eligible for this benefit, the local social service agency must assess and provide basic and supplemental difficulty of care rates as determined by the universal assessment under section 256O.240. If it is determined that additional services are needed to meet the child's needs in the home that is not or cannot be met by the foster care program, the need would be referred to the waivered service program.

Subd. 15. **Overpayments.** The commissioner has the authority to collect any amount of foster care, adoption assistance, and guardianship assistance paid to a caregiver in excess of the payment due. Payments covered by this subdivision include basic maintenance needs payments, supplemental difficulty of care payments, and reimbursement of home and vehicle modifications under subdivision 7. Prior to any collection, the commissioner or the commissioner's designee shall notify the caregiver in writing, including:

(1) the amount of the overpayment and an explanation of the cause of overpayment;

(2) clarification of the corrected amount;

(3) a statement of the legal authority for the decision;

(4) information about how the caregiver can correct the overpayment;

(5) if repayment is required, when the payment is due and a person to contact to review a repayment plan;

(6) a statement that the caregiver is entitled to a fair hearing review by the department; and

(7) the procedure for seeking the review in clause (6).

Subd. 16. **Payee.** For adoption assistance and guardianship assistance cases, the payment may only be made to the adoptive parent or relative custodian specified on the agreement. If there is more than one adoptive parent or relative custodian, both parties must be listed as the payee unless otherwise specified in writing according to policies outlined by the commissioner. In the event of divorce or separation of the caregivers, a change of payee may be made in writing according to policies outlined by the commissioner. If both caregivers are in agreement as to the change, it may be made according to a process outlined by the commissioner. If there is not agreement as to the change, a court order indicating the party who is to receive the payment is needed before a change can be processed. If the change of payee is disputed, the commissioner may withhold the payment until agreement is reached. A noncustodial caregiver may request notice in writing of review, modification, or termination of the adoption assistance or guardianship assistance agreement. In the event of the death of a payee, a change of payee consistent with sections 256O.220 and 256O.230 may be made in writing according to policies outlined by the commissioner.

Subd. 17. **Notification of change.** (a) Parents or relative custodians who have an adoption assistance agreement or guardianship assistance agreement in place shall keep the agency administering the program informed of the parent's or custodian's address and circumstances which would make them ineligible for the payments or eligible for the payments in a different amount.

(b) For the duration of the agreement, the adoptive parent or relative custodian agrees to notify the agency administering the program in writing within 30 days of the following changes:

(1) change in the family's address;

(2) change in the legal custody status of the child;

(3) child's completion of high school, if this occurs after the child attains age 18;

(4) date of termination of the parental rights of the adoptive parent, transfer of permanent legal and physical custody to another person, or other determination that the adoptive parent or relative custodian is no longer legally responsible for support of the child;

(5) date the adoptive parent or relative custodian is no longer providing support to the child;

(6) date of death of the child;

(7) date of death of the adoptive parent or relative custodian;

(8) date the child enlists in the military;

(9) date of marriage of the child;

(10) date the child becomes an emancipated minor through legal action of another state;

(11) separation or divorce of the adoptive parent or relative custodian;

(12) change of the caregiver's employment or educational enrollment status, if the child has not attained age 13 and the child care component of the assessment under section 256O.240, subdivision 2, was used to determine the assessment level; and

(13) residence of the child outside the home for a period of more than 30 consecutive days.

Subd. 18. **Termination notice for caregiver.** The responsible agency must provide a child's caregiver written notice of termination of payment. Termination notices must be sent at least 15 days before the final payment or in the case of an unplanned termination, the notice is sent within three days of the end of the payment. The written notice must minimally include the following:

(1) the date payment will end;

(2) the reason payments will end and the event that is the basis to terminate payment;

(3) a statement that the provider is entitled to a fair hearing review by the department consistent with section 256.045, subdivision 3;

(4) the procedure to request a fair hearing; and

(5) name, telephone number, and, if available, an electronic contact address of a contact person at the county or state.

Sec. 14. **[256O.260] FEDERAL SHARE, STATE SHARE, LOCAL SHARE.**

Subdivision 1. **Federal share.** For the purposes of determining a child's eligibility under title IV-E of the Social Security Act for a child in foster care, the county of financial responsibility or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, shall use the eligibility requirements outlined in section 472 of the Social Security Act. For a child who qualifies for guardianship assistance or adoption assistance, the county of financial responsibility or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, shall use the eligibility requirements outlined in section 473 of the Social Security Act. In each case, the agency paying the maintenance payments must be reimbursed for the costs from the federal money available for this purpose.

Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care adoption assistance program under section 259.67. The commissioner may transfer funds into the account if a deficit occurs.

Subd. 3. **Local share.** The county of financial responsibility under section 256G.02 or tribal social service agency authorized in section 256.01, subdivision 14b, at the time of placement for foster care or finalization of the agreement for guardianship assistance or adoption assistance, shall pay the local share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care adoption assistance program under section 259.67. The county of financial responsibility under section 256G.02 or tribal social service agency authorized in section 256.01, subdivision 14b, shall pay the entire cost of any initial clothing allowance, child-placing agency administrative payments, or other support services it authorizes, except as provided under other provisions of law. In cases of federally required adoption assistance where there is no county of financial responsibility, or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, as provided in section 256O.240, subdivision 5, the commissioner shall pay the local share.

Subd. 4. **Nonfederal share.** The commissioner shall establish a percentage share of the maintenance payments, reduced by federal reimbursements under title IV-E of the Social Security Act, to be paid by the state and to be paid by the county of financial responsibility under section

256G.02 or tribal social service agency authorized in section 256.01, subdivision 14b. These state and local shares shall initially be calculated based on the ratio of the average appropriate expenditures made by the state and all counties and tribal social service agencies authorized in section 256.01, subdivision 14b, during state fiscal years 2008, 2009, and 2010. For purposes of this calculation, appropriate expenditures for the counties and tribal social service agencies shall include basic and difficulty of care payments for foster care, not including any initial clothing allowance, child-placing agency administrative payments, child care, or other ancillary expenditures, reduced by federal reimbursements. For purposes of this calculation, appropriate expenditures for the state must include adoption assistance and relative custody assistance, reduced by federal reimbursements. For each of the periods January 1, 2011, to June 30, 2012, and fiscal years 2013 and 2014, the commissioner shall adjust this initial percentage of state and local shares to reflect the relative expenditure trends during state fiscal years 2008, 2009, and 2010. The fiscal year 2014 set of percentages must be used for all subsequent years.

Subd. 5. **Adjustments for proportionate shares among legally responsible agencies.** For children who transition into Northstar Care for Children under section 256O.270, subdivision 7, and for children on the pre-Northstar Care adoption assistance program under section 259.67, the commissioner shall adjust the expenditures by each county or tribal social service agency so that its relative share is proportional to its foster care expenditures as determined under subdivision 4 for state fiscal years 2008, 2009, and 2010 compared with similar costs of all county or tribal social service agencies.

Sec. 15. **[256O.270] ADMINISTRATION.**

Subdivision 1. **Responsibilities.** (a) The county of financial responsibility or, for children in the American Indian Child Welfare Initiative, the responsible tribal social service agency authorized in section 256.01, subdivision 14b, shall determine the eligibility for Northstar Care for Children for children in foster care under section 256O.210, and for those children determined eligible, shall further determine each child's eligibility for title IV-E of the Social Security Act.

(b) Subject to commissioner approval, the legally responsible agency shall determine the eligibility for Northstar Care for Children for children in guardianship assistance under section 256O.220 and children in adoption assistance under section 256O.230, and for those children determined eligible, shall further determine each child's eligibility for title IV-E of the Social Security Act.

(c) The legally responsible agency is responsible for the administration of Northstar Care for Children for children in foster care, and for assisting the commissioner with the administration of Northstar Care for Children for children in guardianship assistance and adoption assistance by conducting assessments, reassessments, negotiations, and other activities as specified by the commissioner under subdivision 2.

Subd. 2. **Procedures, requirements, and deadlines.** The commissioner shall specify procedures, requirements, and deadlines for the administration of Northstar Care for Children according to sections 256O.001 to 256O.270, including for transitioning children into Northstar Care for Children under subdivision 7. The commissioner shall periodically review all such procedures, requirements, and deadlines, including the assessment tool and process under section 256O.240, in consultation with counties, tribes, and representatives of caregivers and may alter them as needed.

Subd. 3. **Administration of title IV-E programs.** The title IV-E foster care, guardianship assistance, and adoption assistance programs shall operate within the statutes and rules set forth by the federal government in the Social Security Act and Code of Federal Regulations.

Subd. 4. **Reporting.** The commissioner shall specify required fiscal and statistical reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

Subd. 5. **Promotion of programs.** The commissioner or the commissioner's designee shall actively seek ways to promote the guardianship assistance and adoption assistance programs, including informing prospective relative custodians of eligible children of the availability of guardianship assistance and prospective adoptive parents of eligible children under the commissioner's guardianship of the availability of adoption assistance. All families who adopt children under the commissioner's guardianship must be informed as to the adoption tax credit.

Subd. 6. **Appeals and fair hearings.** (a) A caregiver has the right to appeal to the commissioner pursuant to section 256.045 when eligibility for Northstar Care for Children is denied, and when payment or the agreement for eligible child is modified or terminated.

(b) A relative custodian or adoptive parent has additional rights to appeal to the commissioner under section 256.045. The rights include when the commissioner terminates or modifies the guardianship assistance or adoption assistance agreement or when the commissioner denies an application for guardianship assistance or adoption assistance. A prospective relative custodian or adoptive parent who disagrees with a decision by the commissioner prior to transfer of permanent legal and physical custody or finalization of the adoption may request review of the decision by the commissioner or may appeal the decision under section 256.045. A guardianship assistance or adoption assistance agreement must be signed and in effect prior to the court order that transfers permanent legal and physical custody or the adoption finalization, however in some cases, there may be extenuating circumstances as to why an agreement was not entered into prior to the finalization of permanency for the child. Caregivers who believe that extenuating circumstances exist in the case of the caregiver's child may request a fair hearing. Caregivers have the responsibility of proving that extenuating circumstances exist. Caregivers are required to provide written documentation of each eligibility criterion at the fair hearing. Examples of extenuating circumstances include: relevant facts regarding the child were known by the placing agency and not presented to the caregiver prior to transfer of permanent legal and physical custody or finalization of the adoption, failure by the commissioner or the commissioner's designee to advise potential caregivers about the availability of guardianship assistance or adoption assistance for children in the state foster care system. If an appeals judge finds through the fair hearing process that extenuating circumstances existed and that the child met all eligibility criteria at the time the transfer of permanent legal and physical custody was ordered or the adoption was finalized, the effective date and any associated federal financial participation must be retroactive to the date of the request for a fair hearing.

Subd. 7. **Transition; timelines; assessments.** (a) All eligible children shall participate in an initial assessment under section 256O.240, subdivision 3.

(b) All children in foster care, relative custody assistance, or adoption assistance are eligible for Northstar Care for Children as specified in sections 256O.210, 256O.220, and 256O.230. All children in foster care or receiving relative custody assistance under section 257.85 on December 31, 2010, must be transitioned into Northstar Care for Children as of January 1, 2011. Children in

adoption assistance under section 259.67 on December 31, 2010, whose caregivers sign no later than November 24, 2010, an agreement to transition to Northstar Care for Children as provided under sections 256O.230 and 256O.240 must be added to Northstar Care for Children as of January 1, 2011. A child receiving adoption assistance under section 259.67 whose caregivers sign an agreement to transition to Northstar Care for Children as provided under sections 256O.230 and 256O.240 between December 1, 2010, and March 31, 2011, must be added to Northstar Care for Children for the first calendar month at least 31 calendar days after the date of the signing of the agreement. A child receiving adoption assistance under section 259.67 whose caregivers do not sign an agreement to transition to Northstar Care for Children by March 31, 2011, must remain on the pre-Northstar Care adoption assistance program under section 259.67 until the child is no longer eligible for the program.

Subd. 8. **Transition; distribution of program information.** Between May 1, 2010, and June 30, 2010, all foster parents with a child placed in the foster parents' home, relative custodians with executed or signed relative custody assistance agreements, adoptive parents with executed or signed adoption assistance agreements, and preadoptive parents with a preadoptive placement in the parents' home shall receive written information about Northstar Care for Children. Foster parents with a child placed in the foster parents' home between July 1, 2010, and December 31, 2010, shall receive written information about Northstar Care for Children at the time of the child's placement. Relative custodians who sign a relative custody assistance agreement and prospective adoptive parents who sign an adoption assistance agreement subsequent to June 30, 2010, shall receive written information about Northstar Care for Children no later than when the relative custody assistance agreement or the adoption assistance agreement is signed by the caregiver.

(1) The legally responsible agency shall mail, electronically distribute, or personally provide foster parents with placed children with written information about Northstar Care for Children.

(2) The agency responsible for providing the relative custody assistance payment shall mail, electronically distribute, or personally provide relative custodians with relative custody assistance agreements with written information about Northstar Care for Children when the relative custodians' mail or email address is known. The responsible social service agency shall make reasonable efforts to locate relative custodians with signed or executed relative custody assistance agreements whose mail or email address is known.

(3) For cases where the adoption assistance agreement is executed or submitted to the commissioner for review and approval prior to May 1, 2010, the commissioner shall mail or electronically distribute information about Northstar Care for Children to the adoptive parent. The commissioner shall make reasonable efforts to locate the adoptive parent whose mail or email address is unknown. For cases where the adoption assistance agreement is executed or submitted to the commissioner for review on or after May 1, 2010, and on or before November 24, 2010, the responsible social service agency shall mail, electronically distribute, or personally provide preadoptive parents with written information about Northstar Care for Children.

(4) Information must minimally include a summary of the provisions of the new program, an overview of the assessment process, the transition time frame, and actions required by the foster parent, relative custodian, or adoptive parent during the transition period, including the procedure to opt in to Northstar Care for Children and renegotiate the adoption assistance agreement for adoption assistance cases.

Subd. 9. **Transition; renegotiation of adoption assistance agreements.** Adoptive parents shall provide written notice to the commissioner of the adoptive parents' intent to renegotiate their adoption assistance program or remain on the pre-Northstar Care adoption assistance program according to section 259.67 within 60 days of receiving the written notice in subdivision 8. The commissioner may extend this time frame if it is determined that the adoptive parent has good cause to warrant extension of this consideration period. If adoptive parents decide to opt in to Northstar Care for Children, the adoptive parents' adoption assistance agreement must be renegotiated according to section 256O.240, subdivision 10. If an adoptive parent would like to opt in to Northstar Care for Children, but does not believe that the assessment under section 256O.240 was completed accurately, the adoptive parent shall indicate this in writing to the commissioner and must be given an extension of the consideration period while a reassessment is completed. The commissioner may not extend the time frame to renegotiate adoption assistance agreements after March 31, 2011. All adoption assistance agreements under Northstar Care for Children for children transitioning from the adoption assistance program under section 259.67 must be renegotiated and signed by all parties no later than March 31, 2011. The commissioner may establish additional requirements or deadlines for implementing the transition.

Subd. 10. **Effective date of payment rates.** The new rates for payment under Northstar Care for Children must be determined under section 256O.250 and effective according to the timelines in subdivision 7, paragraph (b).

Subd. 11. **Purchase of child-specific adoption services.** The commissioner may reimburse the placing agency for appropriate adoption services for children eligible under section 259.67, subdivision 35.

Sec. 16. Minnesota Statutes 2008, section 257.85, subdivision 2, is amended to read:

Subd. 2. **Scope.** The provisions of this section apply to those situations in which the legal and physical custody of a child is established with a relative or important friend with whom the child has resided or had significant contact according to section 260C.201, subdivision 11, by a district court order issued on or after July 1, 1997, and on or before November 24, 2010, or a tribal court order issued on or after July 1, 2005, and on or before November 24, 2010, when the child has been removed from the care of the parent by previous district or tribal court order.

EFFECTIVE DATE. This section is effective August 1, 2009.

Sec. 17. Minnesota Statutes 2008, section 257.85, subdivision 5, is amended to read:

Subd. 5. **Relative custody assistance agreement.** (a) A relative custody assistance agreement will not be effective, unless it is signed by the local agency and the relative custodian no later than 30 days after the date of the order establishing permanent legal and physical custody, and on or before November 24, 2010, except that a local agency may enter into a relative custody assistance agreement with a relative custodian more than 30 days after the date of the order if it certifies that the delay in entering the agreement was through no fault of the relative custodian and the agreement is signed and in effect on or before November 24, 2010. There must be a separate agreement for each child for whom the relative custodian is receiving relative custody assistance.

(b) Regardless of when the relative custody assistance agreement is signed by the local agency and relative custodian, the effective date of the agreement shall be the date of the order establishing permanent legal and physical custody.

(c) If MFIP is not the applicable program for a child at the time that a relative custody assistance agreement is entered on behalf of the child, when MFIP becomes the applicable program, if the relative custodian had been receiving custody assistance payments calculated based upon a different program, the amount of relative custody assistance payment under subdivision 7 shall be recalculated under the Minnesota family investment program.

(d) The relative custody assistance agreement shall be in a form specified by the commissioner and shall include provisions relating to the following:

(1) the responsibilities of all parties to the agreement;

(2) the payment terms, including the financial circumstances of the relative custodian, the needs of the child, the amount and calculation of the relative custody assistance payments, and that the amount of the payments shall be reevaluated annually;

(3) the effective date of the agreement, which shall also be the anniversary date for the purpose of submitting the annual affidavit under subdivision 8;

(4) that failure to submit the affidavit as required by subdivision 8 will be grounds for terminating the agreement;

(5) the agreement's expected duration, which shall not extend beyond the child's eighteenth birthday;

(6) any specific known circumstances that could cause the agreement or payments to be modified, reduced, or terminated and the relative custodian's appeal rights under subdivision 9;

(7) that the relative custodian must notify the local agency within 30 days of any of the following:

(i) a change in the child's status;

(ii) a change in the relationship between the relative custodian and the child;

(iii) a change in composition or level of income of the relative custodian's family;

(iv) a change in eligibility or receipt of benefits under MFIP, or other assistance program; and

(v) any other change that could affect eligibility for or amount of relative custody assistance;

(8) that failure to provide notice of a change as required by clause (7) will be grounds for terminating the agreement;

(9) that the amount of relative custody assistance is subject to the availability of state funds to reimburse the local agency making the payments;

(10) that the relative custodian may choose to temporarily stop receiving payments under the agreement at any time by providing 30 days' notice to the local agency and may choose to begin receiving payments again by providing the same notice but any payments the relative custodian chooses not to receive are forfeit; and

(11) that the local agency will continue to be responsible for making relative custody assistance payments under the agreement regardless of the relative custodian's place of residence.

EFFECTIVE DATE. This section is effective August 1, 2009.

Sec. 18. Minnesota Statutes 2008, section 257.85, subdivision 6, is amended to read:

Subd. 6. **Eligibility criteria.** (a) A local agency shall enter into a relative custody assistance agreement under subdivision 5 if it certifies that the following criteria are met:

(1) the juvenile court has determined or is expected to determine that the child, under the former or current custody of the local agency, cannot return to the home of the child's parents;

(2) the court, upon determining that it is in the child's best interests, has issued or is expected to issue an order transferring permanent legal and physical custody of the child; and

(3) the child either:

(i) is a member of a sibling group to be placed together; or

(ii) has a physical, mental, emotional, or behavioral disability that will require financial support.

When the local agency bases its certification that the criteria in clause (1) or (2) are met upon the expectation that the juvenile court will take a certain action, the relative custody assistance agreement does not become effective until and unless the court acts as expected.

(b) After November 24, 2010, no new relative custody assistance agreements shall be executed. Agreements that were signed on or before November 24, 2010, and were not in effect because the proposed transfer of permanent legal and physical custody of the child did not occur on or before November 24, 2010, must be renegotiated according to the terms of Northstar Care for Children in chapter 256O.

EFFECTIVE DATE. This section is effective August 1, 2009.

Sec. 19. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 11. **Purpose and general eligibility requirements.** (a) The purpose of the adoption assistance program is to help make adoption possible for children who would otherwise remain in foster care.

(b) To be eligible for adoption assistance, a child must:

(1) be determined to be a child with special needs, according to subdivision 12;

(2) meet the applicable citizenship and immigration requirements in subdivision 13; and

(3)(i) meet the criteria outlined in section 473 of the Social Security Act; or

(ii) have had foster care payments paid on the child's behalf while in out-of-home placement through the county or tribe, and be either under the guardianship of the commissioner or under the jurisdiction of a Minnesota tribe, with adoption in accordance with tribal law as the child's documented permanency plan.

(c) In addition to the requirements in paragraph (b), the child's adoptive parents must meet the applicable background study requirements outlined in subdivision 14.

(d) The legally responsible agency shall make a title IV-E adoption assistance eligibility determination for each child. Children who meet all eligibility criteria except those specific to title IV-E adoption assistance shall receive adoption assistance paid through state funds.

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

Sec. 20. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 12. **Special needs determination.** (a) A child is considered a child with special needs under this section if all of the requirements in paragraphs (b) to (g) are met.

(b) There has been a determination that the child cannot or should not be returned to the home of the child's parents as evidenced by:

(1) a court-ordered termination of parental rights;

(2) a petition to terminate parental rights;

(3) a consent to adopt accepted by the court under sections 260C.201, subdivision 11, and 259.24;

(4) in circumstances when tribal law permits the child to be adopted without a termination of parental rights, a judicial determination by tribal court indicating the valid reason why the child cannot or should not return home;

(5) a voluntary relinquishment under section 259.25 or 259.47 or, if relinquishment occurred in another state, the applicable laws in that state; or

(6) the death of the legal parent.

(c) There exists a specific factor or condition because of which it is reasonable to conclude that the child cannot be placed with adoptive parents without providing adoption assistance as evidenced by:

(1) a determination by the Social Security Administration that the child meets all medical or disability requirements of title XVI of the Social Security Act with respect to eligibility for Supplemental Security Income benefits;

(2) a documented physical, mental, emotional, or behavioral disability not covered under clause (1);

(3) membership in a sibling group being adopted at the same time by the same parent;

(4) adoptive placement in the home of a parent who previously adopted another child born of the same mother or father for whom they receive adoption assistance; or

(5) documentation that the child is a high-risk child, according to subdivision 17.

(d) A reasonable but unsuccessful effort must have been made to place the child with adoptive parents without providing adoption assistance as evidenced by:

(1)(i) a documented search for an appropriate adoptive placement; or

(ii) a determination by the commissioner that such a search would not be in the best interests of the child; and

(2) a written statement from the identified prospective adoptive parents that they are either unwilling or unable to adopt the child without adoption assistance.

(e) To meet the requirement of a documented search for an appropriate adoptive placement under paragraph (d), clause (1), item (i), the placing agency minimally must:

(1) give consideration, as required by section 260C.212, subdivision 5, to placement with a relative;

(2) for an Indian child covered by the Indian Child Welfare Act, comply with the placement preferences identified in the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act; and

(3) review all families approved for adoption who are associated with the placing agency.

If the review of families associated with the placing agency results in the identification of an appropriate adoptive placement for the child, the placing agency must provide documentation of the placement decision to the commissioner as part of the application for adoption assistance.

If two or more appropriate families are not approved or available within the placing agency, the agency shall locate additional prospective adoptive families by registering the child with the State Adoption Exchange, as required under section 259.75. If registration with the State Adoption Exchange does not result in an appropriate family for the child, the agency shall employ other recruitment methods, as outlined in recruitment policies and procedures prescribed by the commissioner, to meet this requirement.

(f) The requirement for a documented search for an appropriate adoptive placement under paragraph (d), including review of all families approved for adoption that are associated with the placing agency, registration of the child with the State Adoption Exchange, and additional recruitment methods, must be waived if:

(1) the child is being adopted by a relative;

(2) the child is being adopted by foster parents with whom the child has developed significant emotional ties while in their care as a foster child;

(3) the child is being adopted by a family that previously adopted a child of the same mother or father; or

(4) the court determines that adoption by the identified family is in the child's best interest.

For an Indian child covered by the Indian Child Welfare Act, a waiver must not be granted unless the placing agency has complied with the placement preferences identified in the Indian Child Welfare Act and the Minnesota Indian Family Preservation Act.

(g) Once the placing agency has determined that placement with an identified family is in the child's best interest and made full written disclosure about the child's social and medical history, the agency must ask the prospective adoptive parents if they are willing to adopt the child without adoption assistance. If the identified family is either unwilling or unable to adopt the child without adoption assistance, they must provide a written statement to this effect to the placing agency to fulfill the requirement to make a reasonable effort to place the child without adoption assistance, and a copy of this statement shall be included in the adoption assistance application. If the identified family desires to adopt the child without adoption assistance, the family must provide a written statement to this effect to the placing agency and the statement must be maintained in the permanent

adoption record of the placing agency. For children under the commissioner's guardianship, the placing agency shall submit a copy of this statement to the commissioner to be maintained in the permanent adoption record.

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

Sec. 21. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 13. **Citizenship and immigration status.** (a) A child must be a citizen of the United States or otherwise eligible for federal public benefits according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for title IV-E adoption assistance.

(b) A child must be a citizen of the United States or meet the qualified alien requirements as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, in order to be eligible for state-funded adoption assistance.

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

Sec. 22. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 14. **Background study.** (a) A background study under section 259.41 must be completed on each prospective adoptive parent. If the background study reveals:

(1) a felony conviction at any time for child abuse or neglect;

(2) spousal abuse;

(3) a crime against children, including child pornography;

(4) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(5) a felony conviction within the past five years for physical assault, battery, or a drug-related offense,

the adoptive parent is prohibited from receiving title IV-E adoption assistance on behalf of an otherwise eligible child.

(b) A prospective adoptive parent who possesses one of the felony convictions in paragraph (a) may receive state-funded adoption assistance on behalf of an otherwise eligible child if the court has made a judicial determination that:

(1) the legally responsible agency has thoroughly reviewed the felony conviction and has considered the impact, if any, that the conviction may have on the child's safety, well-being, and permanency;

(2) the conviction likely does not pose a current or future safety risk to the child;

(3) there is no other available permanency resource that is appropriate for the child; and

(4) the adoptive placement is in the child's best interest.

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

Sec. 23. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 15. **Residency.** A child placed in the state from another state or a tribe outside of the state is not eligible for state-funded adoption assistance through the state. A child placed in the state from another state or a tribe outside of the state may be eligible for title IV-E adoption assistance through the state of Minnesota if all eligibility factors are met and there is no state agency that has responsibility for placement and care of the child.

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

Sec. 24. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 16. **Exceptions and exclusions.** Payments for adoption assistance shall not be made to a biological parent of the child or a stepparent who adopts the child. Direct placement adoptions under section 259.47 or the equivalent in tribal code are not eligible for state-funded adoption assistance. A child who is adopted by the child's legal custodian or guardian is not eligible for state-funded adoption assistance. A child who is adopted by the child's legal custodian or guardian may be eligible for title IV-E adoption assistance if all required eligibility factors are met. International adoptions are not eligible for adoption assistance unless the adopted child has been placed into foster care through the public child welfare system subsequent to the failure of the adoption and all required eligibility factors are met.

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

Sec. 25. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 17. **Documentation.** Documentation must be provided to verify that a child meets the special needs criteria outlined in subdivision 12.

(a) Documentation of a disability is limited to evidence deemed appropriate by the commissioner.

(b) To qualify as being a high-risk child, the placing agency must provide to the commissioner one or more of the following:

(1) documented information in a county or tribal social service department record or court record that a relative within the first or second degree of the child has a medical diagnosis or medical history, including diagnosis of a significant mental health or chemical dependency issue, which could result in the child's development of a disability during childhood;

(2) documented information that while in the public child welfare system, the child has experienced three or more placements with extended family or different foster homes that could affect the normal attachment process;

(3) documented evidence in a county or tribal social service department record that the child experienced neglect in the first three years of life, or sustained physical injury, sexual abuse, or physical disease that could have a long-term effect on physical, emotional, or mental development; or

(4) documented evidence in a medical or hospital record, law enforcement record, county or tribal social service department record, court record, or record of an agency under a contract with a county social service agency or the state to provide child welfare services that the birth mother used

drugs or alcohol during pregnancy which could later result in the child's development of a disability.

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

Sec. 26. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 18. **Termination.** (a) An adoption assistance agreement shall terminate in any of the following circumstances:

(1) the child attains the age of 18, unless an extension as outlined in subdivisions 20 to 23, is applied for by the adoptive parents and granted by the commissioner;

(2) the commissioner determines that the adoptive parents are no longer legally responsible for support of the child;

(3) the commissioner determines that the adoptive parents are no longer providing financial support to the child;

(4) death of the child; or

(5) the adoptive parents request termination of the adoption assistance agreement in writing.

(b) An adoptive parent is considered no longer legally responsible for support of the child in any of the following circumstances:

(1) parental rights to the child are legally terminated;

(2) permanent legal and physical custody or guardianship of the child is transferred to another individual;

(3) death of the adoptive parent;

(4) enlistment of the child in the military;

(5) marriage of the child; or

(6) emancipation of the child through legal action of another state.

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

Sec. 27. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 19. **Death of adoptive parent or adoption dissolution.** (a) The adoption assistance agreement ends upon death or termination of parental rights of both the adoptive parents in the case of a two-parent adoption, or the sole adoptive parent in the case of a single-parent adoption, but the child maintains eligibility for state-funded or title IV-E adoption assistance in a subsequent adoption if the following criteria are met:

(1) the child is determined to be a child with special needs as outlined in subdivision 12;

(2) the subsequent adoptive parents reside in Minnesota; and

(3) no state agency outside of Minnesota has responsibility for placement and care of the child at the time of the subsequent adoption.

(b) According to federal regulations, if the child had a title IV-E adoption assistance agreement prior to the death of the adoptive parents or dissolution of the adoption, and a state agency outside of the state of Minnesota has responsibility for placement and care of the child at the time of the subsequent adoption, the state of Minnesota is not responsible for determining whether the child meets the definition of special needs, entering into the adoption assistance agreement, and making any adoption assistance payments outlined in the new agreement.

(c) According to federal regulations, if the child had a title IV-E adoption assistance agreement prior to the death of the adoptive parents or dissolution of the adoption, the subsequent adoptive parents reside outside of the state of Minnesota, and no state agency has responsibility for placement and care of the child at the time of the subsequent adoption, the state of Minnesota is not responsible for determining whether the child meets the definition of special needs, entering into the adoption assistance agreement, and making any adoption assistance payments outlined in the new agreement.

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

Sec. 28. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 20. **Extension, past age 18.** Under certain limited circumstances a child may qualify for extension of the adoption assistance agreement beyond the date the child attains age 18. An application for extension must be completed and submitted by the adoptive parent at least 90 days prior to the date the child attains age 18, unless the child's adoption is scheduled to finalize less than 90 days prior to that date in which case the application for extension must be completed and submitted with the adoption assistance application. The application for extension must be made according to policies and procedures prescribed by the commissioner, including documentation of eligibility, and on forms prescribed by the commissioner.

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

Sec. 29. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 21. **Extension based on a continuing physical or mental disability.** (a) Extensions based on a child's continuing physical or mental disability must be applied for prior to the date the child attains age 18 and according to the requirements under subdivision 20. The commissioner must not grant an extension on this basis if an extension based on continued enrollment in a secondary education or being a child whose adoption finalized after age 16 was previously granted for the child.

(b) A child is eligible for extension of the adoption assistance agreement up to the date the child attains age 21 if the following criteria are met:

(1) the child has a mental or physical disability upon which eligibility for adoption assistance was based which warrants the continuation of assistance;

(2) the child is unable to obtain self-sustaining employment due to the aforementioned mental or physical disability; and

(3) the child needs significantly more care and support than what is typical for an individual of the same age.

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

Sec. 30. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 22. **Extension based on continued enrollment in a secondary education program.** (a) If a child does not qualify for extension based on a continuing physical or mental disability or a parent chooses not to apply for such extension, the adoptive parents may make an application for continuation of adoption assistance based on enrollment in a secondary education program.

(b) If a child is enrolled full-time in a secondary education program or a program leading to an equivalent credential, the child is eligible for extension to the expected gradation date or the date the child attains age 19, whichever is earlier. If a child receives a school-based extension and at any time ceases to be enrolled in a full-time secondary education program or a program leading to an equivalent credential, the adoptive parents are responsible to notify the commissioner and the agreement must terminate.

(c) Extensions based on continuation in a secondary education program must be paid from state funds only, unless the child meets the extension criteria outlined in subdivision 23.

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

Sec. 31. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 23. **Extension for children whose adoption finalized after age 16.** A child who attained the age of 16 prior to finalization of their adoption is eligible for extension of the adoption assistance agreement to the date the child attains age 21 if the child is:

(1) completing a secondary education program 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 child.

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

Sec. 32. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 24. **Adoption assistance certification.** The placing agency shall certify a child as eligible for adoption assistance according to policies and procedures, and on forms, prescribed by the commissioner. Professional documentation must be submitted with the certification, and when applicable, the supplemental adoption assistance needs assessment, to establish eligibility for the amount of payment requested. This form must be submitted with the adoption assistance agreement under subdivision 25.

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

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

Subd. 25. **Adoption assistance agreement.** (a) In order to receive adoption assistance benefits,

a written, binding agreement on a form approved by the commissioner must be established and completed by the placing agency prior to finalization of the adoption. The agreement must be negotiated with the parents, in the case of a two-parent adoption, or the adoptive parent, in the case of a single-parent adoption, as required in subdivision 26. The parents, an approved representative from the placing agency, and the commissioner or the commissioner's designee must sign the agreement prior to the effective date of the adoption decree. The adoption assistance certification and agreement must be granted or denied by the commissioner no later than 15 working days after receipt. A fully executed copy of the signed agreement must be given to each party. Termination or disruption of the preadoptive placement preceding adoption finalization makes the agreement with that family void.

(b) The agreement must specify the following:

(1) duration of the agreement;

(2) the nature and amount of any payment, services, and assistance to be provided under such agreement;

(3) the child's eligibility for Medicaid services;

(4) the terms of the payment;

(5) eligibility for reimbursement of nonrecurring expenses associated with adopting the child, to the extent that the total cost does not exceed $2,000 per child;

(6) that the agreement must remain in effect regardless of the state of which the adoptive parents are residents at any given time;

(7) provisions for modification of the terms of the agreement; and

(8) the effective date of the agreement.

(c) The agreement is effective the date of the adoption decree.

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

Sec. 34. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 26. **Negotiation of the agreement.** (a) A monthly payment is provided as part of the adoption assistance agreement to support the care of a child who has manifested special needs. The amount of the payment made on behalf of a child eligible for adoption assistance is determined through agreement between the adoptive parents and the commissioner or the commissioner's designee. The agreement shall take into consideration the circumstances of the adopting parents and the needs of the child being adopted. The income of the adoptive parents must not be taken into consideration when determining eligibility for adoption assistance or the amount of the payments under subdivision 28. At the written request of the adoptive parents, the amount of the payment in the agreement may be renegotiated when there is a change in the child's needs or the family's circumstances.

(b) The adoption assistance agreement of a child who is identified as a high-risk child must not include a monthly payment unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by

modifying the agreement accordingly. An adoptive parent of a high-risk child with an adoption assistance agreement may request a renegotiation of the adoption assistance agreement under subdivision 27 to include a monthly payment, if the parent has written professional documentation that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability shall be limited to evidence deemed appropriate by the commissioner.

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

Sec. 35. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 27. **Renegotiation of the agreement.** (a) An adoptive parent of a child with an adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When an adoptive parent requests renegotiation of the agreement, a reassessment of the child must be completed. If the reassessment indicates that the child's level has changed, the commissioner or the commissioner's designee and the parent shall renegotiate the agreement to include a payment with the level determined appropriate through the reassessment process. The agreement must not be renegotiated unless the commissioner and the parent mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) An adoptive parent of a high-risk child with an adoption assistance agreement may request renegotiation of the agreement to include a monthly payment, if the parent has written professional documentation that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be renegotiated unless the commissioner and the adoptive parent mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

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

Sec. 36. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 28. **Benefits and payments.** (a) Eligibility for medical assistance for children receiving adoption assistance is as specified in section 256B.055.

(b) The basic maintenance payments must be made according to the following schedule for all children except those eligible for adoption assistance based on high risk of developing a disability:

Birth through age five	up to $247 per month
Age six through age 11	up to $277 per month
Age 12 through age 14	up to $307 per month
Age 15 and older	up to $337 per month

A child must receive the maximum payment amount for the child's age, unless a lesser amount is negotiated with and agreed to by the prospective adoptive parent.

(c) Supplemental adoption assistance needs payments, in addition to basic maintenance payments, are available for a child whose disability necessitates care, supervision, and structure beyond that ordinarily provided in a family setting to persons of the same age. These payments are related to the severity of a child's disability and the level of parenting required to care for the child, and must be made according to the following schedule:

Level I	up to $150 per month
Level II	up to $275 per month
Level III	up to $400 per month
Level IV	up to $500 per month

A child's level shall be assessed on a supplemental maintenance needs assessment form prescribed by the commissioner. A child must receive the maximum payment amount for the child's assessed level, unless a lesser amount is negotiated with and agreed to by the prospective adoptive parent.

(d) Reimbursement for special nonmedical expenses is available to all children except those eligible for adoption assistance based on high risk of developing a disability. Reimbursements under this paragraph will be made only after the adoptive parents document that an application for the applicable service was denied by the local social service agency, community agencies, local school district, local public health department, the parent's insurance provider, or the child's Medicaid program. Reimbursements must be made according to the policies and procedures prescribed by the commissioner and are limited to:

(1) child care;

(2) respite care;

(3) camping program;

(4) home and vehicle modifications;

(5) family counseling;

(6) postadoption counseling;

(7) services to children under age three who are developmentally delayed;

(8) specialized communication equipment; and

(9) burial expenses.

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

Sec. 37. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 29. **Child income or income attributable to the child.** If a child for whom a parent is receiving adoption assistance is also receiving Supplemental Security Income (SSI) or Retirement, Survivors, Disability Insurance (RSDI), the certifying agency shall inform the adoptive parents that the child's adoption assistance must be reported to the Social Security Administration.

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

Sec. 38. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 30. **Payments.** (a) Payments to parents under adoption assistance must be made monthly.

(b) Payments must commence when the commissioner receives the adoption decree from the court, the legally responsible agency, or the parent. Payments must be made according to policies and procedures prescribed by the commissioner.

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

Sec. 39. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 31. **Overpayments.** (a) The commissioner has the authority to collect any amount of adoption assistance paid to a parent in excess of the payment due. Payments covered by this subdivision include basic maintenance needs payments, supplemental maintenance needs payments, and reimbursements of nonmedical expenses under subdivision 28. Prior to any collection, the commissioner or designee shall notify the parent in writing, including:

(1) the amount of the overpayment and an explanation of the cause of overpayment;

(2) clarification of the corrected amount;

(3) a statement of the legal authority for the decision;

(4) information about how the parent can correct the overpayment;

(5) if repayment is required, when the payment is due and a person to contact to review a repayment plan;

(6) a statement that the parent has a right to a fair hearing review by the department; and

(7) the procedure for seeking such a review.

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

Sec. 40. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 32. **Payee.** For adoption assistance cases, the payment may only be made to the adoptive parent specified on the agreement. If there is more than one adoptive parent, both parties must be listed as the payee unless otherwise specified in writing according to policies and procedures prescribed by the commissioner. In the event of divorce or separation of the parents, a change of payee may be made in writing according to policies and procedures prescribed by the commissioner. If both parents are in agreement as to the change, it may be made according to a process prescribed by the commissioner. If there is not agreement as to the change, a court order indicating the party who is to receive the payment is needed before a change can be processed. In the event of the death of the payee, a change of payee consistent with subdivision 19 may be made in writing according to policies and procedures prescribed by the commissioner.

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

Sec. 41. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 33. **Notification of change.** (a) An adoptive parent who has an adoption assistance agreement in place shall keep the agency administering the program informed of the parent's

address and circumstances which would make them ineligible for the payments or eligible for the payments in a different amount.

(b) For the duration of the agreement, the adoptive parent agrees to notify the agency administering the program in writing within 30 days of the following changes:

(1) change in the family's address;

(2) change in the legal custody status of the child;

(3) child's completion of high school, if this occurs after the child attains age 18;

(4) date of termination of the parental rights of the adoptive parent, transfer of permanent legal and physical custody to another person, or other determination that the adoptive parent is no longer legally responsible for the support of the child;

(5) date the adoptive parent is not longer providing support to the child;

(6) date of death of the child;

(7) date of death of the adoptive parent;

(8) date the child enlists in the military;

(9) date of marriage of the child;

(10) date the child becomes an emancipated minor through legal action of another state;

(11) separation or divorce of the adoptive parent; and

(12) residence of the child outside the home for a period of more than 30 consecutive days.

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

Sec. 42. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 34. **Termination notice for parent.** The commissioner shall provide the child's parent written notice of termination of payment. Termination notices must be sent at least 15 days before the final payment or in the case of an unplanned termination, the notice is sent within three days of the end of the payment. The written notice must minimally include the following:

(1) the date payment will end;

(2) the reason payments will end and the event that is the basis to terminate payment;

(3) a statement that the parent has a right to a fair hearing review by the department consistent with section 256.045, subdivision 3;

(4) the procedure to request a fair hearing; and

(5) the agency name and address to which a fair hearing request must be sent.

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

Sec. 43. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 35. **Reimbursement of costs through purchase of service.** (a) Subject to policies and procedures prescribed by the commissioner and the provisions of this subdivision, a child-placing agency licensed in Minnesota or any other state, or local or tribal social services agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing child-specific adoption services. Adoption services under this subdivision may include child-specific recruitment, child-specific training and home studies for prospective adoptive parents, and placement services.

(b) An eligible child must have a goal of adoption, which may include an adoption according to tribal law, and meet one of the following criteria:

(1) is a ward of the Minnesota commissioner of human services or a ward of a Minnesota tribal court under section 260.755, subdivision 20, who meets one of the criteria under subdivision 12, paragraph (b), and one of the criteria under subdivision 12, paragraph (c), clauses (1) to (5); or

(2) is under the guardianship of a Minnesota-licensed child-placing agency who meets one of the eligibility criteria under subdivision 12, paragraph (b), and one of the criteria in subdivision 12, paragraph (c), clauses (1) to (4).

(c) A child-placing agency licensed in Minnesota or any other state shall receive reimbursement for adoption services it purchase for or directly provides to an eligible child. Tribal social services shall receive reimbursement for adoption services it purchases for or directly provides to an eligible child. A local social services agency shall receive reimbursement only for adoption services it purchases for an eligible child.

(d) Before providing adoption services for which reimbursement is sought under this subdivision, a reimbursement agreement, on the forms prescribed by the commissioner, must be signed by the commissioner. No reimbursement under this subdivision must be made to an agency for services provided prior to signatures by all required parties on a reimbursement agreement. Separate reimbursement agreements must be made for each child and separate records must be kept on each child for whom a reimbursement agreement is made. Reimbursement shall not be made unless the commissioner of human services agrees that the reimbursement costs are reasonable and appropriate. The commissioner may spend up to $16,000 for each purchase of service agreement per child. Only one agreement per child is allowed, unless an exception is granted by the commissioner and agreed to in writing by the commissioner prior to commencement of services. Funds encumbered and obligated under such an agreement for the child remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(e) The commissioner shall make reimbursement payments directly to the agency providing the service if direct reimbursement is specified by the purchase of service agreement and if the request for reimbursement is submitted by the local or tribal social services agency along with verification on a form prescribed by the commissioner that the service was provided.

(f) The commissioner shall set aside an amount not to exceed five percent of the total amount of fiscal year appropriation from the state of Minnesota for the adoption assistance program to reimburse placing agencies for adoption services. When adoption assistance payments for children's needs exceed 95 percent of the total amount of fiscal year appropriation from the state of Minnesota for the adoption assistance program, the amount of reimbursement available to placing agencies for adoption services is reduced correspondingly.

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

Sec. 44. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 36. **Indian children.** A child certified as eligible for adoption assistance under this section who is protected under the Federal Indian Child Welfare Act of 1978 should, whenever possible, be served by the tribal governing body, tribal courts, or a licensed Indian child-placing agency.

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

Sec. 45. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 37. **Administration responsibilities.** (a) Subject to commissioner approval, the legally responsible agency shall determine the eligibility for adoption assistance under this section, and for those children determined eligible, shall further determine each child's eligibility for title IV-E of the Social Security Act.

(b) The legally responsible agency is responsible for assisting the commissioner with the administration of the adoption assistance by conducting assessments, reassessments, negotiations, and other activities as specified by the commissioner under this section.

(c) The certifying agency shall notify an adoptive parent of a child's eligibility for Medicaid in their state of residence. The certifying agency shall refer the adoptive parent to apply for Medicaid in the financial office in their county of residence. The certifying agency shall inform adoptive parents of the requirement to comply with the rules of the applicable Medicaid program.

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

Sec. 46. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 38. **Procedures, requirements, and deadlines.** The commissioner shall specify procedures, requirements, and deadlines for the administration of adoption assistance in accordance with this section. As needed, the commissioner shall review all procedures, requirements, and deadlines, including the designated forms, in consultation with counties, tribes, and representatives of parents, and may alter them as needed.

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

Sec. 47. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 39. **Administration of title IV-E programs.** The title IV-E adoption assistance program shall operate within the statute and rules set forth by the federal government in the Social Security Act and Code of Federal Regulations.

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

Sec. 48. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 40. **Reporting.** The commissioner shall specify required fiscal and statistical reports under section 256.01, subdivision 2, paragraph (q), and other reports as necessary.

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

Sec. 49. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 41. **Promotion of programs.** The commissioner or the commissioner's designee shall actively seek ways to promote the adoption assistance program, including informing prospective adoptive parents of eligible children under the commissioner's guardianship of the availability of adoption assistance. All families who adopt children under the commissioner's guardianship must be informed as to the adoption tax credit.

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

Sec. 50. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 42. **Appeals and fair hearings.** (a) A prospective adoptive parent has the right to appeal to the commissioner under section 256.045 when eligibility for adoption assistance is denied, and when payment or the agreement for an eligible child is modified or terminated.

(b) An adoptive parent has additional rights to appeal to the commissioner under section 256.045. These include when the commissioner terminates or modifies the adoption assistance agreement or when the commissioner denies an application for adoption assistance. A prospective adoptive parent who disagrees with a decision by the commissioner prior to finalization of the adoption may request review of the decision by the commissioner, or may appeal the decision under section 256.045. An adoption assistance agrement must be signed and in effect prior to the court order that finalizes the adoption; however, in some cases, there may be extenuating circumstances as to why an agreement was not entered into prior to the adoption finalization. An adoptive parent who believes that extenuating circumstances exist in the case of an adoption finalizing prior to entering of an adoption assistance agreement may request a fair hearing. Parents have the responsibility of proving that extenuating circumstances exist. Parents are required to provide written documentation of each eligibility criterion at the fair hearing. Examples of extenuating circumstances include: relevant facts regarding the child were known by the placing agency and not presented to the parent prior to finalization of the adoption, or failure by the commissioner or the commissioner's designee to advise a potential parent about the availability of adoption assistance for a child in the state foster care system. If an appeals judge finds through the fair hearing process that extenuating circumstances existed and that the child met all eligibility criteria at the time the adoption was finalized, the effective date and any associated federal financial participation shall be retroactive to the date of the request for a fair hearing.

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

Sec. 51. Minnesota Statutes 2008, section 259.67, is amended by adding a subdivision to read:

Subd. 43. **No new executions of adoption assistance agreements.** After November 24, 2010, no new adoption assistance agreements must be executed under this section. Agreements that were signed on or before November 24, 2010, and were not in effect because the adoption finalization of the child did not occur on or before November 24, 2010, must be renegotiated according to the terms of Northstar Care for Children under section 256O.001 to 256O.270. Agreements signed and in effect on or before November 24, 2010, must continue according to the terms of this section and applicable rules for the duration of the agreement, unless the adoptive parents choose to renegotiate their agreement in accordance with the terms of Northstar Care for Children. After November 24, 2010, this section and associated rules must apply to a child whose adoption assistance agreements were in effect on or before November 24, 2010, and whose adoptive parents have chosen not to renegotiate their agreement according to the terms of Northstar Care for Children.

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

Sec. 52. Minnesota Statutes 2008, section 260B.441, is amended to read:

260B.441 ~~COST,~~ PAYMENT FOR FOSTER CARE, RESIDENTIAL PLACEMENT, AND CLOTHING ALLOWANCE.

Subdivision 1. **Responsibility for placement costs.** ~~In addition to the usual care and services given by public and private agencies, the necessary cost incurred by the commissioner of human services in providing care for such child shall be paid by the county committing such child which, subject to uniform rules established by the commissioner of human services, may receive a reimbursement not exceeding one-half of such costs from funds made available for this purpose by the legislature during the period beginning July 1, 1985, and ending December 31, 1985. Beginning January 1, 1986, the necessary cost incurred by the commissioner of human services in providing care for the child must be paid by the county committing the child.~~ Chapter 256O establishes the responsibility for cost and payment for eligible children placed in family foster care settings or in permanent placement with a relative custodian or adoptive parent. Responsibility for placement costs and payment in any other setting is with the county, consistent with chapter 256G, or the tribes authorized in section 256.01, subdivision 14b.

Subd. 2. **Federal title IV-E.** Foster care maintenance payments under title IV-E of the Social Security Act are defined in subdivisions 4 and 5 and section 256O.020. Every effort must be made to establish a child's eligibility for title IV-E, using the criteria in the Social Security Act, United States Code, title 42, sections 670 to 676. Payment of title IV-E funds in Northstar Care for Children is specified in section 256O.260. In all other circumstances, the county or tribal agency authorized in section 256.01, subdivision 14b, responsible for payment of the maintenance costs must be reimbursed from the federal funds available for the purpose.

Subd. 3. **Child resources.** ~~Where such~~ When a child in foster care is eligible to receive a grant of ~~Minnesota family investment program~~ Retirement, Survivors, and Disability Insurance (RSDI), or Supplemental Security Income for the aged, blind, and disabled, or a foster care maintenance payment under title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the child's needs shall be met through these programs.

Subd. 4. **Group residential maintenance payments.** When a child is placed in a group residential setting, foster care maintenance payments are payments made on behalf of a child to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, child's personal incidentals, and transportation needs associated with providing the items listed, including transportation to the child's home for visitation. Daily supervision in group residential settings includes routine day-to-day direction and arrangements to ensure the well-being and safety of the child. It may also include reasonable costs of administration and operation of the facility.

Subd. 5. **Initial clothing allowance.** An initial clothing allowance must be available to all children eligible for Northstar Care for Children under section 256O.210 and foster children placed in group residential settings based on the child's individual needs during the first 60 days of the initial placement. The agency shall consider the parent's ability to provide for the child's clothing needs and the residential facility contracts. A clothing allowance must be approved that is consistent with the child's needs. The amount of the initial clothing allowance must not exceed the monthly basic rate for the child's age group under section 256O.260.

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

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256.82, subdivisions 2, 3, 4, and 5; and 257.85, are repealed effective January 1, 2011.

(b) Minnesota Statutes 2008, section 259.67, subdivisions 1, 2, 3, 3a, 4, 5, 6, 7, 8, 9, and 10, are repealed effective July 1, 2009.

(c) Minnesota Rules, parts 9560.0521, subparts 7 and 10; 9560.0650, subparts 1, 3, and 6; 9560.0651; 9560.0652; 9560.0653; 9560.0654; 9560.0655; 9560.0656; 9560.0657; and 9560.0665, subparts 2, 3, 4, 5, 6, 7, 8, and 9, are repealed effective January 1, 2011.

(d) Minnesota Rules, parts 9560.0071; 9560.0081; 9560.0082; 9560.0083; 9560.0091; 9560.0093, subparts 1, 3, and 4; 9560.0101; and 9560.0102, are repealed effective July 1, 2009.

ARTICLE 8

LICENSING

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

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

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

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

(1) in cases of financial hardship;

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

(3) for new providers; or

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

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

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

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

(1) in cases of financial hardship;

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

(3) for new providers.

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

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

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

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

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

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

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

Subd. 4. **License ~~or certification~~ fee for ~~certain programs~~ a child care center.** ~~(a)~~ A child care ~~centers and programs with a licensed capacity~~ center shall pay an annual nonrefundable license ~~or certification~~ fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee Fiscal Year 2010	~~Other Program~~ License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	~~$225~~ $295	~~$400~~ $360
25 to 49 persons	~~$340~~ $410	~~$600~~ $475
50 to 74 persons	~~$450~~ $520	~~$800~~ $585
75 to 99 persons	~~$565~~ $635	~~$1,000~~ $700
100 to 124 persons	~~$675~~ $745	~~$1,200~~ $810
125 to 149 persons	~~$900~~ $970	~~$1,400~~ $1,035

150 to 174 persons	~~$1,050~~ $1,120	~~$1,600~~ $1,185
175 to 199 persons	~~$1,200~~ $1,270	~~$1,800~~ $1,335
200 to 224 persons	~~$1,350~~ $1,420	~~$2,000~~ $1,485
225 or more persons	~~$1,500~~ $1,570	~~$2,500~~ $1,635

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

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

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

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

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$930	$1,460
25 to 49 persons	$1,130	$1,660
50 to 74 persons	$1,330	$1,860
75 to 99 persons	$1,530	$2,060
100 or more persons	$1,730	$2,260

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

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

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$925	$1,430
25 to 49 persons	$1,125	$1,630

50 to 74 persons	$1,325	$1,830
75 to 99 persons	$1,525	$2,030
100 to 124 persons	$1,725	$2,230
125 to 149 persons	$1,925	$2,430
150 to 174 persons	$2,125	$2,630
175 to 199 persons	$2,325	$2,830
200 to 224 persons	$2,525	$3,030
225 or more persons	$3,025	$3,530

(b) A day training and habilitation program licensed under chapter 245B must be assessed a license fee based on the schedule in paragraph (a) unless the license holder serves more than 50 percent of the same persons at two or more locations in the community. Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities must be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.

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

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

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

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$1,000	$1,600
25 to 49 persons	$1,200	$1,800
50 to 74 persons	$1,400	$2,000
75 or more persons	$1,600	$2,200

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

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

(b) In fiscal year 2011 and thereafter, a program licensed to provide crisis respite services for persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable

license fee of $2,000.

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

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

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

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

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

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

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

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

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$713	$1,025
25 to 49 persons	$913	$1,225
50 to 74 persons	$1,113	$1,425
75 to 99 persons	$1,313	$1,625
100 to 124 persons	$1,513	$1,825
125 or more persons	$1,713	$2,025

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

Subd. 4h. **License fee for residential programs serving adults with mental illness.** (a) In fiscal year 2010, a residential program licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve adults with mental illness shall pay an annual nonrefundable license fee of $2,450.

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

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

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

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

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

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

Licensed Capacity	License Fee Fiscal Year 2010	License Fee Fiscal Year 2011 and thereafter
1 to 24 persons	$755	$1,035
25 to 49 persons	$955	$1,235
50 to 74 persons	$1,155	$1,435
75 to 99 persons	$1,355	$1,635
100 to 124 persons	$1,555	$1,835
125 or more persons	$1,755	$2,035

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

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

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

Subd. 4k. **License fee for independent living assistance for youth.** A program licensed to provide independent living assistance for youth under section 245A.22, shall pay an annual

nonrefundable license fee of $2,000.

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

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

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

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2008, section 245C.10, is amended by adding a subdivision to read:

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

ARTICLE 9

HEALTH CARE

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

Subd. 7. **Transfers from the commissioner of human services.** ~~(a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner annually to clinical medical education programs that meet the qualifications of~~

~~subdivision 3 based on the formula in subdivision 4, paragraph (a).~~

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

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

(a) Of the amount transferred under section 256B.69, subdivision 5c, paragraph (a), clauses (1) to (4), $21,714,000 must be distributed as follows:

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

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

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

(4) $1,121,640 must be distributed by the commissioner to clinical medical education dental innovation grants under subdivision 7a; and

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

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

Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26, school districts may enroll as medical assistance providers or subcontractors and bill the Department of Human Services under the medical assistance fee for service claims processing system for special education services which are covered services under chapter 256B, which are provided in the school setting for a medical assistance recipient, and for whom the district has secured informed consent consistent with section 13.05, subdivision 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type of covered service. School districts shall be reimbursed by the commissioner of human services for the federal share of individual education plan health-related services that qualify for reimbursement by medical assistance, minus up to five percent retained by the commissioner of human services for administrative costs~~, not to exceed $350,000 per fiscal year~~. The commissioner may withhold up to five percent of each payment to a school district. Following the end of each fiscal year, the commissioner shall settle up with each school district in order to ensure that collections from each district for departmental administrative costs are made on a pro rata basis according

to federal earnings for these services in each district. A school district is not eligible to enroll as a home care provider or a personal care provider organization for purposes of billing home care services under sections 256B.0651 and 256B.0653 to 256B.0656 until the commissioner of human services issues a bulletin instructing county public health nurses on how to assess for the needs of eligible recipients during school hours. To use private duty nursing services or personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school.

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more

frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, ~~and~~ for the first 24 months of the rebased period beginning January 1, 2009, and for the first three months of the rebased period beginning January 1, 2011. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 6. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

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

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

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

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

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

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

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2010, to reflect this reduction.

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

(i) In addition to the reductions in paragraphs (b) and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for mental health services within diagnosis-related groups 424 to 432 before third-party liability and spenddown, is reduced 5.2 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from

this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

Sec. 7. Minnesota Statutes 2008, 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 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. 8. Minnesota Statutes 2008, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying

trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

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

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

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

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

Sec. 9. Minnesota Statutes 2008, 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~~ $6,000 in total net assets, plus $200 for each additional legal dependent, and a household of one person must not own more than ~~$10,000~~ $3,000 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;

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

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

(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.

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective for requests for medical assistance submitted on or after July 1, 2009.

Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets, including capital and operating assets of a trade or business, and income for all applicants, and for all recipients upon renewal.

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

Sec. 12. Minnesota Statutes 2008, section 256B.057, subdivision 3, is amended to read:

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

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

Sec. 13. Minnesota Statutes 2008, 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) 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 (c); and

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

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

(b) 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, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, 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.

(c) 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; and

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

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

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

(e)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be 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. 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.

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

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

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

(5) 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.

(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.

Sec. 14. Minnesota Statutes 2008, section 256B.0575, is amended to read:

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

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

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

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

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

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

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

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

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

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

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

(9) amounts for reasonable expenses as defined in subdivision 2, incurred for necessary medical or remedial care for the institutionalized person that are not ~~medical assistance covered expenses and that are not~~ subject to payment by a third party.

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

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

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

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

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

(3) if one of the following circumstances apply:

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

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

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

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

(1) during the enrollee's current period of eligibility including retroactive months associated with the current period of eligibility for medical assistance payment of long-term care services; or

(2) within three months before the effective date of the period of eligibility identified in subdivision 1, paragraph (b), clause (3), item (i).

(b) For expenses incurred during the period identified in paragraph (a), clause (1), reasonable expenses do not include:

(1) expenses for services or equipment covered under chapter 256B by medical assistance or a home and community-based waiver; or

(2) any additional expenses for services and equipment otherwise covered under chapter 256B.

(c) For expenses incurred during the period identified in paragraph (a), clause (2), reasonable expenses do not include any amount incurred for long-term care services during a period of ineligibility due to uncompensated transfers, or long-term care facility expenses incurred without a timely preadmission screening under section 256B.0911.

Sec. 15. Minnesota Statutes 2008, section 256B.0595, subdivision 1, is amended to read:

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

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

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

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was

provided.

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

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

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

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

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

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

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

(ii) purchased with proceeds from:

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

(B) a simplified employee pension within the meaning of section 408(k) of the Internal Revenue

Code; or

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2008, 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 ~~penalty~~ 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 ~~application of the penalty~~ period of ineligibility resulting from the uncompensated transfer; and

(3) cannot begin during any other period of ineligibility.

(d) If a calculation of a ~~penalty~~ 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 begins. A period of ineligibility must not be adjusted if less than the full amounts of the transferred assets or the full cash values of the transferred assets are returned.

EFFECTIVE DATE. This section is effective for periods of ineligibility established on or after July 1, 2009.

Sec. 17. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3g. **Chiropractic services.** Chiropractic services are not covered.

Sec. 18. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3h. **Podiatric services.** Podiatric services are not covered.

Sec. 19. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy for eligible recipients under 21 years of age. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy for eligible recipients under 21 years of age. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to read:

Subd. 8b. **Speech language pathology and audiology services.** Medical assistance covers speech language pathology and related services, including specialized maintenance therapy for eligible recipients under 21 years of age. Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed at the same rate as services performed by a speech language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.

Sec. 22. Minnesota Statutes 2008, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** Medical assistance covers dental services for children under 21 years of age and pregnant women. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

Sec. 23. Minnesota Statutes 2008, 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 plus a fixed dispensing fee; the maximum allowable cost set by the federal government or 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. Effective July 1, 2008, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~14~~ 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. 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 generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the

commissioner.

(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 the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(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, 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.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2008.

Sec. 24. Minnesota Statutes 2008, section 256B.0625, subdivision 17, is amended to read:

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

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

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation includes driver-assisted service to eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the nearest appropriate health care provider, using the most direct route available. The maximum medical assistance reimbursement rates for special transportation services are:

(1) $17 for the base rate and ~~$1.35~~ $1.95 per mile for services to eligible persons who need a

wheelchair-accessible van;

(2) ~~$11.50~~ $8.50 for the base rate and $1.30 per mile for services to eligible persons who do not need a wheelchair-accessible van; and

(3) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for services to eligible persons who need a stretcher-accessible vehicle.

Sec. 25. Minnesota Statutes 2008, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individual education plan be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota Board of Teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individual education plan health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education plan. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education plan.

Sec. 26. Minnesota Statutes 2008, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

(b) For the purposes of this section, the person's estate must consist of:

(1) the person's probate estate;

(2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

(3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent the interests or proceeds of those interests become part of the probate estate under section 524.6-307;

(4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent the interests become part of the probate estate under section 524.6-207; and

(5) assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangements.

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

(d) For the purpose of recovery in a single person's estate or the estate of a survivor of a married couple, "other arrangement" includes any other means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including, but not limited to, transfers between spouses which are permitted, prohibited, or penalized for purposes of medical assistance.

(e) A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

~~(a)~~ (1) the person was over 55 years of age, and received services under this chapter;

~~(b)~~ (2) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital; or

~~(c)~~ (3) the person received general assistance medical care services under chapter 256D.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

Sec. 27. Minnesota Statutes 2008, section 256B.15, subdivision 1h, is amended to read:

Subd. 1h. **Estates of specific persons receiving medical assistance.** (a) For purposes of this section, paragraphs (b) to ~~(k)~~ (j) apply if a person received medical assistance for which a claim may be filed under this section and died single, or the surviving spouse of the couple and was not

survived by any of the persons described in subdivisions 3 and 4.

~~(b) For purposes of this section, the person's estate consists of: (1) the person's probate estate; (2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death; (3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent they become part of the probate estate under section 524.6-307; (4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent they become part of the probate estate under section 524.6-207; and (5) the person's legal title or interest at the time of the person's death in real property transferred under a transfer-on-death deed under section 507.071, or in the proceeds from the subsequent sale of the person's interest in the real property. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section shall be a creditor under section 524.6-307.~~

~~(c)~~ (b) Notwithstanding any law or rule to the contrary, the person's life estate or joint tenancy interest in real property not subject to a medical assistance lien under sections 514.980 to 514.985 on the date of the person's death shall not end upon the person's death and shall continue as provided in this subdivision. The life estate in the person's estate shall be that portion of the interest in the real property subject to the life estate that is equal to the life estate percentage factor for the life estate as listed in the Life Estate Mortality Table of the health care program's manual for a person who was the age of the medical assistance recipient on the date of the person's death. The joint tenancy interest in real property in the estate shall be equal to the fractional interest the person would have owned in the jointly held interest in the property had they and the other owners held title to the property as tenants in common on the date the person died.

~~(d)~~ (c) The court upon its own motion, or upon motion by the personal representative or any interested party, may enter an order directing the remaindermen or surviving joint tenants and their spouses, if any, to sign all documents, take all actions, and otherwise fully cooperate with the personal representative and the court to liquidate the decedent's life estate or joint tenancy interests in the estate and deliver the cash or the proceeds of those interests to the personal representative and provide for any legal and equitable sanctions as the court deems appropriate to enforce and carry out the order, including an award of reasonable attorney fees.

~~(e)~~ (d) The personal representative may make, execute, and deliver any conveyances or other documents necessary to convey the decedent's life estate or joint tenancy interest in the estate that are necessary to liquidate and reduce to cash the decedent's interest or for any other purposes.

~~(f)~~ (e) Subject to administration, all costs, including reasonable attorney fees, directly and immediately related to liquidating the decedent's life estate or joint tenancy interest in the decedent's estate, shall be paid from the gross proceeds of the liquidation allocable to the decedent's interest and the net proceeds shall be turned over to the personal representative and applied to payment of the claim presented under this section.

~~(g)~~ (f) The personal representative shall bring a motion in the district court in which the estate is being probated to compel the remaindermen or surviving joint tenants to account for and deliver to the personal representative all or any part of the proceeds of any sale, mortgage, transfer, conveyance, or any disposition of real property allocable to the decedent's life estate or joint

tenancy interest in the decedent's estate, and do everything necessary to liquidate and reduce to cash the decedent's interest and turn the proceeds of the sale or other disposition over to the personal representative. The court may grant any legal or equitable relief including, but not limited to, ordering a partition of real estate under chapter 558 necessary to make the value of the decedent's life estate or joint tenancy interest available to the estate for payment of a claim under this section.

~~(h)~~ (g) Subject to administration, the personal representative shall use all of the cash or proceeds of interests to pay an allowable claim under this section. The remaindermen or surviving joint tenants and their spouses, if any, may enter into a written agreement with the personal representative or the claimant to settle and satisfy obligations imposed at any time before or after a claim is filed.

~~(i)~~ (h) The personal representative may, at their discretion, provide any or all of the other owners, remaindermen, or surviving joint tenants with an affidavit terminating the decedent's estate's interest in real property the decedent owned as a life tenant or as a joint tenant with others, if the personal representative determines in good faith that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section, or if the personal representative has filed an affidavit with the court that the estate has other assets sufficient to pay a claim, as presented, or if there is a written agreement under paragraph ~~(h)~~ (g), or if the claim, as allowed, has been paid in full or to the full extent of the assets the estate has available to pay it. The affidavit may be recorded in the office of the county recorder or filed in the Office of the Registrar of Titles for the county in which the real property is located. Except as provided in section 514.981, subdivision 6, when recorded or filed, the affidavit shall terminate the decedent's interest in real estate the decedent owned as a life tenant or a joint tenant with others. The affidavit shall:

(1) be signed by the personal representative;

(2) identify the decedent and the interest being terminated;

(3) give recording information sufficient to identify the instrument that created the interest in real property being terminated;

(4) legally describe the affected real property;

(5) state that the personal representative has determined that neither the decedent nor any of the decedent's predeceased spouses received any medical assistance for which a claim could be filed under this section;

(6) state that the decedent's estate has other assets sufficient to pay the claim, as presented, or that there is a written agreement between the personal representative and the claimant and the other owners or remaindermen or other joint tenants to satisfy the obligations imposed under this subdivision; and

(7) state that the affidavit is being given to terminate the estate's interest under this subdivision, and any other contents as may be appropriate.

The recorder or registrar of titles shall accept the affidavit for recording or filing. The affidavit shall be effective as provided in this section and shall constitute notice even if it does not include recording information sufficient to identify the instrument creating the interest it terminates. The affidavit shall be conclusive evidence of the stated facts.

~~(j)~~ (i) The holder of a lien arising under subdivision 1c shall release the lien at the holder's expense against an interest terminated under paragraph ~~(h)~~ (g) to the extent of the termination.

~~(k)~~ (j) If a lien arising under subdivision 1c is not released under paragraph ~~(j)~~ (i), prior to closing the estate, the personal representative shall deed the interest subject to the lien to the remaindermen or surviving joint tenants as their interests may appear. Upon recording or filing, the deed shall work a merger of the recipient's life estate or joint tenancy interest, subject to the lien, into the remainder interest or interest the decedent and others owned jointly. The lien shall attach to and run with the property to the extent of the decedent's interest at the time of the decedent's death.

Sec. 28. Minnesota Statutes 2008, section 256B.15, subdivision 2, is amended to read:

Subd. 2. **Limitations on claims.** The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, ~~clause (b)~~ paragraph (e), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, shall be payable from the full value of all of the predeceased spouse's assets and interests which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. The claim is not payable from the value of assets or proceeds of assets in the estate attributable to a predeceased spouse whom the individual married after the death of the predeceased recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with assets which were not marital property or jointly owned property after the death of the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

Sec. 29. Minnesota Statutes 2008, section 256B.15, is amended by adding a subdivision to read:

Subd. 2b. **Controlling provisions.** (a) For purposes of this subdivision and subdivisions 1a and 2, paragraphs (b) to (d) apply.

(b) At the time of death of a recipient spouse and solely for purpose of recovery of medical assistance benefits received, a predeceased recipient spouse shall have a legal title or interest in the undivided whole of all of the property which the recipient and the recipient's surviving spouse owned jointly or which was marital property at any time during their marriage regardless of the form of ownership and regardless of whether it was owned or titled in the names of one or both the recipient and the recipient's spouse. Title and interest in the property of a predeceased recipient spouse shall not end or extinguish upon the person's death and shall continue for the purpose of allowing recovery of medical assistance in the estate of the surviving spouse. Upon the death of the predeceased recipient spouse, title and interest in the predeceased spouse's property shall vest in the surviving spouse by operation of law and without the necessity for any probate or decree of descent proceedings and shall continue to exist after the death of the predeceased spouse and the surviving spouse to permit recovery of medical assistance. The recipient spouse and the surviving spouse of a deceased recipient spouse shall not encumber, disclaim, transfer, alienate, hypothecate, or otherwise

divest themselves of these interests before or upon death.

(c) For purposes of this section, "marital property" includes any and all real or personal property of any kind or interests in such property the predeceased recipient spouse and their spouse, or either of them, owned at the time of their marriage to each other or acquired during their marriage regardless of whether it was owned or titled in the names of one or both of them. If either or both spouses of a married couple received medical assistance, all property owned during the marriage or which either or both spouses acquired during their marriage shall be presumed to be marital property for purposes of recovering medical assistance unless there is clear and convincing evidence to the contrary.

(d) The agency responsible for the claim for medical assistance for a recipient spouse may, at its discretion, release specific real and personal property from the provisions of this section. The release shall extinguish the interest created under paragraph (b) in the land it describes upon filing or recording. The release need not be attested, certified, or acknowledged as a condition of filing or recording and shall be filed or recorded in the office of the county recorder or registrar of titles, as appropriate, in the county where the real property is located. The party to whom the release is given shall be responsible for paying all fees and costs necessary to record and file the release. If the property described in the release is registered property, the registrar of titles shall accept it for recording and shall record it on the certificate of title for each parcel of property described in the release. If the property described in the release is abstract property, the recorder shall accept it for filing and file it in the county's grantor-grantee indexes and any tract index the county maintains for each parcel of property described in the release.

Sec. 30. Minnesota Statutes 2008, section 256B.15, is amended by adding a subdivision to read:

Subd. 9. **Commissioner's intervention.** The commissioner shall be permitted to intervene as a party in any proceeding involving recovery of medical assistance upon filing a notice of intervention and serving such notice on the other parties.

Sec. 31. Minnesota Statutes 2008, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). The funds in paragraphs (b) and (c) are appropriated to the commissioner to offset medical assistance expenditures.

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County~~,~~ and Hennepin County Medical Center~~, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center~~ shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds~~. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27~~; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment

money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

Sec. 32. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, 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, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, 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 for the prepaid medical assistance and general assistance medical care programs 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. 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. 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 paragraph that is reasonably expected to be returned.

(d)(1) Effective for services rendered on or after January 1, 2009, the commissioner shall withhold three percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs. 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.~~

(2) 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 paragraph. The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

Sec. 33. Minnesota Statutes 2008, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) Except as provided in paragraph (c), the commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, the following:

(1) an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments as specified in this clause. Until January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments and after the regional rate adjustments under section 256B.69, subdivision 5b, is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, ~~$2,157,000~~ $4,314,000 from the capitation rates paid under this section ~~plus any federal matching funds on this amount~~;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. Effective July 1, 2009, and thereafter, the transfers required by paragraph (a), clauses (1) to (4), must not exceed the total amount transferred for fiscal year 2009. Any excess must first reduce the amounts otherwise required to be transferred under paragraph (a), clauses (2) to (4), and then proportionally reduce the transfers under paragraph (a), clause (1).

(c) Effective July 1, 2003, the amount reduced from the prepaid general assistance medical care payments under paragraph (a), clause (1), shall be transferred to the general fund.

(d) Beginning July 1, 2010, of the amounts in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund. The balance of the transfers under paragraph (a) must be transferred to the medical education and research fund no earlier than July 1 of the following fiscal year.

Sec. 34. Minnesota Statutes 2008, section 256B.69, subdivision 5f, is amended to read:

Subd. 5f. **Capitation rates.** (a) Beginning July 1, 2002, the capitation rates paid under this section are increased by $12,700,000 per year. Beginning July 1, 2003, the capitation rates paid under this section are increased by $4,700,000 per year.

(b) Beginning July 1, 2009, the capitation rates paid under this section are increased each year by the lesser of $21,714,000 or an amount equal to the difference between the estimated value of the reductions described in subdivision 5c, paragraph (a), clause (1), and the amount of the limit described in subdivision 5c, paragraph (b).

Sec. 35. **[256B.695] PAYMENT FOR BASIC CARE SERVICES.**

Effective service date July 1, 2009, total payments for basic care services, except prescription drugs, medical supplies, prosthetics, lab, radiology, and medical transportation, shall be reduced by 3.0 percent, prior to third-party liability and spenddown calculation. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

Sec. 36. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, ~~or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c),~~ and who satisfies one of the requirements in clause (1) or clauses (2) and (3):

(1) ~~who is~~ the person must be receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; ~~or~~

(2) ~~who is~~ the person must be a resident of Minnesota~~; and~~:

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision

3c, and who applies during an inpatient hospitalization that occurs on or before January 1, 2010; or

~~(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.~~

~~(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (c).~~

~~(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.~~

~~(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (c), an individual must complete a new application.~~

~~(e) Applicants and recipients eligible under paragraph (a), clause (1), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:~~

~~(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;~~

~~(2) fail to meet the requirements of section 256L.09, subdivision 2;~~

~~(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;~~

~~(4) are classified as end-stage renal disease beneficiaries in the Medicare program;~~

~~(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;~~

~~(6) are eligible under paragraph (j);~~

~~(7) receive treatment funded pursuant to section 254B.02; or~~

~~(8) reside in the Minnesota sex offender program defined in chapter 246B.~~

(3) the person must meet at least one of the following criteria:

(i) the person has applied for and is awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(ii) the person is homeless as defined by United States Code, title 42, section 11301, et seq.;

(iii) the person is classified as an end-stage renal disease beneficiary in the Medicare program;

(iv) the person is enrolled in private health care coverage as defined in section 256B.02,

subdivision 9;

(v) the person is:

(A) detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(B) is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order; and

(C) continues to meet other eligibility requirements of this subdivision;

(vi) the person receives treatment funded under section 254B.02; or

(vii) the person resides in the Minnesota sex offender program defined in chapter 246B.

~~(f)~~ (b) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization ~~but may reapply if there is a subsequent period of inpatient hospitalization~~ that occurs on or before January 1, 2010.

~~(g) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (c) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (c), (e), and (f).~~

~~(h)~~ (c) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary.

~~(i)~~ (d) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

~~(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility~~

~~as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.~~

~~(k)~~ (e) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

~~(l)~~ (f) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

~~(m)~~ (g) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

~~(n)~~ (h) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

~~(o)~~ (i) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

~~(p)~~ (j) Effective July 1, 2003, general assistance medical care emergency services end.

(k) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

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

Sec. 37. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

(15) mental health services covered under chapter 256B;

(16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(17) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(19) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(20) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(22) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(23) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical

assistance program according to section 256B.0625, subdivisions 13 to 13g.

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(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; and

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

(1) $25 for nonemergency visits to a hospital-based emergency room; and

(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(i) General assistance medical care reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of the co-payments effective January 1, 2009.

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

(k) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003.

This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. 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, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

(u) In addition to the reductions in paragraphs (k) and (l), effective service date July 1, 2009, total payments for basic care services, except prescription drugs, medical supplies, prosthetics, lab, radiology, and medical transportation, shall be reduced by 3.0 percent, prior to third-party liability and spenddown calculation. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

Sec. 38. Minnesota Statutes 2008, section 256L.01, subdivision 1a, is amended to read:

Subd. 1a. **Child.** (a) "Child" means an individual under 21 years of age, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Effective July 1, 2010, or upon federal approval, whichever is later, "child" means an individual under 21 years of age, an emancipated minor, and an emancipated minor's spouse.

Sec. 39. Minnesota Statutes 2008, section 256L.01, subdivision 3a, is amended to read:

Subd. 3a. **Family with children.** (a) "Family with children" means:

(1) parents and their children residing in the same household; or

(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; and their wards who are children residing in the same household.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

(c) This subdivision expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 40. Minnesota Statutes 2008, section 256L.01, is amended by adding a subdivision to read:

Subd. 3b. **Family premium.** Effective July 1, 2011, or upon federal approval, whichever is later, "family premium" means the premium determined according to section 256L.15, subdivision 2a or 2b, based on gross individual or gross family income.

Sec. 41. Minnesota Statutes 2008, section 256L.01, subdivision 4, is amended to read:

Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income. This subdivision expires July 1, 2011, or upon federal approval, whichever is later.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year. This subdivision expires July 1, 2011, or upon federal approval, whichever is later.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility. This subdivision expires July 1, 2011, or upon federal approval, whichever is later.

(d) Beginning July 1, 2011, or upon federal approval, whichever is later, "gross individual or gross family income" means the total income for all family members, calculated for the six-month period of eligibility, for purposes of determining the premium under section 256L.15.

Sec. 42. Minnesota Statutes 2008, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** (a) "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(b) Effective July 1, 2011, or upon federal approval, whichever is later, "income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the methodologies for families with children in section 256B.056, subdivision 1a. The deductions in section 256B.056, subdivision 1c, paragraph (a), clause (3), must apply to the income calculated to determine eligibility for children age two through 18. The deductions in section 256B.056, subdivision 1c, paragraph (b), must apply to the income calculated to determine eligibility for children ages 19 and 20.

~~(b)~~ (c) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.

Sec. 43. Minnesota Statutes 2008, section 256L.02, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** (a) The MinnesotaCare program is established to promote access to appropriate health care services to ~~assure~~ ensure healthy children and adults. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Effective July 1, 2010, or upon federal approval, whichever is later, the purpose of the MinnesotaCare program is to promote access to appropriate health care services to ensure healthy children.

Sec. 44. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of finance makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, ~~stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third,~~ upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; ~~fourth~~ second, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and ~~fifth~~ third, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

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

Sec. 45. Minnesota Statutes 2008, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services~~, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services~~, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 46. Minnesota Statutes 2008, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **Pregnant women and children; MinnesotaCare health care reform waiver.** (a) Beginning January 1, 1999, children and pregnant women are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Pregnant women and children are exempt from the provisions of subdivision 5, regarding co-payments. Pregnant women and children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program under chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Sec. 47. Minnesota Statutes 2008, section 256L.03, subdivision 1b, is amended to read:

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling $30 or more, paid after the date of conception, shall be refunded. This subdivision expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 48. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Effective July 1, 2010, or upon federal approval, whichever is later, covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spend down.

~~(b)~~ (c) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Sec. 49. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. 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; and

(5) $6 for nonemergency visits to a hospital-based emergency room.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the

$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) This subdivision expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 50. Minnesota Statutes 2008, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a)(1) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified. This clause expires upon implementation of clause (2).

(2) Effective July 1, 2010, or upon federal approval, whichever is later, children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section.

(b)(1) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members. This clause expires upon implementation of clause (2).

(2) Effective July 1, 2010, or upon federal approval, whichever is later, if one child from a family is enrolled, all children must be enrolled, unless other insurance in available. Families cannot choose to enroll only certain uninsured children.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $57,500. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal. This paragraph expires July 1, 2009, or upon federal approval, whichever is later.

(f) Effective July 1, 2011, or upon federal approval, whichever is later, children ages two through 18 whose countable income is above 150 percent of the federal poverty guidelines but not in excess of 275 percent of the federal poverty guidelines shall be eligible for MinnesotaCare according to this section.

(g) Effective July 1, 2011, or upon federal approval, whichever is later, children ages 19 and 20 whose countable income is above 100 percent of the federal poverty guidelines but not in excess of 275 percent of the federal poverty guidelines shall be eligible for MinnesotaCare according to this

section.

Sec. 51. Minnesota Statutes 2008, section 256L.04, subdivision 1a, is amended to read:

Subd. 1a. **Social Security number required.** (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

Sec. 52. Minnesota Statutes 2008, section 256L.04, subdivision 2, is amended to read:

Subd. 2. **Third-party liability, paternity, and other medical support.** (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, to be eligible for MinnesotaCare, children and parents, guardians, and relative caretakers of enrolled children must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

~~(b)~~ (c) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(d) Beginning July 1, 2010, or upon federal approval, whichever is later, a parent, guardian, or relative caretaker of a child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for

whom the person can legally assign rights, according to applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program based solely on the child's parent, relative caretaker, or guardian failure to cooperate in establishing paternity or obtaining medical support.

Sec. 53. Minnesota Statutes 2008, section 256L.04, subdivision 8, is amended to read:

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible. This paragraph expires January 1, 2010.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination. This paragraph expires January 1, 2010.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance. Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), may choose to enroll in either MinnesotaCare or medical assistance. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(d) Beginning July 1, 2011, or upon federal approval, whichever is later, children who become ineligible due to a decrease in income must be redetermined for medical assistance.

~~(d)~~ (e) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Sec. 54. Minnesota Statutes 2008, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States, qualified noncitizens, and other persons residing lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, eligibility for MinnesotaCare is limited to citizens or nationals of the United States, qualified noncitizens, and other persons residing lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

Sec. 55. Minnesota Statutes 2008, section 256L.04, subdivision 13, is amended to read:

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** (a) Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, if a relative caretaker, foster parent, or legal guardian applies for the children in the household, only the children's income is counted for purposes of eligibility under this chapter.

Sec. 56. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) Beginning July 1, 2005, 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. This paragraph expires upon implementation of paragraph (d).

(b) As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. This paragraph expires upon implementation of paragraph (d).

(c) The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved or at renewal, whichever the family receiving covered health services prefers. 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. This paragraph expires upon implementation of paragraph (d).

(d) Effective July 1, 2009, 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)~~ (e) 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)~~ (f) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

~~(d)~~ (g) 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)~~ (h) Effective September 1, 2006, the effective date of coverage for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, is the first day of the month following the last day of general assistance medical care coverage. This paragraph expires January 1, 2010.

Sec. 57. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a)(1) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved. This clause expires upon implementation of clause (2).

(2) Effective July 1, 2011, or upon federal approval, whichever is later, an enrollee's eligibility must be renewed every six months. The six-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period.

(c) If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies.

(d) The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

~~(c)~~ (e) Effective September 1, 2006, for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section

256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care. This paragraph expires January 1, 2010.

~~(d)~~ (f) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month. This paragraph expires July 1, 2009.

Sec. 58. Minnesota Statutes 2008, section 256L.05, subdivision 3b, is amended to read:

Subd. 3b. **Reapplication.** (a) Beginning January 1, 1999, families and individuals must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, children must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria.

Sec. 59. Minnesota Statutes 2008, section 256L.05, subdivision 3c, is amended to read:

Subd. 3c. **Retroactive coverage.** (a) Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance or general assistance medical care for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance or general assistance medical care. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for children who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing.

Sec. 60. Minnesota Statutes 2008, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** (a) The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in

the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c). This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Effective July 1, 2010, or upon federal approval, whichever is later, the commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all children enrolled in the MinnesotaCare program whose income is equal to or more than 225 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

Sec. 61. Minnesota Statutes 2008, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2)(i) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; or (ii) beginning July 1, 2011, or upon federal approval, whichever is later, adjust sliding scale premium payments based upon both increases and decreases in gross family income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d)(1) Effective upon federal approval, nonpayment of the premium will result in disenrollment from the plan effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule. This paragraph expires July 1, 2009.

(2) Effective July 1, 2009, nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four

calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

Sec. 62. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

Subd. 1a. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992; children who enrolled in the MinnesotaCare program after September 30, 1992, under Laws 1992, chapter 549, article 4, section 17; and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) Notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this paragraph shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2a, paragraph (b).

(d) Notwithstanding paragraphs (b) and (c), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000.

(e) This subdivision is effective August 1, 2005, and expires July 1, 2011, or upon federal approval, whichever is later.

Sec. 63. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

Subd. 1b. **General requirements; contingent on federal approval.** (a) Effective July 1, 2011, or upon federal approval, whichever is later, children enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or

individual exceeds program income limits.

(b) Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. This paragraph expires January 1, 2010.

(c) Notwithstanding paragraphs (a) and (b), and subdivision 1a, paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Beginning July 1, 2011, or upon federal approval, whichever is later, children may remain enrolled in MinnesotaCare if ten percent of their income as defined in section 256L.01, subdivision 5, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this paragraph shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2b, paragraph (b).

(d) Notwithstanding paragraphs (a) and (b), and subdivision 1a, paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 64. Minnesota Statutes 2008, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, to be eligible for MinnesotaCare, a child must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A child whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible. This subdivision does not apply to a child who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

~~(b)~~ (c) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

~~(c)~~ (d) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized

coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Sec. 65. Minnesota Statutes 2008, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(b) Effective July 1, 2011, or upon federal approval, whichever is later, children enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal.

~~(b)~~ (c) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(d) Beginning July 1, 2011, or upon federal approval, whichever is later, medical assistance and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

~~(c)~~ (e) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part

A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

~~(d)~~ (f) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

(g) Beginning July 1, 2011, or upon federal approval, whichever is later, applicants who were recipients of medical assistance within one month of application must meet the provisions of this subdivision and subdivision 2.

~~(e)~~ (h) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.

Sec. 66. Minnesota Statutes 2008, section 256L.07, subdivision 5, is amended to read:

Subd. 5. **Voluntary disenrollment for members of military.** (a) Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to individuals and families enrolled under this subdivision upon 12-month renewal. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military under age 21 and children whose parents are military members may choose to voluntarily disenroll from the program when one or more family members are called to active duty, and may reenroll during or following that member's tour of active duty. Those children shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to children enrolled under this subdivision upon renewal.

Sec. 67. Minnesota Statutes 2008, section 256L.07, subdivision 7, is amended to read:

Subd. 7. **Exception for certain children.** (a) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

(b) This subdivision expires July 1, 2009.

Sec. 68. Minnesota Statutes 2008, section 256L.09, subdivision 2, is amended to read:

Subd. 2. **Residency requirement.** (a) To be eligible for health coverage under the MinnesotaCare program, adults without children must be permanent residents of Minnesota. This

paragraph expires January 1, 2010.

(b) To be eligible for health coverage under the MinnesotaCare program, pregnant women, families, and children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(c) Effective July 1, 2010, or upon federal approval, whichever is later, to be eligible for health coverage under the MinnesotaCare program, children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403.

Sec. 69. Minnesota Statutes 2008, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

(b) Effective service date July 1, 2009, total payments for basic care services, except prescription drugs, medical supplies, prosthetics, lab, radiology, and medical transportation, shall be reduced by 3.0 percent, prior to third-party liability and spenddown calculation. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2010, to reflect this reduction.

Sec. 70. Minnesota Statutes 2008, section 256L.11, subdivision 2a, is amended to read:

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** (a) Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a). This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, subdivision 2 must not apply to services provided to children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Sec. 71. Minnesota Statutes 2008, section 256L.11, subdivision 6, is amended to read:

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees ~~eligible under section 256L.04, subdivision 7, or~~ who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring during the period of July 1, 1997, through June 30, 1998, for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits in excess of the $10,000 annual inpatient benefit limit.

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

Sec. 72. Minnesota Statutes 2008, section 256L.12, subdivision 6, is amended to read:

Subd. 6. **Co-payments and benefit limits.** (a) Enrollees are responsible for all co-payments in sections 256L.03, subdivision 5, and 256L.035, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

(b) This subdivision expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 73. Minnesota Statutes 2008, 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, 2003, to December 31, 2003, the commissioner shall withhold .5 percent of managed care plan payments under this section pending completion of performance targets. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year if performance targets in the contract are achieved. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(c) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care 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. 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. 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 paragraph that is reasonably expected to be returned.

(d) For services rendered on or after January 1, 2010, the commissioner shall withhold an additional three percent of managed care 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.

(e) 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 paragraph. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b) or (c).

Sec. 74. Minnesota Statutes 2008, 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~~ 2a. This paragraph expires July 1, 2010, or upon federal approval, whichever is later.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, children shall pay a premium determined according to subdivision 2b.

~~(b)~~ (c) 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. This paragraph expires July 1, 2011, or upon federal approval, whichever is later.

~~(c)~~ (d) Effective upon federal approval, 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. This paragraph expires June 30, 2010.

Sec. 75. Minnesota Statutes 2008, section 256L.15, is amended by adding a subdivision to read:

Subd. 2a. **Sliding fee scale to determine percentage of gross individual or family income.** (a) Effective August 1, 2005, the commissioner shall establish a sliding fee scale to determine the percentage of gross individual or family income that households at different income levels must pay

to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall not be adjusted until eligibility renewal.

(b) Effective August 1, 2005, children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for children under age two and pregnant women and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) This subdivision expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 76. Minnesota Statutes 2008, section 256L.15, is amended by adding a subdivision to read:

Subd. 2b. **Sliding fee scale to determine monthly gross income.** (a) Effective July 1, 2010, or upon federal approval, whichever is later, the commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross family income for children with family incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for children in a family of five must be used for children in families of more than five. Effective July 1, 2009, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines.

The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a child or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Effective July 1, 2010, or upon federal approval, whichever is later, children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

Sec. 77. Minnesota Statutes 2008, section 256L.15, is amended by adding a subdivision to read:

Subd. 3a. **Exceptions to sliding scale.** Effective July 1, 2011, or upon federal approval, whichever is later, children ages 19 and 20 enrolled under section 256L.04, subdivision 1, paragraph (a), in families with income at or below 150 percent of the federal poverty guidelines pay a monthly premium of $4.

Sec. 78. Minnesota Statutes 2008, section 256L.17, is amended by adding a subdivision to read:

Subd. 8. **Expiration.** This section expires July 1, 2010, or upon federal approval, whichever is later.

Sec. 79. Minnesota Statutes 2008, section 501B.89, is amended by adding a subdivision to read:

Subd. 4. **Annual filing requirement for supplemental needs trusts.** (a) A trustee of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or (C), shall submit to the commissioner of human services, at the time of a beneficiary's request for medical assistance, the following information about the trust:

(1) a copy of the trust instrument; and

(2) an inventory of the beneficiary's trust account assets and the value of those assets.

(b) A trustee of a trust under subdivision 3 and United States Code, title 42, section 1396p(d)(4)(A) or (C), shall submit an accounting of the beneficiary's trust account to the commissioner of human services at least annually until the trust, or the beneficiary's interest in the trust, terminates. Accountings are due on the anniversary of the execution date of the trust unless another annual date is established by the terms of the trust. The accounting must include the following information for the accounting period:

(1) an inventory of trust assets and the value of those assets at the beginning of the accounting period;

(2) additions to the trust during the accounting period and the source of those additions;

(3) itemized distributions from the trust during the accounting period, including the purpose of the distributions and to whom the distributions were made;

(4) an inventory of trust assets and the value of those assets at the end of the accounting period;

and

(5) changes to the trust instrument during the accounting period.

(c) For the purpose of paragraph (b), an accounting period is 12 months unless an accounting period of a different length is permitted by the commissioner.

EFFECTIVE DATE. This section is effective for applications for medical assistance and renewals of medical assistance submitted on or after July 1, 2009.

Sec. 80. Minnesota Statutes 2008, section 519.05, is amended to read:

519.05 LIABILITY OF HUSBAND AND WIFE.

(a) A spouse is not liable to a creditor for any debts of the other spouse. Where husband and wife are living together, they shall be jointly and severally liable for necessary medical services that have been furnished to either spouse, including any claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and necessary household articles and supplies furnished to and used by the family. Notwithstanding this paragraph, in a proceeding under chapter 518 the court may apportion such debt between the spouses.

(b) Either spouse may close a credit card account or other unsecured consumer line of credit on which both spouses are contractually liable, by giving written notice to the creditor.

Sec. 81. Laws 2005, First Special Session chapter 4, article 8, section 66, the effective date, is amended to read:

EFFECTIVE DATE. ~~Paragraph (a) is effective August 1, 2007, or upon HealthMatch implementation, whichever is later, and~~ Paragraph (e) is effective September 1, 2006.

Sec. 82. Laws 2008, chapter 358, article 3, section 8, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, 2009~~, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained~~.

Sec. 83. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256.962, subdivisions 1, 2, 5, and 7; 256B.76, subdivision 4; 256L.07, subdivision 1; 256L.09, subdivision 2; 256L.11, subdivision 7; and 256L.15, subdivisions 2 and 3, are repealed.

(b) Minnesota Statutes 2008, sections 256B.057, subdivision 2c; and 256L.07, subdivision 7, are repealed effective July 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor when federal approval is obtained.

(c) Minnesota Statutes 2008, section 256.969, subdivisions 26 and 27, are repealed effective July 1, 2009.

(d) Minnesota Statutes 2008, sections 256L.04, subdivisions 7 and 9; 256L.05, subdivision 1b; 256L.07, subdivision 6; 256L.09, subdivisions 4, 5, and 6; and 256L.15, subdivision 4, are repealed effective January 1, 2010.

(e) Laws 2005, chapter 10, article 1, sections 56; and 57; Laws 2005, First Special Session chapter 4, article 8, sections 67; 69; 74; and 75; Laws 2007, chapter 147, article 5, sections 28; and 33; and Laws 2008, chapter 358, article 3, sections 10; 11; and 14, are repealed.

(f) Laws 2005, First Special Session chapter 4, article 8, section 61, the effective date; Laws 2007, chapter 147, article 13, section 2, the effective date; Laws 2007, chapter 147, article 5, section 32, the effective date; and Laws 2008, chapter 358, article 3, sections 8, the effective date; and 9, the effective date, are repealed.

ARTICLE 10

STATE-OPERATED SERVICES COST OF CARE

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

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

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

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

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

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

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

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

Subd. 1a. **Clients in state-operated community-based programs; determination.** For clients admitted to a state-operated community-based program, the commissioner shall make an investigation to determine the available health plan coverage for services being provided. If the health plan coverage requires a co-pay or deductible, or if there is no available health plan coverage, the commission shall make an investigation as necessary to determine, and as

circumstances require redetermine, what part of the noncovered cost of care, if any, the client is able to pay. If the client is unable to pay the uncovered cost of care, the commissioner shall make a determination as to the ability of the client's relatives to pay. The client and relatives shall provide the commissioner documents and proof necessary to determine their ability to pay. Failure to provide the commissioner with sufficient information to determine ability to pay may make the client or relatives liable for the full cost of care until the time when sufficient information is provided. If it is determined that the responsible party does not have the ability to pay, the commissioner shall waive payment of the portion that exceeds ability to pay under the determination.

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

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

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

246.511 RELATIVE RESPONSIBILITY.

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

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

246.52 PAYMENT FOR CARE; ORDER; ACTION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The commissioner shall issue an order to the client or the guardian of the estate, if there is one,

requiring them to pay to the state the amounts so determined, the total of which shall not exceed the full cost of care. The order shall specifically state the commissioner's determination and must be conclusive, unless appealed. When a client fails to pay the amount due, the attorney general, upon request of the commissioner, may institute, or direct the appropriate county attorney to institute, civil action to recover the amount.

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

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

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

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

Subd. 3. **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 must not apply to any claim against an estate made under this section to recover cost of care.

Sec. 15. **[246B.10] LIABILITY OF COUNTY; REIMBURSEMENT.**

The client's county shall pay to the state a portion of the cost of care provided in the Minnesota sex offender program to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall equal ten percent of the cost of care, as determined by the commissioner, for each day or portion of a day, that the client spends at the facility. If payments received by the state under sections 246.50 to 246.53 exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246B.07.

Sec. 16. **REPEALER.**

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

ARTICLE 11

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2008, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, $175 annually;

(2) for construction of a monitoring well, $215, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, $175 annually;

(4) for a monitoring well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit, $50 annually. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, and organization formed for the joint exercise of powers under section 471.59, a board of health or community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

(5) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is $215, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is $175 per site regardless of the number of monitoring wells located on site;

~~(5)~~ (6) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, $215, which includes the state core function fee;

~~(6)~~ (7) for a vertical heat exchanger with less than ten tons of heating/cooling capacity, $215;

(8) for a vertical heat exchanger with ten to 50 tons of heating/cooling capacity, $425;

(9) for a vertical heat exchanger with greater than 50 tons of heating/cooling capacity, $650;

~~(7)~~ (10) for a dewatering well that is unsealed under a maintenance permit, $175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for $875 annually for dewatering wells recorded on the permit; and

~~(8)~~ (11) for an elevator boring, $215 for each boring.

Sec. 2. Minnesota Statutes 2008, section 144.121, subdivision 1a, is amended to read:

Subd. 1a. **Fees for ionizing radiation-producing equipment.** (a) A facility with ionizing radiation-producing equipment must pay an annual initial or annual renewal registration fee consisting of a base facility fee of ~~$66~~ $100 and an additional fee for each radiation source, as follows:

(1)	medical or veterinary equipment	$ ~~53~~ 100
(2)	dental x-ray equipment	$ ~~33~~ 40
~~(3)~~	~~accelerator~~	~~$ 66~~
~~(4)~~	~~radiation therapy equipment~~	~~$ 66~~
~~(5)~~ (3)	x-ray equipment not used on humans or animals	$ ~~53~~ 100
~~(6)~~ (4)	devices with sources of ionizing radiation not used on humans or animals	$ ~~53~~ 100

(b) A facility with radiation therapy and accelerator equipment must pay an annual registration fee of $500. A facility with an industrial accelerator must pay an annual registration fee of $150.

(c) Electron microscopy equipment is exempt from the registration fee requirements of this section.

Sec. 3. Minnesota Statutes 2008, section 144.121, subdivision 1b, is amended to read:

Subd. 1b. **Penalty fee for late registration.** Applications for initial or renewal registrations submitted to the commissioner after the time specified by the commissioner shall be accompanied by ~~a penalty fee of $20~~ an amount equal to 25 percent of the fee due in addition to the fees prescribed in subdivision 1a.

Sec. 4. Minnesota Statutes 2008, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

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

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

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	~~$7,555~~ $7,655 plus ~~$13~~ $16 per bed
Non-JCAHO and non-AOA hospitals	~~$5,180~~ $5,280 plus ~~$247~~ $250 per bed

Nursing home	$183 plus $91 per bed

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 144.1222, subdivision 1a, is amended to read:

Subd. 1a. **Fees.** All plans and specifications for public pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. All public pool construction plans submitted for review after January 1, 2009, must be certified by a professional engineer registered in the state of Minnesota. If the commissioner determines, upon review of the plans,

that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each pool, ~~$800~~ $1,500;

(2) each spa pool, ~~$500~~ $800;

(3) each slide, ~~$400~~ $600;

(4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum fee of ~~$10,000~~ $15,000;

(5) alterations to an existing pool without changing the size or configuration of the pool, ~~$400~~ $600;

(6) removal or replacement of pool disinfection equipment only, ~~$75~~ $100; and

(7) request for variance from the public pool and spa rules, $500.

Sec. 6. Minnesota Statutes 2008, section 144.226, subdivision 4, is amended to read:

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

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

Sec. 7. Minnesota Statutes 2008, section 144.72, subdivision 1, is amended to read:

Subdivision 1. ~~**Permits**~~ **License required.** The state commissioner of health is authorized to issue ~~permits for the operation of youth camps which are required to obtain the permits~~ a license according to chapter 157.

Sec. 8. Minnesota Statutes 2008, section 144.72, subdivision 3, is amended to read:

Subd. 3. **Issuance of ~~permits~~ license.** If the commissioner should determine from the application that the health and safety of the persons using the camp will be properly safeguarded, the commissioner may, prior to actual inspection of the camp, issue the ~~permit~~ license in writing. ~~No fee shall be charged for the permit.~~ The ~~permit~~ license shall be posted in a conspicuous place on the premises occupied by the camp.

Sec. 9. Minnesota Statutes 2008, section 144.9501, is amended by adding a subdivision to read:

Subd. 8a. **Disclosure pamphlet.** "Disclosure pamphlet" means the EPA pamphlet titled "Renovate Right: Important Lead Hazard Information for Families, Child Care Providers and

Schools" developed under section 406(a) of the Toxic Substance Control Act.

Sec. 10. Minnesota Statutes 2008, section 144.9501, subdivision 22b, is amended to read:

Subd. 22b. **Lead sampling technician.** "Lead sampling technician" means an individual who performs clearance inspections for ~~nonabatement or nonorder lead hazard reduction~~ renovation sites~~,~~ and lead dust sampling ~~in other settings, or visual assessment for deteriorated paint~~ for nonabatement sites, and who is registered with the commissioner under section 144.9505.

Sec. 11. Minnesota Statutes 2008, section 144.9501, subdivision 26a, is amended to read:

Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services; ~~or~~

(9) swab team services~~.~~;

(10) renovation activities; or

(11) activities performed to comply with lead orders issued by a board of health.

(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:

~~(1) activities such as remodeling, renovation, installation, rehabilitation, or landscaping activities, the primary intent of which is to remodel, repair, or restore a structure or dwelling, rather than to permanently eliminate lead hazards, even though these activities may incidentally result in a reduction in lead hazards; or~~

~~(2) interim control activities that are not performed as a result of a lead order and that do not disturb painted surfaces that total more than:~~

~~(i)~~ (1) 20 square feet (two square meters) on exterior surfaces; or

~~(ii)~~ (2) ~~two~~ six square feet (~~0.2~~ 0.6 square meters) in an interior room~~; or~~.

~~(iii) ten percent of the total surface area on an interior or exterior type of component with a small surface area.~~

Sec. 12. Minnesota Statutes 2008, section 144.9501, is amended by adding a subdivision to read:

Subd. 26b. **Renovation.** "Renovation" means the modification of any affected property that results in the disturbance of painted surfaces, unless that activity is performed as an abatement. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

Sec. 13. Minnesota Statutes 2008, section 144.9505, subdivision 1g, is amended to read:

Subd. 1g. **Certified lead firm.** ~~A person within the state intending to directly perform or cause to be performed through subcontracting or similar delegation any regulated lead work shall first obtain certification from the commissioner~~ A person who employs individuals to perform regulated lead work outside of the person's property must obtain certification as a lead firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. The certification fee is $100, is nonrefundable, and must be submitted with each application. The certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

Sec. 14. Minnesota Statutes 2008, section 144.9505, subdivision 4, is amended to read:

Subd. 4. **Notice of regulated lead work.** (a) At least five working days before starting work at each regulated lead worksite, the person performing the regulated lead work shall give written notice to the commissioner and the appropriate board of health.

(b) This provision does not apply to lead hazard screen, lead inspection, lead risk assessment, lead sampling technician, renovation, or lead project design activities.

Sec. 15. Minnesota Statutes 2008, section 144.9508, subdivision 2, is amended to read:

Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

(b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead-dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead-safe practices including prohibited practices, preparation, disposal, and cleanup. The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods

shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead-based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

(k) The commissioners shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act to ensure that renovation is a pre-1978 affected property where a child or pregnant female resides is conducted in a manner that protects health and the environment.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act.

Sec. 16. Minnesota Statutes 2008, section 144.9508, subdivision 3, is amended to read:

Subd. 3. **Licensure and certification.** The commissioner shall adopt rules to license lead supervisors, lead workers, lead project designers, lead inspectors, ~~and~~ lead risk assessors, and lead sampling technicians. The commissioner shall also adopt rules requiring certification of firms that perform regulated lead work ~~and rules requiring registration of lead sampling technicians~~. The commissioner shall require periodic renewal of licenses~~,~~ and certificates~~, and registrations~~ and shall establish the renewal periods.

Sec. 17. Minnesota Statutes 2008, section 144.9508, subdivision 4, is amended to read:

Subd. 4. **Lead training course.** The commissioner shall establish by rule requirements for training course providers and the renewal period for each lead-related training course required for certification or licensure. The commissioner shall establish criteria in rules for the content and presentation of training courses intended to qualify trainees for licensure under subdivision 3. The commissioner shall establish criteria in rules for the content and presentation of training courses for lead ~~interim control workers~~ renovation and lead sampling technicians. Training course permit fees shall be nonrefundable and must be submitted with each application in the amount of $500 for an initial training course, $250 for renewal of a permit for an initial training course, $250 for a refresher training course, and $125 for renewal of a permit of a refresher training course.

Sec. 18. Minnesota Statutes 2008, section 144.97, subdivision 2, is amended to read:

Subd. 2. **~~C~~ertification Accreditation.** ~~"Certification" means written acknowledgment of a laboratory's demonstrated capability to perform tests for a specific purpose~~ "Accreditation" means written acknowledgment that a laboratory has the policies, procedures, equipment, and practices to produce reliable data in the analysis of environmental samples.

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

Sec. 19. Minnesota Statutes 2008, section 144.97, subdivision 4, is amended to read:

Subd. 4. **~~C~~ontract Commercial laboratory.** "~~Contract~~ Commercial laboratory" means a laboratory that performs tests on samples on a contract or fee-for-service basis.

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

Sec. 20. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision to read:

Subd. 5a. **Field of testing.** "Field of testing" means the combination of analyte, method, matrix, and test category for which a laboratory may hold accreditation.

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

Sec. 21. Minnesota Statutes 2008, section 144.97, subdivision 6, is amended to read:

Subd. 6. **Laboratory.** "Laboratory" means the state, a person, corporation, or other entity, including governmental, that examines, analyzes, or tests samples in a specified physical location.

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

Sec. 22. Minnesota Statutes 2008, section 144.97, is amended by adding a subdivision to read:

Subd. 8. **Test category.** "Test category" means the combination of program and category as provided by section 144.98, subdivisions 3, paragraph (b), clauses (1) to (10), and 3a, paragraph (a), clauses (1) to (5).

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

Sec. 23. Minnesota Statutes 2008, section 144.98, subdivision 1, is amended to read:

Subdivision 1. **Authorization.** The commissioner of health ~~may certify~~ shall accredit environmental laboratories ~~that test environmental samples~~ according to national standards

developed using a consensus process as established by Circular A-119, published by the United States Office of Management and Budget.

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

Sec. 24. Minnesota Statutes 2008, section 144.98, subdivision 2, is amended to read:

Subd. 2. **Rules and standards.** The commissioner may adopt rules to ~~implement this section, including:~~ carry out the commissioner's responsibilities under the national standards specified in subdivisions 1 and 2a.

~~(1) procedures, requirements, and fee adjustments for laboratory certification, including provisional status and recertification;~~

~~(2) standards and fees for certificate approval, suspension, and revocation;~~

~~(3) standards for environmental samples;~~

~~(4) analysis methods that assure reliable test results;~~

~~(5) laboratory quality assurance, including internal quality control, proficiency testing, and personnel training; and~~

~~(6) criteria for recognition of certification programs of other states and the federal government.~~

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

Sec. 25. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 2a. **Standards.** The commissioner shall accredit laboratories according to the most current environmental laboratory accreditation standards under subdivision 1 and as accepted by the accreditation bodies recognized by the National Environmental Laboratory Accreditation Program, NELAP, of the NELAC Institute.

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

Sec. 26. Minnesota Statutes 2008, section 144.98, subdivision 3, is amended to read:

Subd. 3. **Annual fees.** (a) An application for ~~certification~~ accreditation under subdivision ~~1~~ 6 must be accompanied by the ~~biennial fee~~ annual fees specified in this subdivision. The ~~fees are for~~ annual fees include:

(1) base ~~certification~~ accreditation fee, ~~$1,600~~ $1,500;

(2) sample preparation techniques ~~fees~~ fee, ~~$100~~ $200 per technique; ~~and~~

(3) an administrative fee for laboratories located outside this state, $3,750; and

(4) test category ~~certification~~ fees~~:~~.

~~Test Category~~	~~Certification Fee~~
~~Clean water program bacteriology~~	~~$800~~

~~Safe drinking water program bacteriology $800~~

~~Clean water program inorganic chemistry $800~~

~~Safe drinking water program inorganic chemistry $800~~

~~Clean water program chemistry metals $1,200~~

~~Safe drinking water program chemistry metals $1,200~~

~~Resource conservation and recovery program chemistry metals $1,200~~

~~Clean water program volatile organic compounds $1,500~~

~~Safe drinking water program volatile organic compounds $1,500~~

~~Resource conservation and recovery program volatile organic compounds $1,500~~

~~Underground storage tank program volatile organic compounds $1,500~~

~~Clean water program other organic compounds $1,500~~

~~Safe drinking water program other organic compounds $1,500~~

~~Resource conservation and recovery program other organic compounds $1,500~~

~~Clean water program radiochemistry $2,500~~

~~Safe drinking water program radiochemistry $2,500~~

~~Resource conservation and recovery program agricultural contaminants $2,500~~

~~Resource conservation and recovery program emerging contaminants $2,500~~

(b) ~~Laboratories located outside of this state that require an on-site inspection shall be assessed an additional $3,750 fee.~~ For the programs in subdivision 3a, the commissioner may accredit laboratories for fields of testing under the categories listed in clauses (1) to (10) upon completion of the application requirements provided by subdivision 6 and receipt of the fees for each category under each program that accreditation is requested. The categories offered and related fees include:

(1) microbiology, $450;

(2) inorganics, $450;

(3) metals, $1,000;

(4) volatile organics, $1,300;

(5) other organics, $1,300;

(6) radiochemistry, $1,500;

(7) emerging contaminants, $1,500;

(8) agricultural contaminants, $1,250;

(9) toxicity (bioassay), $1,000; and

(10) physical characterization, $250.

(c) The total ~~biennial certification~~ annual fee includes the base fee, the sample preparation techniques fees, the test category fees per program, and, when applicable, ~~the on-site inspection fee~~ an administrative fee for out-of-state laboratories.

~~(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.~~

~~(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.~~

~~(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is $500 per variance.~~

~~(g) Refunds or credits shall not be made for analytes or methods requested but not approved.~~

~~(h) Certification of a laboratory shall not be awarded until all fees are paid.~~

Sec. 27. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 3a. **Available programs, categories, and analytes.** (a) The commissioner shall accredit laboratories that test samples under the following programs:

(1) the clean water program, such as compliance monitoring under the federal Clean Water Act, and ambient monitoring of surface and ground water, or analysis of biological tissue;

(2) the safe drinking water program, including compliance monitoring under the federal Safe Drinking Water Act, and the state requirements for monitoring private wells;

(3) the resource conservation and recovery program, including federal and state requirements for monitoring solid and hazardous wastes, biological tissue, leachates, and ground water monitoring wells not intended as drinking water sources;

(4) the underground storage tank program; and

(5) the clean air program, including air and emissions testing under the federal Clean Air Act, and state and federal requirements for vapor intrusion monitoring.

(b) The commissioner shall maintain and publish a list of analytes available for accreditation. The list must be reviewed at least once every six months and the changes published in the State Register and posted on the program's Web site. The commissioner shall publish the notification of changes and review comments on the changes no less than 30 days from the date the list is published.

Sec. 28. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 3b. **Additional fees.** (a) Laboratories located outside of this state that require an on-site assessment more frequent than once every two years must pay an additional assessed fee of $3,000 per assessment for each additional on-site assessment conducted. The laboratory must pay the fee within 15 business days of receiving the commissioner's notification that an on-site assessment is required. The commissioner may conduct additional on-site assessments to determine a laboratory's continued compliance with the standards provided in subdivision 2a.

(b) A late fee of $200 shall be added to the annual fee for accredited laboratories submitting renewal applications to the commissioner after November 1.

(c) A change fee shall be assessed if a laboratory requests additional fields of testing at any time other than when initially applying for or renewing its accreditation. A change fee does not apply for applications to add fields of testing for new analytes in response to the published notice under subdivision 3a, paragraph (b), if the laboratory holds valid accreditation for the changed test category and applies for additional analytes within the same test category. The change fee is equal to the applicable test category fee for the field of testing requested. An application that requests accreditation of multiple fields of testing within a test category requires a single payment of the applicable test category fee per application submitted.

(d) A variance fee shall be assessed if a laboratory requests a variance from a standard provided in subdivision 2a. The variance fee is $500 per variance.

(e) The commissioner shall assess a fee for changes to laboratory information regarding ownership, name, address, or personnel. Laboratories must submit changes through the application process under subdivision 6. The information update fee is $250 per application.

(f) Fees must be set so that the total fees support the laboratory accreditation program. Direct costs of the accreditation service include program administration, assessments, the agency's general support costs, and attorney general costs attributable to the fee function.

Sec. 29. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 3c. **Refunds and nonpayment.** Refunds or credits shall not be made for applications received but not approved. Accreditation of a laboratory shall not be awarded until all fees are paid.

Sec. 30. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 6. **Application.** (a) Laboratories seeking accreditation must apply on a form provided by the commissioner, include the laboratory's procedures and quality manual, and pay the applicable fees.

(b) Laboratories may be fixed-base or mobile. The commissioner shall accredit mobile laboratories individually and require a vehicle identification number, license plate number, or other uniquely identifying information in addition to the application requirements of paragraph (a).

(c) Laboratories maintained on separate properties, even though operated under the same management or ownership, must apply separately. Laboratories with more than one building on the same or adjoining properties do not need to submit a separate application.

(d) The commissioner may accredit laboratories located out-of-state. Accreditation for out-of-state laboratories may be obtained directly from the commissioner following the requirements in paragraph (a), or out-of-state laboratories may be accredited through a reciprocal agreement if the laboratory:

(1) is accredited by a NELAP-recognized accreditation body for those fields of testing in which the laboratory requests accreditation from the commissioner;

(2) submits an application and documentation according to this subdivision; and

(3) submits a current copy of the laboratory's unexpired accreditation from a NELAP-recognized accreditation body showing the fields of accreditation for which the laboratory is currently accredited.

(e) Under the conflict of interest determinations provided in section 43A.38, subdivision 6, clause (a), the commissioner shall not accredit governmental laboratories operated by agencies of the executive branch of the state. If accreditation is required, laboratories operated by agencies of the executive branch of the state must apply for accreditation through any other NELAP-recognized accreditation body.

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

Sec. 31. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 6a. **Implementation and effective date.** All laboratories must comply with standards under this section by July 1, 2009. Fees under subdivisions 3 and 3b apply to applications received and accreditations issued after June 30, 2009. Accreditations issued on or after June 30, 2009, shall expire upon their current expiration date.

Sec. 32. Minnesota Statutes 2008, section 144.98, is amended by adding a subdivision to read:

Subd. 7. **Initial accreditation and annual accreditation renewal.** (a) The commissioner shall issue or renew accreditation after receipt of the completed application and documentation required in this section, provided the laboratory maintains compliance with the standards specified in subdivision 2a, and attests to the compliance on the application form.

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

(c) Applications for renewal of accreditation must be received by November 1 and no earlier than October 1 of each year. The commissioner shall send annual renewal notices to laboratories 90 days before expiration. Failure to receive a renewal notice does not exempt laboratories from meeting the annual November 1 renewal date.

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

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

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

Sec. 33. Minnesota Statutes 2008, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417;

144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.992; 144.97 to 144.98; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

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

Sec. 34. Minnesota Statutes 2008, section 148.6445, is amended by adding a subdivision to read:

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

Sec. 35. Minnesota Statutes 2008, section 153A.17, is amended to read:

153A.17 EXPENSES; FEES.

The expenses for administering the certification requirements including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15 and the Consumer Information Center under section 153A.18 must be paid from initial application and examination fees, renewal fees, penalties, and fines. All fees are nonrefundable. The initial and annual renewal certificate application fee is ~~$350~~ $700, the examination fee is ~~$250~~ $500 for the written portion and ~~$250~~ $500 for the practical portion each time one or the other is taken~~, and~~. For persons meeting the requirements of section 148.515, subdivision 2, the fee for the practical portion of the hearing instrument dispensing examination is $250 each time it is taken. The trainee application fee is $200. Effective July 1, 2009, a surcharge of $550 shall be paid at the time of certification application or renewal until June 30, 2011, to recover the commissioner's accumulated direct expenditures for administering the requirements of this chapter. The penalty fee for late submission of a renewal application is $200. The fee for verification of certification to other jurisdictions or entities is $25. All fees, penalties, and fines received must be deposited in the state government special revenue fund. The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

Sec. 36. Minnesota Statutes 2008, section 157.15, is amended by adding a subdivision to read:

Subd. 20. **Youth camp.** "Youth camp" has the meaning given in section 144.71, subdivision 2.

Sec. 37. Minnesota Statutes 2008, section 157.16, is amended to read:

157.16 LICENSES REQUIRED; FEES.

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. ~~Seasonal and temporary food stands and~~ Special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort; the name under which the

business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts shall be issued ~~for the calendar year for which application is made and shall expire on December 31 of such year~~ on an annual basis. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of ~~$50~~ $60 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of ~~$100~~ $120 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, youth camps, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of ~~$300~~ $360 shall be added to the license fee for establishments operating more than 30 days without a license.

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a ~~$28~~ $35 nonrefundable certification fee payable to the Department of Health. The commissioner shall issue a duplicate certificate to replace a lost, destroyed, or mutilated certificate if the applicant submits a completed application on a form provided by the commissioner for a duplicate certificate and pays $20 to the department for the cost of duplication.

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All food and beverage service establishments, except special event food stands, and all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base fee of $150.

(c) A special event food stand shall pay a flat fee of ~~$40~~ $50 annually. "Special event food stand" means a fee category where food is prepared or served in conjunction with celebrations, county fairs, or special events from a special event food stand as defined in section 157.15.

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee category, additional food service, or required additional inspection specified in this paragraph:

(1) Limited food menu selection, ~~$50~~ $60. "Limited food menu selection" means a fee category that provides one or more of the following:

(i) prepackaged food that receives heat treatment and is served in the package;

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

(2) Small establishment, including boarding establishments, ~~$100~~ $120. "Small establishment" means a fee category that has no salad bar and meets one or more of the following:

(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(ii) serves dipped ice cream or soft serve frozen desserts;

(iii) serves breakfast in an owner-occupied bed and breakfast establishment;

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, ~~$260~~ $310. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, ~~$460~~ $540. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, ~~$50~~ $60.

(6) Beer or wine table service, ~~$50~~ $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, ~~$135~~ $165.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, ~~$8~~ $10, including hotels, motels, lodging establishments, and resorts, up to a maximum of ~~$800~~ $1,000. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public pool, ~~$180~~ $325; each additional public pool, ~~$100~~ $175. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

(10) First spa, ~~$110~~ $175; each additional spa, ~~$50~~ $100. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, ~~$50~~ $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(12) Additional food service, ~~$130~~ $150. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food to the public.

(13) Additional inspection fee, ~~$300~~ $360. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(e) A fee ~~of $350~~ for review of ~~the~~ construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, ~~or~~ resorts ~~with five or more sleeping units.~~, seasonal food stands, and mobile food units. The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	limited food menu	$275
	small establishment	$400
	medium establishment	$450
	large food establishment	$500
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$350
Alcohol	beer or wine table service	$150

	alcohol service from bar	$250
Lodging	< 25 rooms	$375
	≥ 25 to < 100 rooms	$400
	≥ 100 rooms	$500
	< five cabins	$350
	≥ five to < ten cabins	$400
	≥ ten cabins	$450

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, ~~or~~ resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee ~~of $250~~ must be submitted with the remodeling plans. ~~A fee of $250 must be submitted for new construction or remodeling for a restaurant with a limited food menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.~~ The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	limited food menu	$250
	small establishment	$300
	medium establishment	$350
	large food establishment	$400
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
Alcohol	beer or wine table service	$150
	alcohol service from bar	$250
Lodging	< 25 rooms	$250
	≥ 25 to < 100 rooms	$300
	≥ 100 rooms	$450
	< five cabins	$250
	≥ five to < ten cabins	$350
	≥ ten cabins	$400

(g) ~~Seasonal temporary food stands and~~ Special event food stands are not required to submit

construction or remodeling plans for review.

(h) Youth camp fee, $500.

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Subd. 4. **Posting requirements.** Every food and beverage service establishment, youth camp, hotel, motel, lodging establishment, public pool, or resort must have the license posted in a conspicuous place at the establishment. Mobile food units, food carts, and seasonal temporary food stands shall be issued decals with the initial license and each calendar year with license renewals. The current license year decal must be placed on the unit or stand in a location determined by the commissioner. Decals are not transferable.

Sec. 38. Minnesota Statutes 2008, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter ~~shall not be construed to~~ does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) any building constructed and primarily used for religious worship;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to or affiliated with such fraternal or patriotic organizations. Such organizations may organize events at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen; ~~and~~

(9) a home school in which a child is provided instruction at home~~.~~; and

(10) concession stands operated in conjunction with school-sponsored events on school property are exempt from the 21-day restriction.

Sec. 39. Minnesota Statutes 2008, section 327.14, is amended by adding a subdivision to read:

Subd. 9. **Special event recreational camping area.** "Special event recreational camping area" means a recreational camping area which operates no more than two times annually and for no more than 14 consecutive days.

Sec. 40. Minnesota Statutes 2008, section 327.15, is amended to read:

327.15 LICENSE REQUIRED; RENEWAL; ~~PLANS FOR EXPANSION~~ FEES.

Subdivision 1. **License required; plan review.** No person, firm or corporation shall establish, maintain, conduct or operate a manufactured home park or recreational camping area within this state without first obtaining ~~a~~ an annual license therefor from the state Department of Health. Any person wishing to obtain a license shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the manufactured home park or recreational camping area, the name under which the business is to be conducted, and any other information as may be required by the commissioner to complete the application for license. Any person, firm, or corporation desiring to operate either a manufactured home park or a recreational camping area on the same site in connection with the other, need only obtain one license. ~~A license shall expire and be renewed as prescribed by the commissioner pursuant to section 144.122.~~ The license shall state the number of manufactured home sites and recreational camping sites allowed according to state commissioner of health approval. ~~No renewal license shall be issued if the number of sites specified in the application exceeds those of the original application~~ The number of licensed sites shall not be increased unless the plans for expansion ~~or the construction for expansion~~ are submitted and the expansion first approved by the Department of Health. ~~Any manufactured home park or recreational camping area located in more than one municipality shall be dealt with as two separate manufactured home parks~~

~~or camping areas.~~ The license shall be conspicuously displayed in the office of the manufactured home park or camping area. The license is not transferable as to person or place.

Subd. 2. **License renewal.** Initial and renewal licenses for all manufactured home parks and recreational camping areas shall be issued annually and shall have an expiration date included on the license. Any person who operates a manufactured home park or recreational camping area after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $120 shall be added to the total of the license fee for any manufactured home park or recreational camping area operating without a license for a period of up to 30 days. A late fee of $360 shall be added to the license fee for any manufactured home park or recreational camping area operating more than 30 days without a license.

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Recreational camping areas and manufactured home parks must pay the highest applicable fee under paragraph (c). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas, except special event recreational camping areas, shall pay an annual base fee of $150 plus $4 for each licensed site, except that any operator of a manufactured home park or recreational camping area who is licensed under section 157.16 for the same location shall not be required to pay the base fee.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to less than 100 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 and less than 100 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Subd. 4. **Fees, special event recreational camping areas.** (a) The following fees are required for special event recreational camping areas licensed under this chapter.

(b) All special event recreational camping areas shall pay an annual fee of $150 plus $1 for each licensed site.

(c) A special event recreational camping area shall pay a late fee of $360 for failing to obtain a license prior to operating.

(d) The following fees must accompany a plan review application for initial construction of a special event recreational camping area:

(1) for initial construction of less than 25 special event recreational camping sites, $375;

(2) for initial construction of 25 to less than 100 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application for expansion of a special event recreational camping area:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 and less than 100 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 41. Minnesota Statutes 2008, section 327.16, is amended to read:

327.16 ~~LICENSE~~ PLAN REVIEW APPLICATION.

Subdivision 1. **Made to state Department of Health.** The plan review application for ~~license to operate and maintain~~ a manufactured home park or recreational camping area shall be made to the state Department of Health, at such office and in such manner as may be prescribed by that department.

Subd. 2. **Contents.** The ~~applicant for a primary license or annual license shall make application in writing~~ plan review application shall be made upon a form provided by the state Department of Health setting forth:

(1) The full name and address of the applicant or applicants, or names and addresses of the partners if the applicant is a partnership, or the names and addresses of the officers if the applicant is a corporation.

(2) A legal description of the site, lot, field, or tract of land upon which the applicant proposes to operate and maintain a manufactured home park or recreational camping area.

(3) The proposed and existing facilities on and about the site, lot, field, or tract of land for

the proposed construction or alteration and maintaining of a sanitary community building for toilets, urinals, sinks, wash basins, slop-sinks, showers, drains, laundry facilities, source of water supply, sewage, garbage and waste disposal; except that no toilet facilities shall be required in any manufactured home park which permits only manufactured homes equipped with toilet facilities discharging to water carried sewage disposal systems; and method of fire and storm protection.

(4) The proposed method of lighting the structures and site, lot, field, or tract of land upon which the manufactured home park or recreational camping area is to be located.

(5) The calendar months of the year which the applicant will operate the manufactured home park or recreational camping area.

(6) Plans and drawings for new construction or alteration, including buildings, wells, plumbing and sewage disposal systems.

Subd. 3. ~~**Fees;**~~ **Approval.** The application for ~~the primary license~~ plan review shall be submitted with all plans and specifications enumerated in subdivision 2, ~~and payment of a fee in an amount prescribed by the state commissioner of health pursuant to section 144.122~~ and shall be accompanied by an approved zoning permit from the municipality or county wherein the park is to be located, or a statement from the municipality or county that it does not require an approved zoning permit. ~~The fee for the annual license shall be in an amount prescribed by the state commissioner of health pursuant to section 144.122. All license fees paid to the commissioner of health shall be turned over to the state treasury.~~ The fee submitted for the ~~primary license~~ plan review shall be retained by the state even though the proposed project is not approved and a license is denied.

When construction has been completed in accordance with approved plans and specifications the state commissioner of health shall promptly cause the manufactured home park or recreational camping area and appurtenances thereto to be inspected. When the inspection and report has been made and the state commissioner of health finds that all requirements of sections 327.10, 327.11, 327.14 to 327.28, and such conditions of health and safety as the state commissioner of health may require, have been met by the applicant, the state commissioner of health shall forthwith issue the ~~primary~~ license in the name of the state.

Subd. 4. ~~**Sanitary facilities**~~ **Compliance with current state law.** ~~During the pendency of the application for such primary license any change in the sanitary or safety facilities of the intended manufactured home park or recreational camping area shall be immediately reported in writing to the state Department of Health through the office through which the application was made. If no objection is made by the state Department of Health to such change in such sanitary or safety facilities within 60 days of the date such change is reported, it shall be deemed to have the approval of the state Department of Health.~~ Any manufactured home park or recreational camping area must be constructed and operated according to all applicable state electrical, fire, plumbing, and building codes.

Subd. 5. **Permit.** When the plans and specifications have been approved, the state Department of Health shall issue an approval report permitting the applicant to construct or make alterations upon a manufactured home park or recreational camping area and the appurtenances thereto according to the plans and specifications presented.

Such approval does not relieve the applicant from securing building permits in municipalities that require permits or from complying with any other municipal ordinance or ordinances, applicable

thereto, not in conflict with this statute.

Subd. 6. **Denial of construction.** If the application to construct or make alterations upon a manufactured home park or recreational camping area and the appurtenances thereto or a ~~primary~~ license to operate and maintain the same is denied by the state commissioner of health, the commissioner shall so state in writing giving the reason or reasons for denying the application. If the objections can be corrected the applicant may amend the application and resubmit it for approval, and if denied the applicant may appeal from the decision of the state commissioner of health as provided in section 144.99, subdivision 10.

Sec. 42. Minnesota Statutes 2008, section 327.20, subdivision 1, is amended to read:

Subdivision 1. **Rules.** No domestic animals or house pets of occupants of manufactured home parks or recreational camping areas shall be allowed to run at large, or commit any nuisances within the limits of a manufactured home park or recreational camping area. Each manufactured home park or recreational camping area licensed under the provisions of sections 327.10, 327.11, and 327.14 to 327.28 shall, among other things, provide for the following~~, in the manner hereinafter specified~~:

(1) A responsible attendant or caretaker shall be in charge of every manufactured home park or recreational camping area at all times, who shall maintain the park or area, and its facilities and equipment in a clean, orderly and sanitary condition. In any manufactured home park containing more than 50 lots, the attendant, caretaker, or other responsible park employee, shall be readily available at all times in case of emergency.

(2) All manufactured home parks shall be well drained and be located so that the drainage of the park area will not endanger any water supply. No wastewater from manufactured homes or recreational camping vehicles shall be deposited on the surface of the ground. All sewage and other water carried wastes shall be discharged into a municipal sewage system whenever available. When a municipal sewage system is not available, a sewage disposal system acceptable to the state commissioner of health shall be provided.

(3) No manufactured home shall be located closer than three feet to the side lot lines of a manufactured home park, if the abutting property is improved property, or closer than ten feet to a public street or alley. Each individual site shall abut or face on a driveway or clear unoccupied space of not less than 16 feet in width, which space shall have unobstructed access to a public highway or alley. There shall be an open space of at least ten feet between the sides of adjacent manufactured homes including their attachments and at least three feet between manufactured homes when parked end to end. The space between manufactured homes may be used for the parking of motor vehicles and other property, if the vehicle or other property is parked at least ten feet from the nearest adjacent manufactured home position. The requirements of this paragraph shall not apply to recreational camping areas and variances may be granted by the state commissioner of health in manufactured home parks when the variance is applied for in writing and in the opinion of the commissioner the variance will not endanger the health, safety, and welfare of manufactured home park occupants.

(4) An adequate supply of water of safe, sanitary quality shall be furnished at each manufactured home park or recreational camping area. The source of the water supply shall first be approved by the state Department of Health.

(5) All plumbing shall be installed in accordance with the rules of the state commissioner of

labor and industry and the provisions of the Minnesota Plumbing Code.

(6) In the case of a manufactured home park with less than ten manufactured homes, a plan for the sheltering or the safe evacuation to a safe place of shelter of the residents of the park in times of severe weather conditions, such as tornadoes, high winds, and floods. The shelter or evacuation plan shall be developed with the assistance and approval of the municipality where the park is located and shall be posted at conspicuous locations throughout the park. The park owner shall provide each resident with a copy of the approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c. Nothing in this paragraph requires the Department of Health to review or approve any shelter or evacuation plan developed by a park. Failure of a municipality to approve a plan submitted by a park shall not be grounds for action against the park by the Department of Health if the park has made a good faith effort to develop the plan and obtain municipal approval.

(7) A manufactured home park with ten or more manufactured homes, licensed prior to March 1, 1988, shall provide a safe place of shelter for park residents or a plan for the evacuation of park residents to a safe place of shelter within a reasonable distance of the park for use by park residents in times of severe weather, including tornadoes and high winds. The shelter or evacuation plan must be approved by the municipality by March 1, 1989. The municipality may require the park owner to construct a shelter if it determines that a safe place of shelter is not available within a reasonable distance from the park. A copy of the municipal approval and the plan shall be submitted by the park owner to the Department of Health. The park owner shall provide each resident with a copy of the approved shelter or evacuation plan, as provided by section 327C.01, subdivision 1c.

(8) A manufactured home park with ten or more manufactured homes, receiving ~~a primary~~ an initial license after March 1, 1988, must provide the type of shelter required by section 327.205, except that for manufactured home parks established as temporary, emergency housing in a disaster area declared by the President of the United States or the governor, an approved evacuation plan may be provided in lieu of a shelter for a period not exceeding 18 months.

(9) For the purposes of this subdivision, "park owner" and "resident" have the ~~meaning~~ meanings given them in section 327C.01.

Sec. 43. Minnesota Statutes 2008, section 327.20, is amended by adding a subdivision to read:

Subd. 4. **Special event recreational camping areas.** Each special event camping area licensed under sections 327.10, 327.11, and 327.14 to 327.28 is subject to this section.

(1) Recreational camping vehicles and tents, including attachments, must be separated from each other and other structures by at least seven feet.

(2) A minimum area of 300 square feet per site must be provided and the total number of sites must not exceed one site for every 300 square feet of usable land area.

(3) Each site must abut or face a driveway or clear unoccupied space of at least 16 feet in width, which space must have unobstructed access to a public roadway.

(4) If no approved on-site water supply system is available, hauled water may be used, provided that persons using hauled water comply with Minnesota Rules, parts 4720.4000 to 4720.4600.

(5) Nonburied sewer lines may be permitted provided they are of approved materials, watertight, and properly maintained.

(6) If a sanitary dumping station is not provided on-site, arrangements must be made with a licensed sewage pumper to service recreational camping vehicle holding tanks as needed.

(7) Toilet facilities must be provided consisting of toilets connected to an approved sewage disposal system, portable toilets, or approved, properly constructed privies.

(8) Toilets must be provided in the ratio of one toilet for each sex for each 150 sites.

(9) Toilets must be not more than 400 feet from any site.

(10) If a central building or buildings are provided with running water, then toilets and hand-washing lavatories must be provided in the building or buildings that meet the requirements of this subdivision.

(11) Showers, if provided, must be provided in the ratio of one shower for each sex for each 250 sites. Showerheads must be provided, where running water is available, for each camping event exceeding two nights.

(12) Central toilet and shower buildings, if provided, must be constructed with adequate heating, ventilation, and lighting, and floors of impervious material sloped to drain. Walls must be of a washable material. Permanent facilities must meet the requirements of the Americans with Disabilities Act.

(13) An adequate number of durable, covered, watertight containers must be provided for all garbage and refuse. Garbage and refuse must be collected as often as necessary to prevent nuisance conditions.

(14) Campgrounds must be located in areas free of poison ivy or other noxious weeds considered detrimental to health. Sites must not be located in areas of tall grass or weeds and sites must be adequately drained.

(15) Campsites for recreational vehicles may not be located on inclines of greater than eight percent grade or one inch drop per lineal foot.

(16) A responsible attendant or caretaker must be available on-site at all times during the operation of any special event recreational camping area that has 50 or more sites.

Sec. 44. **REPEALER.**

(a) Minnesota Statutes 2008, sections 62U.08; 103I.112; 144.9501, subdivision 17b; and 327.14, subdivisions 5 and 6, are repealed.

(b) Minnesota Rules, part 4626.2015, subpart 9, is repealed.

ARTICLE 12

TECHNICAL

Section 1. Minnesota Statutes 2008, section 125A.744, subdivision 3, is amended to read:

Subd. 3. **Implementation.** Consistent with section 256B.0625, subdivision 26, school districts may enroll as medical assistance providers or subcontractors and bill the Department of Human Services under the medical assistance fee for service claims processing system for special education

services which are covered services under chapter 256B, which are provided in the school setting for a medical assistance recipient, and for whom the district has secured informed consent consistent with section 13.05, subdivision 4, paragraph (d), and section 256B.77, subdivision 2, paragraph (p), to bill for each type of covered service. School districts shall be reimbursed by the commissioner of human services for the federal share of individual education plan health-related services that qualify for reimbursement by medical assistance, minus up to five percent retained by the commissioner of human services for administrative costs, not to exceed $350,000 per fiscal year. The commissioner may withhold up to five percent of each payment to a school district. Following the end of each fiscal year, the commissioner shall settle up with each school district in order to ensure that collections from each district for departmental administrative costs are made on a pro rata basis according to federal earnings for these services in each district. A school district is not eligible to enroll as a home care provider or a personal care provider organization for purposes of billing home care services under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 until the commissioner of human services issues a bulletin instructing county public health nurses on how to assess for the needs of eligible recipients during school hours. To use private duty nursing services or personal care services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school.

Sec. 2. Minnesota Statutes 2008, section 144A.46, subdivision 1, is amended to read:

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122.

(d) The commissioner of health, in consultation with the commissioner of human services, shall provide recommendations to the legislature by February 15, 2009, for provider standards for personal care assistant services as described in section ~~256B.0655~~ 256B.0659.

Sec. 3. Minnesota Statutes 2008, section 176.011, subdivision 9, is amended to read:

Subd. 9. **Employee.** "Employee" means any person who performs services for another for hire including the following:

(1) an alien;

(2) a minor;

(3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and peace officer while engaged in the enforcement of peace or in the pursuit or capture of a person charged with or

suspected of crime;

(4) a person requested or commanded to aid an officer in arresting or retaking a person who has escaped from lawful custody, or in executing legal process, in which cases, for purposes of calculating compensation under this chapter, the daily wage of the person shall be the prevailing wage for similar services performed by paid employees;

(5) a county assessor;

(6) an elected or appointed official of the state, or of a county, city, town, school district, or governmental subdivision in the state. An officer of a political subdivision elected or appointed for a regular term of office, or to complete the unexpired portion of a regular term, shall be included only after the governing body of the political subdivision has adopted an ordinance or resolution to that effect;

(7) an executive officer of a corporation, except those executive officers excluded by section 176.041;

(8) a voluntary uncompensated worker, other than an inmate, rendering services in state institutions under the commissioners of human services and corrections similar to those of officers and employees of the institutions, and whose services have been accepted or contracted for by the commissioner of human services or corrections as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services in institutions where the services are performed by paid employees;

(9) a voluntary uncompensated worker engaged in emergency management as defined in section 12.03, subdivision 4, who is:

(i) registered with the state or any political subdivision of it, according to the procedures set forth in the state or political subdivision emergency operations plan; and

(ii) acting under the direction and control of, and within the scope of duties approved by, the state or political subdivision.

The daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed by paid employees;

(10) a voluntary uncompensated worker participating in a program established by a local social services agency. For purposes of this clause, "local social services agency" means any agency established under section 393.01. In the event of injury or death of the worker, the wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid in the county at the time of the injury or death for similar services performed by paid employees working a normal day and week;

(11) a voluntary uncompensated worker accepted by the commissioner of natural resources who is rendering services as a volunteer pursuant to section 84.089. The daily wage of the worker for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(12) a voluntary uncompensated worker in the building and construction industry who renders services for joint labor-management nonprofit community service projects. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(13) a member of the military forces, as defined in section 190.05, while in state active service, as defined in section 190.05, subdivision 5a. The daily wage of the member for the purpose of calculating compensation under this chapter shall be based on the member's usual earnings in civil life. If there is no evidence of previous occupation or earning, the trier of fact shall consider the member's earnings as a member of the military forces;

(14) a voluntary uncompensated worker, accepted by the director of the Minnesota Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily wage of the worker, for the purposes of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(15) a voluntary uncompensated worker, other than a student, who renders services at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the Blind, and whose services have been accepted or contracted for by the commissioner of education, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(16) a voluntary uncompensated worker, other than a resident of the veterans home, who renders services at a Minnesota veterans home, and whose services have been accepted or contracted for by the commissioner of veterans affairs, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(17) a worker performing services under section ~~256B.0655~~ 256B.0659 for a recipient in the home of the recipient or in the community under section 256B.0625, subdivision 19a, who is paid from government funds through a fiscal intermediary under section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33. For purposes of maintaining workers' compensation insurance, the employer of the worker is as designated in law by the commissioner of the Department of Human Services, notwithstanding any other law to the contrary;

(18) students enrolled in and regularly attending the Medical School of the University of Minnesota in the graduate school program or the postgraduate program. The students shall not be considered employees for any other purpose. In the event of the student's injury or death, the weekly wage of the student for the purpose of calculating compensation under this chapter, shall be the annualized educational stipend awarded to the student, divided by 52 weeks. The institution in which the student is enrolled shall be considered the "employer" for the limited purpose of determining responsibility for paying benefits under this chapter;

(19) a faculty member of the University of Minnesota employed for an academic year is also an employee for the period between that academic year and the succeeding academic year if:

(a) the member has a contract or reasonable assurance of a contract from the University of Minnesota for the succeeding academic year; and

(b) the personal injury for which compensation is sought arises out of and in the course of activities related to the faculty member's employment by the University of Minnesota;

(20) a worker who performs volunteer ambulance driver or attendant services is an employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other entity for which the worker performs the services. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(21) a voluntary uncompensated worker, accepted by the commissioner of administration, rendering services as a volunteer at the Department of Administration. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(22) a voluntary uncompensated worker rendering service directly to the Pollution Control Agency. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees;

(23) a voluntary uncompensated worker while volunteering services as a first responder or as a member of a law enforcement assistance organization while acting under the supervision and authority of a political subdivision. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees;

(24) a voluntary uncompensated member of the civil air patrol rendering service on the request and under the authority of the state or any of its political subdivisions. The daily wage of the member for the purposes of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees; and

(25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in sections 145A.04 and 145A.06, responding at the request of or engaged in training conducted by the commissioner of health. The daily wage of the volunteer for the purposes of calculating compensation payable under this chapter is established in section 145A.06. A person who qualifies under this clause and who may also qualify under another clause of this subdivision shall receive benefits in accordance with this clause.

If it is difficult to determine the daily wage as provided in this subdivision, the trier of fact may determine the wage upon which the compensation is payable.

Sec. 4. Minnesota Statutes 2008, section 245C.03, subdivision 2, is amended to read:

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 to have a background study completed under this chapter.

Sec. 5. Minnesota Statutes 2008, section 245C.04, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** (a) The commissioner shall conduct a

background study of an individual required to be studied under section 245C.03, subdivision 2, at least upon application for initial enrollment under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659.

(b) Organizations required to initiate background studies under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 for individuals described in section 245C.03, subdivision 2, must submit a completed background study form to the commissioner before those individuals begin a position allowing direct contact with persons served by the organization.

Sec. 6. Minnesota Statutes 2008, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 7. Minnesota Statutes 2008, section 256B.04, subdivision 16, is amended to read:

Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

The commissioner of human services shall establish an advisory group including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rule the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the Department of Health to the legislature by February 15, 1992.

Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by a qualified professional supervising the personal care assistant unless the recipient selects the fiscal agent option under section ~~256B.0655, subdivision 7~~ 256B.0659, subdivision 33;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county and shall waive the requirement for personal care assistants required to join an agency for the first time during 1993 when personal care services are provided under a relative hardship waiver under Minnesota Statutes 1992, section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies providing personal care services have refused to employ or contract with the independent personal care assistant.

Sec. 8. Minnesota Statutes 2008, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if

the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911 and the home care independent rating document under section ~~256B.0655, subdivision 4, clause (3)~~ 256B.0659, adjusted to address age-appropriate standards for children age 18 and under, pursuant to section ~~256B.0655, subdivision 3~~ 256B.0659.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/MR" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/MR if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/MR services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/MR, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/MR;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

(h) Children eligible for medical assistance services under section 256B.055, subdivision 12, as of June 30, 1995, must be screened according to the criteria in this subdivision prior to January 1, 1996. Children found to be ineligible may not be removed from the program until January 1, 1996.

Sec. 9. Minnesota Statutes 2008, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under sections 256B.0651 to 256B.0656 and 256B.0659: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with developmental disabilities;

(4) "relocation targeted case management" includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the lesser of:

(i) the last 180 consecutive days of an eligible recipient's institutional stay; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistant services.** Medical assistance covers personal care assistant services in a recipient's home. To qualify for personal care assistant services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistant services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistant services in an in-home setting according to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Medical assistance does not cover personal care assistant services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistant services or forgoes the facility per diem for the leave days that personal care assistant services are used. All personal care assistant services must be provided according to sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Personal care assistant services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care assistant services, if they are granted a waiver under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Notwithstanding the provisions of section ~~256B.0655, subdivision 2, paragraph (b), clause (4)~~ 256B.0659, the noncorporate legal guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be granted a hardship waiver under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659, to be reimbursed to provide personal care assistant services to the recipient, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 11. Minnesota Statutes 2008, section 256B.0651, subdivision 13, is amended to read:

Subd. 13. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section and sections ~~256B.0653~~ 256B.0652 to 256B.0656 and 256B.0659. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

Sec. 12. Minnesota Statutes 2008, section 256B.0652, subdivision 3, is amended to read:

Subd. 3. **Assessment and prior authorization process.** Effective January 1, 1996, for purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and prior authorization process for persons receiving both home care and home and community-based waivered services for persons with developmental disabilities shall meet the requirements of sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community-based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give prior authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community-based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community-based waivered services for persons with developmental disabilities.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and prior authorization process will be held separate and distinct from the provision of services.

Sec. 13. Minnesota Statutes 2008, section 256B.0657, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistant services under section ~~256B.0655~~ 256B.0659;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services not related by blood or marriage;

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian or parent to carry them out, the guardian or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll or exclude recipients, including guardians and parents, under the following circumstances:

(1) recipients who have been restricted by the Primary Care Utilization Review Committee may be excluded for a specified time period;

(2) recipients who exit the self-directed supports option during the recipient's service plan year

shall not access the self-directed supports option for the remainder of that service plan year; and

(3) when the department determines that the recipient cannot manage recipient responsibilities under the program.

Sec. 14. Minnesota Statutes 2008, section 256B.0657, subdivision 6, is amended to read:

Subd. 6. **Services covered.** (a) Services covered under the self-directed supports option include:

(1) personal care assistant services under section ~~256B.0655~~ 256B.0659; and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

Sec. 15. Minnesota Statutes 2008, section 256B.0657, subdivision 8, is amended to read:

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be equal to the greater of either:

(1) the annual amount of personal care assistant services under section ~~256B.0655~~ 256B.0659 that the recipient has used in the most recent 12-month period; or

(2) the amount determined using the consumer support grant methodology under section 256.476, subdivision 11, except that the budget amount shall include the federal and nonfederal share of the average service costs.

Sec. 16. Minnesota Statutes 2008, 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. 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 ~~and 256B.0653~~ 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.

Sec. 17. Minnesota Statutes 2008, section 256B.501, subdivision 4a, is amended to read:

Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner shall adjust the limits of the established average daily reimbursement rates for waivered services to include the cost of home care services that may be provided to waivered services recipients. This adjustment must be used to maintain or increase services and shall not be used by county agencies for inflation increases for waivered services vendors. Home care services referenced in this section are those listed in section 256B.0651, subdivision 2. The average daily reimbursement rates established in accordance with the provisions of this subdivision apply only to the combined average, daily costs of waivered and home care services and do not change home care limitations under sections 256B.0651 ~~and 256B.0653~~ to 256B.0656 and 256B.0659. Waivered services recipients receiving home care as of June 30, 1992, shall not have the amount of their services reduced as a result of this section.

Sec. 18. Minnesota Statutes 2008, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(a) 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) 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 assistant services pursuant to section ~~256B.0655, subdivision 2~~ 256B.0659; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.

Sec. 19. Minnesota Statutes 2008, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section ~~256B.0655, subdivision 2~~ 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section ~~256B.0655, subdivision 2~~ 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

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

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

Sec. 20. Minnesota Statutes 2008, section 256J.45, subdivision 3, is amended to read:

Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county agency shall not impose the sanction under section 256J.46 if it determines that the participant has good cause for failing to attend orientation. Good cause exists when:

(1) appropriate child care is not available;

(2) the participant is ill or injured;

(3) a family member is ill and needs care by the participant that prevents the participant from attending orientation. For a caregiver with a child or adult in the household who meets the disability or medical criteria for home care services under section ~~256B.0655, subdivision 1c~~ 256B.0659, or a

home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when an interruption in the provision of those services occurs which prevents the participant from attending orientation;

(4) the caregiver is unable to secure necessary transportation;

(5) the caregiver is in an emergency situation that prevents orientation attendance;

(6) the orientation conflicts with the caregiver's work, training, or school schedule; or

(7) the caregiver documents other verifiable impediments to orientation attendance beyond the caregiver's control.

(b) Counties must work with clients to provide child care and transportation necessary to ensure a caregiver has every opportunity to attend orientation.

Sec. 21. Minnesota Statutes 2008, section 604A.33, subdivision 1, is amended to read:

Subdivision 1. **Application.** This section applies to residential treatment programs for children or group homes for children licensed under chapter 245A, residential services and programs for juveniles licensed under section 241.021, providers licensed pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care provider organizations under section ~~256B.0655, subdivision 1g~~ 256B.0659, providers of day training and habilitation services under sections 252.40 to 252.46, board and lodging facilities licensed under chapter 157, intermediate care facilities for persons with developmental disabilities, and other facilities licensed to provide residential services to persons with developmental disabilities.

Sec. 22. Minnesota Statutes 2008, section 609.232, subdivision 11, is amended to read:

Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651~~, and 256B.0653~~ to 256B.0656 and 256B.0659; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

Sec. 23. Minnesota Statutes 2008, section 626.5572, subdivision 6, is amended to read:

Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a residential or nonresidential facility required to be licensed to serve adults under sections 245A.01 to 245A.16; a home care provider licensed or required to be licensed under section 144A.46; a hospice provider licensed under sections 144A.75 to 144A.755; or a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651~~, and 256B.0653~~ to 256B.0656, and 256B.0659.

(b) For home care providers and personal care attendants, the term "facility" refers to the provider or person or organization that exclusively offers, provides, or arranges for personal care services, and does not refer to the client's home or other location at which services are rendered.

Sec. 24. Minnesota Statutes 2008, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistant services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, ~~and~~ 256B.0653 to 256B.0656, and 256B.0659; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

ARTICLE 13

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2008, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** ~~The county board shall,~~ (a) Prior to admission, except in

the case of emergency admission, ~~determine the needed level of care for~~ all children referred for treatment of severe emotional disturbance in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if public funds are used to pay for the services. ~~The county board shall also determine the needed level of care for all children admitted to an acute care hospital for treatment of severe emotional disturbance if public funds other than reimbursement under chapters 256B and 256D are used to pay for the services.~~

(b) The county board shall determine the appropriate level of care when county-controlled funds are used to pay for the services. When the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care. When the child is an Indian tribal member seeking placement through the tribe in a tribally operated or contracted facility, the tribe must determine the appropriate level of care. When more than one entity bears responsibility for coverage, the entities shall coordinate level of care determination activities to the extent possible.

(c) The level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's need.

(d) When a level of care determination is conducted, the ~~county board~~ responsible entity may not determine that referral or admission to a treatment foster care setting~~,~~ or residential treatment facility~~, or acute care hospital~~ is not appropriate solely because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment that includes a functional assessment which evaluates family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care. The validated tool must be approved by the commissioner of human services. If a diagnostic assessment including a functional assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether or not these services are available and accessible to the child and family.

During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

The level of care determination shall comply with section 260C.212. ~~Wherever possible,~~ The

parent shall be consulted in the process, unless clinically ~~inappropriate~~ detrimental to the child.

The level of care determination, and placement decision, and recommendations for mental health services must be documented in the child's record.

~~An alternate review process may be approved by the commissioner if the county board demonstrates that an alternate review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (4).~~

Sec. 2. Minnesota Statutes 2008, section 254A.02, is amended by adding a subdivision to read:

Subd. 8a. **Placing authority.** "Placing authority" means a county, prepaid health plan, or tribal governing board governed by Minnesota Rules, parts 9530.6600 to 9530.6655.

Sec. 3. **[254A.081] GRANTS FOR DETOXIFICATION SERVICES.**

(a) Effective January 1, 2011, funds appropriated for alcohol and drug abuse services from the children's and community services act grants under section 256M.40 must be allocated to counties for detoxification services as defined in section 254A.08.

(b) Funds must be allocated in proportion to the percent of state population at or below 100 percent of the federal poverty guideline residing in each county.

(c) Upon receipt of county expenditure reports for January to June of each year, the commissioner shall pay each county based on the county's actual expenditures to date plus projected expenditures for the remainder of the calendar year up to the total amount of the allocation.

(d) By January 31, 2012, and each year thereafter, counties shall report actual expenditures for detoxification services for the prior year. The commissioner shall reallocate unexpended funds to counties that expended more than their allocation, based on the percent of state population at or below 100 percent of the federal poverty guideline residing in each eligible county.

Sec. 4. Minnesota Statutes 2008, section 254A.16, is amended by adding a subdivision to read:

Subd. 6. **Monitoring.** The commissioner shall gather and placing authorities shall provide information to measure compliance with Minnesota Rules, parts 9530.6600 to 9530.6655. The commissioner shall specify the format for data collection to facilitate tracking, aggregating, and using the information.

Sec. 5. Minnesota Statutes 2008, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **Local agencies to pay state for county share.** Local agencies shall pay the state for the county share of the services authorized by the local agency, except when the payment is made according to section 254B.09, subdivision 8.

Sec. 6. **[254B.11] MAXIMUM RATES.**

The commissioner shall publish maximum rates for vendors of the consolidated chemical dependency treatment fund by July 1 of each year for implementation the following January 1. Rates for calendar year 2010 must not exceed 185 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. Unless a new rate methodology is developed

under section 254B.12, rates for services provided on and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. Payment for services provided by Indian Health Services or by agencies operated by Indian tribes for medical assistance-eligible individuals must be governed by the applicable federal rate methodology.

Sec. 7. **[254B.12] RATE METHODOLOGY.**

(a) The commissioner shall, with broad-based stakeholder input, develop a recommendation and present a report to the 2011 legislature, including proposed legislation for a new rate methodology for the consolidated chemical dependency treatment fund. The new methodology must replace county-negotiated rates with a uniform statewide methodology that must include:

(1) a graduated reimbursement scale based on the patients' level of acuity and complexity; and

(2) beginning July 1, 2011, retroactive quality incentive payments up to four percent of each provider's prior-year approved chemical dependency fund claims.

(b) The quality incentive payments under paragraph (a), clause (2), must be based on each provider's performance in the prior year relating to certain program criteria, based on best practices in addiction treatment. The quality incentive criteria under paragraph (a), clause (2), may include program completion rates, national outcome measures, program innovations, lack of licensing violations, and other measures to be determined by the commissioner.

Sec. 8. Minnesota Statutes 2008, section 256B.0625, subdivision 41, is amended to read:

Subd. 41. **Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a ~~county through a~~ residential facility under contract with a county or Indian tribe, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

Sec. 9. Minnesota Statutes 2008, section 256B.0625, subdivision 47, is amended to read:

Subd. 47. **Treatment foster care services.** Effective July 1, ~~2007~~ 2011, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Sec. 10. Minnesota Statutes 2008, section 256B.0944, is amended by adding a subdivision to read:

Subd. 4a. **Alternative provider standards.** If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Sec. 11. Minnesota Statutes 2008, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

~~(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per-day contract rate that relates to rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of financial responsibility.~~

~~(c)~~ (b) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

(c) The payment rate negotiated and paid to a provider by prepaid health plans under section 256B.69 for services under this section must be supplemented by the commissioner from state appropriations to cover the nontreatment costs at a rate equal to the portion of the county negotiated per diem attributable to nontreatment service costs for that provider as determined by the commissioner of human services.

(d) Payment for mental health rehabilitative services provided under this section by or under contract with an Indian tribe or tribal organization or by agencies operated by or under contract with an Indian tribe or tribal organization may be made according to section 256B.0625, subdivision 34, or other relevant federally approved rate setting methodology.

Sec. 12. Minnesota Statutes 2008, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval~~ Effective May 1, 2010, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 13. Minnesota Statutes 2008, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical

assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) Effective January 1, 2010, the rate for partial hospitalization for children is increased to equal the rate for partial hospitalization for adults.

Sec. 14. **MENTAL HEALTH PORTION OF CHILDREN'S AND COMMUNITY SERVICES ACT GRANTS.**

The commissioner of human services shall consult with stakeholders to develop a recommendation to the 2010 legislative session regarding administration of the mental health services portion of those funds to be allocated to mental health starting January 1, 2011, from the children's and community services act grants under Minnesota Statutes, section 256M.40. The recommendation must include:

(1) an effective and efficient process to administer these funds together with other mental health services funding;

(2) identification of the priorities and services to be funded;

(3) a reporting and monitoring methodology that is efficient and ensures accountability; and

(4) a funding allocation method.

ARTICLE 14

HEALTH-RELATED FEES

Section 1. Minnesota Statutes 2008, section 148.108, is amended to read:

148.108 FEES.

Subdivision 1. **Fees.** In addition to the fees established in Minnesota Rules, chapter 2500, and according to sections 148.05, 148.06, 148.07, and 148.10, subdivisions 2 and 3, the board is authorized to charge the fees in this section.

Subd. 2. ~~**Annual renewal of inactive acupuncture registration**~~ **License and registration fees.** ~~The annual renewal of an inactive acupuncture registration fee is $25.~~ License and registration fees are as follows:

(1) for a license application fee, $300;

(2) for a license active renewal fee, $220;

(3) for a license inactive renewal fee, $165;

(4) for an acupuncture initial registration fee, $125;

(5) for an acupuncture active registration renewal fee, $75;

(6) for an acupuncture registration reinstatement fee, $50;

(7) for an acupuncture inactive registration renewal fee, $25;

(8) for an animal chiropractic registration fee, $125;

(9) for an animal chiropractic active registration renewal fee, $75; and

(10) for an animal chiropractic inactive registration renewal fee, $25.

~~Subd. 3. **Acupuncture reinstatement.** The acupuncture reinstatement fee is $50.~~

Sec. 2. Minnesota Statutes 2008, section 148D.180, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure are as follows:

(1) for a licensed social worker, $45;

(2) for a licensed graduate social worker, $45;

(3) for a licensed independent social worker, ~~$90~~ $45;

(4) for a licensed independent clinical social worker, ~~$90~~ $45;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$150~~ $85.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required pursuant to section 148D.055.

Sec. 3. Minnesota Statutes 2008, section 148D.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216;

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

(5) for an emeritus license, $43.20; and

(6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Sec. 4. Minnesota Statutes 2008, section 148D.180, subdivision 3, is amended to read:

Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216; and

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

Sec. 5. Minnesota Statutes 2008, section 148D.180, subdivision 5, is amended to read:

Subd. 5. **Late fees.** Late fees are as follows:

(1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision 3; and

(2) supervision plan late fee, $40.

Sec. 6. Minnesota Statutes 2008, section 148E.180, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure are as follows:

(1) for a licensed social worker, $45;

(2) for a licensed graduate social worker, $45;

(3) for a licensed independent social worker, ~~$90~~ $45;

(4) for a licensed independent clinical social worker, ~~$90~~ $45;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$150~~ $85.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Sec. 7. Minnesota Statutes 2008, section 148E.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216;

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50;

(5) for an emeritus license, $43.20; and

(6) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Sec. 8. Minnesota Statutes 2008, section 148E.180, subdivision 3, is amended to read:

Subd. 3. **Renewal fees.** Renewal fees for licensure are as follows:

(1) for a licensed social worker, ~~$115.20~~ $81;

(2) for a licensed graduate social worker, ~~$201.60~~ $144;

(3) for a licensed independent social worker, ~~$302.40~~ $216; and

(4) for a licensed independent clinical social worker, ~~$331.20~~ $238.50.

Sec. 9. Minnesota Statutes 2008, section 148E.180, subdivision 5, is amended to read:

Subd. 5. **Late fees.** Late fees are as follows:

(1) renewal late fee, ~~one-half~~ one-fourth of the renewal fee specified in subdivision 3; and

(2) supervision plan late fee, $40.

Sec. 10. **[156.011] LICENSE, APPLICATION, AND EXAMINATION FEES.**

Subdivision 1. **Application fee.** A person applying for a license to practice veterinary medicine in Minnesota or applying for a permit to take the national veterinary medical examination must pay a $60 nonrefundable application fee to the board. Persons submitting concurrent applications for licensure and a national examination permit shall pay only one application fee.

Subd. 2. **Examination fees.** (a) An applicant for veterinary licensure in Minnesota must successfully pass the Minnesota Veterinary Jurisprudence Examination. The fee for this examination is $60, payable to the board.

(b) An applicant participating in the national veterinary licensing examination must complete a separate application for the national examination and submit the application to the board for approval. Payment for the national examination must be made by the applicant to the national board examination committee.

Sec. 11. **[156.012] INITIAL AND RENEWAL FEE.**

Subdivision 1. **Required for licensure.** A person now licensed to practice veterinary medicine in this state, or who becomes licensed by the Board of Veterinary Medicine to engage in the practice, shall pay an initial fee or a biennial license renewal fee if the person wishes to practice veterinary medicine in the coming two-year period or remain licensed as a veterinarian. A licensure period begins on March 1 and expires the last day of February two years later. A licensee with an even-numbered license shall renew by March 1 of even-numbered years and a licensee with an odd-numbered license shall renew by March 1 of odd-numbered years.

Subd. 2. **Amount.** The initial licensure fee and the biennial renewal fee is $280 and must be paid to the executive director of the board. By January 1 of the first year for which the biennial renewal fee is due, the board shall issue a renewal application to a current licensee to the last address maintained in the board file. Failure to receive this notice does not relieve the licensee of the obligation to pay renewal fees so that they are received by the board on or before the renewal date of March 1.

Initial licenses issued after the start of the licensure renewal period are valid only until the end of the period.

Subd. 3. **Date due.** A licensee must apply for a renewal license on or before March 1 of the first year of the biennial license renewal period. A renewal license is valid from March 1 through the last day of February of the last year of the two-year license renewal period. An application postmarked no later than the last day of February must be considered to have been received on March 1.

Subd. 4. **Late renewal penalty.** An applicant for renewal must pay a late renewal penalty of $140 in addition to the renewal fee if the application for renewal is received after March 1 of the licensure renewal period. A renewed license issued after March 1 of the licensure renewal period is valid only to the end of the period regardless of when the renewal fee is received.

Subd. 5. **Reinstatement fee.** An applicant for license renewal whose license has previously been suspended by official board action for nonrenewal must pay a reinstatement fee of $60 in addition to the $280 renewal fee and the $140 late renewal penalty.

Subd. 6. **Penalty for failure to pay.** Within 30 days after the renewal date, a licensee who has not renewed the license must be notified by letter sent to the last known address of the licensee in the file of the board that the renewal is overdue and that failure to pay the current fee and current late fee within 60 days after the renewal date will result in suspension of the license. A second notice must be sent by registered or certified mail at least seven days before a board meeting occurring 60 days or more after the renewal date to a licensee who has not paid the renewal fee and late fee.

Subd. 7. **Suspension.** The board, by means of a roll call vote, shall suspend the license of a licensee whose license renewal is at least 60 days overdue and to whom notification has been sent as provided in subpart 5. Failure of a licensee to receive notification is not grounds for later challenge by the licensee of the suspension. The former licensee must be notified by registered or certified letter within seven days of the board action. The suspended status placed on a license may be removed only on payment of renewal fees and late penalty fees for each licensure period or part of a period that the license was not renewed. A licensee who fails to renew a license for five years or more must meet the criteria of section 156.071, for relicensure.

Subd. 8. **Inactive license.** (a) A person holding a current active license to practice veterinary medicine in Minnesota may, at the time of the person's next biennial license renewal date, renew the license as an inactive license at one-half the renewal fee of an active license. The license may be continued in an inactive status by renewal on a biennial basis at one-half the regular license fee.

(b) A person holding an inactive license is not permitted to practice veterinary medicine in Minnesota and remains under the disciplinary authority of the board.

(c) A person may convert a current inactive license to an active license upon application to and approval by the board. The application must include:

(1) documentation of licensure in good standing and of having met continuing education requirements of current state of practice, or documentation of having met Minnesota continuing education requirements retroactive to the date of licensure inactivation;

(2) certification by the applicant that the applicant is not currently under disciplinary orders or investigation for acts that could result in disciplinary action in any other jurisdiction; and

(3) payment of a fee equal to the full difference between an inactive and active license if converting during the first year of the biennial license cycle or payment of a fee equal to one-half the difference between an inactive and an active license if converting during the second year of the license cycle.

(d) Deadline for renewal of an inactive license is March 1 of the first year of the biennial license renewal period. A late renewal penalty of one-half the inactive renewal fee must be paid if renewal is received after March 1.

Sec. 12. Minnesota Statutes 2008, section 156.015, is amended to read:

156.015 MISCELLANEOUS FEES.

Subdivision 1. **Verification of licensure.** The board may charge a fee of $25 per license verification to a licensee for verification of licensure status provided to other veterinary licensing boards.

Subd. 2. **Continuing education review.** The board may charge a fee of $50 per submission to a sponsor for review and approval of individual continuing education seminars, courses, wet labs, and lectures. This fee does not apply to continuing education sponsors that already meet the criteria for preapproval under Minnesota Rules, part 9100.1000, subpart 3, item A.

Subd. 3. **Temporary license fee.** A person meeting the requirements for issuance of a temporary permit to practice veterinary medicine under section 156.073, pending examination, who desires a temporary permit shall pay a fee of $60 to the board.

Subd. 4. **Duplicate license.** A person requesting issuance of a duplicate or replacement license shall pay a fee of $15 to the board.

Subd. 5. **Mailing examination and reference materials.** An applicant who resides outside the Twin Cities metropolitan area may request to take the Minnesota Veterinary Jurisprudence Examination by mail. The fee for mailing the examination and reference materials is $15.

Sec. 13. **REPEALER.**

(a) Minnesota Rules, parts 9100.0400, subparts 1 and 3; 9100.0500; and 9100.0600, are repealed.

(b) Minnesota Statutes 2008, section 148D.180, subdivision 8, is repealed.

ARTICLE 15

CORRECTIONAL STATE EMPLOYEES RETIREMENT PLAN - I

Section 1. Minnesota Statutes 2008, section 352.90, is amended to read:

352.90 POLICY.

It is the policy of the legislature to provide special retirement benefits for and special contributions by certain correctional employees who may be required to retire at an early age because they lose the mental or physical capacity required to maintain the safety, security, discipline, and custody of inmates at state correctional facilities ~~or~~, of patients at the Minnesota Security Hospital, or of patients in the Minnesota sex offender program~~, or of patients in the Minnesota extended treatment options program~~.

Sec. 2. Minnesota Statutes 2008, section 352.91, subdivision 1, is amended to read:

Subdivision 1. **Qualifying jobs.** "Covered correctional service" means service performed by a state employee, as defined in section 352.01, who is employed at a state correctional facility, the Minnesota Security Hospital, or the Minnesota sex offender program as:

(1) a corrections officer 1;

(2) a corrections officer 2;

(3) a corrections officer 3;

~~(4) a corrections officer supervisor;~~

~~(5)~~ (4) a corrections lieutenant;

~~(6)~~ (5) a corrections captain;

~~(7)~~ (6) a security counselor;

~~(8)~~ (7) a security counselor lead; ~~or~~

~~(9)~~ (8) a corrections canine officer~~.~~;

(9) group supervisor; or

(10) group supervisor assistant.

Sec. 3. Minnesota Statutes 2008, section 352.91, subdivision 3h, is amended to read:

Subd. 3h. **Employment occupation name changes.** (a) If the occupational title of a state employee covered by the Minnesota correctional employees retirement plan changes from the applicable title listed in subdivision 1, ~~2, 2a, 3c, 3d, 3e, 3f, or 3g,~~ qualification for coverage by the correctional state employees retirement plan continues until the July 1 next following the title change if the commissioner of finance certifies to the executive director of the Minnesota State Retirement System and to the executive director of the Legislative Commission on Pensions and Retirement that the duties, requirements, and responsibilities of the new occupational title are substantially identical to the duties, requirements, and responsibilities of the prior occupational title.

(b) If the commissioner of finance does not certify a new occupational title under paragraph (a), eligibility for future correctional state employees retirement coverage terminates as of the start of the first payroll period next following the effective date of the occupational title change.

(c) For consideration by the Legislative Commission on Pensions and Retirement during the legislative session next following an occupational title change involving a state employee in covered correctional service, the commissioner of finance shall submit the applicable draft proposed legislation reflecting the occupational title change covered by this section.

Sec. 4. **REPEALER.**

Minnesota Statutes 2008, section 352.91, subdivisions 2, 2a, 3c, 3d, 3e, 3f, 3g, 3i, 4a, 4b, and 5, are repealed.

Sec. 5. **EFFECTIVE DATE.**

Sections 1 to 4 are effective July 1, 2009.

ARTICLE 16

CORRECTIONAL STATE EMPLOYEES RETIREMENT PLAN - II

Section 1. Minnesota Statutes 2008, section 352.72, subdivision 1, is amended to read:

Subdivision 1. **Entitlement to annuity.** (a) Except as provided in paragraph (b), any person who has been an employee covered by a retirement system listed in paragraph ~~(b)~~ (c) is entitled when qualified to an annuity from each fund if total allowable service in all funds or in any two of these funds totals three or more years.

(b) If the combination of retirement plans includes the correctional state employees retirement plan of the Minnesota State Retirement System, no retirement annuity is payable from the correctional state employees retirement plan unless the person has credit for at least ten years of covered correctional service under section 352.91, although any covered correctional service may be used to establish eligibility for an annuity from another retirement plan and a service credit transfer under section 352.93, subdivision 4a, may be elected.

(c) This section applies to the Minnesota State Retirement System, the Public Employees Retirement Association including the Public Employees Retirement Association police and fire fund, the Teachers Retirement Association, the State Patrol Retirement Association, or any other public employee retirement system in the state with a similar provision, except as noted in paragraph ~~(c)~~ (d).

~~(c)~~ (d) This section does not apply to ~~other~~ funds providing benefits for police officers or firefighters under chapter 423A, 423B, or 424A.

~~(d)~~ (e) No portion of the allowable service upon which the retirement annuity from one fund is based shall be again used in the computation for benefits from another fund. No refund may have been taken from any one of these funds since service entitling the employee to coverage under the system or the employee's membership in any of the associations last terminated. The annuity from each fund must be determined by the appropriate provisions of the law except that the requirement that a person must have at least three years allowable service in the respective system or association does not apply for the purposes of this section if the combined service in two or more of these funds equals three or more years.

Sec. 2. Minnesota Statutes 2008, section 352.93, subdivision 1, is amended to read:

Subdivision 1. **Basis of annuity; when to apply.** After separation from state service, an employee covered under section 352.91 who has reached age 55 years and has credit for at least ~~three~~ ten years of covered correctional service ~~or a combination of covered correctional service and general employees state retirement plan service~~ is entitled upon application to a retirement annuity under this section, based only on covered correctional employees' service. Application may be made no earlier than 60 days before the date the employee is eligible to retire by reason of both age and service requirements.

Sec. 3. Minnesota Statutes 2008, section 352.93, subdivision 2a, is amended to read:

Subd. 2a. **Early retirement.** Any covered correctional employee who becomes at least 50 years old and who has at least ~~three~~ ten years of ~~allowable~~ covered correctional service is entitled upon application to a reduced retirement annuity equal to the annuity calculated under subdivision 2, reduced by two-tenths of one percent for each month that the correctional employee is under age 55 at the time of retirement.

Sec. 4. Minnesota Statutes 2008, section 352.93, subdivision 4, is amended to read:

Subd. 4. **Employee with regular and correctional service.** A former employee who has both

regular and correctional service shall, if the employee has at least ten years of covered correctional service and is otherwise qualified, receive an annuity based on both periods of service under applicable sections of law but no period of service shall be used more than once in calculating the annuity.

Sec. 5. Minnesota Statutes 2008, section 352.93, is amended by adding a subdivision to read:

Subd. 4a. **Service credit transfer and partial refund in certain instances.** An employee covered under section 352.91 who has reached the age of 55 years and who has credit for less than ten years of covered correctional service may, upon written application, have that covered correctional service credited as allowable service credit in the general state employees retirement plan and used to calculate a retirement annuity under sections 352.115 and 352.116, and receive, 30 days following retirement, a refund of that portion of employee contributions during covered correctional service under section 352.92, subdivision 1, that exceeds the employee contributions required under the general state employees retirement plan under section 352.04, subdivision 2, for the same period, plus annual compound interest on the partial refund amount from the date of each contribution until the date of refund payment at the rate of six percent.

Sec. 6. Minnesota Statutes 2008, section 356.30, subdivision 1, is amended to read:

Subdivision 1. **Eligibility; computation of annuity.** (a) Notwithstanding any provisions of the laws governing the retirement plans enumerated in subdivision 3, a person who has met the qualifications of paragraph (b) may elect to receive a retirement annuity from each enumerated retirement plan, other than the correctional state employees retirement plan of the Minnesota State Retirement System, in which the person has at least one-half year of allowable service, based on the allowable service in each plan, subject to the provisions of paragraph (c).

(b) A person may receive, upon retirement, a retirement annuity from each enumerated retirement plan, other than the correctional state employees retirement plan of the Minnesota State Retirement System, in which the person has at least one-half year of allowable service, and augmentation of a deferred annuity calculated at the appropriate rate under the laws governing each public pension plan or fund named in subdivision 3, based on the date of the person's initial entry into public employment from the date the person terminated all public service if:

(1) the person has allowable service totaling an amount that allows the person to receive an annuity in any two or more of the enumerated plans; and

(2) the person has not begun to receive an annuity from any enumerated plan or the person has made application for benefits from each applicable plan and the effective dates of the retirement annuity with each plan under which the person chooses to receive an annuity are within a one-year period.

(c) The retirement annuity from each plan must be based upon the allowable service, accrual rates, and average salary in the applicable plan except as further specified or modified in the following clauses:

(1) the laws governing annuities must be the law in effect on the date of termination from the last period of public service under a covered retirement plan with which the person earned a minimum of one-half year of allowable service credit during that employment;

(2) the "average salary" on which the annuity from each covered plan in which the employee has

credit in a formula plan must be based on the employee's highest five successive years of covered salary during the entire service in covered plans;

(3) the accrual rates to be used by each plan must be those percentages prescribed by each plan's formula as continued for the respective years of allowable service from one plan to the next, recognizing all previous allowable service with the other covered plans;

(4) the allowable service in all the plans must be combined in determining eligibility for and the application of each plan's provisions in respect to reduction in the annuity amount for retirement prior to normal retirement age; ~~and~~

(5) the annuity amount payable for any allowable service under a nonformula plan of a covered plan must not be affected, but such service and covered salary must be used in the above calculation~~.~~; and

(6) for a person who was a member of the correctional state employees retirement plan, the person must have at least ten years of covered correctional service under section 352.91 in order to receive a retirement annuity from that plan, but may apply for a service credit transfer and partial refund under section 352.93, subdivision 4a.

(d) This section does not apply to any person whose final termination from the last public service under a covered plan was before May 1, 1975.

(e) For the purpose of computing annuities under this section, the accrual rates used by any covered plan, except the public employees police and fire plan, the judges retirement fund, and the State Patrol retirement plan, must not exceed the percent specified in section 356.315, subdivision 4, per year of service for any year of service or fraction thereof. The formula percentage used by the judges retirement fund must not exceed the percentage rate specified in section 356.315, subdivision 8, per year of service for any year of service or fraction thereof. The accrual rate used by the public employees police and fire plan and the State Patrol retirement plan must not exceed the percentage rate specified in section 356.315, subdivision 6, per year of service for any year of service or fraction thereof. The accrual rate or rates used by the legislators retirement plan must not exceed 2.5 percent, but this limit does not apply to the adjustment provided under section 3A.02, subdivision 1, paragraph (c).

(f) Any period of time for which a person has credit in more than one of the covered plans must be used only once for the purpose of determining total allowable service.

(g) If the period of duplicated service credit is more than one-half year, or the person has credit for more than one-half year, with each of the plans, each plan must apply its formula to a prorated service credit for the period of duplicated service based on a fraction of the salary on which deductions were paid to that fund for the period divided by the total salary on which deductions were paid to all plans for the period.

(h) If the period of duplicated service credit is less than one-half year, or when added to other service credit with that plan is less than one-half year, the service credit must be ignored and a refund of contributions made to the person in accord with that plan's refund provisions.

Sec. 7. **EFFECTIVE DATE.**

Sections 1 to 6 are effective July 1, 2009.

ARTICLE 17

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations by fund made in this article.

		2010		**2011**		**Total**
General	$	5,311,561,000	$	5,544,392,000	$	10,855,953,000
State Government Special Revenue		60,719,000		60,532,000		121,251,000
Health Care Access		372,976,000		118,764,000		491,740,000
Federal TANF		281,030,000		274,912,000		555,942,000
Lottery Prize		1,665,000		1,665,000		3,330,000
Clean Water		1,250,000		2,500,000		3,750,000
Total	**$**	**6,029,201,000**	**$**	**6,002,765,000**	**$**	**12,031,966,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium" is fiscal years 2010 and 2011. Appropriations for the fiscal year ending June 30, 2009, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 5,861,298,000**	**$ 5,840,623,000**

Appropriations by Fund

	2010	2011
General	5,237,520,000	5,475,544,000
State Government Special Revenue	565,000	565,000

Health Care Access	352,251,000	99,670,000
Federal TANF	269,297,000	263,179,000
Lottery Prize	1,665,000	1,665,000

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

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

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

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

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

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

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

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

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

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

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

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

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1),

if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

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

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

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

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

(f) Notwithstanding any contrary provision in this article, this provision expires June 30, 2013.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to $6,707,000 per year for fiscal year 2010 through fiscal year 2011.

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

(1) fiscal year 2010, $42,079,000;

(2) fiscal year 2011, $61,494,000;

(3) fiscal year 2012, $44,236,000; and

(4) fiscal year 2013, $46,952,000.

Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

TANF Transfer to Federal Child Care and Development Fund. The following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2010, $9,415,000;

(2) fiscal year 2011, $24,568,000;

(3) fiscal year 2012, $26,866,000; and

(4) fiscal year 2013, $29,664,000.

The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Child Care and Development Fund Unexpended Balance. (a) The commissioner shall determine the unexpended balance of the federal Child Care and Development Fund (CCDF) for the basic sliding fee child care program by February 28, 2009. The balance must first be used to fund programs described in paragraph (b) and the remainder must be available for the basic sliding fee child care under Minnesota Statutes, section 119B.03.

(b) Notwithstanding Minnesota Statutes, section 119B.03, subdivision 5b, and Minnesota Rules, part 3400.0060, subpart 4, the commissioner shall expend up to $763,000 in fiscal year 2010 and up to $760,000 in fiscal year 2011 to continue the school readiness service agreements pilot under Minnesota Statutes, section 119B.231. The commissioner shall expend up to $990,000 in fiscal year 2011 to support the

Parent Aware pilot. The commissioner shall ensure that all child care and development funds are expended according to the federal Child Care and Development Fund regulations.

Food Stamps Employment and Training. Notwithstanding Minnesota Statutes, sections 256J.626 and 256D.051, subdivisions 1a, 6b, and 6c, federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures and child care assistance program expenditures for two-parent families must be deposited in the general fund. The amount of funds must be limited to $3,400,000 in fiscal year 2010 and $4,400,000 in fiscal years 2011 through 2013, contingent on approval by the federal Food and Nutrition Service. Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

Subd. 2. **Agency Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Financial Operations

	Appropriations by Fund	
General	3,380,000	3,908,000
Health Care Access	1,241,000	1,016,000
Federal TANF	122,000	122,000

(b) Legal and Regulatory Operations

	Appropriations by Fund	
General	13,690,000	13,470,000
State Government Special Revenue	440,000	440,000

Health Care Access	943,000	943,000
Federal TANF	100,000	100,000

Base Adjustment. The general fund base is decreased $4,550,000 in fiscal year 2012 and $4,550,000 in fiscal year 2013. The state government special revenue fund base is increased $4,500,000 in fiscal year 2012 and $4,500,000 in fiscal year 2013.

(c) Management Operations

	Appropriations by Fund	
General	4,715,000	4,715,000
Health Care Access	242,000	242,000

(d) Information Technology Operations

	Appropriations by Fund	
General	28,077,000	28,077,000
Health Care Access	4,856,000	4,868,000

Subd. 3. **Revenue and Pass-Through Revenue Expenditures** 75,161,000 91,656,000

This appropriation is from the federal TANF fund.

Subd. 4. **Children and Economic Assistance Grants**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	67,984,000	75,077,000
Federal TANF	82,257,000	71,494,000

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	110,961,000	99,111,000

MFIP Consolidated Fund. The MFIP consolidated fund TANF appropriation is reduced by $2,750,000 in fiscal year 2010 and $5,500,000 in fiscal year 2011.

(c) MFIP Child Care Assistance Grants	52,219,000	37,204,000
(d) Basic Sliding Fee Child Care Assistance Grants	42,855,000	42,330,000

Base Adjustment. The general fund base is increased by $5,000 in fiscal year 2012 and $7,000 in fiscal year 2013.

(e) Child Care Development Grants	1,389,000	1,340,000

Child Care Program Integrity Funds for State Fraud Program. Child care program integrity grants are reduced to $49,000 in fiscal year 2010 and $0 in fiscal year 2011 for the purpose of funding state assumption of the county fraud prevention investigation function.

(f) Child Support Enforcement Grants	3,705,000	3,705,000

(g) Children's Services Grants

	Appropriations by Fund	
General	50,590,000	54,879,000
Federal TANF	200,000	200,000

Base Adjustment. The general fund base is increased by $4,625,000 in fiscal year 2012 and $7,192,000 in fiscal year 2013.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for these purposes.

Adoption Assistance, Relative Custody Assistance, and Northstar Care for Children. The commissioner may transfer unencumbered appropriation balances for adoption assistance, relative custody assistance, and Northstar care for children between fiscal years and between programs.

(h) Children and Community Services Grants	67,604,000	67,463,000

Targeted Case Management Temporary Funding Adjustment. The commissioner shall recover from each county and tribe receiving a targeted case management temporary funding payment in fiscal year 2008 an amount equal to that payment. The commissioner shall recover one-half of the funds by February 1, 2010, and the remainder by February 1, 2011. At the commissioner's discretion and at the request of a county or tribe, the commissioner may revise the payment schedule, but full payment must not be delayed beyond May 1, 2011. The commissioner may use the recovery procedure under Minnesota Statutes, section 256.017, to recover the funds. Recovered funds must be deposited into the general fund.

CCSA Distribution. Beginning July 1, 2011, the general fund base must be distributed among program categories according to the following percentages: Children's Services, 56.5 percent; Mental Health and Chemical Dependency 28.0 percent; and Adult and Disability 15.5 percent. The commissioner shall transfer funds from this appropriation to implement this distribution.

Children and Communities Services Act Distribution of County Social Services Block Grant (SSBG) Funds. Beginning January 1, 2011, the federal SSBG funds available for grants for the calendar year will be distributed among programs according to the following percentages: children's services, 51.8 percent; mental health and chemical dependency, 28.9 percent; and adult and disability, 19.3 percent. Funds transferred from the TANF

block grant to SSBG shall be considered part of the distribution to the children's services program.

(i) General Assistance Grants	49,301,000	49,723,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Combining Emergency Assistance for MSA and GA. The amount appropriated for emergency general assistance funds is limited to no more than $8,989,812 in fiscal year 2010 and $8,989,812 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants	31,774,000	32,757,000
(k) Group Residential Housing Grants	105,229,000	107,268,000
(l) Children's Mental Health Grants	16,885,000	16,882,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(m) Other Children and Economic Assistance Grants	14,818,000	13,865,000

Fraud Prevention Grants for State Fraud Program. Fraud prevention investigation grants are reduced to $463,000 in fiscal year 2010 and $0 in fiscal year 2011 for the purposes of funding state assumption of the county fraud prevention investigation function.

Subd. 5. **Children and Economic Assistance Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Children and Economic Assistance Administration

	Appropriations by Fund	
General	11,950,000	12,844,000
Federal TANF	496,000	496,000

(b) Children and Economic Assistance Operations

	Appropriations by Fund	
General	34,263,000	33,423,000
Health Care Access	361,000	361,000

State Assumption of County Fraud Prevention Program. Of the amounts appropriated, $1,682,000 in fiscal year 2010 and $2,536,000 in fiscal year 2011 is available to fund state assumption of county fraud prevention programs.

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2010 and 2011 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Subd. 6. **Basic Health Care Grants**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants 320,717,000 69,978,000

This appropriation is from the health care access fund.

(b) MA Basic Health Care Grants - Families and Children 979,255,000 1,027,604,000

Medical Education Research Costs (MERC). (1) Of these funds, the commissioner of human services shall transfer $38,000,000 in fiscal year 2010 to the medical education research fund. These funds must restore the fiscal year 2009 unallotment of the transfers under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), for the July 1, 2008, through June 30, 2009, period.

(2) In fiscal year 2010, the commissioner of human services shall reduce the amount transferred to the medical education research fund under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), for the July 1, 2009, through June 30, 2010, period by $28,000,000. The commissioner shall first reduce the transfers under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), clauses (2), (3), and (4), and second, proportionally reduce the transfers under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), clause (1), to meet the $28,000,000 reduction.

(c) MA Basic Health Care Grants - Elderly and Disabled 1,156,525,000 1,251,736,000

Minnesota Disability Health Options. The monthly enrollment of home and community-based services recipients, including personal care assistance and private duty nurse recipients, in the Minnesota disability health options program shall not exceed 1,043 in calendar year 2009, 1,201 in calendar year 2010, and 1,402 in calendar year 2011.

Hospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for Minnesota health care program enrollees must be delayed as follows: (1) for fiscal year 2010, the payments for the month of

June must be included in the first payments in fiscal year 2011; and (2) for fiscal year 2011, the payments in the month of June must be included in the first payment of fiscal year 2012. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments.

Nonhospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for nonhospital acute care services for Minnesota health care program enrollees must be delayed as follows: (1) the last payment for fiscal year 2010 must be included in the first payment for fiscal year 2011; and (2) the last payment for fiscal year 2011 must be included in the first payment for fiscal year 2012. This payment delay must not include nursing facilities, intermediate care facilities for developmental disabilities, home and community-based services, prepaid health plans, personal care provider organizations, and home health agencies. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments.

(d) General Assistance Medical Care Grants	333,074,000	362,264,000

(e) Other Health Care Grants

	Appropriations by Fund	
General	205,000	205,000
Health Care Access	900,000	150,000

Subd. 7. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Health Care Administration

	Appropriations by Fund	
General	5,274,000	5,235,000
Health Care Access	789,000	746,000

Base Adjustment. The health care access fund

base is increased by $183,000 in fiscal year 2012.

(b) Health Care Operations

	Appropriations by Fund	
General	19,685,000	18,830,000
Health Care Access	21,452,000	20,616,000

Base Adjustment. The health care access fund base is decreased by $667,000 in fiscal year 2012 and $1,170,000 in fiscal year 2013. The general fund base is decreased by $278,000 in fiscal year 2012 and $278,000 in fiscal year 2013.

Subd. 8. **Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Aging and Adult Services Grants	14,532,000	19,703,000

Base Adjustment. The general fund base is increased by $1,181,000 in fiscal year 2012 and $2,093,000 in fiscal year 2013.

Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $240,000 per year for fiscal years 2010 and 2011. This reduction shall not adjust the base appropriation.

(b) Alternative Care Grants	50,507,000	45,269,000

Base Adjustment. The general fund base is decreased by $681,000 in fiscal year 2012 and $1,078,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.	475,969,000	476,918,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	1,100,137,000	1,155,618,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals

having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver allocations. Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

(e) Mental Health Grants

	Appropriations by Fund	
General	76,989,000	78,456,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,924,000	1,909,000
(g) Chemical Dependency Entitlement Grants	112,316,000	121,295,000

Payments for Substance Abuse Treatment. For services provided in fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed rates charged for services in excess of those in effect on January 1, 2009. If statutes authorize a cost-of-living adjustment during fiscal years 2010 and 2011, then notwithstanding any law to the contrary, fiscal years 2010 and 2011 rates must not exceed those in effect on January 2, 2009, plus any authorized cost-of-living adjustments.

(h) Chemical Dependency Nonentitlement Grants	1,383,000	1,036,000
(i) Other Continuing Care Grants	18,168,000	12,300,000

Base Adjustment. The general fund base is decreased $1,142,000 in fiscal year 2012 and $2,146,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Subd. 9. **Continuing Care Management**

	Appropriations by Fund	
General	25,036,000	25,079,000
State Government Special Revenue	125,000	125,000
Lottery Prize	157,000	157,000

The general fund base is decreased $2,900,000 in fiscal year 2012 and $2,900,000 in fiscal year 2013.

Subd. 10. **State-Operated Services** 257,399,000 264,442,000

The amounts that may be spent from the appropriation for each purpose are as follows:

Transfer Authority Related to State-Operated Services. Money appropriated to finance state-operated services may be transferred between the fiscal years of the biennium with the approval of the commissioner of finance.

County Past Due Receivables. The commissioner is authorized to withhold county federal administrative reimbursement when the county of financial responsibility for cost-of-care payments due the state under Minnesota Statutes, section 246.54 or 253B.045, is 90 days past due. The commissioner shall deposit the withheld federal administrative earnings for the county into the general fund to settle the claims with the county of financial responsibility. The process for withholding funds is governed by Minnesota Statutes, section 256.017.

(a) Adult Mental Health Services	110,216,000	114,953,000

Appropriation Limitation. No part of the appropriation in this article to the commissioner for mental health treatment services provided by state-operated services shall be used for the Minnesota sex offender program.

Community Behavioral Health Hospitals. Under Minnesota Statutes, section 246.51, subdivision 1, a determination order for the clients served in a community behavioral health hospital operated by the commissioner of human services is only required when a client's third-party coverage has been exhausted.

(b) Minnesota Security Hospital and METO Services	82,918,000	82,652,000

Minnesota Security Hospital. For the purposes of enhancing the safety of the public, improving supervision, and enhancing community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative of care from the state-operated services transitional services program consistent with Minnesota Statutes, section 246.014.

(c) Minnesota Sex Offender Services	64,265,000	66,837,000

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**147,432,000**	**$**	**141,858,000**

Appropriations by Fund

	2010	2011
General	68,309,000	63,116,000
State Government Special Revenue	45,415,000	45,415,000
Health Care Access	20,725,000	19,094,000

Federal TANF	11,733,000	11,733,000
Clean Water	1,250,000	2,500,000

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

	Appropriations by Fund	
General	43,430,000	38,237,000
State Government Special Revenue	1,033,000	1,033,000
Health Care Access	7,642,000	7,719,000
Federal TANF	11,733,000	11,733,000

Funding Usage. Up to 75 percent of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program. The general fund reduction of $5,193,000 in fiscal year 2011 for local public health grants is onetime and the base funding for local public health grants for fiscal year 2012 is increased by $5,193,000.

Statewide Health Improvement Programs. Of the health care access fund appropriation, $6,000,000 per fiscal year is for the statewide health improvement program. Up to ten percent of the funding may be used for administrative purposes. Base funding for this program expires June 30, 2013.

TANF Appropriations. (1) $1,156,000 of the TANF funds are appropriated each year to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF funds are appropriated each year to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF funds are appropriated each year to the commissioner

for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,998,000 of the TANF funds are appropriated each year to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $998,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a. The commissioner may use five percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and may use ten percent of the funds appropriated each fiscal year to provide training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
General	7,593,000	7,593,000
State Government Special Revenue	14,173,000	14,173,000
Health Care Access	13,083,000	11,375,000

MERC Federal Compliance. Notwithstanding Laws 2008, chapter 363, article 18, section 4, subdivision 3, the base level funding for the commissioner to distribute to the Mayo Clinic for transitional funding while federal compliance changes are made to the medical education and research cost funding distribution formula shall be $0 for fiscal years 2010 and 2011.

Value-Based Insurance Designs. The commissioner of health, in consultation with the commissioner of human services, commerce, and Minnesota management and budget, shall study and report to the legislature on value-based insurance designs that vary enrollee cost-sharing based on clinical or cost-effectiveness of services. In performing this study, the commissioner shall consult with and seek input from health plans, health care providers, and employers. The commissioner shall report to the legislature by January 15, 2010.

Base Adjustment. The general fund base is $8,593,000 for each of fiscal years 2012 and 2013. The health care access fund base is $10,775,000 in fiscal year 2012 and $7,641,000 in fiscal year 2013.

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	9,930,000	9,930,000
State Government Special Revenue	30,209,000	30,209,000
Clean Water	1,250,000	2,500,000

Clean Water Act Funding. Of the appropriations from the clean water fund, $805,000 in fiscal year 2010 and $1,610,000 in fiscal year 2012 are for protection of drinking water sources and $445,000 in fiscal year 2010 and $890,000 in fiscal year 2011 are for addressing public health concerns related to contaminants found in Minnesota drinking water for which no health-based drinking water standard exists.

Subd. 5. **Administrative Support Services** 7,356,000 7,356,000

Sec. 5. **HEALTH RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 14,035,000 $ 13,848,000**

This appropriation is from the state government special revenue fund.

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2.	**Board of Chiropractic Examiners**	447,000	447,000
Subd. 3.	**Board of Dentistry**	1,009,000	1,009,000
Subd. 4.	**Board of Dietetic and Nutrition Practice**	105,000	105,000
Subd. 5.	**Board of Marriage and Family Therapy**	137,000	137,000
Subd. 6.	**Board of Medical Practice**	3,682,000	3,682,000
Subd. 7.	**Board of Nursing**	3,287,000	3,289,000
Subd. 8.	**Board of Nursing Home Administrators**	1,212,000	1,023,000

Administrative Services Unit - Operating Costs. Of this appropriation, $524,000 in fiscal year 2010 and $526,000 in fiscal year 2011 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year 2010, $201,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $79,000 in fiscal year 2010 and $89,000 in fiscal year 2011 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2010 and $200,000 in fiscal year 2011 are for

costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Subd. 9. **Board of Optometry**	101,000	101,000
Subd. 10. **Board of Pharmacy**	1,388,000	1,388,000
Subd. 11. **Board of Physical Therapy**	295,000	295,000
Subd. 12. **Board of Podiatry**	56,000	56,000
Subd. 13. **Board of Psychology**	806,000	806,000
Subd. 14. **Board of Social Work**	921,000	921,000
Subd. 15. **Board of Veterinary Medicine**	195,000	195,000
Subd. 16. **Board of Behavioral Health and Therapy**	394,000	394,000

Sec. 6. **EMERGENCY MEDICAL SERVICES BOARD** **$** **3,992,000** **$** **3,992,000**

Appropriations by Fund

	2010	2011
General	3,288,000	3,288,000
State Government Special Revenue	704,000	704,000

Longevity Award and Incentive Program. Of the general fund appropriation, $700,000 in fiscal year 2010 and $700,000 in fiscal

year 2011 are to the board for the ambulance service personnel longevity award and incentive program, under Minnesota Statutes, section 144E.40.

Health Professional Services Program. $704,000 in fiscal year 2010 and $704,000 in fiscal year 2011 from the state government special revenue fund are for the health professional services program.

Sec. 7. **COUNCIL ON DISABILITY**	**$**	**524,000**	**$**	**524,000**
Sec. 8. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**1,655,000**	**$**	**1,655,000**
Sec. 9. **OMBUDSPERSON FOR FAMILIES**	**$**	**265,000**	**$**	**265,000**

Sec. 10. Minnesota Statutes 2008, section 16A.725, subdivision 3, is amended to read:

Subd. 3. **Fund reimbursements.** ~~(a)~~ Each fiscal year, the commissioner of finance shall ~~first~~ transfer from the health impact fund to the general fund an amount sufficient to offset the general fund cost of the certified expenditures under subdivision 2 or the balance of the fund, whichever is less.

~~(b) If any balance remains in the health impact fund after the transfer in paragraph (a), the commissioner of finance shall transfer to the health care access fund the amount sufficient to offset the health care access fund cost of the certified expenditures in subdivision 2, or the balance of the fund, whichever is less.~~

Sec. 11. Minnesota Statutes 2008, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established in the general fund. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with developmental disability or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry

Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the general fund.

Sec. 12. Minnesota Statutes 2008, section 144.1501, subdivision 5, is amended to read:

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the ~~health care access~~ general fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Sec. 13. Minnesota Statutes 2008, section 145.986, subdivision 5, is amended to read:

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. In the report due on January 15, 2010, the commissioner shall include recommendations on a sustainable funding source for the statewide health improvement program ~~other than the health care access fund~~.

Sec. 14. **[256.0191] RECEIPTS FOR SYSTEMS PROJECTS.**

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

Sec. 15. Minnesota Statutes 2008, section 295.58, is amended to read:

295.58 DEPOSIT OF REVENUES AND PAYMENT OF REFUNDS.

The commissioner shall deposit all revenues, including penalties and interest, derived from the taxes imposed by sections 295.50 to 295.57 and from the insurance premiums tax imposed by section 297I.05, subdivision 5, on health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the ~~health care access~~ general fund. There is annually appropriated from the ~~health care access~~ general fund to the commissioner of revenue the amount necessary to make refunds under this chapter.

Sec. 16. Minnesota Statutes 2008, section 297I.05, subdivision 5, is amended to read:

Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.** (a) A tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums on all direct business received by the organization, network, or corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

(b) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the ~~health care access~~ general fund. Refunds of overpayments of tax imposed by this subdivision must be paid from the ~~health care access~~ general fund. There is annually appropriated from the ~~health care access~~ general fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 17. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 1, as amended by Laws 2004, chapter 272, article 2, section 2, is amended to read:

Subdivision 1. **Total Appropriation**	**$ 3,848,049,000**	**$ 4,135,780,000**
Summary by Fund		
General	3,301,811,000	3,561,055,000
State Government	534,000	534,000
Special Revenue Health Care Access	273,723,000	302,272,000
Federal TANF	270,425,000	270,363,000
Lottery Cash Flow	1,556,000	1,556,000

FEDERAL CONTINGENCY APPROPRIATION. (a) Federal Medicaid funds made available under title IV of the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 are appropriated to the commissioner of human services for use in the state's medical assistance and MinnesotaCare programs. The commissioners of human services and finance shall report to the legislative advisory committee on the additional federal Medicaid

matching funds that will be available to the state.

(b) Because of the availability of these funds, the following policies shall become effective:

(1) medical assistance and MinnesotaCare eligibility and local financial participation changes provided for in this act may be implemented prior to September 2, 2003, or may be delayed as necessary to maximize the use of federal funds received under title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003;

(2) the aggregate cap on the services identified in Minnesota Statutes, section 256L.035, paragraph (a), clause (3), shall be increased from $2,000 to $5,000. This increase shall expire at the end of fiscal year 2007. Funds may be transferred from the general fund to the health care access fund as necessary to implement this provision; and

(3) the following payment shifts shall not be implemented:

(i) MFIP payment shift found in subdivision 11;

(ii) the county payment shift found in subdivision 1; and

(iii) the delay in medical assistance and general assistance medical care fee-for-service payments found in subdivision 6.

(c) Notwithstanding section 14, paragraphs (a) and (b) shall expire June 30, 2007.

RECEIPTS FOR SYSTEMS PROJECTS. Appropriations and federal receipts for information system projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota office of technology, funded by the legislature, and approved

by the commissioner of finance may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

GIFTS. Notwithstanding Minnesota Statutes, chapter 7, the commissioner may accept on behalf of the state additional funding from sources other than state funds for the purpose of financing the cost of assistance program grants or nongrant administration. All additional funding is appropriated to the commissioner for use as designated by the grantor of funding.

SYSTEMS CONTINUITY. In the event of disruption of technical systems or computer operations, the commissioner may use available grant appropriations to ensure continuity of payments for maintaining the health, safety, and well-being of clients served by programs administered by the department of human services. Grant funds must be used in a manner consistent with the original intent of the appropriation.

NONFEDERAL SHARE TRANSFERS. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF FUNDS APPROPRIATED TO OTHER ENTITIES. Any expenditures from the TANF block grant shall be expended in accordance with the requirements and limitations of part A of title IV of the Social Security Act, as amended, and any other applicable federal requirement or limitation. Prior to any expenditure of these funds, the commissioner shall assure that funds are expended in compliance with the requirements and limitations of federal law and that any reporting requirements of federal law are

met. It shall be the responsibility of any entity to which these funds are appropriated to implement a memorandum of understanding with the commissioner that provides the necessary assurance of compliance prior to any expenditure of funds. The commissioner shall receipt TANF funds appropriated to other state agencies and coordinate all related interagency accounting transactions necessary to implement these appropriations. Unexpended TANF funds appropriated to any state, local, or nonprofit entity cancel at the end of the state fiscal year unless appropriating language permits otherwise.

TANF FUNDS TRANSFERRED TO OTHER FEDERAL GRANTS. The commissioner must authorize transfers from TANF to other federal block grants so that funds are available to meet the annual expenditure needs as appropriated. Transfers may be authorized prior to the expenditure year with the agreement of the receiving entity. Transferred funds must be expended in the year for which the funds were appropriated unless appropriation language permits otherwise. In accelerating transfer authorizations, the commissioner must aim to preserve the future potential transfer capacity from TANF to other block grants.

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

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

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

119B.15;

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

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

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

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

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) By August 31 of each year, the commissioner shall make a preliminary calculation to determine the likelihood that the state will meet its annual federal work participation requirement under Code of Federal Regulations, title 45, sections 261.21 and 261.23, after adjustment for any caseload reduction credit under Code of Federal Regulations, title 45, section 261.41. If the commissioner determines that the state will meet its federal work participation rate for the federal fiscal year ending that September, the commissioner may reduce the expenditure under paragraph (a), clause (1), to the extent allowed under Code of Federal Regulations, title 45, section 263.1(a)(2).

(d) For fiscal years beginning with state fiscal year 2003, the commissioner shall

assure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 25 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(e) If nonfederal expenditures for the programs and purposes listed in paragraph (a) are insufficient to meet the state's TANF/MOE requirements, the commissioner shall recommend additional allowable sources of nonfederal expenditures to the legislature, if the legislature is or will be in session to take action to specify additional sources of nonfederal expenditures for TANF/MOE before a federal penalty is imposed. The commissioner shall otherwise provide notice to the legislative commission on planning and fiscal policy under paragraph (g).

(f) If the commissioner uses authority granted under section 11, or similar authority granted by a subsequent legislature, to meet the state's TANF/MOE requirement in a reporting period, the commissioner shall inform the chairs of the appropriate legislative committees about all transfers made under that authority for this purpose.

(g) If the commissioner determines that nonfederal expenditures under paragraph (a) are insufficient to meet TANF/MOE expenditure requirements, and if the legislature is not or will not be in session to take timely action to avoid a federal penalty, the commissioner may report nonfederal expenditures from other allowable sources as TANF/MOE expenditures after the requirements of this paragraph are met. The commissioner may report nonfederal expenditures in addition to those specified under paragraph (a) as nonfederal TANF/MOE expenditures, but only ten days after the commissioner of finance

has first submitted the commissioner's recommendations for additional allowable sources of nonfederal TANF/MOE expenditures to the members of the legislative commission on planning and fiscal policy for their review.

(h) The commissioner of finance shall not incorporate any changes in federal TANF expenditures or nonfederal expenditures for TANF/MOE that may result from reporting additional allowable sources of nonfederal TANF/MOE expenditures under the interim procedures in paragraph (g) into the February or November forecasts required under Minnesota Statutes, section 16A.103, unless the commissioner of finance has approved the additional sources of expenditures under paragraph (g).

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

(j) Notwithstanding section 14, paragraph (a), clauses (1) to (6), and paragraphs (b) to (j) expire June 30, 2007.

WORKING FAMILY CREDIT EXPENDITURES AS TANF MOE. The commissioner may claim as TANF maintenance of effort up to the following amounts of working family credit expenditures for the following fiscal years:

(1) fiscal year 2004, $7,013,000;

(2) fiscal year 2005, $25,133,000;

(3) fiscal year 2006, $6,942,000; and

(4) fiscal year 2007, $6,707,000.

FISCAL YEAR 2003 APPROPRIATIONS CARRYFORWARD. Effective the day following final enactment, notwithstanding Minnesota Statutes, section 16A.28, or any

other law to the contrary, state agencies and constitutional offices may carry forward unexpended and unencumbered nongrant operating balances from fiscal year 2003 general fund appropriations into fiscal year 2004 to offset general budget reductions.

TRANSFER OF GRANT BALANCES. Effective the day following final enactment, the commissioner of human services, with the approval of the commissioner of finance and after notification of the chair of the senate health, human services and corrections budget division and the chair of the house of representatives health and human services finance committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2003, in fiscal year 2003 among the MFIP, MFIP child care assistance under Minnesota Statutes, section 119B.05, general assistance, general assistance medical care, medical assistance, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

TANF APPROPRIATION CANCELLATION. Notwithstanding the provisions of Laws 2000, chapter 488, article 1, section 16, any prior appropriations of TANF funds to the department of trade and economic development or to the job skills partnership board or any transfers of TANF funds from another agency to the department of trade and economic development or to the job skills partnership board are not available until expended, and if unobligated as of June 30, 2003, these appropriations or transfers shall cancel to the TANF fund.

SHIFT COUNTY PAYMENT. The commissioner shall make up to 100 percent of the calendar year 2005 payments to counties for developmental disabilities semi-independent living services grants, developmental disabilities family support

grants, and adult mental health grants from fiscal year 2006 appropriations. This is a onetime payment shift. Calendar year 2006 and future payments for these grants are not affected by this shift. This provision expires June 30, 2006.

CAPITATION RATE INCREASE. Of the health care access fund appropriations to the University of Minnesota in the higher education omnibus appropriation bill, ~~$2,157,000 in fiscal year 2004 and $2,157,000 in fiscal year 2005 are to be used to increase the capitation payments under~~ for fiscal years beginning on July 1, 2003, and thereafter, $2,157,000 each year must be transferred to the commissioner for purposes of Minnesota Statutes, section 256B.69. Notwithstanding the provisions of section 14, this provision shall not expire.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2003.

Sec. 18. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of finance, and after notification of the chairs of the relevant senate budget division and house of representatives finance division committee, may transfer unencumbered appropriation balances for the biennium ending June 30, 2011, within fiscal years among the MFIP, general assistance, general assistance medical care, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Human Services and Health as the commissioners consider necessary, with the advance approval of the commissioner of finance. The commissioner shall inform the chairs of the relevant house and senate health committees quarterly about transfers made under this provision.

Sec. 19. **2007 AND 2008 APPROPRIATION AMENDMENTS.**

(a) The base for the integrated service projects authorized under Laws 2007, chapter 147, article 19, section 3, subdivision 4, paragraph (b), as amended by Laws 2008, chapter 363, article 18, section 7, paragraph (b), is $1,250,000 in fiscal year 2010 and $0 in fiscal year 2011. This paragraph is effective retroactively from July 1, 2008.

(b) Notwithstanding Laws 2007, chapter 147, article 19, section 3, subdivision 4, paragraph (g), as amended by Laws 2008, chapter 363, article 18, section 7, the TANF fund base for the Children's Mental Health Pilots is $0 in fiscal year 2011. This paragraph is effective retroactively from July 1,

2008.

(c) Notwithstanding Laws 2007, chapter 147, article 19, section 3, subdivision 4, paragraph (g), as amended by Laws 2008, chapter 363, article 18, section 7, the appropriations for grants for programs serving young parents do not become part of the agency's base. This paragraph is effective retroactively from July 1, 2008.

(d) Notwithstanding Laws 2007, chapter 147, article 19, section 3, subdivision 4, paragraph (k), as amended by Laws 2008, chapter 363, article 18, section 7, the appropriation for People Incorporated does not become part of the agency's base. This paragraph is effective retroactively from July 1, 2008.

(e) The appropriation for patient incentive programs under Laws 2007, chapter 147, article 19, section 3, subdivision 6, paragraph (e), is canceled. This paragraph is effective retroactively from July 1, 2007.

(f) The onetime general fund base reduction for Child Care Development Grants under Laws 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (d), is increased by $4,000. This paragraph is effective retroactively from July 1, 2008.

(g) The base for Children Services Grants under Laws 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (e), is decreased $1,000 in each year of the fiscal year 2010 and 2011 biennium. This paragraph is effective retroactively from July 1, 2008.

(h) Notwithstanding Laws 2008, chapter 363, article 18, section 3, subdivision 4, the general fund base adjustment for Children and Community Services Grants under Laws 2008, chapter 363, article 18, section 3, subdivision 4, paragraph (f), is increased by $98,000 each year of fiscal years 2010 and 2011. This paragraph is effective retroactively from July 1, 2008.

(i) The base for Other Continuing Care Grants under Laws 2008, chapter 363, article 18, section 3, subdivision 6, paragraph (h), is decreased by $10,000 in fiscal year 2010. This paragraph is effective retroactively from July 1, 2008.

(j) The appropriation for the Community-Based Health Care Demonstration Project under Minnesota Statutes, section 62Q.80, subdivision 1a, authorized under Laws 2007, chapter 147, article 19, section 3, subdivision 6, paragraph (e), is canceled. This paragraph is effective retroactively from July 1, 2007.

(k) The appropriation for Section 125 Employer Incentives in Laws 2008, chapter 358, article 5, section 4, subdivision 3, is reduced by $800,000. This paragraph is effective retroactively from July 1, 2008.

Sec. 20. **HEALTH CARE ACCESS FUND RESOURCES AND APPROPRIATIONS.**

Effective July 1, 2009, all health care access fund resources and agency appropriations become general fund resources and agency appropriations.

Sec. 21. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 22. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2011, unless a different expiration date is explicit.

Sec. 23. **REPEALER.**

(a) Minnesota Statutes 2008, section 16A.724, is repealed.

(b) Minnesota Statutes 2008, section 62U.10, subdivision 4, is repealed.

(c) Minnesota Statutes 2008, section 256L.02, subdivision 3, is repealed.

(d) Minnesota Statutes 2008, section 295.581, is repealed.

Sec. 24. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2009, unless a different effective date is specified."

Delete the title and insert:

"A bill for an act relating to state government; establishing the governor's budget for health and human services; amending provisions related to continuing care, child care, Minnesota family investment program, adult supports, program integrity, child support, licensing, health care programs including MinnesotaCare, medical assistance and general assistance medical care, state-operated services, the Department of Health, chemical and mental health, health-related fees, and correctional state employees retirement plans; establishing the Protecting Children and Strengthening Families Act; establishing Northstar Care for Children; establishing and increasing fees; creating work groups; requiring reports; appropriating money; amending Minnesota Statutes 2008, sections 16A.725, subdivision 3; 62J.692, subdivision 7; 103I.208, subdivision 2; 119B.02, subdivision 5; 119B.09, subdivision 7; 119B.12, subdivision 1; 119B.13, subdivisions 1, 6; 125A.744, subdivision 3; 144.0724, subdivisions 2, 4, 8, by adding subdivisions; 144.121, subdivisions 1a, 1b; 144.122; 144.1222, subdivision 1a; 144.1501, subdivisions 2, 5; 144.226, subdivision 4; 144.72, subdivisions 1, 3; 144.9501, subdivisions 22b, 26a, by adding subdivisions; 144.9505, subdivisions 1g, 4; 144.9508, subdivisions 2, 3, 4; 144.97, subdivisions 2, 4, 6, by adding subdivisions; 144.98, subdivisions 1, 2, 3, by adding subdivisions; 144.99, subdivision 1; 144A.46, subdivision 1; 145.986, subdivision 5; 148.108; 148.6445, by adding a subdivision; 148D.180, subdivisions 1, 2, 3, 5; 148E.180, subdivisions 1, 2, 3, 5; 153A.17; 156.015; 157.15, by adding a subdivision; 157.16; 157.22; 176.011, subdivision 9; 245.4885, subdivision 1; 245A.03, by adding a subdivision; 245A.10, subdivisions 2, 3, 4, 5, by adding subdivisions; 245A.11, by adding a subdivision; 245C.03, subdivision 2; 245C.04, subdivision 3; 245C.10, subdivision 3, by adding a subdivision; 246.50, subdivision 5, by adding subdivisions; 246.51, by adding subdivisions; 246.511; 246.52; 246B.01, by adding subdivisions; 252.43; 252.46, by adding a subdivision; 254A.02, by adding a subdivision; 254A.16, by adding a subdivision; 254B.03, subdivision 3; 256.01, subdivision 2b, by adding a subdivision; 256.045, subdivision 3; 256.969, subdivisions 2b, 3a; 256.975, subdivision 7; 256.991; 256B.04, subdivisions 14, 16; 256B.055, subdivision 12; 256B.056, subdivisions 3b, 3c, 3d, 10; 256B.057, subdivisions 3, 9; 256B.0575; 256B.0595, subdivisions 1, 2; 256B.0621, subdivision 2; 256B.0625, subdivisions 6a, 7, 8, 8a, 8b, 9, 13e, 17, 19a, 19c, 26, 41, 47, by adding subdivisions; 256B.0651; 256B.0652; 256B.0653; 256B.0654; 256B.0655, subdivision 4; 256B.0657, subdivisions 2, 6, 8; 256B.0911, subdivisions

1, 1a, 3, 3a, 4a, 5, 6, 7, by adding subdivisions; 256B.0913, subdivision 4; 256B.0915, subdivisions 3e, 3h, 5, by adding a subdivision; 256B.0917, by adding a subdivision; 256B.092, subdivision 8a, by adding a subdivision; 256B.0944, by adding a subdivision; 256B.0945, subdivision 4; 256B.0947, subdivision 1; 256B.15, subdivisions 1a, 1h, 2, by adding subdivisions; 256B.199; 256B.37, subdivisions 1, 5; 256B.437, subdivision 6; 256B.441, by adding subdivisions; 256B.49, subdivisions 12, 13, 14, 17, by adding a subdivision; 256B.501, subdivision 4a; 256B.5012, by adding a subdivision; 256B.69, subdivisions 5a, 5c, 5f; 256B.761; 256D.03, subdivisions 3, 4; 256D.06, subdivision 2; 256D.09, subdivision 6; 256D.46; 256D.49, subdivision 3; 256G.02, subdivision 6; 256I.03, subdivision 7; 256I.05, subdivision 1a; 256J.20, subdivision 3; 256J.21, subdivision 2; 256J.24, subdivisions 3, 4, 5a, 10; 256J.37, subdivision 3a, by adding a subdivision; 256J.38, subdivision 1; 256J.45, subdivision 3; 256J.53, subdivision 2; 256J.575, subdivision 3; 256J.621; 256J.626, subdivision 6; 256J.751, by adding a subdivision; 256J.95, subdivision 12; 256L.01, subdivisions 1a, 3a, 4, 5, by adding a subdivision; 256L.02, subdivisions 1, 3; 256L.03, subdivisions 1, 1a, 1b, 3, 5; 256L.04, subdivisions 1, 1a, 2, 8, 10, 13; 256L.05, subdivisions 3, 3a, 3b, 3c, 5; 256L.06, subdivision 3; 256L.07, subdivisions 2, 3, 5, 7, by adding subdivisions; 256L.09, subdivision 2; 256L.11, subdivisions 1, 2a, 6; 256L.12, subdivisions 6, 9; 256L.15, subdivision 1, by adding subdivisions; 256L.17, by adding a subdivision; 257.85, subdivisions 2, 5, 6; 259.67, by adding subdivisions; 260B.441; 270A.09, by adding a subdivision; 295.58; 297I.05, subdivision 5; 327.14, by adding a subdivision; 327.15; 327.16; 327.20, subdivision 1, by adding a subdivision; 352.72, subdivision 1; 352.90; 352.91, subdivisions 1, 3h; 352.93, subdivisions 1, 2a, 4, by adding a subdivision; 356.30, subdivision 1; 393.07, subdivision 10; 501B.89, by adding a subdivision; 518A.53, subdivisions 1, 4, 10; 518A.60; 519.05; 604A.33, subdivision 1; 609.232, subdivision 11; 626.5572, subdivisions 6, 21; Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 1, as amended; Laws 2005, First Special Session chapter 4, article 8, section 66; Laws 2008, chapter 358, article 3, section 8; proposing coding for new law in Minnesota Statutes, chapters 156; 246B; 254A; 254B; 256; 256B; proposing coding for new law as Minnesota Statutes, chapters 256N; 256O; repealing Minnesota Statutes 2008, sections 16A.724; 62U.08; 62U.10, subdivision 4; 103I.112; 144.9501, subdivision 17b; 148D.180, subdivision 8; 246.51, subdivision 1; 246.53, subdivision 3; 256.82, subdivisions 2, 3, 4, 5; 256.962, subdivisions 1, 2, 5, 7; 256.969, subdivisions 26, 27; 256.983; 256B.057, subdivision 2c; 256B.0655, subdivisions 1, 1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13; 256B.071, subdivisions 1, 2, 3, 4; 256B.0951; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256B.76, subdivision 4; 256I.06, subdivision 9; 256J.626, subdivision 7; 256L.02, subdivision 3; 256L.04, subdivisions 7, 9; 256L.05, subdivision 1b; 256L.07, subdivisions 1, 6, 7; 256L.09, subdivisions 2, 4, 5, 6; 256L.11, subdivision 7; 256L.15, subdivisions 2, 3, 4; 257.85; 259.67, subdivisions 1, 2, 3, 3a, 4, 5, 6, 7, 8, 9, 10; 295.581; 327.14, subdivisions 5, 6; 352.91, subdivisions 2, 2a, 3c, 3d, 3e, 3f, 3g, 3i, 4a, 4b, 5; Laws 1988, chapter 689, section 251; Laws 2005, chapter 10, article 1, sections 56; 57; Laws 2005, First Special Session chapter 4, article 8, sections 61; 67; 69; 74; 75; Laws 2007, chapter 147, article 5, sections 28; 32; 33; article 13, section 2; Laws 2008, chapter 358, article 3, sections 8; 9; 10; 11; 14; Minnesota Rules, parts 4626.2015, subpart 9; 9100.0400, subparts 1, 3; 9100.0500; 9100.0600; 9500.1243, subpart 3; 9500.1261, subparts 3, 4, 5, 6; 9560.0071; 9560.0081; 9560.0082; 9560.0083; 9560.0091; 9560.0093, subparts 1, 3, 4; 9560.0101; 9560.0102; 9560.0521, subparts 7, 10; 9560.0650, subparts 1, 3, 6; 9560.0651; 9560.0652; 9560.0653; 9560.0654; 9560.0655; 9560.0656; 9560.0657; 9560.0665, subparts 2, 3, 4, 5, 6, 7, 8, 9."

Pursuant to Rule 7, Senator Hann questioned whether the Pogemiller amendment was in order. The President ruled the amendment was in order.

Senator Pogemiller moved to amend the Pogemiller amendment to S.F. No. 695 as follows:

Page 337, line 9, before "The" insert "(a)"

Page 337, after line 16, insert:

"(b) Federal stimulus funds shall be appropriated to the commissioners of health and human services to be used for the purposes for which the funds were intended."

The motion prevailed. So the amendment to the amendment was adopted.

The question recurred on the Pogemiller amendment, as amended.

The roll was called, and there were yeas 9 and nays 54, as follows:

Those who voted in the affirmative were:

Day	Gimse	Jungbauer	Ortman	Vandeveer
Gerlach	Johnson	Michel	Pariseau	

Those who voted in the negative were:

Anderson	Doll	Kubly	Olson, G.	Scheid
Bakk	Erickson Ropes	Langseth	Olson, M.	Senjem
Berglin	Fischbach	Latz	Pappas	Sheran
Betzold	Fobbe	Limmer	Pogemiller	Sieben
Carlson	Foley	Lourey	Prettner Solon	Skoe
Chaudhary	Frederickson	Lynch	Rest	Skogen
Clark	Hann	Marty	Robling	Stumpf
Cohen	Higgins	Metzen	Rosen	Tomassoni
Dahle	Ingebrigtsen	Moua	Rummel	Torres Ray
Dibble	Kelash	Murphy	Saltzman	Wiger
Dille	Koch	Olseen	Saxhaug	

The motion did not prevail. So the Pogemiller amendment, as amended, was not adopted.

Senator Limmer moved to amend S.F. No. 695 as follows:

Page 114, after line 5, insert:

"Sec. 13. Minnesota Statutes 2008, section 256J.49, subdivision 13, is amended to read:

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

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

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

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. Unpaid work experience is only an option if the participant has been unable to obtain or maintain paid employment in the competitive labor market, and no paid work experience programs are available to the participant. Prior to

placing a participant in unpaid work, the county must inform the participant that the participant will be notified if a paid work experience or supported work position becomes available. Unless a participant consents in writing to participate in unpaid work experience, the participant's employment plan may only include unpaid work experience if including the unpaid work experience in the plan will meet the following criteria:

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

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

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

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

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

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

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

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

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 22 and nays 41, as follows:

Those who voted in the affirmative were:

Day	Gerlach	Jungbauer	Ortman	Senjem
Dille	Gimse	Koch	Pariseau	Vandeveer
Erickson Ropes	Hann	Limmer	Robling	
Fischbach	Ingebrigtsen	Michel	Rosen	
Frederickson	Johnson	Olson, G.	Saltzman	

Those who voted in the negative were:

Anderson	Bakk	Berglin	Betzold	Carlson

Chaudhary	Higgins	Metzen	Rest	Stumpf
Clark	Kelash	Moua	Rummel	Tomassoni
Cohen	Kubly	Murphy	Saxhaug	Torres Ray
Dahle	Langseth	Olseen	Scheid	Wiger
Dibble	Latz	Olson, M.	Sheran	
Doll	Lourey	Pappas	Sieben	
Fobbe	Lynch	Pogemiller	Skoe	
Foley	Marty	Prettner Solon	Skogen	

The motion did not prevail. So the amendment was not adopted.

Senator Hann moved to amend S.F. No. 695 as follows:

Page 321, delete lines 8 to 13

Page 336, after line 14, insert:

"**Transfer.** $6,404,000 shall be transferred from the health care access fund to the general fund in fiscal year 2010."

Correct the subdivision and section totals and the appropriations by fund

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 26 and nays 38, as follows:

Those who voted in the affirmative were:

Day	Frederickson	Jungbauer	Ortman	Senjem
Dille	Gerlach	Koch	Pariseau	Vandeveer
Doll	Gimse	Koering	Robling	
Erickson Ropes	Hann	Limmer	Rosen	
Fischbach	Ingebrigtsen	Michel	Saltzman	
Fobbe	Johnson	Olson, G.	Scheid	

Those who voted in the negative were:

Anderson	Dahle	Lourey	Pappas	Skoe
Bakk	Dibble	Lynch	Pogemiller	Skogen
Berglin	Foley	Marty	Prettner Solon	Stumpf
Betzold	Higgins	Metzen	Rest	Tomassoni
Carlson	Kelash	Moua	Rummel	Torres Ray
Chaudhary	Kubly	Murphy	Saxhaug	Wiger
Clark	Langseth	Olseen	Sheran	
Cohen	Latz	Olson, M.	Sieben	

The motion did not prevail. So the amendment was not adopted.

S.F. No. 695 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 40 and nays 23, as follows:

Those who voted in the affirmative were:

Anderson	Dibble	Langseth	Pappas	Scheid
Berglin	Dille	Latz	Pogemiller	Sheran
Betzold	Doll	Lourey	Prettner Solon	Sieben
Carlson	Fobbe	Lynch	Rest	Skoe
Chaudhary	Foley	Metzen	Rosen	Stumpf
Clark	Higgins	Moua	Rummel	Tomassoni
Cohen	Kelash	Murphy	Saltzman	Torres Ray
Dahle	Koering	Olseen	Saxhaug	Wiger

Those who voted in the negative were:

Day	Gimse	Koch	Olson, G.	Senjem
Erickson Ropes	Hann	Kubly	Olson, M.	Skogen
Fischbach	Ingebrigtsen	Limmer	Ortman	Vandeveer
Frederickson	Johnson	Marty	Pariseau	
Gerlach	Jungbauer	Michel	Robling	

So the bill, as amended, was passed and its title was agreed to.

Senator Pogemiller moved that S.F. No. 695 be laid on the table. The motion prevailed.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

APPOINTMENTS

Senator Pogemiller from the Subcommittee on Conference Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

H.F. No. 2: Senators Stumpf; Olson, G.; Saltzman; Wiger and Dahle.

H.F. No. 936: Senators Sheran, Senjem and Erickson Ropes.

Senator Pogemiller moved that the foregoing appointments be approved. The motion prevailed.

MEMBERS EXCUSED

Senators Bonoff and Sparks were excused from the Session of today. Senator Vickerman was excused from the Session of today at 3:15 p.m. Senator Koering was excused from the Session of today from 4:00 to 4:20 p.m. Senator Bakk was excused from the Session of today at 4:45 p.m.

ADJOURNMENT

Senator Pogemiller moved that the Senate do now adjourn until 11:00 a.m., Tuesday, April 28, 2009. The motion prevailed.

Peter S. Wattson, Secretary of the Senate (Legislative)

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