A bill for an act

relating to state government; making changes to health and human services programs; amending continuing care, agency management, children and family services, and health care; awarding housing access grants; requiring studies and reports; making supplemental appropriations; reducing certain appropriations; making forecast adjustments; clarifying appropriations and transfers; amending Minnesota Statutes 2006, sections 13.461, by adding a subdivision; 256.01, by adding a subdivision; 256.741, subdivisions 2, 2a, 3; 256.969, subdivisions 2b, 20; 256B.0571, subdivisions 8, 9; 256B.0621, subdivisions 2, 6, 10; 256B.0924, subdivisions 4, 6; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256B.69, subdivisions 5a, 6, by adding subdivisions; 256B.692, subdivision 2, by adding a subdivision; 256D.44, subdivisions 2, 5; 256L.12, subdivision 9; 518A.50; 518A.53, subdivision 5; Minnesota Statutes 2007 Supplement, sections 256.741, subdivision 1; 256B.0625, subdivision 20; 256B.0631, subdivisions 1, 3; 256B.199; 256B.434, subdivision 19; 256J.621; Laws 2007, chapter 147, article 2, section 21; article 19, section 3, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 256B; repealing Minnesota Statutes 2006, sections 256.741, subdivision 15; 256J.24, subdivision 6; Minnesota Statutes 2007 Supplement, section 256.969, subdivision 27.

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

ARTICLE 1
CONTINUING CARE

Section 1. Minnesota Statutes 2006, 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: 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. 2. Minnesota Statutes 2006, section 256B.0621, subdivision 6, is amended to read:

Subd. 6. **Eligible services.** (a) Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery and engaging in advocacy as needed to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) assisting individuals in order to access needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner ~~in the 180-day period~~ before the recipient's discharge.

(b) Relocation targeted county case management includes services under paragraph (a), clauses (1), (2), and (4). Relocation service coordination includes services under paragraph (a), clauses (3) and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

Sec. 3. Minnesota Statutes 2006, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461

to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services,

each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 5. **[256B.0658] HOUSING ACCESS GRANTS.**

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals eligible for publicly funded home and community-based services, including state plan home care, to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assessment to assure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section 8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

Sec. 6. Minnesota Statutes 2006, section 256B.0924, subdivision 4, is amended to read:

Subd. 4. **Targeted case management service activities.** (a) For persons with developmental disabilities, targeted case management services must meet the provisions of section 256B.092.

(b) For persons not eligible as a person with a developmental disability, targeted case management service activities include:

(1) an assessment of the person's need for targeted case management services;

(2) the development of a written personal service plan;

(3) a regular review and revision of the written personal service plan with the recipient and the recipient's legal representative, and others as identified by the recipient, to ensure access to necessary services and supports identified in the plan;

(4) effective communication with the recipient and the recipient's legal representative and others identified by the recipient;

(5) coordination of referrals for needed services with qualified providers;

(6) coordination and monitoring of the overall service delivery to ensure the quality and effectiveness of services;

(7) assistance to the recipient and the recipient's legal representative to help make an informed choice of services;

(8) advocating on behalf of the recipient when service barriers are encountered or referring the recipient and the recipient's legal representative to an independent advocate;

(9) monitoring and evaluating services identified in the personal service plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(10) conducting face-to-face monitoring with the recipient at least twice a year;

(11) completing and maintaining necessary documentation that supports and verifies the activities in this section;

(12) coordinating with the medical assistance facility discharge planner ~~in the 180-day period~~ prior to the recipient's discharge into the community; and

(13) a personal service plan developed and reviewed at least annually with the recipient and the recipient's legal representative. The personal service plan must be revised when there is a change in the recipient's status. The personal service plan must identify:

(i) the desired personal short and long-term outcomes;

(ii) the recipient's preferences for services and supports, including development of a person-centered plan if requested; and

(iii) formal and informal services and supports based on areas of assessment, such as: social, health, mental health, residence, family, educational and vocational, safety, legal, self-determination, financial, and chemical health as determined by the recipient and the recipient's legal representative and the recipient's support network.

Sec. 7. Minnesota Statutes 2006, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of finance. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility ~~and may not exceed more than six months in a calendar year~~; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 8. Minnesota Statutes 2006, section 256B.19, subdivision 1d, is amended to read:

Subd. 1d. **Portion of nonfederal share to be paid by certain counties.** (a) In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

(b) Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(c) Beginning in 2002, in addition to any transfer under paragraph (b), each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $10,784. The provisions of paragraph (b) apply to transfers under this paragraph.

~~(d) Beginning in 2003, in addition to any transfer under paragraphs (b) and (c), each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as~~

~~licensee, multiplied by $2,230. The provisions of paragraph (b) apply to transfers under this paragraph.~~

~~(c)~~ (d) The commissioner may reduce the intergovernmental transfers under ~~paragraphs~~ paragraph (c) ~~and (d)~~ based on the commissioner's determination of the payment rate in section 256B.431, subdivision 23, paragraphs (c)~~,~~ and (d)~~, and (c)~~. Any adjustments must be made on a per-bed basis and must result in an amount equivalent to the total amount resulting from the rate adjustment in section 256B.431, subdivision 23, paragraphs (c)~~,~~ and (d)~~, and (c)~~.

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

Sec. 9. Minnesota Statutes 2006, section 256B.431, subdivision 23, is amended to read:

Subd. 23. **County nursing home payment adjustments.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, on that date, was county-owned and operated, with the county named as licensee by the commissioner of health, and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility on that date.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

(c) Beginning in 2002, in addition to any payment under paragraph (a), the commissioner shall pay to a nursing facility described in paragraph (a) an adjustment in an amount equal to $29.55 per calendar day multiplied by the number of beds licensed in the facility on that date. The provisions of paragraphs (a) and (b) apply to payments under this paragraph.

~~(d) Beginning in 2003, in addition to any payment under paragraphs (a) and (c), the commissioner shall pay to a nursing facility described in paragraph (a) an adjustment in an amount equal to $6.11 per calendar day multiplied by the number of beds licensed in the facility on that date. The provisions of paragraphs (a) and (b) apply to payments under this paragraph.~~

~~(c)~~ (d) The commissioner may reduce payments under ~~paragraphs~~ paragraph (c) ~~and (d)~~ based on the commissioner's determination of Medicare upper payment limits. Any

adjustments must be proportional to adjustments made under section 256B.19, subdivision 1d, paragraph ~~(c)~~ (d).

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

Sec. 10. Minnesota Statutes 2007 Supplement, section 256B.434, subdivision 19, is amended to read:

Subd. 19. **Nursing facility rate increases beginning October 1, 2007, and October 1, 2008.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each nursing facility reimbursed under this section operating payment rate adjustments equal to 1.87 percent of the operating payment rates in effect on September 30, 2007. For the rate year beginning October 1, 2008, the commissioner shall make available to each nursing facility reimbursed under this section, operating payment rate adjustments equal to 2.0 percent of the operating payment rates in effect on September 30, 2008.

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to nursing facilities effective October 1, 2007, or October 1, 2008, as applicable.

(f) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with the following requirements:

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the nursing facility's payroll period that includes October 1~~, 2007~~ of each year, shall be allowed if they were not used in the prior year's application;

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1~~, 2007,~~ of the year in which the rate adjustments are effective and prior to April 1~~, 2008~~ of the following year; and

(4) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustment under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

Sec. 11. Minnesota Statutes 2006, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Sec. 12. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

Subd. 2. **Standard of assistance for persons eligible for medical assistance waivers or at risk of placement in a group residential housing facility.** The state standard of assistance for a person who: (1) is eligible for a medical assistance home and community-based services waiver ~~or a person who~~; (2) has been determined by the local agency to meet the plan requirements for placement in a group residential housing facility under section 256I.04, subdivision 1a~~,~~; or (3) is eligible for a shelter needy payment under subdivision 5, paragraph (f); is the standard established in subdivision 3, paragraph (a) or (b).

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 13. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

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

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United

States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) (1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual

which is in effect on the first day of ~~January~~ July of ~~the previous~~ each year will be added to the standards of assistance established in subdivisions 1 to 4 for ~~individuals~~ adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622~~, and who are shelter needy~~; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage.

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

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

EFFECTIVE DATE. This section is effective January 1, 2009.

ARTICLE 2
AGENCY MANAGEMENT

Section 1. Minnesota Statutes 2006, section 13.461, is amended by adding a subdivision to read:

Subd. 24a. **Managed care plans.** Data provided to the commissioner of human services by managed care plans relating to contracts and provider payment rates are classified under section 256B.69, subdivision 9b.

Sec. 2. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Automation and coordination for state health care programs.** (a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By July 1, 2010, the commissioner shall improve coordination between state health care programs and social service programs including but not limited to WIC, free and reduced-price school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. The system must also permit enrollees to renew state health care program enrollment through these social services programs. By January 15, 2010, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts, and report estimated local and state costs of implementation and evaluate funding alternatives, including possible federal reimbursement.

(c) By January 15, 2010, the commissioner shall establish and implement an automated process to send out state health care program renewal forms in the most common foreign languages to those state health care program enrollees who request renewal forms in those foreign languages. The commissioner, as part of the initial enrollment process, shall inform applicants of the availability of this option.

(d) Beginning July 1, 2010, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information at the time of each enrollee contact. The commissioner shall report the costs of automatically updating contact information across programs to health care providers and county agencies.

Sec. 3. Minnesota Statutes 2006, 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.

Sec. 4. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based purchasing plan administrative costs for a prepaid health plan provided under this section or section 256B.692 must not exceed by more than five percent that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue. The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

(b) Capitated rate payments for administrative costs must be reduced to exclude onetime or sporadic expenditures in the prior year unless the managed care plan certifies that the expenditure will recur during the contract year. The commissioner shall verify

these certifications on an annual basis and recoup any payments made for onetime or sporadic expenditures that did not occur in the prior year.

(c) Expenses under section 62D.12, subdivision 9a, clause (4), are not allowable administrative expenses for rate-setting purposes under this section, unless approved by the commissioner.

Sec. 5. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 5j. **Treatment of investment earnings.** Capitation rates shall treat investment income and interest earnings as income to the same extent that investment-related expenses are treated as administrative expenditures.

Sec. 6. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 9a. **Administrative expense reporting.** Each managed care plan and county-based purchasing plan must provide to the commissioner detailed information on administrative spending, including:

(1) itemized lists of costs for claims processing and provider network management;

(2) detailed reports of costs for contracts with providers and third-party administrators;

(3) a detailed analysis of administrative spending for each Minnesota health care program;

(4) a detailed analysis of the provider's allocation of administrative expenses among its public and commercial lines of business;

(5) a detailed analysis of administrative costs by service category; and

(6) a detailed analysis of onetime and sporadic expenditures included in the administrative spending category.

Sec. 7. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 9b. **Reporting of subcontracts and provider payment rates.** (a) Each managed care plan and county-based purchasing plan must provide to the commissioner:

(1) detailed information on contracts with health care providers; and

(2) detailed information on reimbursement rates paid by the managed care plan to providers under contract with the plan.

(b) Data provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02.

Sec. 8. Minnesota Statutes 2006, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and, effective January 1, 2010, fiscal solvency of chapter 62D, applicable to health maintenance organizations~~, or chapter 62N, applicable to community integrated service networks,~~ will be met~~.~~ according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A ~~county~~ county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

Sec. 9. Minnesota Statutes 2006, section 256B.692, is amended by adding a subdivision to read:

Subd. 4a. **Expenditure of revenues.** (a) A county that has elected to participate in a county-based purchasing plan under this section shall use any excess revenues over expenses that are received by the county and are not needed for capital reserves under subdivision 2, to increase payments to providers, or to repay county investments or contributions to the county-based purchasing plan, for prevention, early intervention, and health care programs, services, or activities.

(b) A county-based purchasing plan under this section is subject to the unreasonable expense provisions of section 62D.19.

Sec. 10. Minnesota Statutes 2006, 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.

Sec. 11. **REPORT ON FINANCIAL MANAGEMENT OF HEALTH CARE PROGRAMS.**

The commissioner of human services shall report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with the following information regarding financial management of health care programs:

(1) a status report on implementation of the cost containment strategies identified in the 2005 "Strategies for Savings" report. The report must include:

(i) information on progress made towards implementation of cost-saving strategies;

(ii) an explanation of why certain strategies were not implemented; and

(iii) where appropriate, alternative strategies to those recommended in 2005 for containing public health care program costs;

(2) a description of and, to the extent possible, an explanation of recent differences between the health plan net revenue targets established by the commissioner for health plans participating in public health care programs and the actual net revenue realized by the plans from public programs;

(3) the adequacy of public health care programs for fee-for-service rates, including an identification of service areas or geographical regions where enrollees have difficulty accessing providers as the result of inadequate provider payments. This report must include recommendations to increase rates as needed to eliminate identified access problems; and

(4) a progress report on implementation of Minnesota Statutes, section 256B.76, paragraph (e), requiring payments for physician and professional services to be based on Medicare relative value units, and an estimated completion date for implementation of this payment system.

Sec. 12. **HEALTH PLAN AND COUNTY-BASED PURCHASING PLAN REQUIREMENTS.**

(a) The commissioner of health shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, guidelines to ensure that health plans, and county-based purchasing plans where applicable, have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs. The guidelines shall be consistent with generally accepted accounting principles and principles from the National Association of Insurance Commissioners. The guidelines shall not have the effect of changing allocation for Medicare-related programs as permitted by federal law and the Centers for Medicare and Medicaid Services.

(b) The commissioner of health, in cooperation with the commissioners of commerce and human services, shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, detailed standards and procedures for examining the reasonableness of health plan and county-based purchasing plan administrative expenditures for publicly funded programs. These standards and procedures must include a process for detailed examinations of individual programs and functional areas.

(c) The commissioner of health shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, a more efficient method for a health plan, and a county-based purchasing plan where appropriate, to demonstrate to the

commissioner that providers in the plan's network have appropriate credentials. The commissioner shall review issues regarding:

(1) the duplicate review of credentials at a health care provider by multiple health plans;

(2) the review of the credentials of all staff of a health care provider when only limited staff will be in the plan network; and

(3) other duplicative credentialing issues.

Sec. 13. **OMBUDSMAN FOR MANAGED CARE STUDY.**

The commissioner of human services, in cooperation with the ombudsman for managed care, shall study and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with recommendations on whether the duties of the ombudsman should be expanded to include advocating on behalf of public health care programs fee-for-service enrollees. The report must include:

(1) a comparison of recourses available to managed care clients versus fee-for-service clients when service problems occur; and

(2) an estimate of any net cost increase from this change in the ombudsman's duties, taking into account any reduction in the commissioner's duties.

Sec. 14. **REPORTING MANAGED CARE PERFORMANCE DATA.**

The commissioner of human services, in cooperation with the commissioner of health, shall report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with recommendations on the adoption of a single method to compute and publicly report managed health care performance measures in order to avoid confusion about the plans' performance levels. The study must include recommendations regarding coordinated use by the two agencies of the following data sources:

(1) Healthcare Effectiveness Data and Information Set (HEDIS) from managed care organizations;

(2) data that health plans submit to claim reimbursement for health care procedures; and

(3) data collected from medical record reviews of randomly selected individuals.

Sec. 15. **PUBLIC DENTAL COVERAGE PROGRAM STUDY.**

(a) The commissioner of human services shall undertake a study to determine whether alternative approaches to offering dental coverage to public programs enrollees would result in:

(1) improved access to dental care;

(2) cost savings to providers and the department; and

(3) improved quality and outcomes of care.

Alternatives considered must include moving to a single dental plan administrator, retaining the current model, and other innovative approaches. Issues relating to chronic disease management, medical and dental interface, plan payment approaches, and provider payment should also be addressed. The report must make a recommendation on whether to alter the current approach to contracting for dental services, and include a detailed plan on how to implement any changes. The commissioner shall consult with dentists, safety net dental providers, dental plans, health plans and county-based purchasing organizations, patients and advocates, and other interested parties in developing their findings and recommendations.

(b) By December 15, 2008, the commissioner of human services shall report findings and recommendations to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

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

Sec. 16. **WORK GROUP; TARGETED CASE MANAGEMENT.**

(a) The commissioner of human services shall convene a work group and seek information from counties, juvenile court staff, guardians ad litem, and mental health and child welfare advocates on the impact of federal regulations that cut funding for targeted case management services and the child support administrative collection system. The work group shall consider the impact these cuts will have on child protection, mental health, and housing relocation services.

(b) The commissioner shall issue a report from the work group summarizing the impact of the federal budget cuts on persons eligible for targeted case management services and the impact on county budgets. This report shall include budget and policy strategies to restore service levels to that of the year prior to the effective date of the federal regulations. A preliminary report shall be issued on December 15, 2008.

ARTICLE 3
CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2007 Supplement, section 256.741, subdivision 1, is amended to read:

Subdivision 1. ~~**Public assistance**~~ **Definitions.** (a) The term "direct support" as used in this chapter and chapters 257, 518, 518A, and 518C refers to an assigned support payment from an obligor which is paid directly to a recipient of ~~TANF or MFIP~~ public assistance.

(b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A, and 518C, includes any form of assistance provided under the AFDC program formerly codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter 256, MFIP under chapter 256J, work first program formerly codified under chapter 256K; child care assistance provided through the child care fund under chapter 119B; any form of medical assistance under chapter 256B; MinnesotaCare under chapter 256L; and foster care as provided under title IV-E of the Social Security Act.

(c) The term "child support agency" as used in this section refers to the public authority responsible for child support enforcement.

(d) The term "public assistance agency" as used in this section refers to a public authority providing public assistance to an individual.

(e) The terms "child support" and "arrears" as used in this section have the meanings provided in section 518A.26.

(f) The term "maintenance" as used in this section has the meaning provided in section 518.003.

Sec. 2. Minnesota Statutes 2006, section 256.741, subdivision 2, is amended to read:

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under any of the following programs: the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program formerly codified under chapter 256K is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for the Minnesota family investment program unless the caregiver assigns all rights to child support and ~~spousal~~ maintenance benefits according to this section.

(1) ~~An~~ The assignment ~~made according to this section~~ is effective as to~~:~~

~~(i)~~ any current child support and current ~~spousal~~ maintenance~~; and~~.

~~(ii) any accrued child support and spousal maintenance arrears.~~

~~(2) An assignment made after September 30, 1997, is effective as to:~~

~~(i) any current child support and current spousal maintenance;~~

~~(ii) any accrued child support and spousal maintenance arrears collected before October 1, 2000, or the date the individual terminates assistance, whichever is later; and~~

~~(iii) any accrued child support and spousal maintenance arrears collected under federal tax intercept.~~

(2) Any child support or maintenance arrears that accrue while an individual is receiving public assistance in the form of assistance under any of the programs listed in this paragraph are permanently assigned to the state.

(3) The assignment of current child support and current maintenance ends on the date the individual ceases to receive or is no longer eligible to receive public assistance under any of the programs listed in this paragraph.

(b) An individual receiving public assistance in the form of medical assistance, including MinnesotaCare, is considered to have assigned to the state at the time of application all rights to medical support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom medical assistance is provided.

(1) An assignment made after September 30, 1997, is effective as to any medical support accruing after the date of medical assistance or MinnesotaCare eligibility.

(2) Any medical support arrears that accrue while an individual is receiving public assistance in the form of medical assistance, including MinnesotaCare, are permanently assigned to the state.

(3) The assignment of current medical support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of medical assistance or MinnesotaCare.

(c) An individual receiving public assistance in the form of child care assistance under the child care fund pursuant to chapter 119B is considered to have assigned to the state at the time of application all rights to child care support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom child care assistance is provided.

~~An~~ (1) The assignment ~~made according to this paragraph~~ is effective as to~~:~~

~~(1)~~ any current child care support ~~and any child care support arrears assigned and accruing after July 1, 1997, that are collected before October 1, 2000; and~~.

(2) ~~any accrued child care support arrears collected under federal tax intercept.~~ Any child care support arrears that accrue while an individual is receiving public assistance in the form of child care assistance under the child care fund in chapter 119B are permanently assigned to the state.

(3) The assignment of current child care support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of child care assistance under the child care fund under chapter 119B.

Sec. 3. Minnesota Statutes 2006, section 256.741, subdivision 2a, is amended to read:

Subd. 2a. **~~Families-first~~ Distribution of child support ~~arrearages~~.** (a) The state shall distribute current child support and maintenance received by the state to an individual who assigns the right to that support under subdivision 2, paragraph (a).

(b) When the public authority collects child support arrearages on behalf of an individual who is receiving public assistance ~~provided under MFIP or MFIP-R under this chapter, MFIP under chapter 256J, or work first under chapter 256K, and the public authority has the option of applying the collection to arrears permanently assigned to the state or to arrears temporarily assigned to the state~~, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

(c) When the public authority collects child support arrearages on behalf of an individual who is not receiving public assistance, the public authority shall first apply the collection to satisfy those arrears that are not permanently assigned to the state.

(d) When the public authority collects child support arrearages certified under the federal tax offset, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

Sec. 4. Minnesota Statutes 2006, section 256.741, subdivision 3, is amended to read:

Subd. 3. **Existing assignments.** Assignments based on the receipt of public assistance in existence prior to July 1, 1997, are permanently assigned to the state. Arrears that accrued prior to the receipt of assistance that were assigned to the state between July 1, 1997, and October 1, 2009, must no longer be assigned as of October 1, 2009.

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

Sec. 5. Minnesota Statutes 2007 Supplement, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION ~~BONUS~~ FOOD BENEFITS.

(a) Effective March 1, 2010, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program (MFIP) ~~cash assistance~~ with earnings, a participant who is employed may be eligible for ~~transitional assistance~~ work participation food benefits of $75 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 ~~a transitional assistance payment~~ work participation food benefits, the participant shall not receive MFIP ~~cash assistance~~ 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 ~~cash assistance~~ and meets the other criteria in this section, ~~transitional assistance is~~ work participation food benefits are available for up to 24 consecutive months.

(c) Expenditures on the program are maintenance of effort state funds 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 ~~transitional assistance~~ work participation food benefits under this section do not count toward the participant's MFIP 60-month time limit.

Sec. 6. Minnesota Statutes 2006, section 518A.50, is amended to read:

518A.50 PAYMENT TO PUBLIC AGENCY.

(a) This section applies to all proceedings involving a support order, including, but not limited to, a support order establishing an order for past support or reimbursement of public assistance.

(b) The court shall direct that all payments ordered for maintenance or support be made to the public authority responsible for child support enforcement so long as the obligee is receiving or has applied for public assistance, or has applied for child support or maintenance collection services. Public authorities responsible for child support enforcement may act on behalf of other public authorities responsible for child support enforcement, including the authority to represent the legal interests of or execute documents on behalf of the other public authority in connection with the establishment, enforcement, and collection of child support, maintenance, or medical support, and collection on judgments.

(c) Payments made to the public authority ~~other than payments under section 518A.53~~ must be credited as of the date the payment is received by the central collections

unit~~.~~, except that payments made under section 518A.53 may be considered to have been paid as of the date the obligor received the remainder of the income.

(d) Monthly amounts received by the public agency responsible for child support enforcement from the obligor that are greater than the monthly amount of public assistance granted to the obligee must be remitted to the obligee.

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

Sec. 7. Minnesota Statutes 2006, section 518A.53, subdivision 5, is amended to read:

Subd. 5. **Payor of funds responsibilities.** (a) An order for or notice of withholding is binding on a payor of funds upon receipt. Withholding must begin no later than the first pay period that occurs after 14 days following the date of receipt of the order for or notice of withholding. In the case of a financial institution, preauthorized transfers must occur in accordance with a court-ordered payment schedule.

(b) A payor of funds shall withhold from the income payable to the obligor the amount specified in the order or notice of withholding and amounts specified under subdivisions 6 and 9 and shall remit the amounts withheld to the public authority within seven business days of the date the obligor is paid the remainder of the income. The payor of funds shall include with the remittance the Social Security number of the obligor, the case type indicator as provided by the public authority and the date the obligor is paid the remainder of the income. ~~The obligor is considered to have paid the amount withheld as of the date the obligor received the remainder of the income.~~ A payor of funds may combine all amounts withheld from one pay period into one payment to each public authority, but shall separately identify each obligor making payment.

(c) A payor of funds shall not discharge, or refuse to hire, or otherwise discipline an employee as a result of wage or salary withholding authorized by this section. A payor of funds shall be liable to the obligee for any amounts required to be withheld. A payor of funds that fails to withhold or transfer funds in accordance with this section is also liable to the obligee for interest on the funds at the rate applicable to judgments under section 549.09, computed from the date the funds were required to be withheld or transferred. A payor of funds is liable for reasonable attorney fees of the obligee or public authority incurred in enforcing the liability under this paragraph. A payor of funds that has failed to comply with the requirements of this section is subject to contempt sanctions under section 518A.73. If the payor of funds is an employer or independent contractor and violates this subdivision, a court may award the obligor twice the wages lost as a result of this violation. If a court finds a payor of funds violated this subdivision, the court

shall impose a civil fine of not less than $500. The liabilities in this paragraph apply to intentional noncompliance with this section.

(d) If a single employee is subject to multiple withholding orders or multiple notices of withholding for the support of more than one child, the payor of funds shall comply with all of the orders or notices to the extent that the total amount withheld from the obligor's income does not exceed the limits imposed under the Consumer Credit Protection Act, United States Code, title 15, section 1673(b), giving priority to amounts designated in each order or notice as current support as follows:

(1) if the total of the amounts designated in the orders for or notices of withholding as current support exceeds the amount available for income withholding, the payor of funds shall allocate to each order or notice an amount for current support equal to the amount designated in that order or notice as current support, divided by the total of the amounts designated in the orders or notices as current support, multiplied by the amount of the income available for income withholding; and

(2) if the total of the amounts designated in the orders for or notices of withholding as current support does not exceed the amount available for income withholding, the payor of funds shall pay the amounts designated as current support, and shall allocate to each order or notice an amount for past due support, equal to the amount designated in that order or notice as past due support, divided by the total of the amounts designated in the orders or notices as past due support, multiplied by the amount of income remaining available for income withholding after the payment of current support.

(e) When an order for or notice of withholding is in effect and the obligor's employment is terminated, the obligor and the payor of funds shall notify the public authority of the termination within ten days of the termination date. The termination notice shall include the obligor's home address and the name and address of the obligor's new payor of funds, if known.

(f) A payor of funds may deduct one dollar from the obligor's remaining salary for each payment made pursuant to an order for or notice of withholding under this section to cover the expenses of withholding.

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

Sec. 8. Laws 2007, chapter 147, article 2, section 21, the effective date, is amended to read:

EFFECTIVE DATE. Subdivision 1 is effective February 1, 2008, and subdivision 2 is effective ~~May 1, 2008~~ March 1, 2009.

Sec. 9. Laws 2007, chapter 147, article 19, section 3, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ 5,294,627,000 $ 5,695,458,000**

Appropriations by Fund	2008	2009
General	4,614,727,000	4,940,293,000
State Government Special Revenue	549,000	565,000
Health Care Access	426,628,000	492,759,000
Federal TANF	250,537,000	260,051,000
Lottery Prize Fund	2,185,000	1,790,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

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 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.

Pay for Performance. (a) Of the general fund appropriation, $272,000 each year is available to the commissioner of human services only under the following circumstances:

(1) $272,000 shall be made available by the commissioner of finance on January 1, 2009, only after notification by the commissioner of human services to the commissioner of finance and to the chairs of the relevant house of representatives and senate finance and policy committees that the average number of days from the receipt of a MinnesotaCare application at the state processing unit until the initial eligibility determination of the application was 30 days or less during the period October 1, 2007, to September 30, 2008. Applications transferred from counties to the state processing unit are excluded from this calculation; and

(2) $272,000 shall be made available by the commissioner of finance on January 1, 2009, only after notification by the commissioner of human services to the commissioner of finance and to the chairs of the relevant house of representatives and senate finance and policy committees that the commissioner initiated a separate treatment program for persons in the Minnesota sex offenders program who are between the ages of 18 and 25 by January 1, 2008.

(b) Regardless of whether these appropriations are made available to the commissioner of human services, they shall be part of base level funding for the biennium beginning July 1, 2009.

Purchasing Alliance Fund Transfer.

On September 1, 2007, any remaining balance in the purchasing alliance stop-loss fund account established under Minnesota

Statutes, section 256.956, shall transfer to the general fund.

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 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) The commissioner shall ensure that the MOE 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;

(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); and

(4) 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) If allowable by the federal Office of Family Assistance, the commissioner may claim excess MOE with respect to federal fiscal years 2006 and 2007 to the extent that working family credit expenditures are otherwise available to supplement the state's MOE claim for those years after considering the expenditures allowed in this subdivision.

If other qualified expenditures are available, the commissioner may use those expenditures as excess MOE and by April 15, 2009, shall report those expenditures to the chairs of the senate and house of representatives Finance Committees, the senate Health and Human Services Budget Division, and house of representatives Health Care and Human Services Finance Division.

~~(d)~~ (f) 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, does not apply if the grants or aids are federal TANF funds.

~~(c)~~ (g) Notwithstanding any contrary provision in this article, this rider expires June 30, 2011.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to $6,707,000 per year for fiscal year 2008 through fiscal year 2011. Notwithstanding any contrary provision in this article, this rider expires June 30, 2011.

Additional Working Family Credit Expenditures to be Claimed for TANF/MOE. In addition to the amounts provided in this section, the commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

(1) fiscal year 2008, ~~$11,097,000~~ $28,222,000;

(2) fiscal year 2009, ~~$25,401,000~~ $42,905,000;

(3) fiscal year 2010, ~~$20,398,000~~ $29,026,000; and

(4) fiscal year 2011, ~~$19,841,000~~ $28,361,000.

Notwithstanding any contrary provision in this article, this rider expires June 30, 2011.

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 2008 and $2,157,000 in fiscal year 2009 are to be used to increase the capitation payments under Minnesota Statutes, section 256B.69.

Sec. 10. **REPEALER.**

Minnesota Statutes 2006, sections 256.741, subdivision 15; and 256J.24, subdivision 6, are repealed.

ARTICLE 4
HEALTH CARE

Section 1. Minnesota Statutes 2006, 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, ~~and~~ January 1, 2005, and for the first year of the rebased period beginning January 1, 2009. 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. 2. Minnesota Statutes 2006, section 256.969, subdivision 20, is amended to read:

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by

March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph

exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(e) For admissions occurring on or after July 1, 2008, fee-for-service inpatient payments must increase eight percent for a hospital with a medical assistance inpatient utilization rate of 17.95 percent of total patient days as of the base year in effect on July 1, 2005, and nine percent for a hospital with a medical assistance inpatient utilization rate of 59.60 percent of total patient days as of the base year in effect on July 1, 2005. Payments made to managed care plans must not be increased to reflect this increase. For purposes of this paragraph, medical assistance does not include general assistance medical care.

Sec. 3. Minnesota Statutes 2006, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual who meets the requirements in this paragraph is eligible to participate in the partnership program. The individual must:

(1) be a Minnesota resident at the time coverage first became effective under the partnership policy; and

(2) be a beneficiary of a partnership policy that (i) is issued on or after the effective date of the state plan amendment implementing the partnership program in Minnesota, or (ii) qualifies as a partnership policy under the provisions of subdivision 8a~~; and~~.

~~(3) have exhausted all of the benefits under the partnership policy as described in this section. Benefits received under a long-term care insurance policy before July 1, 2006, do not count toward the exhaustion of benefits required in this subdivision.~~

Sec. 4. Minnesota Statutes 2006, section 256B.0571, subdivision 9, is amended to read:

Subd. 9. **Medical assistance eligibility.** (a) Upon application for medical assistance program payment of long-term care services by an individual who meets the requirements described in subdivision 8, the commissioner shall determine the individual's eligibility for medical assistance according to paragraphs (b) to (i).

(b) After determining assets subject to the asset limit under section 256B.056, subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall allow the individual to designate assets to be protected from recovery under subdivisions 13 and 15 up to the dollar amount of the benefits utilized under the partnership policy as of the effective date of eligibility for medical assistance program payment of long-term care

services. Benefits utilized under a long-term care insurance policy before July 1, 2006, do not count for the purpose of determining the amount of assets that can be designated. Designated assets shall be disregarded for purposes of determining eligibility for payment of long-term care services. The dollar amount of benefits utilized must be equal to the amount of claims paid by the issuer under the policy as verified by the issuer.

(c) The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of ~~initial~~ application for medical assistance payment of long-term care services. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) ~~If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services,~~ As the individual continues to utilize benefits under a partnership policy after eligibility for medical assistance payment of long-term care services begins, the individual may designate, for additional protection, an increase in the value of protected assets and additional assets that become available during the individual's lifetime ~~for protection under this section~~ up to the amount of additional benefits utilized. The individual must make the designation in writing to the county agency no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program. ~~Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15 or 524.3-1202, or otherwise.~~ The amount used for this purpose must reduce the unused amount of asset protection available to protect assets in the individual's estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

(h) Assets designated under this subdivision shall not be subject to penalty under section 256B.0595.

(i) The commissioner shall otherwise determine the individual's eligibility for payment of long-term care services according to medical assistance eligibility requirements.

Sec. 5. Minnesota Statutes 2007 Supplement, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $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;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital-based emergency room; and

(4) $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.

(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:

(1) $6 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~~.~~; and

(3) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly co-payments must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on co-payments.

(c) Recipients of medical assistance are responsible for all co-payments in this subdivision.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment, except that ~~reimbursement for prescription drugs~~ reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum or the $7 per month maximum effective January 1, 2009, for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent co-payment limit.

(b) The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(c) Medical assistance 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.

Sec. 7. **[256B.194] FEDERAL PAYMENTS.**

Subdivision 1. **Payments at actual cost.** Notwithstanding any other statute or rule to the contrary, for providers that are units of government, the commissioner may limit medical assistance and MinnesotaCare payments to a provider's actual cost of providing services, according to the Centers for Medicare and Medicaid Services (CAMS) final rule referenced in this subdivision. The commissioner may also require medical assistance and MinnesotaCare providers to provide any information necessary to determine Medicaid-related costs, and require the cooperation of providers in any audit or review necessary to ensure payments are limited to cost. This section does not apply to providers who are exempt from the provisions of the CAMS final rule. This subdivision becomes

effective when the CAMS final rule, published May 29, 2007, at Federal Register, Vow. 72, No. 100, governing payments to providers that are units of government goes into effect at the end of the moratorium imposed by Congress.

Subd. 2. **Loss of federal financial participation.** For all transfers, certified expenditures, and medical assistance payments listed in this subdivision, if the commissioner determines that federal financial participation is no longer available for the medical assistance payments listed, then related obligations for the nonfederal share of payments and the medical assistance payments must terminate. The commissioner shall notify all affected parties of the loss of federal financial participation, and the resulting payments and obligations that are terminated. If the commissioner determines that federal financial participation is no longer available for any medical assistance payments or contributions to the nonfederal share of medical assistance payments that have already been made, the commissioner may collect the medical assistance payments from providers and return contributions of the nonfederal share to its source. The transfers, certified expenditures, and medical assistance payments subject to this section are those specified in section 62J.692, subdivision 7, paragraphs (b) and (c); 256B.19, subdivisions 1c and 1d; 256B.195; 256B.431, subdivision 23; and 256B.69, subdivision 5c, paragraph (a), clauses (2) to (4); Laws 2002, chapter 220, article 17, section 2, subdivision 3; and Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 1.

Sec. 8. Minnesota Statutes 2007 Supplement, 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).

(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~~ to offset medical assistance expenditures; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in this 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.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2007.

Sec. 9. Minnesota Statutes 2006, 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 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 two 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. 10. Minnesota Statutes 2006, 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 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, 2009, the commissioner shall withhold two 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. 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.

Sec. 11. **FEDERAL APPROVAL FOR INCREASED DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.**

By January 1, 2009, the commissioner of human services, in cooperation with hospitals with high rates of utilization by medical assistance enrollees, shall develop and submit for federal approval a proposal to increase disproportionate share hospital payments to Minnesota hospitals. In developing the proposal, the commissioner shall consider, but is not required to adopt, disproportionate share hospital payment proposals from other states that have received federal approval.

Sec. 12. **REPEALER.**

Minnesota Statutes 2007 Supplement, section 256.969, subdivision 27, is repealed retroactively from July 1, 2007.

ARTICLE 5
HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2007, chapter 147, or other law 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 "2008" and "2009" used in this article mean that the addition or subtraction from appropriations listed under them are available for the fiscal year ending June 30, 2008, or June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Supplemental appropriations and reductions for the fiscal year ending June 30, 2008, are effective the day following final enactment.

		APPROPRIATIONS Available for the Year Ending June 30	
		2008	2009
Sec. 2. **HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**	$	(34,855,000)	$ (56,265,000)
Appropriations by Fund			
	2008	2009	
General	(51,980,000)	(80,296,000)	
Health Care Access	0	(3,292,000)	
Federal TANF	17,125,000	27,323,000	
Subd. 2. **Agency Management**			
Financial Operations		0	(5,867,000)
The amounts that may be spent from the appropriation for each purpose are as follows:			
Base Adjustment. The general fund base is increased $23,000 in fiscal year 2010 and $26,000 in fiscal year 2011.			
Subd. 3. **Revenue and Pass-Through Revenue Expenditures**			
Federal TANF		25,000,000	27,039,000
Additional TANF Transfer to Social Services Block Grant. In addition to transfers allowed under prior law, $5,754,000 in fiscal year 2009 is appropriated to the commissioner for the purposes of providing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal social services block grant to meet this appropriation. The funds must be distributed to counties for the children and community services grant according to the formula for			

state appropriations in Minnesota Statutes, chapter 256M.

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	(17,125,000)	(25,947,000)
Federal TANF	17,125,000	27,311,000

(b) **MFIP Child Care Assistance Grants** 0 0

(c) **Children's Services Grants** (311,000) (1,663,000)

Base Adjustment. The general fund base is increased $1,726,000 in fiscal year 2010 and $1,742,000 in fiscal year 2011 due to the onetime increase in adoption assistance grants and the onetime decreases in relative custody assistance grants, and county shift for children's mental health grants.

Funding Usage. Up to 75 percent of the fiscal year 2010 appropriation for children's mental health screening grants may be used to fund calendar year 2009 allocations for these programs, with the resulting calendar year funding pattern continuing into the future.

Subd. 4a. **Children and Economic Assistance Management**

General 0 12,000

Children and Economic Assistance Operations

	Appropriations by Fund	
General	0	12,000

MAXIS costs. $12,000 is appropriated in fiscal year 2009 for MAXIS systems costs. This appropriation is onetime only.

Subd. 5. **Basic Health Care Grants**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MinnesotaCare Grants**

Health Care Access	0	(3,292,000)

Incentive Program and Outreach Grants. Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000 from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

(b) **MA Basic Health Care Grants - Families and Children**	(17,985,000)	(24,848,000)

Hospital Payment Delay. Notwithstanding Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 6, payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for medical assistance enrollees are delayed as follows: (1) for fiscal year 2008, the last payments for the month of June must be included in the first payments in fiscal year 2009; and (2) for fiscal year 2009, the last payments in the month of June must be included in the first payment of fiscal year 2010. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments.

(c) **MA Basic Health Care Grants - Elderly and Disabled**	(14,028,000)	(2,254,000)

Minnesota Disability Health Options Rate Setting Methodology. The commissioner shall develop and implement a methodology for risk adjusting payments for community alternatives for disabled individuals (CADI) and traumatic brain injury (TBI) home and community-based waiver services delivered under the Minnesota disability health options program (MnDHO) effective January 1, 2009. The commissioner shall take into account the weighting system used to determine county waiver allocations in developing the new payment methodology. Growth in the number of enrollees receiving CADI or TBI waiver payments through MnDHO is limited to an increase of 200 enrollees in each calendar year from January 2009 through December 2011. If those limits are reached, additional members may be

enrolled in MnDHO for basic care services only as defined under Minnesota Statutes, section 256B.69, subdivision 28, and the commissioner may establish a waiting list for future access of MnDHO members to those waiver services.

Critical Access Dental Reimbursement. Effective for fiscal years beginning on or after July 1, 2009, funding for medical assistance critical access dental reimbursement rates must be paid from the health care access fund.

(d) **General Assistance Medical Care Grants**	0	(3,729,000)

MinnesotaCare Outreach Grants Special Revenue Account. The balance in the MinnesotaCare outreach grants special revenue account at the close of fiscal year 2008 must be transferred to the general fund.

Subd. 6. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

Health Care Administration	0	100,000

Subd. 7. **Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **MA Long-Term Care Facilities Grants**	(2,306,000)	(2,291,000)
(b) **MA Long-Term Care Waivers and Home Care Grants**	0	(5,397,000)

Manage Growth in TBI and CADI Waiver. During the fiscal years beginning on July 1, 2008, July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based programs

covered under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the traumatic brain injury (TBI) waiver to 200 allocations in each year of the biennium and the community alternatives for disabled individuals (CADI) waiver to 1,500 allocations each year of the biennium. 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. Notwithstanding any contrary section in this article, this provision expires June 30, 2011.

(c) **Mental Health Grants**	0	(4,555,000)

Base Adjustment. The general fund base is increased $5,270,000 in fiscal year 2010 and $5,450,000 in fiscal year 2011 due to the county payment shift for adult mental health grants.

Targeted Case Management Work Group. $15,000 is appropriated from the general fund for fiscal year 2009 to the commissioner of human services for administrative costs directly related to the operation of the targeted case management work group.

(d) **Chemical Dependency Entitlement Grants**	0	(1,503,000)

Payments for Substance Abuse Treatment. For services provided in fiscal year 2009, 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 May 31, 2008. If statutes authorize a

cost-of-living adjustment during fiscal year 2009, then notwithstanding any law to the contrary, fiscal year 2009 rates may not exceed those in effect on May 31, 2008, plus any authorized cost-of-living adjustments.

Chemical Dependency Treatment Fund Special Revenue Account. The lesser of the balance of the consolidated chemical dependency treatment fund at the close of fiscal year 2008 or $2,650,000 must be transferred and deposited into the general fund.

(e) **Chemical Dependency Nonentitlement Grants**	0	2,150,000

Base Level Adjustment. The general fund base for chemical dependency nonentitlement treatment grants shall be increased by $150,000 for fiscal years 2010 and 2011 for increased grants for methamphetamine treatment.

American Indian Youth Program. Of the general fund appropriation, $2,000,000 in fiscal year 2009 is for grants to be awarded competitively to American Indian tribes to purchase or develop one or more culturally specific treatment programs designed to serve youth from native cultures. This appropriation is onetime and available until spent.

(f) **Other Continuing Care Grants**	0	(4,381,000)

Base Level Adjustment. The general fund base is increased $7,633,000 in fiscal year 2010 and $5,332,000 in fiscal year 2011, due to the onetime reduction of HIV grants in fiscal year 2009, an increase each year for

housing grants under Minnesota Statutes, section 256B.0658, and the adjustment for the county grant payment shift for developmental disability semi-independent services grants and developmental disability family support grants.

Housing Access Grants. Of the general fund appropriation, $250,000 is appropriated in fiscal year 2009 for housing access grants under Minnesota Statutes, section 256B.0658.

Funding Usage. Up to 75 percent of the fiscal year 2010 appropriation for developmental disability semi-independent living services grants and developmental disability family support grants may be used to fund calendar year 2009 allocations for these programs, with the resulting calendar year funding pattern continuing into the future.

Subd. 8. **State-Operated Services**

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 to the state under Minnesota Statutes, section 246.54 or 253B.045, is 180 days past due. The commissioner shall deposit the federal administrative withholding into the general fund to settle the claims with the county of financial responsibility.

Mental Health Services	(225,000)	(300,000)

Sec. 3. **Health Department**

Federally Qualified Health Centers. Effective for fiscal years beginning on or after July 1, 2009, the general fund appropriation of $1,500,000 each fiscal year for federally qualified health centers under Minnesota Statutes, section 145.9269, is eliminated and is replaced by a $1,500,000 appropriation each fiscal year from the health care access fund.

MERC Federal Compliance. Effective for fiscal years beginning on or after July 1, 2009, the general fund appropriation of $2,000,000 each fiscal year to the Mayo Clinic for the purpose of providing transition funding while federal compliance changes are made to the medical education and research cost funding distribution formula is eliminated and is replaced by a $2,000,000 appropriation each fiscal year from the health care access fund.

ARTICLE 6
HEALTH AND HUMAN SERVICES FORECAST CHANGES

Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2007, chapter 147, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2008" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2008. The figure "2009" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2009.

		2008		**2009**
General	$	6,739,000	$	52,350,000
Health Care Access		(84,156,000)		(96,019,000)
TANF		(28,427,000)		(7,441,000)
Total	**$**	**(105,844,000)**	**$**	**(51,110,000)**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**			**$ (105,844,000)**	**$ (51,110,000)**
	Appropriations by Fund			
	2008	2009		
General	6,739,000	52,350,000		
Health Care Access	(84,156,000)	(96,019,000)		
TANF	(28,427,000)	(7,441,000)		
Subd. 2. **Revenue and Pass-Through**				
TANF	1,187,000	1,507,000		
Subd. 3. **Children and Economic Assistance Grants**				
General	(4,960,000)	5,925,000		
TANF	(29,614,000)	(8,948,000)		

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund			
General	25,139,000	11,665,000		
TANF	(29,614,000)	(8,948,000)		
(b) **MFIP Child Care Assistance Grants**			(26,141,000)	(10,710,000)
(c) **General Assistance Grants**			2,529,000	6,033,000
(d) **Minnesota Supplemental Aid Grants**			299,000	500,000
(e) **Group Residential Housing Grants**			(6,786,000)	(1,563,000)
Subd. 4. **Basic Health Care Grants**				
General	30,075,000	48,389,000		
Health Care Access	(84,156,000)	(96,019,000)		

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MinnesotaCare**

Health Care Access	(84,156,000)	(96,019,000)		
(b) **MA Basic Health Care - Families and Children**			13,525,000	7,005,000

(c) **MA Basic Health Care - Elderly and Disabled**		(2,292,000)	5,479,000
(d) **General Assistance Medical Care**		18,842,000	35,905,000
Subd. 5. **Continuing Care Grants**		(18,376,000)	(1,964,000)
The amounts that may be spent from this appropriation for each purpose are as follows:			
(a) **MA Long-Term Care Facilities**		(10,986,000)	(2,148,000)
(b) **MA Long-Term Care Waivers**		(18,484,000)	(13,598,000)
(c) **Chemical Dependency Entitlement Grants**		11,094,000	13,782,000

ARTICLE 7
APPROPRIATIONS AND TRANSFERS

Section 1. **DUPLICATE APPROPRIATIONS.**

Unless another act explicitly provides otherwise, appropriations and transfers made in this act and other acts must be implemented only once, even if the provision or a similar provision with the same fiscal effect in the same fiscal year is included in another act. This section applies to laws enacted in the 2008 regular session.

APPENDIX
Article locations in H3976-1

256.741 CHILD SUPPORT AND MAINTENANCE.

Subd. 15. **Child support distribution.** The state shall distribute current child support and maintenance received by the state to an individual who assigns the right to that support under subdivision 2, paragraph (a).

256.969 PAYMENT RATES.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199 and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth; or

(5) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.