

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; making forecast adjustments; amending Minnesota Statutes 2006, sections 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; 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; 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.

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

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

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

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

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

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

8.31 (i) Notwithstanding section 256B.041, county payments for the cost of case
8.32 management services provided by county staff shall not be made to the commissioner of
8.33 finance. For the purposes of targeted case management services provided by county staff
8.34 under this section, the centralized disbursement of payments to counties under section
8.35 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.

~~(e)~~ (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 (e)~~. 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 (e)~~.

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.~~

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

11.1 adjustments must be proportional to adjustments made under section 256B.19, subdivision
11.2 1d, paragraph ~~(e)~~ (d).

11.3 Sec. 10. Minnesota Statutes 2006, section 256B.69, subdivision 6, is amended to read:

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

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

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

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

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

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

11.25 Sec. 11. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

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

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

12.1 Sec. 12. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

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

12.6 (a) The county agency shall pay a monthly allowance for medically prescribed
12.7 diets if the cost of those additional dietary needs cannot be met through some other
12.8 maintenance benefit. The need for special diets or dietary items must be prescribed by
12.9 a licensed physician. Costs for special diets shall be determined as percentages of the
12.10 allotment for a one-person household under the thrifty food plan as defined by the United
12.11 States Department of Agriculture. The types of diets and the percentages of the thrifty
12.12 food plan that are covered are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

12.34 (d) The county agency shall continue to pay a monthly allowance of \$68 for
12.35 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
12.36 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. 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.

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 "arrear" 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 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 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

19.1 pay period that occurs after 14 days following the date of receipt of the order for or notice
19.2 of withholding. In the case of a financial institution, preauthorized transfers must occur in
19.3 accordance with a court-ordered payment schedule.

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

19.14 (c) A payor of funds shall not discharge, or refuse to hire, or otherwise discipline an
19.15 employee as a result of wage or salary withholding authorized by this section. A payor of
19.16 funds shall be liable to the obligee for any amounts required to be withheld. A payor of
19.17 funds that fails to withhold or transfer funds in accordance with this section is also liable
19.18 to the obligee for interest on the funds at the rate applicable to judgments under section
19.19 549.09, computed from the date the funds were required to be withheld or transferred.
19.20 A payor of funds is liable for reasonable attorney fees of the obligee or public authority
19.21 incurred in enforcing the liability under this paragraph. A payor of funds that has failed
19.22 to comply with the requirements of this section is subject to contempt sanctions under
19.23 section 518A.73. If the payor of funds is an employer or independent contractor and
19.24 violates this subdivision, a court may award the obligor twice the wages lost as a result
19.25 of this violation. If a court finds a payor of funds violated this subdivision, the court
19.26 shall impose a civil fine of not less than \$500. The liabilities in this paragraph apply to
19.27 intentional noncompliance with this section.

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

19.34 (1) if the total of the amounts designated in the orders for or notices of withholding
19.35 as current support exceeds the amount available for income withholding, the payor of
19.36 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

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

21.4 **Receipts for Systems Projects.**

21.5 Appropriations and federal receipts for
21.6 information system projects for MAXIS,
21.7 PRISM, MMIS, and SSIS must be deposited
21.8 in the state system account authorized in
21.9 Minnesota Statutes, section 256.014. Money
21.10 appropriated for computer projects approved
21.11 by the Minnesota Office of Enterprise
21.12 Technology, funded by the legislature, and
21.13 approved by the commissioner of finance,
21.14 may be transferred from one project to
21.15 another and from development to operations
21.16 as the commissioner of human services
21.17 considers necessary. Any unexpended
21.18 balance in the appropriation for these
21.19 projects does not cancel but is available for
21.20 ongoing development and operations.

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

21.26 (1) \$272,000 shall be made available by the
21.27 commissioner of finance on January 1, 2009,
21.28 only after notification by the commissioner
21.29 of human services to the commissioner of
21.30 finance and to the chairs of the relevant house
21.31 of representatives and senate finance and
21.32 policy committees that the average number
21.33 of days from the receipt of a MinnesotaCare
21.34 application at the state processing unit until
21.35 the initial eligibility determination of the

22.1 application was 30 days or less during the
22.2 period October 1, 2007, to September 30,
22.3 2008. Applications transferred from counties
22.4 to the state processing unit are excluded from
22.5 this calculation; and

22.6 (2) \$272,000 shall be made available by the
22.7 commissioner of finance on January 1, 2009,
22.8 only after notification by the commissioner
22.9 of human services to the commissioner of
22.10 finance and to the chairs of the relevant
22.11 house of representatives and senate finance
22.12 and policy committees that the commissioner
22.13 initiated a separate treatment program for
22.14 persons in the Minnesota sex offenders
22.15 program who are between the ages of 18 and
22.16 25 by January 1, 2008.

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

22.22 **Purchasing Alliance Fund Transfer.**

22.23 On September 1, 2007, any remaining
22.24 balance in the purchasing alliance stop-loss
22.25 fund account established under Minnesota
22.26 Statutes, section 256.956, shall transfer to
22.27 the general fund.

22.28 **Nonfederal Share Transfers.** The

22.29 nonfederal share of activities for which
22.30 federal administrative reimbursement is
22.31 appropriated to the commissioner may be
22.32 transferred to the special revenue fund.

22.33 **TANF Maintenance of Effort.** (a) In order
22.34 to meet the basic MOE requirements of the
22.35 TANF block grant specified under Code

23.1 of Federal Regulations, title 45, section
23.2 263.1, the commissioner may only report
23.3 nonfederal money expended for allowable
23.4 activities listed in the following clauses as
23.5 TANF/MOE expenditures:

23.6 (1) MFIP cash, diversionary work program,
23.7 and food assistance benefits under Minnesota
23.8 Statutes, chapter 256J;

23.9 (2) the child care assistance programs
23.10 under Minnesota Statutes, sections 119B.03
23.11 and 119B.05, and county child care
23.12 administrative costs under Minnesota
23.13 Statutes, section 119B.15;

23.14 (3) state and county MFIP administrative
23.15 costs under Minnesota Statutes, chapters
23.16 256J and 256K;

23.17 (4) state, county, and tribal MFIP
23.18 employment services under Minnesota
23.19 Statutes, chapters 256J and 256K;

23.20 (5) expenditures made on behalf of
23.21 noncitizen MFIP recipients who qualify
23.22 for the medical assistance without federal
23.23 financial participation program under
23.24 Minnesota Statutes, section 256B.06,
23.25 subdivision 4, paragraphs (d), (e), and (j);
23.26 and

23.27 (6) qualifying working family credit
23.28 expenditures under Minnesota Statutes,
23.29 section 290.0671.

23.30 (b) The commissioner shall ensure that
23.31 sufficient qualified nonfederal expenditures
23.32 are made each year to meet the state's
23.33 TANF/MOE requirements. For the activities
23.34 listed in paragraph (a), clauses (2) to

24.1 (6), the commissioner may only report
24.2 expenditures that are excluded from the
24.3 definition of assistance under Code of
24.4 Federal Regulations, title 45, section 260.31.

24.5 (c) The commissioner shall ensure that the
24.6 MOE used by the commissioner of finance
24.7 for the February and November forecasts
24.8 required under Minnesota Statutes, section
24.9 16A.103, contains expenditures under
24.10 paragraph (a), clause (1), equal to at least 16
24.11 percent of the total required under Code of
24.12 Federal Regulations, title 45, section 263.1.

24.13 (d) For the federal fiscal year beginning
24.14 October 1, 2007, the commissioner may not
24.15 claim an amount of TANF/MOE in excess of
24.16 the 75 percent standard in Code of Federal
24.17 Regulations, title 45, section 263.1(a)(2),
24.18 except:

24.19 (1) to the extent necessary to meet the 80
24.20 percent standard under Code of Federal
24.21 Regulations, title 45, section 263.1(a)(1),
24.22 if it is determined by the commissioner
24.23 that the state will not meet the TANF work
24.24 participation target rate for the current year;

24.25 (2) to provide any additional amounts under
24.26 Code of Federal Regulations, title 45, section
24.27 264.5, that relate to replacement of TANF
24.28 funds due to the operation of TANF penalties;

24.29 (3) to provide any additional amounts that
24.30 may contribute to avoiding or reducing
24.31 TANF work participation penalties through
24.32 the operation of the excess MOE provisions
24.33 of Code of Federal Regulations, title 45,
24.34 section 261.43(a)(2); and

25.1 (4) for the purposes of clauses (1) to (3),
25.2 the commissioner may supplement the
25.3 MOE claim with working family credit
25.4 expenditures to the extent such expenditures
25.5 or other qualified expenditures are otherwise
25.6 available after considering the expenditures
25.7 allowed in this section.

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

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

25.25 ~~(d)~~ (f) Minnesota Statutes, section 256.011,
25.26 subdivision 3, which requires that federal
25.27 grants or aids secured or obtained under that
25.28 subdivision be used to reduce any direct
25.29 appropriations provided by law, does not
25.30 apply if the grants or aids are federal TANF
25.31 funds.

25.32 ~~(e)~~ (g) Notwithstanding any contrary
25.33 provision in this article, this rider expires
25.34 June 30, 2011.

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

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

26.13 (1) fiscal year 2008, ~~\$11,097,000~~
26.14 \$28,222,000;

26.15 (2) fiscal year 2009, ~~\$25,401,000~~
26.16 \$42,526,000;

26.17 (3) fiscal year 2010, \$20,398,000; and

26.18 (4) fiscal year 2011, \$19,841,000.

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

26.21 **Capitation Rate Increase.** Of the health care
26.22 access fund appropriations to the University
26.23 of Minnesota in the higher education
26.24 omnibus appropriation bill, \$2,157,000 in
26.25 fiscal year 2008 and \$2,157,000 in fiscal year
26.26 2009 are to be used to increase the capitation
26.27 payments under Minnesota Statutes, section
26.28 256B.69.

26.29 Sec. 10. **REPEALER.**

26.30 Minnesota Statutes 2006, sections 256.741, subdivision 15; and 256J.24, subdivision
26.31 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.

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

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

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

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

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

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

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

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

29.21 (b) After determining assets subject to the asset limit under section 256B.056,
29.22 subdivision 3 or 3c, or 256B.057, subdivision 9 or 10, the commissioner shall allow the
29.23 individual to designate assets to be protected from recovery under subdivisions 13 and
29.24 15 up to the dollar amount of the benefits utilized under the partnership policy as of the
29.25 effective date of eligibility for medical assistance program payment of long-term care
29.26 services. Benefits utilized under a long-term care insurance policy before July 1, 2006,
29.27 do not count for the purpose of determining the amount of assets that can be designated.
29.28 Designated assets shall be disregarded for purposes of determining eligibility for payment
29.29 of long-term care services. The dollar amount of benefits utilized must be equal to the
29.30 amount of claims paid by the issuer under the policy as verified by the issuer.

29.31 (c) The individual shall identify the designated assets and the full fair market value
29.32 of those assets and designate them as assets to be protected at the time of ~~initial~~ application
29.33 for medical assistance payment of long-term care services. The full fair market value of
29.34 real property or interests in real property shall be based on the most recent full assessed
29.35 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.

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

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

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

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

31.11 (1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an
31.12 episode of service which is required because of a recipient's symptoms, diagnosis, or
31.13 established illness, and which is delivered in an ambulatory setting by a physician or
31.14 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
31.15 audiologist, optician, or optometrist;

31.16 (2) \$3 for eyeglasses;

31.17 (3) \$6 for nonemergency visits to a hospital-based emergency room; and

31.18 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
31.19 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
31.20 shall apply to antipsychotic drugs when used for the treatment of mental illness.

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

31.24 (1) \$6 for nonemergency visits to a hospital-based emergency room; ~~and~~

31.25 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
31.26 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
31.27 shall apply to antipsychotic drugs when used for the treatment of mental illness; ~~and~~

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

31.33 (c) Recipients of medical assistance are responsible for all co-payments in this
31.34 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 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 (CMS) 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 CMS final rule. This subdivision becomes effective when the CMS final rule, published May 29, 2007, at Federal Register, Vol. 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 an additional 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 that is reasonably expected to be returned.

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 an additional 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 that is reasonably expected to be returned.

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)**

	<u>Appropriations by Fund</u>	
	<u>2008</u>	<u>2009</u>
<u>General</u>	<u>(51,980,000)</u>	<u>(80,296,000)</u>
<u>Health Care Access</u>	<u>0</u>	<u>(3,292,000)</u>
<u>Federal TANF</u>	<u>17,125,000</u>	<u>27,323,000</u>

Subd. 2. **Agency Management**

37.1	<u>Financial Operations</u>	<u>0</u>	<u>(5,867,000)</u>
37.2	<u>The amounts that may be spent from the</u>		
37.3	<u>appropriation for each purpose are as follows:</u>		
37.4	<u>Base Adjustment.</u> <u>The general fund base</u>		
37.5	<u>is increased \$23,000 in fiscal year 2010 and</u>		
37.6	<u>\$26,000 in fiscal year 2011.</u>		
37.7	<u>Subd. 3. Revenue and Pass-Through Revenue</u>		
37.8	<u>Expenditures</u>		
37.9	<u>Federal TANF</u>	<u>25,000,000</u>	<u>27,039,000</u>
37.10	<u>Subd. 4. Children and Economic Assistance</u>		
37.11	<u>Grants</u>		
37.12	<u>The amounts that may be spent from this</u>		
37.13	<u>appropriation for each purpose are as follows:</u>		
37.14	<u>(a) MFIP/DWP Grants</u>		
37.15	<u>Appropriations by Fund</u>		
37.16	<u>General</u> (17,125,000) (25,959,000)		
37.17	<u>Federal TANF</u> 17,125,000 27,323,000		
37.18	<u>(b) MFIP Child Care Assistance Grants</u>	<u>0</u>	<u>0</u>
37.19	<u>(c) Children's Services Grants</u>	<u>(311,000)</u>	<u>(1,663,000)</u>
37.20	<u>Base Adjustment.</u> <u>The general fund base</u>		
37.21	<u>is increased \$1,726,000 in fiscal year 2010</u>		
37.22	<u>and \$1,742,000 in fiscal year 2011 due to</u>		
37.23	<u>the onetime increase in adoption assistance</u>		
37.24	<u>grants and the onetime decreases in relative</u>		
37.25	<u>custody assistance grants, and county shift</u>		
37.26	<u>for children's mental health grants.</u>		
37.27	<u>Funding Usage.</u> <u>Up to 75 percent of the</u>		
37.28	<u>fiscal year 2010 appropriation for children's</u>		
37.29	<u>mental health screening grants may be used</u>		
37.30	<u>to fund calendar year 2009 allocations for</u>		
37.31	<u>these programs, with the resulting calendar</u>		
37.32	<u>year funding pattern continuing into the</u>		
37.33	<u>future.</u>		

38.1	<u>Subd. 5. Basic Health Care Grants</u>		
38.2	<u>The amounts that may be spent from this</u>		
38.3	<u>appropriation for each purpose are as follows:</u>		
38.4	<u>(a) MinnesotaCare Grants</u>		
38.5	<u>Health Care Access</u>	<u>0</u>	<u>(3,292,000)</u>
38.6	<u>Incentive Program and Outreach Grants.</u>		
38.7	<u>Of the appropriation for the Minnesota health</u>		
38.8	<u>care outreach program in Laws 2007, chapter</u>		
38.9	<u>147, article 19, section 3, subdivision 7,</u>		
38.10	<u>paragraph (b):</u>		
38.11	<u>(1) \$400,000 in fiscal year 2009 from the</u>		
38.12	<u>general fund and \$200,000 in fiscal year 2009</u>		
38.13	<u>from the health care access fund are for the</u>		
38.14	<u>incentive program under Minnesota Statutes,</u>		
38.15	<u>section 256.962, subdivision 5. For the</u>		
38.16	<u>biennium beginning July 1, 2009, base level</u>		
38.17	<u>funding for this activity shall be \$360,000</u>		
38.18	<u>from the general fund and \$160,000 from the</u>		
38.19	<u>health care access fund; and</u>		
38.20	<u>(2) \$100,000 in fiscal year 2009 from the</u>		
38.21	<u>general fund and \$50,000 in fiscal year 2009</u>		
38.22	<u>from the health care access fund are for the</u>		
38.23	<u>outreach grants under Minnesota Statutes,</u>		
38.24	<u>section 256.962, subdivision 2. For the</u>		
38.25	<u>biennium beginning July 1, 2009, base level</u>		
38.26	<u>funding for this activity shall be \$90,000</u>		
38.27	<u>from the general fund and \$40,000 from the</u>		
38.28	<u>health care access fund.</u>		
38.29	<u>(b) MA Basic Health Care Grants - Families</u>		
38.30	<u>and Children</u>	<u>(17,985,000)</u>	<u>(24,848,000)</u>
38.31	<u>Hospital Payment Delay. Notwithstanding</u>		
38.32	<u>Laws 2005, First Special Session chapter 4,</u>		
38.33	<u>article 9, section 2, subdivision 6, payments</u>		
38.34	<u>from the Medicaid Management Information</u>		

39.1 System that would otherwise have been made
39.2 for inpatient hospital services for medical
39.3 assistance enrollees are delayed as follows:
39.4 (1) for fiscal year 2008, the last payments for
39.5 the month of June must be included in the
39.6 first payments in fiscal year 2009; and (2)
39.7 for fiscal year 2009, the last payments in the
39.8 month of June must be included in the first
39.9 payment of fiscal year 2010. The provisions
39.10 of Minnesota Statutes, section 16A.124, shall
39.11 not apply to these delayed payments.

39.12 **(c) MA Basic Health Care Grants - Elderly and**
39.13 **Disabled**

(14,028,000)

(2,254,000)

39.14 **Minnesota Disability Health Options Rate**
39.15 **Setting Methodology.** The commissioner
39.16 shall develop and implement a methodology
39.17 for risk adjusting payments for community
39.18 alternatives for disabled individuals (CADI)
39.19 and traumatic brain injury (TBI) home
39.20 and community-based waiver services
39.21 delivered under the Minnesota disability
39.22 health options program (MnDHO) effective
39.23 January 1, 2009. The commissioner shall
39.24 take into account the weighting system used
39.25 to determine county waiver allocations in
39.26 developing the new payment methodology.
39.27 Growth in the number of enrollees receiving
39.28 CADI or TBI waiver payments through
39.29 MnDHO is limited to an increase of 200
39.30 enrollees in each calendar year from January
39.31 2009 through December 2011. If those limits
39.32 are reached, additional members may be
39.33 enrolled in MnDHO for basic care services
39.34 only as defined under Minnesota Statutes,
39.35 section 256B.69, subdivision 28, and the
39.36 commissioner may establish a waiting list for

40.1	<u>future access of MnDHO members to those</u>		
40.2	<u>waiver services.</u>		
40.3	<u>Critical Access Dental Reimbursement.</u>		
40.4	<u>Effective for fiscal years beginning on or after</u>		
40.5	<u>July 1, 2009, funding for medical assistance</u>		
40.6	<u>critical access dental reimbursement rates</u>		
40.7	<u>must be paid from the health care access</u>		
40.8	<u>fund.</u>		
40.9	<u>(d) General Assistance Medical Care Grants</u>	<u>0</u>	<u>(3,729,000)</u>
40.10	<u>MinnesotaCare Outreach Grants Special</u>		
40.11	<u>Revenue Account.</u> <u>The balance in the</u>		
40.12	<u>MinnesotaCare outreach grants special</u>		
40.13	<u>revenue account at the close of fiscal year</u>		
40.14	<u>2008 must be transferred to the general fund.</u>		
40.15	<u>Subd. 6. Health Care Management</u>		
40.16	<u>The amounts that may be spent from the</u>		
40.17	<u>appropriation for each purpose are as follows:</u>		
40.18	<u>Health Care Administration</u>	<u>0</u>	<u>100,000</u>
40.19	<u>Subd. 7. Continuing Care Grants</u>		
40.20	<u>The amounts that may be spent from the</u>		
40.21	<u>appropriation for each purpose are as follows:</u>		
40.22	<u>(a) MA Long-Term Care Facilities Grants</u>	<u>(2,306,000)</u>	<u>(2,291,000)</u>
40.23	<u>(b) MA Long-Term Care Waivers and Home</u>		
40.24	<u>Care Grants</u>	<u>0</u>	<u>(5,397,000)</u>
40.25	<u>Manage Growth in TBI and CADI Waiver.</u>		
40.26	<u>During the fiscal years beginning on July</u>		
40.27	<u>1, 2008, July 1, 2009, and July 1, 2010,</u>		
40.28	<u>the commissioner shall allocate money</u>		
40.29	<u>for home and community-based programs</u>		
40.30	<u>covered under Minnesota Statutes, section</u>		
40.31	<u>256B.49, to ensure a reduction in state</u>		
40.32	<u>spending that is equivalent to limiting the</u>		
40.33	<u>caseload growth of the traumatic brain injury</u>		

41.1 (TBI) waiver to 200 allocations in each
41.2 year of the biennium and the community
41.3 alternatives for disabled individuals (CADI)
41.4 waiver to 1,500 allocations each year of the
41.5 biennium. Priorities for the allocation of
41.6 funds must be for individuals anticipated to
41.7 be discharged from institutional settings or
41.8 who are at imminent risk of a placement in
41.9 an institutional setting. Notwithstanding any
41.10 contrary section in this article, this provision
41.11 expires June 30, 2011.

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

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

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

41.19 **Payments for Substance Abuse Treatment.**
41.20 For services provided in fiscal year 2009,
41.21 county-negotiated rates and provider claims
41.22 to the consolidated chemical dependency
41.23 fund must not exceed rates charged for
41.24 services in excess of those in effect on
41.25 May 31, 2008. If statutes authorize a
41.26 cost-of-living adjustment during fiscal year
41.27 2009, then notwithstanding any law to the
41.28 contrary, fiscal year 2009 rates may not
41.29 exceed those in effect on May 31, 2008, plus
41.30 any authorized cost-of-living adjustments.

41.31 **Chemical Dependency Treatment Fund**
41.32 **Special Revenue Account.**
41.33 The lesser of the balance of the consolidated
41.34 chemical dependency treatment fund at the
41.35 close of fiscal year 2008 or \$2,500,000 must

42.1	<u>be transferred and deposited into the general</u>		
42.2	<u>fund.</u>		
42.3	<u>(e) Chemical Dependency Nonentitlement</u>		
42.4	<u>Grants</u>	<u>0</u>	<u>2,150,000</u>
42.5	<u>Base Level Adjustment.</u> <u>The general</u>		
42.6	<u>fund base for chemical dependency</u>		
42.7	<u>nonentitlement treatment grants shall be</u>		
42.8	<u>increased by \$150,000 for fiscal years</u>		
42.9	<u>2010 and 2011 for increased grants for</u>		
42.10	<u>methamphetamine treatment.</u>		
42.11	<u>American Indian Youth Program.</u> <u>Of the</u>		
42.12	<u>general fund appropriation, \$2,000,000 in</u>		
42.13	<u>fiscal year 2009 is for grants to be awarded</u>		
42.14	<u>competitively to American Indian tribes to</u>		
42.15	<u>purchase or develop one or more culturally</u>		
42.16	<u>specific treatment programs designed to</u>		
42.17	<u>serve youth from native cultures. This</u>		
42.18	<u>appropriation is onetime and available until</u>		
42.19	<u>spent.</u>		
42.20	<u>(f) Other Continuing Care Grants</u>	<u>0</u>	<u>(4,381,000)</u>
42.21	<u>Base Level Adjustment.</u> <u>The general fund</u>		
42.22	<u>base is increased \$7,633,000 in fiscal year</u>		
42.23	<u>2010 and \$5,332,000 in fiscal year 2011, due</u>		
42.24	<u>to the onetime reduction of HIV grants in</u>		
42.25	<u>fiscal year 2009, an increase each year for</u>		
42.26	<u>housing grants under Minnesota Statutes,</u>		
42.27	<u>section 256B.0658, and the adjustment</u>		
42.28	<u>for the county grant payment shift for</u>		
42.29	<u>developmental disability semi-independent</u>		
42.30	<u>services grants and developmental disability</u>		
42.31	<u>family support grants.</u>		
42.32	<u>Housing Access Grants.</u> <u>Of the general</u>		
42.33	<u>fund appropriation, \$250,000 is appropriated</u>		
42.34	<u>in fiscal year 2009 for housing access</u>		

43.1 grants under Minnesota Statutes, section
43.2 256B.0658.

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

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

43.13 **County Past Due Receivables.** The
43.14 commissioner is authorized to withhold
43.15 county federal administrative reimbursement
43.16 when the county of financial responsibility
43.17 for cost-of-care payments due to the state
43.18 under Minnesota Statutes, section 246.54
43.19 or 253B.045, is 180 days past due. The
43.20 commissioner shall deposit the federal
43.21 administrative withholding into the general
43.22 fund to settle the claims with the county of
43.23 financial responsibility.

43.24 <u>Mental Health Services</u>	(225,000)	(300,000)
--	-----------	-----------

43.25 **Sec. 3. Health Department**

43.26 **Federally Qualified Health Centers.**
43.27 Effective for fiscal years beginning on
43.28 or after July 1, 2009, the general fund
43.29 appropriation of \$1,500,000 each fiscal year
43.30 for federally qualified health centers under
43.31 Minnesota Statutes, section 145.9269, is
43.32 eliminated and is replaced by a \$1,500,000
43.33 appropriation each fiscal year from the health
43.34 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.

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

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation **\$ (105,844,000)** **\$ (51,110,000)**

	<u>2008</u>	<u>2009</u>
<u>General</u>	<u>6,739,000</u>	<u>52,350,000</u>
<u>Health Care Access</u>	<u>(84,156,000)</u>	<u>(96,019,000)</u>
<u>TANF</u>	<u>(28,427,000)</u>	<u>(7,441,000)</u>

45.1	<u>Subd. 2. Revenue and Pass-Through</u>		
45.2	<u>TANF</u>	<u>1,187,000</u>	<u>1,507,000</u>
45.3	<u>Subd. 3. Children and Economic Assistance</u>		
45.4	<u>Grants</u>		
45.5	<u>General</u>	<u>(4,960,000)</u>	<u>5,925,000</u>
45.6	<u>TANF</u>	<u>(29,614,000)</u>	<u>(8,948,000)</u>
45.7	<u>The amounts that may be spent from this</u>		
45.8	<u>appropriation for each purpose are as follows:</u>		
45.9	<u>(a) MFIP/DWP Grants</u>		
45.10	<u>Appropriations by Fund</u>		
45.11	<u>General</u>	<u>25,139,000</u>	<u>11,665,000</u>
45.12	<u>TANF</u>	<u>(29,614,000)</u>	<u>(8,948,000)</u>
45.13	<u>(b) MFIP Child Care Assistance Grants</u>	<u>(26,141,000)</u>	<u>(10,710,000)</u>
45.14	<u>(c) General Assistance Grants</u>	<u>2,529,000</u>	<u>6,033,000</u>
45.15	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>299,000</u>	<u>500,000</u>
45.16	<u>(e) Group Residential Housing Grants</u>	<u>(6,786,000)</u>	<u>(1,563,000)</u>
45.17	<u>Subd. 4. Basic Health Care Grants</u>		
45.18	<u>General</u>	<u>30,075,000</u>	<u>48,389,000</u>
45.19	<u>Health Care Access</u>	<u>(84,156,000)</u>	<u>(96,019,000)</u>
45.20	<u>The amounts that may be spent from this</u>		
45.21	<u>appropriation for each purpose are as follows:</u>		
45.22	<u>(a) MinnesotaCare</u>		
45.23	<u>Health Care Access</u>	<u>(84,156,000)</u>	<u>(96,019,000)</u>
45.24	<u>(b) MA Basic Health Care - Families and</u>		
45.25	<u>Children</u>	<u>13,525,000</u>	<u>7,005,000</u>
45.26	<u>(c) MA Basic Health Care - Elderly and</u>		
45.27	<u>Disabled</u>	<u>(2,292,000)</u>	<u>5,479,000</u>
45.28	<u>(d) General Assistance Medical Care</u>	<u>18,842,000</u>	<u>35,905,000</u>
45.29	<u>Subd. 5. Continuing Care Grants</u>	<u>(18,376,000)</u>	<u>(1,964,000)</u>
45.30	<u>The amounts that may be spent from this</u>		
45.31	<u>appropriation for each purpose are as follows:</u>		

46.1	<u>(a) MA Long-Term Care Facilities</u>	<u>(10,986,000)</u>	<u>(2,148,000)</u>
46.2	<u>(b) MA Long-Term Care Waivers</u>	<u>(18,484,000)</u>	<u>(13,598,000)</u>
46.3	<u>(c) Chemical Dependency Entitlement Grants</u>	<u>11,094,000</u>	<u>13,782,000</u>