

A bill for an act

relating to state government; licensing; state health care programs; continuing care; children and family services; health reform; Department of Health; public health; assessing administrative penalties; requiring reports; making supplemental and contingent appropriations and reductions for the Departments of Health and Human Services and other health-related boards and councils; amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision; 62J.07, subdivision 2, by adding a subdivision; 62J.38; 62Q.19, subdivision 1; 62Q.76, subdivision 1; 62U.05; 119B.025, subdivision 1; 119B.09, subdivision 4; 119B.11, subdivision 1; 144.226, subdivision 3; 144.291, subdivision 2; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144E.37; 214.40, subdivision 7; 245C.27, subdivision 2; 245C.28, subdivision 3; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivision 3; 256B.04, subdivision 14; 256B.055, by adding a subdivision; 256B.056, subdivision 4; 256B.057, subdivision 9; 256B.0625, subdivisions 8, 8a, 8b, 18a, 22, 31, by adding subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644, as amended; 256B.0754, by adding a subdivision; 256B.0915, subdivision 3b; 256B.19, subdivision 1c; 256B.69, subdivisions 20, as amended, 27, by adding subdivisions; 256B.692, subdivision 1; 256B.75; 256B.76, subdivisions 2, 4, by adding a subdivision; 256D.0515; 256J.20, subdivision 3; 256J.24, subdivision 10; 256J.37, subdivision 3a; 256L.02, subdivision 3; 256L.03, subdivision 3, by adding a subdivision; 256L.05, by adding a subdivision; 256L.07, by adding a subdivision; 256L.12, subdivisions 5, 6, 9; 256L.15, subdivision 1; 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 144.0724, subdivision 11; 157.16, subdivision 3; 245C.27, subdivision 1; 252.025, subdivision 7; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969, subdivision 3a; 256B.0625, subdivisions 9, 13e; 256B.0653, subdivision 5; 256B.0911, subdivision 1a; 256B.0915, subdivision 3a; 256B.69, subdivision 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256J.425, subdivision 3; 256L.03, subdivision 5; 256L.11, subdivision 1; 327.15, subdivision 3; Laws 2005, First Special Session chapter 4, article 8, section 66, as amended; Laws 2009, chapter 79, article 3, section 18; article 5, sections 17; 18; 22; 75, subdivision 1; 78, subdivision 5; article 13, sections 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5, subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter 200, article 1, sections 12; 16; 21; article 2, section 2, subdivisions 1,

8; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 62E; 62J; 62Q; 144; 245; 254B; 256; 256B; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; Laws 2009, chapter 79, article 7, section 26, subdivision 3; Laws 2010, chapter 200, article 1, sections 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9; 18; 19.

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

ARTICLE 1

DHS LICENSING

Section 1. Minnesota Statutes 2009 Supplement, section 245C.27, subdivision 1, is amended to read:

Subdivision 1. **Fair hearing when disqualification is not ~~set aside~~ rescinded.** (a) If the commissioner does not ~~set aside~~ rescind a disqualification of an individual under section 245C.22 who is disqualified on the basis of a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245C.15; for a determination under section 626.556 or 626.557 of substantiated maltreatment that was serious or recurring under section 245C.15; or for failure to make required reports under section 626.556, subdivision 3; or 626.557, subdivision 3, pursuant to section 245C.15, subdivision 4, paragraph (b), clause (1), the individual may request a fair hearing under section 256.045, unless the disqualification is deemed conclusive under section 245C.29.

(b) The fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) Except as provided under paragraph (e), if the individual was disqualified based on a conviction of, admission to, or Alford Plea to any crimes listed in section 245C.15, subdivisions 1 to 4, or for a disqualification under section 256.98, subdivision 8, the reconsideration decision under section 245C.22 is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

(d) This subdivision does not apply to a public employee's appeal of a disqualification under section 245C.28, subdivision 3.

(e) Notwithstanding paragraph (c), if the commissioner does not set aside a disqualification of an individual who was disqualified based on both a preponderance

of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245C.29. The scope of the hearing conducted under section 256.045 with regard to the disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case, the reconsideration decision under section 245C.22 is not the final agency decision for purposes of appeal by the disqualified individual.

Sec. 2. Minnesota Statutes 2008, section 245C.27, subdivision 2, is amended to read:

Subd. 2. **Consolidated fair hearing.** (a) If an individual who is disqualified on the bases of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and requests a fair hearing under this section on the disqualification, which has not been ~~set aside~~ rescinded, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification.

(b) A fair hearing is the only administrative appeal of the final agency determination. The disqualified individual does not have the right to challenge the accuracy and completeness of data under section 13.04.

(c) This subdivision does not apply to a public employee's appeal of a disqualification under section 245C.28, subdivision 3.

Sec. 3. Minnesota Statutes 2008, section 245C.28, subdivision 3, is amended to read:

Subd. 3. **Employees of public employer.** (a) If the commissioner does not ~~set aside~~ rescind the disqualification of an individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, the individual may request a contested case hearing under chapter 14, unless the disqualification is deemed conclusive under section 245C.29. The request for a contested case hearing must be made in writing and must be postmarked and sent within 30 calendar days after the employee receives notice that the disqualification has not been ~~set aside~~ rescinded. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245C.15, the scope of the contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245C.22.

(b) If the commissioner does not ~~set aside~~ rescind a disqualification that is based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

4.1 (c) If the commissioner does not rescind a disqualification that is based on a
4.2 preponderance of evidence that the individual committed an act or acts that meet the
4.3 definition of any of the crimes listed in section 245C.15, the scope of the contested case
4.4 hearing must include the disqualification decision. In such cases, a fair hearing must
4.5 not be conducted under section 256.045.

4.6 ~~(e)~~ (d) Rules adopted under this chapter may not preclude an employee in a contested
4.7 case hearing for a disqualification from submitting evidence concerning information
4.8 gathered under this chapter.

4.9 ~~(d)~~ (e) When an individual has been disqualified from multiple licensed programs
4.10 and the disqualifications have not been ~~set aside~~ rescinded under section 245C.22, if at
4.11 least one of the disqualifications entitles the person to a contested case hearing under this
4.12 subdivision, the scope of the contested case hearing shall include all disqualifications from
4.13 licensed programs which were not ~~set aside~~ rescinded.

4.14 ~~(e)~~ (f) In determining whether the disqualification should be set aside, the
4.15 administrative law judge shall consider all of the characteristics that cause the individual
4.16 to be disqualified in order to determine whether the individual poses a risk of harm. The
4.17 administrative law judge's recommendation and the commissioner's order to set aside
4.18 a disqualification that is the subject of the hearing constitutes a determination that the
4.19 individual does not pose a risk of harm and that the individual may provide direct contact
4.20 services in the individual program specified in the set aside.

4.21 Sec. 4. Minnesota Statutes 2009 Supplement, section 256.045, subdivision 3, is
4.22 amended to read:

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

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

4.30 (2) any patient or relative aggrieved by an order of the commissioner under section
4.31 252.27;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative reconsideration is not applicable in family assessments since no determination concerning

maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the request for reconsideration must be postmarked and sent to the investigating agency within 15 calendar days of the individual's or facility's receipt of the final determination. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 15 calendar days after the individual's or facility's receipt of the final determination. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the investigating agency within 30 calendar days of the individual's receipt of the maltreatment determination and notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of education. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the Child Maltreatment Review Panel under section 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency

shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

~~(e) Effective January 1, 2002,~~ If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or the disqualification is not ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

~~(f) Effective January 1, 2002,~~ If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision, and reconsideration of a disqualification as provided under section 245C.22, shall also not be conducted when:

(1) a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 6. Minnesota Statutes 2008, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. If mailed, the request for reconsideration must be postmarked and sent to the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must

be received by the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead agency within 30 calendar days after the individual's receipt of the notice of disqualification.

(b) Except as provided under paragraphs (e) and (f), if the lead agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section 256.045, may submit to the commissioner of human services a written request for a hearing under that statute. The vulnerable adult, or an interested person acting on behalf of the vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review Panel under section 256.021 if the lead agency denies the request or fails to act upon the request, or if the vulnerable adult or interested person contests a reconsidered disposition. The lead agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the lead agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered disposition. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

(c) If, as a result of a reconsideration or review, the lead agency changes the final disposition, it shall notify the parties specified in subdivision 9c, paragraph (d).

(d) For purposes of this subdivision, "interested person acting on behalf of the vulnerable adult" means a person designated in writing by the vulnerable adult to act on behalf of the vulnerable adult, or a legal guardian or conservator or other legal representative, a proxy or health care agent appointed under chapter 145B or 145C, or an individual who is related to the vulnerable adult, as defined in section 245A.02, subdivision 13.

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and

the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, the scope of the contested case hearing must include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing must not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination under this subdivision, and reconsideration of a disqualification under section 245C.22, must not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

If the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under chapter 245C, the hearings of all

parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge.

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2008, section 144.291, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following terms have the meanings given.

(a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(b) "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

13.1 (c) "Health record" means any information, whether oral or recorded in any form or
13.2 medium, that relates to the past, present, or future physical or mental health or condition of
13.3 a patient; the provision of health care to a patient; or the past, present, or future payment
13.4 for the provision of health care to a patient.

13.5 (d) "Identifying information" means the patient's name, address, date of birth,
13.6 gender, parent's or guardian's name regardless of the age of the patient, and other
13.7 nonclinical data which can be used to uniquely identify a patient.

13.8 (e) "Individually identifiable form" means a form in which the patient is or can be
13.9 identified as the subject of the health records.

13.10 (f) "Medical emergency" means medically necessary care which is immediately
13.11 needed to preserve life, prevent serious impairment to bodily functions, organs, or parts,
13.12 or prevent placing the physical or mental health of the patient in serious jeopardy.

13.13 (g) "Patient" means a natural person who has received health care services from a
13.14 provider for treatment or examination of a medical, psychiatric, or mental condition, the
13.15 surviving spouse and parents of a deceased patient, or a person the patient appoints in
13.16 writing as a representative, including a health care agent acting according to chapter 145C,
13.17 unless the authority of the agent has been limited by the principal in the principal's health
13.18 care directive. Except for minors who have received health care services under sections
13.19 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a
13.20 person acting as a parent or guardian in the absence of a parent or guardian.

13.21 (h) "Provider" means:

13.22 (1) any person who furnishes health care services and is regulated to furnish the
13.23 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A,
13.24 151, 153, or 153A;

13.25 (2) a home care provider licensed under section 144A.46;

13.26 (3) a health care facility licensed under this chapter or chapter 144A;

13.27 (4) a physician assistant registered under chapter 147A; and

13.28 (5) an unlicensed mental health practitioner regulated under sections 148B.60 to
13.29 148B.71.

13.30 (i) "Record locator service" means an electronic index of patient identifying
13.31 information that directs providers in a health information exchange to the location of
13.32 patient health records held by providers and group purchasers.

13.33 (j) "Related health care entity" means an affiliate, as defined in section 144.6521,
13.34 subdivision 3, paragraph (b), of the provider releasing the health records, including, but
13.35 not limited to, affiliates of providers participating in a coordinated care delivery system
13.36 established under section 256D.031, subdivision 6.

14.1 Sec. 2. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
14.2 to read:

14.3 Subd. 30. **Review and evaluation of studies.** The commissioner shall review
14.4 all published studies, reports, and program evaluations completed by the Department
14.5 of Human Services, and those requested by the legislature but not completed, for state
14.6 fiscal years 2000 through 2010. For each item, the commissioner shall report the
14.7 legislature's original appropriation for that work, if any, and the actual reported cost of the
14.8 completed work by the Department of Human Services. The commissioner shall make
14.9 recommendations to the legislature about which studies, reports, and program evaluations
14.10 required by law are duplicative, unnecessary, or obsolete. The commissioner shall repeat
14.11 this review every five fiscal years.

14.12 Sec. 3. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:

14.13 **Subd. 3. Surcharge on HMOs and community integrated service networks.** (a)
14.14 Effective October 1, 1992, each health maintenance organization with a certificate of
14.15 authority issued by the commissioner of health under chapter 62D and each community
14.16 integrated service network licensed by the commissioner under chapter 62N shall pay to
14.17 the commissioner of human services a surcharge equal to six-tenths of one percent of the
14.18 total premium revenues of the health maintenance organization or community integrated
14.19 service network as reported to the commissioner of health according to the schedule in
14.20 subdivision 4.

14.21 (b) Effective June 1, 2010: (1) the surcharge under paragraph (a) is increased to 2.5
14.22 percent; and (2) each county-based purchasing plan authorized under section 256B.692
14.23 shall pay to the commissioner a surcharge equal to 2.5 percent of the total premium
14.24 revenues of the plan, as reported to the commissioner of health, according to the payment
14.25 schedule in subdivision 4.

14.26 (c) For purposes of this subdivision, total premium revenue means:

14.27 (1) premium revenue recognized on a prepaid basis from individuals and groups
14.28 for provision of a specified range of health services over a defined period of time which
14.29 is normally one month, excluding premiums paid to a health maintenance organization
14.30 or community integrated service network from the Federal Employees Health Benefit
14.31 Program;

14.32 (2) premiums from Medicare wrap-around subscribers for health benefits which
14.33 supplement Medicare coverage;

14.34 (3) Medicare revenue, as a result of an arrangement between a health maintenance
14.35 organization or a community integrated service network and the Centers for Medicare

15.1 and Medicaid Services of the federal Department of Health and Human Services, for
15.2 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
15.3 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
15.4 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
15.5 1395w-24, respectively, as they may be amended from time to time; and

15.6 (4) medical assistance revenue, as a result of an arrangement between a health
15.7 maintenance organization or community integrated service network and a Medicaid state
15.8 agency, for services to a medical assistance beneficiary.

15.9 If advance payments are made under clause (1) or (2) to the health maintenance
15.10 organization or community integrated service network for more than one reporting period,
15.11 the portion of the payment that has not yet been earned must be treated as a liability.

15.12 ~~(e)~~ (d) When a health maintenance organization or community integrated service
15.13 network merges or consolidates with or is acquired by another health maintenance
15.14 organization or community integrated service network, the surviving corporation or the
15.15 new corporation shall be responsible for the annual surcharge originally imposed on
15.16 each of the entities or corporations subject to the merger, consolidation, or acquisition,
15.17 regardless of whether one of the entities or corporations does not retain a certificate of
15.18 authority under chapter 62D or a license under chapter 62N.

15.19 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
15.20 corporation's surcharge shall be based on the revenues earned in the second previous
15.21 calendar year by all of the entities or corporations subject to the merger, consolidation,
15.22 or acquisition regardless of whether one of the entities or corporations does not retain a
15.23 certificate of authority under chapter 62D or a license under chapter 62N until the total
15.24 premium revenues of the surviving corporation include the total premium revenues of all
15.25 the merged entities as reported to the commissioner of health.

15.26 ~~(e)~~ (f) When a health maintenance organization or community integrated service
15.27 network, which is subject to liability for the surcharge under this chapter, transfers,
15.28 assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability
15.29 for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer
15.30 of the health maintenance organization or community integrated service network.

15.31 ~~(f)~~ (g) In the event a health maintenance organization or community integrated
15.32 service network converts its licensure to a different type of entity subject to liability
15.33 for the surcharge under this chapter, but survives in the same or substantially similar
15.34 form, the surviving entity remains liable for the surcharge regardless of whether one of
15.35 the entities or corporations does not retain a certificate of authority under chapter 62D
15.36 or a license under chapter 62N.

16.1 ~~(g)~~ (h) The surcharge assessed to a health maintenance organization or community
16.2 integrated service network ends when the entity ceases providing services for premiums
16.3 and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

16.4 **EFFECTIVE DATE.** This section is effective June 1, 2010.

16.5 Sec. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is
16.6 amended to read:

16.7 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
16.8 assistance program must not be submitted until the recipient is discharged. However,
16.9 the commissioner shall establish monthly interim payments for inpatient hospitals that
16.10 have individual patient lengths of stay over 30 days regardless of diagnostic category.
16.11 Except as provided in section 256.9693, medical assistance reimbursement for treatment
16.12 of mental illness shall be reimbursed based on diagnostic classifications. Individual
16.13 hospital payments established under this section and sections 256.9685, 256.9686, and
16.14 256.9695, in addition to third party and recipient liability, for discharges occurring during
16.15 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
16.16 inpatient services paid for the same period of time to the hospital. This payment limitation
16.17 shall be calculated separately for medical assistance and general assistance medical
16.18 care services. The limitation on general assistance medical care shall be effective for
16.19 admissions occurring on or after July 1, 1991. Services that have rates established under
16.20 subdivision 11 or 12, must be limited separately from other services. After consulting with
16.21 the affected hospitals, the commissioner may consider related hospitals one entity and
16.22 may merge the payment rates while maintaining separate provider numbers. The operating
16.23 and property base rates per admission or per day shall be derived from the best Medicare
16.24 and claims data available when rates are established. The commissioner shall determine
16.25 the best Medicare and claims data, taking into consideration variables of recency of the
16.26 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
16.27 The commissioner shall notify hospitals of payment rates by December 1 of the year
16.28 preceding the rate year. The rate setting data must reflect the admissions data used to
16.29 establish relative values. Base year changes from 1981 to the base year established for the
16.30 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
16.31 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
16.32 1. The commissioner may adjust base year cost, relative value, and case mix index data
16.33 to exclude the costs of services that have been discontinued by the October 1 of the year
16.34 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
16.35 that encompass portions of two or more rate years shall have payments established based

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

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

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

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

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

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

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2010, to reflect this reduction.

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

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 7.5 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2012, to reflect this reduction. Hospitals that, prior to December 31, 2007, received payment to support the training of residents from an approved graduate medical residency training program pursuant to United States Code, title 42, section 256e, are not subject to the provisions of this paragraph.

Sec. 5. Minnesota Statutes 2008, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; ~~and~~

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

- 19.1 (iii) glide-about chairs;
19.2 (iv) patient lift apparatus;
19.3 (v) wheelchairs and accessories;
19.4 (vi) oxygen administration equipment;
19.5 (vii) respiratory therapy equipment;
19.6 (viii) electronic diagnostic, therapeutic and life-support systems;
19.7 (5) nonemergency medical transportation level of need determinations, disbursement
19.8 of public transportation passes and tokens, and volunteer and recipient mileage and
19.9 parking reimbursements; ~~and~~
19.10 (6) drugs; and
19.11 (7) medical supplies.
19.12 (b) Rate changes under this chapter and chapters 256D and 256L do not affect
19.13 contract payments under this subdivision unless specifically identified.
19.14 (c) The commissioner may not utilize volume purchase through competitive bidding
19.15 and negotiation for special transportation services under the provisions of chapter 16C.

19.16 Sec. 6. Minnesota Statutes 2008, section 256B.055, is amended by adding a
19.17 subdivision to read:

19.18 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
19.19 who is over age 21 and under age 65, who is not pregnant, and who is not described in
19.20 subdivision 4, 7, or another subdivision of this section.

19.21 **EFFECTIVE DATE.** This section is effective upon federal approval and is
19.22 retroactive from April 1, 2010.

19.23 Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

19.24 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under
19.25 section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of
19.26 the federal poverty guidelines. Effective January 1, 2000, and each successive January,
19.27 recipients of supplemental security income may have an income up to the supplemental
19.28 security income standard in effect on that date.

19.29 (b) To be eligible for medical assistance, families and children may have an income
19.30 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
19.31 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
19.32 1996, shall be increased by three percent.

19.33 (c) Effective July 1, 2002, to be eligible for medical assistance, families and children
19.34 may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) In computing income to determine eligibility of persons under paragraphs (a) to (c) and (e) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Numbers 94-566, section 503; 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

(e) To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 15, may have income up to 75 percent of the federal poverty guidelines for family size.

EFFECTIVE DATE. This section is effective upon federal approval and is retroactive from April 1, 2010.

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

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services, ~~including specialized maintenance therapy.~~ Authorization by the commissioner is required to provide services to a recipient beyond any of the following onetime service thresholds: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Sec. 9. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services, ~~including specialized maintenance therapy.~~ Authorization by the commissioner is required to provide services to a recipient beyond any of the following onetime service thresholds: (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or reevaluations. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

21.1 Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to
21.2 read:

21.3 Subd. 8b. **Speech language pathology and audiology services.** Medical assistance
21.4 covers speech language pathology and related services, ~~including specialized maintenance~~
21.5 ~~therapy.~~ Authorization by the commissioner is required to provide services to a recipient
21.6 beyond any of the following onetime service thresholds: (1) 50 treatment sessions with
21.7 any combination of approved CPT codes; and (2) one evaluation. Medical assistance
21.8 covers audiology services and related services. Services provided by a person who has
21.9 been issued a temporary registration under section 148.5161 shall be reimbursed at the
21.10 same rate as services performed by a speech language pathologist or audiologist as long as
21.11 the requirements of section 148.5161, subdivision 3, are met.

21.12 Sec. 11. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
21.13 subdivision to read:

21.14 Subd. 8d. **Chiropractic services.** Payment for chiropractic services is limited to
21.15 one annual evaluation and 12 visits per year unless prior authorization of a greater number
21.16 of visits is obtained.

21.17 Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9,
21.18 is amended to read:

21.19 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

21.20 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
21.21 following services:

21.22 (1) comprehensive exams, limited to once every five years;

21.23 (2) periodic exams, limited to one per year;

21.24 (3) limited exams;

21.25 (4) bitewing x-rays, limited to one set per year;

21.26 (5) periapical x-rays;

21.27 (6) panoramic x-rays or full-mouth radiographs, limited to one every five years,

21.28 and only if provided in conjunction with a posterior extraction or scheduled outpatient
21.29 facility procedure, or as medically necessary for the diagnosis and follow-up of oral and
21.30 maxillofacial pathology and trauma. Panoramic x-rays may be taken once every two years
21.31 for patients who cannot cooperate for intraoral film due to a developmental disability or
21.32 medical condition that does not allow for intraoral film placement;

21.33 (7) prophylaxis, limited to one per year;

21.34 (8) application of fluoride varnish, limited to one per year;

- 22.1 (9) posterior fillings, all at the amalgam rate;
- 22.2 (10) anterior fillings;
- 22.3 (11) endodontics, limited to root canals on the anterior and premolars only, and
- 22.4 molar root canal therapy as deemed medically necessary for patients that are at high risk
- 22.5 of osteonecrosis from molar extractions;
- 22.6 (12) removable prostheses, each dental arch limited to one every six years; including:
- 22.7 (i) relines of full dentures once every six years per dental arch;
- 22.8 (ii) repair of acrylic bases of full dentures and acrylic partial dentures, limited to one
- 22.9 per year; and
- 22.10 (iii) adding a maximum of two denture teeth and two wrought wire clasps per year to
- 22.11 partial dentures per dental arch;
- 22.12 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
- 22.13 abscesses;
- 22.14 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~
- 22.15 (15) full-mouth ~~debridement~~ periodontal scaling and root planing, limited to one
- 22.16 every five years; and
- 22.17 (16) moderate sedation, deep sedation, and general anesthesia, limited to when
- 22.18 provided by an oral maxillofacial surgeon who is board-certified, or actively participating
- 22.19 in the American Board of Oral and Maxillofacial Surgery certification process, when
- 22.20 medically necessary to allow the surgical management of acute oral and maxillofacial
- 22.21 pathology which cannot be accomplished safely with local anesthesia alone and would
- 22.22 otherwise require operating room services.
- 22.23 (c) In addition to the services specified in paragraph (b), medical assistance
- 22.24 covers the following services for adults, if provided in an outpatient hospital setting or
- 22.25 freestanding ambulatory surgical center as part of outpatient dental surgery:
- 22.26 (1) periodontics, limited to periodontal scaling and root planing once every two
- 22.27 years;
- 22.28 (2) general anesthesia; and
- 22.29 (3) full-mouth survey once every ~~five~~ two years.
- 22.30 (d) Medical assistance covers dental services for children that are medically
- 22.31 necessary. The following guidelines apply:
- 22.32 (1) posterior fillings are paid at the amalgam rate;
- 22.33 (2) application of sealants once every five years per permanent molar; and
- 22.34 (3) application of fluoride varnish once every six months.

Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective ~~July 1, 2009~~ July 1, 2010, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~15~~ 12.5 percent or wholesale acquisition cost plus 5.0 percent, whichever is lower. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus ~~30~~ 28.12 percent or wholesale acquisition cost minus 13.76 percent, whichever is lower. Average wholesale price is defined as the price for a drug product listed as the average wholesale price in the commissioner's primary reference source. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the

drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later.

Sec. 14. Minnesota Statutes 2008, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast, \$6.50 for lunch, or \$8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed \$50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 15. Minnesota Statutes 2008, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

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

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a birth center licensed under section 144.615 by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or 70 percent of the statewide average for a facility payment rate made to a

hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(d) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 17. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to read:

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

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

(2) \$3 for eyeglasses;

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

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

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

27.1 (1) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room;

27.2 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject
27.3 to a ~~\$7~~ \$12 per month maximum for prescription drug co-payments. No co-payments shall
27.4 apply to antipsychotic drugs when used for the treatment of mental illness; and

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

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

27.12 **EFFECTIVE DATE.** The amendment to paragraph (b), clause (1), related to the
27.13 co-payment for nonemergency visits is effective January 1, 2011, and the amendment
27.14 to paragraph (b), clause (2), related to the per month maximum for prescription drug
27.15 co-payments is effective July 1, 2010.

27.16 Sec. 18. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to
27.17 read:

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

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

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

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

27.27 (c) Medical assistance reimbursement to fee-for-service providers and payments to
27.28 managed care plans shall not be increased as a result of the removal of ~~the~~ co-payments
27.29 effective on or after January 1, 2009.

27.30 Sec. 19. Minnesota Statutes 2008, section 256B.0644, as amended by Laws 2010,
27.31 chapter 200, article 1, section 6, is amended to read:

27.32 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
27.33 **PROGRAMS.**

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating

medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

~~(d) Any hospital or other provider that is participating in a coordinated care delivery system under section 256D.031, subdivision 6, or receives payments from the uncompensated care pool under section 256D.031, subdivision 8, shall not refuse to provide services to any patient enrolled in general assistance medical care regardless of the availability or the amount of payment.~~

~~(e)~~ (d) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers dispensing prescription drugs according to section 256D.03, subdivision 3.

EFFECTIVE DATE. The amendment striking the existing paragraph (d) is effective 30 days after federal approval of the amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later. The amendment to the new paragraph (d) is effective June 1, 2010.

Sec. 20. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5, is amended to read:

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

(b) Home care therapies must be:

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

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

(3) assessed by an appropriate therapist; and

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

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

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

Sec. 21. **[256B.0755] PAYMENT REFORM DEMONSTRATION PROJECT FOR SPECIAL PATIENT POPULATIONS.**

Subdivision 1. Demonstration project. (a) The commissioner of human services, in consultation with the commissioner of health, shall establish a payment reform demonstration project implementing an alternative payment system for health care providers serving an identified group of patients who are enrolled in a state health care program, and are either high utilizers of high-cost health care services or have characteristics that put them at high risk of becoming high utilizers. The purpose of the demonstration project is to implement and evaluate methods of reducing hospitalizations, emergency room use, high-cost medications and specialty services, admissions to nursing facilities, or use of long-term home and community-based services, in order to reduce the total cost of care and services for the patients.

(b) The commissioner shall give the highest priority to projects that will serve patients who have chronic medical conditions or complex medical needs that are complicated by a physical disability, serious mental illness, or serious socioeconomic factors such as poverty, homelessness, or language or cultural barriers. The commissioner shall also give the highest priority to providers or groups of providers who have the highest concentrations of patients with these characteristics.

(c) The commissioner must implement this payment reform demonstration project in a manner consistent with the payment reform initiative provided in sections 62U.02 to 62U.04.

(d) For purposes of this section, "state health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. Participation. (a) The commissioner shall request eligible providers or groups of providers to submit a proposal to participate in the demonstration project by September 1, 2010. The providers who are interested in participating shall negotiate with the commissioner to determine:

(1) the identified group of patients who are to be enrolled in the program;

(2) the services that are to be included in the total cost of care calculation;

(3) the methodology for calculating the total cost of care, which may take into consideration the impact on costs to other state or local government programs including, but not limited to, social services and income maintenance programs;

(4) the time period to be covered under the bid;

(5) the implementation of a risk adjustment mechanism to adjust for factors that are beyond the control of the provider including nonclinical factors that will affect the cost or outcomes of treatment;

(6) the payment reforms and payment methods to be used under the project, which may include but are not limited to adjustments in fee-for-service payments, payment of care coordination fees, payments for start-up and implementation costs to be recovered or repaid later in the project, payments adjusted based on a provider's proportion of patients who are enrolled in state health care programs; payments adjusted for the clinical or socioeconomic complexity of the patients served, payment incentives tied to use of inpatient and emergency room services, and periodic settle-up adjustments;

(7) methods of sharing financial risk and benefit between the commissioner and the provider or groups of providers, which may include but are not limited to stop-loss arrangements to cover high-cost outlier cases or costs that are beyond the control of the provider, and risk-sharing and benefit-sharing corridors; and

(8) performance and outcome benchmarks to be used to measure performance, achievement of cost-savings targets, and quality of care provided.

(b) A provider or group of providers may submit a proposal for a demonstration project in partnership with a health maintenance organization or county-based purchasing plan for the purposes of sharing risk, claims processing, or administration of the project, or to extend participation in the project to persons who are enrolled in prepaid health care programs.

Subd. 3. **Total cost of care agreement.** Based on negotiations, the commissioner must enter into an agreement with interested and eligible providers or groups of providers to implement projects that are designed to reduce the total cost of care for the identified patients. To the extent possible, the projects shall begin implementation on January 1, 2011, or upon federal approval, whichever is later.

Subd. 4. **Eligibility.** To be eligible to participate, providers or groups of providers must meet certification standards for health care homes established by the Department of Health and the Department of Human Services under section 256B.0751.

Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers and approvals necessary to implement this section and to obtain federal matching funds. To the extent authorized by federal law, the commissioner may waive existing fee-for-service payment rates, provider contract or performance requirements, consumer incentive policies, or other requirements in statute or rule in order to allow the providers or groups of providers to utilize alternative payment and financing methods that will appropriately fund necessary and cost-effective primary care and care coordination services; establish

appropriate incentives for prevention, health promotion, and care coordination; and
mitigate financial harm to participating providers caused by the successful reduction in
preventable hospitalization, emergency room use, and other costly services.

Subd. 6. **Cost neutrality.** The total cost, including administrative costs, of this
demonstration project must not exceed the costs that would otherwise be incurred by
the state had services to the state health care program enrollees participating in the
demonstration project been provided, as applicable for the enrollee, under fee-for-service
or through managed care or county-based purchasing plans.

Sec. 22. [256B.0757] INTENSIVE CARE MANAGEMENT PROGRAM.

Subdivision 1. **Report.** The commissioner shall review medical assistance
enrollment and by July 1, 2011, present a report to the legislature that describes the
common characteristics and costs of those enrollees age 18 and over whose annual medical
costs are greater than 95 percent of all other enrollees, using deidentified data.

Subd. 2. **Intensive care management system established.** The commissioner shall
implement, by January 1, 2012, or upon federal approval, whichever is later, a program
to provide intensive care management to medical assistance enrollees age 18 and over
currently served under fee-for-service, managed care, or county-based purchasing, whose
annual medical care costs are in the top five percent of all medical assistance enrollees.
The intensive care management program must reduce these enrollees' medical assistance
costs by at least 20 percent on average, improve quality of care through care coordination,
and provide financial incentives for providers to deliver care efficiently. The commissioner
may require medical assistance enrollees meeting the criteria specified in this subdivision
to participate in the intensive care management program, and may reassign enrollees
from existing managed care and county-based purchasing plans to those plans that are
participating in the demonstration program. The commissioner shall seek all federal
approvals and waivers necessary to implement the intensive care management program.

Subd. 3. **Request for proposals.** The commissioner of human services shall
request proposals by September 1, 2011, or upon federal approval, whichever is later,
from health care providers, managed care plans, and county-based purchasing plans to
provide intensive care management services under the requirements of subdivision 1.
Proposals submitted must:

(1) designate the medical assistance population and geographic area of the state
to be served;

(2) describe in detail the proposed intensive care management program;

33.1 (3) provide estimates of cost savings to the state and the evidence supporting these
33.2 estimates;

33.3 (4) describe the extent to which the intensive care management program is consistent
33.4 with and builds upon current state health care home, care coordination, and payment
33.5 reform initiatives; and

33.6 (5) meet quality assurance, data reporting, and other criteria specified by the
33.7 commissioner in the request for proposals.

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

33.9 Sec. 23. Minnesota Statutes 2008, section 256B.69, is amended by adding a
33.10 subdivision to read:

33.11 Subd. 5k. **Payment rate modification.** For services rendered on or after August
33.12 1, 2010, the total payment made to managed care and county-based purchasing plans
33.13 under the medical assistance program and under MinnesotaCare for families with children
33.14 shall be increased by 1.4 percent.

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

33.16 Sec. 24. Minnesota Statutes 2008, section 256B.69, is amended by adding a
33.17 subdivision to read:

33.18 Subd. 5l. **Payment reduction.** For services rendered on or after January 1, 2011,
33.19 the total payment made to managed care plans for providing covered services under
33.20 the medical assistance, general assistance medical care, and MinnesotaCare programs
33.21 is reduced by one percent from their current statutory rates. This provision excludes
33.22 payments for nursing home services, home and community-based waivers, home care
33.23 services covered under section 256B.0651, subdivision 2, payments to demonstration
33.24 projects for persons with disabilities, and mental health services added as covered benefits
33.25 after December 31, 2007.

33.26 Sec. 25. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by
33.27 Laws 2010, chapter 200, article 1, section 10, is amended to read:

33.28 Subd. 20. **Ombudsperson.** ~~(a)~~ The commissioner shall designate an ombudsperson
33.29 to advocate for persons required to enroll in prepaid health plans under this section. The
33.30 ombudsperson shall advocate for recipients enrolled in prepaid health plans through
33.31 complaint and appeal procedures and ensure that necessary medical services are provided
33.32 either by the prepaid health plan directly or by referral to appropriate social services. At

the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

~~(b) The commissioner shall designate an ombudsperson to advocate for persons enrolled in a care coordination delivery system under section 256D.031. The ombudsperson shall advocate for recipients enrolled in a care coordination delivery system through the state appeal process and assist enrollees in accessing necessary medical services through the care coordination delivery systems directly or by referral to appropriate services. At the time of enrollment in a care coordination delivery system, the local agency shall inform recipients about the ombudsperson program.~~

EFFECTIVE DATE. This section is effective 30 days after federal approval of the amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later.

Sec. 26. Minnesota Statutes 2008, section 256B.69, subdivision 27, is amended to read:

Subd. 27. **Information for persons with limited English-language proficiency.** Managed care contracts entered into under this section and ~~sections 256D.03, subdivision 4, paragraph (c), and section 256L.12~~ must require demonstration providers to provide language assistance to enrollees that ensures meaningful access to its programs and services according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2010.

Sec. 27. Minnesota Statutes 2008, section 256B.692, subdivision 1, is amended to read:

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance and ~~general assistance medical care~~ who would otherwise be required to or may elect to participate in the prepaid medical assistance or ~~prepaid general assistance medical care programs~~ according to ~~sections~~ section 256B.69 and 256D.03. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to ~~sections~~ section 256B.69, subdivisions 1 to 22, and 256D.03. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2010.

35.1 Sec. 28. Minnesota Statutes 2008, section 256B.75, is amended to read:

35.2 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

35.3 (a) For outpatient hospital facility fee payments for services rendered on or after
35.4 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
35.5 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
35.6 services for which there is a federal maximum allowable payment. Effective for services
35.7 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
35.8 facility fees and emergency room facility fees shall be increased by eight percent over the
35.9 rates in effect on December 31, 1999, except for those services for which there is a federal
35.10 maximum allowable payment. Services for which there is a federal maximum allowable
35.11 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
35.12 allowable payment. Total aggregate payment for outpatient hospital facility fee services
35.13 shall not exceed the Medicare upper limit. If it is determined that a provision of this
35.14 section conflicts with existing or future requirements of the United States government with
35.15 respect to federal financial participation in medical assistance, the federal requirements
35.16 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
35.17 avoid reduced federal financial participation resulting from rates that are in excess of
35.18 the Medicare upper limitations.

35.19 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
35.20 ambulatory surgery hospital facility fee services for critical access hospitals designated
35.21 under section 144.1483, clause (10), shall be paid on a cost-based payment system that is
35.22 based on the cost-finding methods and allowable costs of the Medicare program.

35.23 (c) Effective for services provided on or after July 1, 2003, rates that are based
35.24 on the Medicare outpatient prospective payment system shall be replaced by a budget
35.25 neutral prospective payment system that is derived using medical assistance data. The
35.26 commissioner shall provide a proposal to the 2003 legislature to define and implement
35.27 this provision.

35.28 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
35.29 before third-party liability and spenddown, made to hospitals for outpatient hospital
35.30 facility services is reduced by .5 percent from the current statutory rate.

35.31 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
35.32 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
35.33 facility services before third-party liability and spenddown, is reduced five percent from
35.34 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
35.35 excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(g) Notwithstanding any contrary provision in this section, payment for all outpatient and emergency services provided by any hospital that, prior to December 31, 2007, has received payment to support the training of residents from an approved graduate medical residency training program under United States Code, title 42, section 256e, must be paid for fiscal years 2012 and 2013 an additional \$7,000,000. Payment rates for subsequent fiscal years are as follows:

(1) 2014: 50 percent of costs;

(2) 2015: 60 percent of costs;

(3) 2016: 70 percent of costs;

(4) 2017: 80 percent of costs;

(5) 2018: 90 percent of costs; and

(6) 2019 and thereafter: 100 percent of costs.

Sec. 29. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases

except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. This reduction does not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction does not apply to federally qualified health centers, rural health centers, and Indian health services. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced by three percent over the rates in effect on June 30, 2010. This reduction does not apply to those providers and entities exempt from the reduction in paragraph (c). Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reductions in this paragraph.

(e) Effective for services rendered on or after June 1, 2010, payment rates for physician and professional services billed by physicians employed by and clinics that are owned by a nonprofit health maintenance organization shall be increased by 15 percent. Effective October 1, 2010, payments to managed care and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

Sec. 30. Minnesota Statutes 2008, section 256B.76, subdivision 2, is amended to read:

Subd. 2. Dental reimbursement. (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. For services performed by a state-operated dental clinic pursuant to a contract between the clinic and a managed care plan or a county-based purchasing plan, a supplemental payment shall be made to the clinic by the commissioner that is equal to the amount by which the amount determined under this paragraph exceeds the amount of the payments provided under the contract. Managed care plans and county-based purchasing plans participating in medical assistance must provide to the commissioner any expenditure, cost, and revenue information deemed necessary by the commissioner for purposes of obtaining federal Medicaid matching funds for cost-based reimbursement for state-operated dental clinics. Cost-based reimbursement shall be implemented in managed care contracts beginning January 1, 2011.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

Sec. 31. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists

and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the health plan companies in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner. In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:

(1) the utilization rate in the service area in which the dentist or dental clinic operates for dental services to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage;

(2) the level of services provided by the dentist or dental clinic to patients covered by medical assistance, general assistance medical care, or MinnesotaCare as their primary source of coverage; ~~and~~. The commissioner shall pay critical access dental provider payments to a dentist or dental clinic that meets any one of the following criteria:

(i) at least 40 percent of patient encounters are with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare;

(ii) the dental clinic or dental group is owned and operated by a nonprofit operation under chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare;

(iii) the dental clinic is associated with an oral health or dental education program operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system; or

(iv) the dental clinic is a state-operated dental clinic;

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within ~~the~~ a geographic service area, and to ensure that the maximum travel distance or travel time is the lesser of 60 miles or 60 minutes;

(4) whether the provider has completed the application for critical access dental provider designation by the due date, and has provided correct information;

(5) whether the dentist or dental clinic meets the quality and continuity of care criteria recommended by the dental services advisory committee and adopted by the department; and

(6) whether the dentist or dental clinic serves people in all Minnesota health care programs.

In the absence of a critical access dental provider in a service area, the commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

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

Sec. 32. Minnesota Statutes 2008, section 256B.76, is amended by adding a subdivision to read:

Subd. 4a. Designation and termination of critical access dental providers. (a) Notwithstanding the provisions in subdivision 4, the commissioner may review and not designate an individual dentist or dental clinic as a critical access dental provider under subdivision 4 or section 256L.11, subdivision 7, when the dentist or clinic:

(1) has been subject to a corrective or disciplinary action by the Board of Dentistry related to fraud or direct patient care. Designation shall not be made until the provider is no longer subject to a corrective or disciplinary action related to fraud or direct patient care; or

(2) has been subject, within the past three years, to a postinvestigation action by the commissioner of human services or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to 9505.2245. The provider shall not be considered for critical access dental designation until the January following the year in which the action has ended.

(b) The commissioner may terminate a critical access designation of an individual dentist or clinic if the dentist or clinic:

(1) becomes subject to a disciplinary or corrective action by the Board of Dentistry related to fraud or direct patient care. The provider shall not be considered for critical access designation until the January following the year in which the action has ended;

(2) becomes subject to a postinvestigation action by the commissioner of human services or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to 9505.2245;

(3) does not meet the quality and continuity of care criteria that have been recommended by the Dental Services Advisory Committee and adopted by the department;
or

(4) does not serve people in all Minnesota public health care programs.

(c) Any termination is effective on the date of notification of the:

(1) postinvestigative action;

(2) disciplinary or corrective action by the Minnesota Board of Dentistry; or

(3) determination of not meeting quality and continuity of care criteria.

41.1 The commissioner may review postinvestigative actions taken by a health plan
41.2 under contract to provide dental services to Minnesota health care program enrollees.
41.3 After an investigation conducted by the Department of Human Services surveillance unit,
41.4 the findings of the health plan may be incorporated to determine if a provider will be
41.5 designated or terminated from the program.

41.6 (d) A provider who has been terminated or not designated under this section may
41.7 appeal only through the contested hearing process as defined in section 14.02, subdivision
41.8 3, by filing with the commissioner a written request of appeal. The appeal request must
41.9 be received by the commissioner no later than 30 days after notification of termination
41.10 or nondesignation.

41.11 (e) The commissioner may make an exception to paragraphs (a) and (b) if an action
41.12 taken by the Board of Dentistry or the commissioner is the result of events not directly
41.13 related to patient care or that will not affect direct patient care to Minnesota health care
41.14 program enrollees.

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

41.16 Sec. 33. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

41.17 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

41.18 (a) Effective for services provided on or after July 1, 2009, total payments for
41.19 basic care services, shall be reduced by three percent, prior to third-party liability and
41.20 spenddown calculation. This reduction applies to physical therapy services, occupational
41.21 therapy services, and speech language pathology and related services provided on or after
41.22 July 1, 2010. Effective July 1, 2010, the commissioner shall classify physical therapy
41.23 services, occupational therapy services, and speech language pathology and related
41.24 services as basic care services. Payments made to managed care plans and county-based
41.25 purchasing plans shall be reduced for services provided on or after October 1, 2009,
41.26 to reflect this reduction.

41.27 (b) This section does not apply to physician and professional services, inpatient
41.28 hospital services, family planning services, mental health services, dental services,
41.29 prescription drugs, medical transportation, federally qualified health centers, rural health
41.30 centers, Indian health services, and Medicare cost-sharing.

41.31 Sec. 34. **[256B.767] MEDICARE PAYMENT LIMIT.**

41.32 Effective for services rendered on or after July 1, 2010, fee-for-service payment
41.33 rates for physician and professional services under section 256B.76, subdivision 1, and

42.1 basic care services subject to the rate reduction specified in section 256B.766, shall not
42.2 exceed the Medicare payment rate for the applicable service.

42.3 Sec. 35. **[256B.768] FEE-FOR-SERVICE PAYMENT INCREASE.**

42.4 Effective for services rendered on or after January 1, 2011, the commissioner shall
42.5 increase fee-for-service payment rates by seven percent for physician and professional
42.6 services under section 256B.76, subdivision 1, and basic care services subject to the rate
42.7 reduction specified in section 256B.766.

42.8 Sec. 36. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as
42.9 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

42.10 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
42.11 the general assistance medical care program shall be administered according to section
42.12 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
42.13 which shall continue to be administered under this section and funded under section
42.14 256D.031, subdivision 9, beginning June 1, 2010.

42.15 (b) Outpatient prescription drug coverage under general assistance medical care is
42.16 limited to prescription drugs that:

42.17 (1) are covered under the medical assistance program as described in section
42.18 256B.0625, subdivisions 13 and 13d; and

42.19 (2) are provided by manufacturers that have fully executed general assistance
42.20 medical care rebate agreements with the commissioner and comply with the agreements.
42.21 Outpatient prescription drug coverage under general assistance medical care must conform
42.22 to coverage under the medical assistance program according to section 256B.0625,
42.23 subdivisions 13 to ~~13g~~ 13h.

42.24 (c) Outpatient prescription drug coverage does not include drugs administered in a
42.25 clinic or other outpatient setting.

42.26 (d) For the period beginning April 1, 2010, to May 31, 2010, general assistance
42.27 medical care covers the services listed in subdivision 4.

42.28 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2010.

42.29 Sec. 37. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

42.30 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for
42.31 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
42.32 each state revenue and expenditure forecast, the commissioner must make an assessment
42.33 of the expected expenditures for the covered services for the remainder of the current

biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order, but shall not be implemented before July 1, 2014: first, stop enrollment of single adults and households without children; and second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; ~~third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program.~~ If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall ~~further limit enrollment or decrease premium subsidies~~ notify the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, and present recommendations to the chairs and commission for limiting expenditures to the estimated amount of revenue.

EFFECTIVE DATE. This section is effective upon federal approval of the amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4.

Sec. 38. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical

assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of \$10,000, unless supplemental hospital coverage has been purchased under subdivision 3c.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 39. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision to read:

Subd. 3c. Supplemental hospital coverage. (a) Effective January 1, 2011, or upon federal approval, whichever is later, the commissioner shall offer all MinnesotaCare applicants, and all enrollees during the open enrollment periods specified in paragraph (b), the opportunity to purchase at full cost, supplemental hospital coverage to cover inpatient hospital expenses in excess of the inpatient hospital annual limit established under subdivision 3. Premiums for this coverage may vary only for age and shall be collected by the commissioner using the procedures established for the sliding scale premium determined under section 256L.15.

(b) The commissioner shall notify all persons submitting applications of the option to purchase this coverage at the time of application. The commissioner shall provide persons enrolled in MinnesotaCare on the effective date of this subdivision with the opportunity to purchase this supplemental coverage during an initial open enrollment period. Following this initial open enrollment period, the commissioner shall provide all enrollees with the opportunity to purchase this supplemental coverage during an annual open enrollment period during the month of November with coverage to take effect the following January 1.

Sec. 40. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual;

(2) \$3 per prescription for adult enrollees;

(3) \$25 for eyeglasses for adult enrollees;

(4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) \$6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and \$3.50 effective January 1, 2011.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and if supplemental coverage has not been purchased under subdivision 3c, amounts which exceed the \$10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

EFFECTIVE DATE. The amendment to paragraph (e) is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 41. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Disclosure statement for inpatient hospital limit.** The commissioner shall develop, and include with MinnesotaCare application and renewal materials, a disclosure statement that contains the following or similar language: "For adults without children, and for parents and relative caretakers with family gross income that exceeds 215 percent of the federal poverty guidelines, who are not pregnant, coverage of inpatient hospital services under MinnesotaCare is subject to an annual limit of \$10,000. Enrollees subject to the limit may be responsible for inpatient hospital costs that exceed the \$10,000 annual limit."

Sec. 42. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

Subd. 9. **Firefighters; volunteer ambulance attendants.** (a) For purposes of this subdivision, "qualified individual" means:

(1) a volunteer firefighter with a department as defined in section 299N.01, subdivision 2, who has passed the probationary period; and

(2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed by the commissioner is eligible for MinnesotaCare without meeting other eligibility requirements of this chapter, but must pay premiums equal to the average expected capitation rate for adults with no children paid under section 256L.12. Individuals eligible under this subdivision shall receive coverage for the benefit set provided to adults with no children.

Sec. 43. Minnesota Statutes 2009 Supplement, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. Medical assistance rate to be used. (a) Payment to providers under sections 256L.01 to 256L.11 shall be at the same rates and conditions established for medical assistance, except as provided in subdivisions 2 to 6.

(b) Effective for services provided on or after July 1, 2009, total payments for basic care services shall be reduced by three percent, in accordance with section 256B.766.

Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(c) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(d) Effective for services provided on or after July 1, 2010, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (d). Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2010, to reflect this reduction.

Sec. 44. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance ~~or general assistance medical care~~ will remain in the same managed care plan if the managed care plan has a contract for that population. ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare ~~and general assistance medical care programs~~ program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

EFFECTIVE DATE. This section is effective retroactively from April 1, 2010.

Sec. 45. Minnesota Statutes 2008, section 256L.12, subdivision 6, is amended to read:

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in sections 256L.03, subdivision 5, and 256L.035, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit, unless supplemental hospital coverage has been purchased under subdivision 3c.

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval, whichever is later.

Sec. 46. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2003, to December 31, 2003, the commissioner shall withhold .5 percent of managed care plan payments under this section pending completion of performance targets. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year if performance targets in the contract are achieved. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(c) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved. ~~A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.~~

(d) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan payments under this section. The withheld funds must be returned no sooner than July 1, and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b) or (c).

49.1 (e) A managed care plan or a county-based purchasing plan under section 256B.692
49.2 may include as admitted assets under section 62D.044 any amount withheld under this
49.3 section.

49.4 Sec. 47. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:

49.5 Subdivision 1. **Medical assistance coverage.** The commissioner of human services
49.6 shall establish a demonstration project to provide additional medical assistance coverage
49.7 for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth
49.8 who are burdened by health disparities associated with the cumulative health impact
49.9 of toxic environmental exposures. Under this demonstration project, the additional
49.10 medical assistance coverage for this population must include, but is not limited to, home
49.11 environmental assessments for triggers of asthma, in-home asthma education on the proper
49.12 medical management of asthma by a certified asthma educator or public health nurse with
49.13 asthma management training limited to two visits per child. Coverage also includes the
49.14 following durable medical equipment: high efficiency particulate air (HEPA) cleaners,
49.15 HEPA vacuum cleaners, allergy bed and pillow encasements, high filtration filters for
49.16 forced air gas furnaces, and dehumidifiers with medical tubing to connect the appliance to
49.17 a floor drain, if the listed item is medically ~~necessary~~ useful to reduce asthma symptoms.
49.18 Provision of these items of durable medical equipment must be preceded by a home
49.19 environmental assessment for triggers of asthma and in-home asthma education on the
49.20 proper medical management of asthma by a Certified Asthma Educator or public health
49.21 nurse with asthma management training.

49.22 Sec. 48. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

49.23 Subd. 5. **Expiration.** This section, with the exception of subdivision 4, expires
49.24 ~~December 31, 2010~~ June 30, 2011. Subdivision 4 expires December 31, 2011.

49.25 Sec. 49. Laws 2010, chapter 200, article 1, section 12, subdivision 6, is amended to
49.26 read:

49.27 Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the
49.28 commissioner shall contract with hospitals or groups of hospitals that qualify under
49.29 paragraph (b) and agree to deliver services according to this subdivision. Contracting
49.30 hospitals shall develop and implement a coordinated care delivery system to provide health
49.31 care services to individuals who are eligible for general assistance medical care under this
49.32 section and who either choose to receive services through the coordinated care delivery
49.33 system or who are enrolled by the commissioner under paragraph (c). A contracting

hospital may negotiate a limit to the number of general assistance medical care enrollees it serves, but must comply with the emergency care requirements of United States Code, title 42, 1395dd (EMTALA). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

~~Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.~~

Coordinated care delivery system contracts are in effect from June 1, 2010, to December 31, 2010, or upon the effective date of the expansion of medical assistance coverage to include adults without children, whichever is later.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems that provide services within 25 miles of the individual's community of residence. The commissioner may assign an applicant or recipient to a coordinated care delivery system that provides services

51.1 within 25 miles of the individual's community of residence, if no choice is made by the
51.2 applicant or recipient. The commissioner shall consider a recipient's zip code, city of
51.3 residence, county of residence, or distance from a participating coordinated care delivery
51.4 system when determining default assignment. An applicant or recipient may decline
51.5 enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care
51.6 delivery system, the recipient must agree to receive all nonemergency services through the
51.7 coordinated care delivery system. Enrollment in a coordinated care delivery system is
51.8 for six months and may be renewed for additional six-month periods, except that initial
51.9 enrollment is for six months or until the end of a recipient's period of general assistance
51.10 medical care eligibility, whichever occurs first. A recipient who continues to meet the
51.11 eligibility requirements of this section is not eligible to enroll in MinnesotaCare during
51.12 a period of enrollment in a coordinated care delivery system. From June 1, 2010, to
51.13 November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery
51.14 system may seek services from a hospital eligible for reimbursement under the temporary
51.15 uncompensated care pool established under subdivision 8. After November 30, 2010,
51.16 services are available only through a coordinated care delivery system.

51.17 (d) A hospital must provide access to cost-effective outpatient services available
51.18 in its service area. The hospital may contract and coordinate with providers and clinics
51.19 for the delivery of services and shall contract with federally qualified health centers and
51.20 essential community providers as defined under section 62Q.19, subdivision 1, paragraph
51.21 (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a
51.22 hospital to provide services through the coordinated care delivery system, the provider
51.23 may not refuse to provide services to any recipient enrolled in the system, and payment for
51.24 services shall be negotiated with the hospital and paid by the hospital from the system's
51.25 allocation under subdivision 7.

51.26 (e) A coordinated care delivery system must:

51.27 (1) provide the covered services required under paragraph (a) to recipients enrolled
51.28 in the coordinated care delivery system, and comply with the requirements of subdivision
51.29 4, paragraphs (b) to (g);

51.30 (2) establish a process to monitor enrollment and ensure the quality of care provided;
51.31 and

51.32 (3) in cooperation with counties, coordinate the delivery of health care services with
51.33 existing homeless prevention, supportive housing, and rent subsidy programs and funding
51.34 administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

(k) If a recipient is transferred from a hospital that is not participating in a coordinated care delivery system to a hospital participating in a coordinated care delivery system, in order to receive a higher level of care, the transferring hospital remains eligible to receive any available funding through the temporary uncompensated care pool for the care initially provided at that hospital. The hospital participating in the coordinated care delivery system shall be responsible only for care provided at that hospital, and is not financially liable for the initial care provided by the transferring hospital.

Sec. 50. Laws 2010, chapter 200, article 1, section 12, subdivision 7, is amended to read:

Subd. 7. **Payments; rate setting for the hospital coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, adjusted for any limits on the number of general assistance medical care enrollees accepted by a hospital, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

~~(b)~~ (c) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

~~(c)~~ (d) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

~~(d)~~ (e) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

Sec. 51. Laws 2010, chapter 200, article 1, section 12, subdivision 8, is amended to read:

Subd. 8. **Temporary uncompensated care pool.** (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from

54.1 the pool must be distributed, within the limits of the available appropriation, to hospitals
54.2 that are not part of a coordinated care delivery system established under subdivision
54.3 6. Payments from the pool must also be distributed, within the limits of the available
54.4 appropriation, to ambulance services licensed under chapter 144E that respond to a request
54.5 for an emergency ambulance call or interfacility transfer for a general assistance medical
54.6 care enrollee, if the call or transfer originates from a location more than 25 miles from the
54.7 health care facility that receives the enrollee.

54.8 (b) Hospitals seeking reimbursement from this pool must submit an invoice to
54.9 the commissioner in a form prescribed by the commissioner for payment for services
54.10 provided to an applicant or recipient not enrolled in a coordinated care delivery system. A
54.11 payment amount, as calculated under current law, must be determined, but not paid, for
54.12 each admission of or service provided to a general assistance medical care recipient on
54.13 or after June 1, 2010, to ~~November 30~~ December 31, 2010, or until medical assistance
54.14 coverage is expanded to include adults without children, whichever is later.

54.15 (c) The aggregated payment amounts for each hospital must be calculated as a
54.16 percentage of the total calculated amount for all hospitals.

54.17 (d) Distributions from the uncompensated care pool for each hospital must be
54.18 determined by multiplying the factor in paragraph (c) by the amount of money in the
54.19 uncompensated care pool that is available for the six-month period.

54.20 (e) The commissioner shall apply for federal matching funds under section
54.21 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

54.22 (f) Outpatient prescription drugs are not eligible for payment under this subdivision.

54.23 Sec. 52. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to
54.24 read:

54.25 **EFFECTIVE DATE.** This section is effective for services rendered on or after
54.26 April 1, 2010, except that subdivision 4 is effective June 1, 2010.

54.27 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2010.

54.28 Sec. 53. Laws 2010, chapter 200, article 1, section 16, is amended to read:

54.29 Sec. 16. Minnesota Statutes 2008, section 256L.05, subdivision 3c, is amended to
54.30 read:

54.31 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
54.32 date of coverage shall be the first day of the month following termination from medical
54.33 assistance for families and individuals who are eligible for MinnesotaCare and who

submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at six-month renewal.

55.8 **EFFECTIVE DATE.** This section is effective June 1, 2010.

55.9 Sec. 54. Laws 2010, chapter 200, article 1, section 21, is amended to read:

55.10 **Sec. 21. REPEALER.**

55.11 (a) Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; and 256D.03,
55.12 subdivision 9, are repealed effective April 1, 2010.

55.13 (b) Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is repealed
55.14 effective ~~April~~ June 1, 2010.

55.15 (c) Minnesota Statutes 2008, section 256B.195, subdivisions 4 and 5, are repealed
55.16 effective for federal fiscal year 2010.

55.17 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
55.18 3, are repealed effective for federal fiscal year 2010.

55.19 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
55.20 4; and 256L.17, subdivision 7, are repealed January 1, 2011.

55.21 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2010.

55.22 Sec. 55. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

55.23	Subdivision 1. Total Appropriation	\$	(7,985,000)	\$	(93,128,000)
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55.24 Appropriations by Fund

55.25	2010	2011
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55.26	General	34,807,000	118,493,000
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55.27	Health Care Access	(42,792,000)	(211,621,000)
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55.28 The amounts that may be spent for each

55.29 purpose are specified in the following

55.30 subdivisions.

55.31 Special Revenue Fund Transfers.

56.1 (1) The commissioner shall transfer the
56.2 following amounts from special revenue
56.3 fund balances to the general fund by June
56.4 30 of each respective fiscal year: \$410,000
56.5 for fiscal year 2010, and \$412,000 for fiscal
56.6 year 2011.

56.7 (2) Actual transfers made under clause (1)
56.8 must be separately identified and reported as
56.9 part of the quarterly reporting of transfers
56.10 to the chairs of the relevant senate budget
56.11 division and house of representatives finance
56.12 division.

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

56.14 Sec. 56. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

56.15 Subd. 8. **Transfers**

56.16 The commissioner must transfer \$29,538,000
56.17 in fiscal year 2010 and \$18,462,000 in fiscal
56.18 year 2011 from the health care access fund to
56.19 the general fund. This is a onetime transfer.

56.20 The commissioner must transfer \$4,800,000
56.21 from the consolidated chemical dependency
56.22 treatment fund to the general fund by June
56.23 30, 2010.

56.24 **Compulsive Gambling Special Revenue**
56.25 **Administration.** The lottery prize fund
56.26 appropriation for compulsive gambling
56.27 administration is reduced by \$6,000 for fiscal
56.28 year 2010 and \$4,000 for fiscal year 2011
56.29 ~~must be transferred from the lottery prize~~
56.30 ~~fund appropriation for compulsive gambling~~
56.31 ~~administration to the general fund by June~~
56.32 ~~30 of each respective fiscal year. These are~~
56.33 onetime reductions.

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

57.2 Sec. 57. **EARLY EXPANSION.**

57.3 All costs related to implementation of Minnesota Statutes, sections 256B.055,
57.4 subdivision 15, and 256B.056, subdivision 4, paragraph (e), shall be paid from the health
57.5 care access fund.

57.6 **EFFECTIVE DATE.** This section is effective upon federal approval and is
57.7 retroactive to April 1, 2010.

57.8 Sec. 58. **FISCAL AND ACTUARIAL ANALYSIS.**

57.9 The commissioner of human services shall offer a request for proposal and accept
57.10 bids for the completion of a complete fiscal and actuarial analysis of 2010 House File 135
57.11 and 2010 Senate File 118. The commissioner shall report this analysis to the chairs of the
57.12 health and human services finance and policy divisions in the house of representatives and
57.13 senate no later than December 15, 2010.

57.14 Sec. 59. **REPEALER; TRANSFER.**

57.15 (a) Laws 2010, chapter 200, article 1, section 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8,
57.16 and 9, are repealed.

57.17 (b) Laws 2010, chapter 200, article 1, sections 18; and 19, are repealed.

57.18 (c) Minnesota Statutes 2008, section 256D.03, subdivisions 3a, 3b, 5, 6, 7, and 8,
57.19 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, are repealed.

57.20 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective 30 days after federal
57.21 approval of the amendments in this article to Minnesota Statutes, sections 256B.055,
57.22 subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later,
57.23 and all remaining unspent appropriations for the program established by Laws 2010,
57.24 chapter 200, are transferred to the health care access fund. Paragraph (c) is effective
57.25 30 days after federal approval of the amendments in this article to Minnesota Statutes,
57.26 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011,
57.27 whichever is later.

57.28 **ARTICLE 3**

57.29 **CONTINUING CARE**

57.30 Section 1. Minnesota Statutes 2009 Supplement, section 252.27, subdivision 2a,
57.31 is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is \$4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines; and

(3) if the adjusted gross income is greater than 545 percent of federal poverty guidelines ~~and less than 675 percent of federal poverty guidelines~~, the parental contribution shall be ~~7.5~~ 12.5 percent of adjusted gross income; and

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 7.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ten percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and~~

~~(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.~~

If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be

deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 2. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

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

(1) but for excess earnings or assets, meets the definition of disabled under the supplemental security income program;

61.1 (2) is at least 16 but less than 65 years of age;
61.2 (3) meets the asset limits in paragraph (c); and
61.3 (4) ~~effective November 1, 2003~~, pays a premium and other obligations under
61.4 paragraph (e).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62.8 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
62.9 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
62.10 commissioner must reimburse the enrollee for Medicare Part B premiums under section
62.11 256B.0625, subdivision 15, paragraph (a).

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

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

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

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

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

63.1 (j) The commissioner shall notify enrollees annually beginning at least 24 months
63.2 before the person's 65th birthday of the medical assistance eligibility rules affecting
63.3 income, assets, and treatment of a spouse's income and assets that will be applied upon
63.4 reaching age 65.

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

63.6 Sec. 3. Minnesota Statutes 2009 Supplement, section 256B.0915, subdivision 3a,
63.7 is amended to read:

63.8 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
63.9 waived services to an individual elderly waiver client except for individuals described
63.10 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
63.11 mix resident class to which the elderly waiver client would be assigned under Minnesota
63.12 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
63.13 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
63.14 which the resident assessment system as described in section 256B.438 for nursing home
63.15 rate determination is implemented. Effective on the first day of the state fiscal year in
63.16 which the resident assessment system as described in section 256B.438 for nursing home
63.17 rate determination is implemented and the first day of each subsequent state fiscal year, the
63.18 monthly limit for the cost of waived services to an individual elderly waiver client shall
63.19 be the rate of the case mix resident class to which the waiver client would be assigned
63.20 under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the
63.21 previous state fiscal year, adjusted by ~~the greater of any legislatively adopted home and~~
63.22 ~~community-based services percentage rate increase or the average statewide percentage~~
63.23 ~~increase in nursing facility payment rates~~ adjustment.

63.24 (b) The monthly limit for the cost of waived services to an individual elderly
63.25 waiver client assigned to a case mix classification A under paragraph (a) with (1) no
63.26 dependencies in activities of daily living, (2) only one dependency in bathing, dressing,
63.27 grooming, or walking, or (3) a dependency score of less than three if eating is the only
63.28 dependency, shall be the lower of the case mix classification amount for case mix A as
63.29 determined under paragraph (a) or the case mix classification amount for case mix A
63.30 effective on October 1, 2008, per month for all new participants enrolled in the program
63.31 on or after July 1, 2009. This monthly limit shall be applied to all other participants who
63.32 meet this criteria at reassessment.

63.33 (c) If extended medical supplies and equipment or environmental modifications are
63.34 or will be purchased for an elderly waiver client, the costs may be prorated for up to
63.35 12 consecutive months beginning with the month of purchase. If the monthly cost of a

recipient's waived services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a) or (b).

Sec. 4. Minnesota Statutes 2008, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. Cost limits for elderly waiver applicants who reside in a nursing facility. (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waived services, a monthly conversion limit for the cost of elderly waived services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the resident currently resides, but in effect on June 30, 2010, and adjusted annually by any legislatively adopted percentage change in the elderly waiver services rates. That per diem shall be multiplied by 365 and, divided by 12, less and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate ~~may~~ must be adjusted by ~~the greater of any subsequent legislatively adopted home and community-based services percentage rate increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

65.1 (1) cost of all waived services, including ~~extended medical~~ specialized supplies
65.2 and equipment and environmental ~~modifications and~~ accessibility adaptations; and

65.3 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
65.4 by medical assistance.

65.5 Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is
65.6 amended to read:

65.7 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
65.8 commissioner may implement demonstration projects to create alternative integrated
65.9 delivery systems for acute and long-term care services to elderly persons and persons
65.10 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
65.11 coordination, improve access to quality services, and mitigate future cost increases.
65.12 The commissioner may seek federal authority to combine Medicare and Medicaid
65.13 capitation payments for the purpose of such demonstrations and may contract with
65.14 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
65.15 services shall be administered according to the terms and conditions of the federal contract
65.16 and demonstration provisions. For the purpose of administering medical assistance funds,
65.17 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
65.18 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
65.19 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
65.20 items B and C, which do not apply to persons enrolling in demonstrations under this
65.21 section. An initial open enrollment period may be provided. Persons who disenroll from
65.22 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
65.23 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
65.24 the health plan's participation is subsequently terminated for any reason, the person shall
65.25 be provided an opportunity to select a new health plan and shall have the right to change
65.26 health plans within the first 60 days of enrollment in the second health plan. Persons
65.27 required to participate in health plans under this section who fail to make a choice of
65.28 health plan shall not be randomly assigned to health plans under these demonstrations.
65.29 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
65.30 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
65.31 the commissioner may contract with managed care organizations, including counties, to
65.32 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
65.33 disabled persons only. For persons with a primary diagnosis of developmental disability,
65.34 serious and persistent mental illness, or serious emotional disturbance, the commissioner
65.35 must ensure that the county authority has approved the demonstration and contracting

design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waived services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until four years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. ~~The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during~~

~~state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs.~~ A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods for contract years starting in 2012, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract years 2010 and 2011 for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d),

including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 6. **[256.4825] REPORT REGARDING PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES.**

The Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of each year, beginning in 2012, to the chairs and ranking minority members of the legislative committees with jurisdiction over programs serving people with disabilities as provided in this section. The report must describe the existing state policies and goals for programs serving people with disabilities including, but not limited to, programs for employment, transportation, housing, education, quality assurance, consumer direction, physical and programmatic access, and health. The report must provide data and measurements to assess the extent to which the policies and goals are being met. The commissioner of human services and the commissioners of other state agencies administering programs for people with disabilities shall cooperate with the Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and provide those organizations with existing published information and reports that will assist in the preparation of the report.

Sec. 7. **CASE MANAGEMENT REFORM.**

(a) By February 1, 2011, the commissioner of human services shall provide specific recommendations and language for proposed legislation to:

(1) define the administrative and the service functions of case management and make changes to improve the funding for administrative functions;

(2) standardize and simplify processes, standards, and timelines for administrative functions of case management within the Department of Human Services, Disability Services Division, including eligibility determinations, resource allocation, management of dollars, provision for assignment of one case manager at a time per person, waiting lists,

69.1 quality assurance, host county concurrence requirements, county of financial responsibility
69.2 provisions, and waiver compliance; and

69.3 (3) increase opportunities for consumer choice of case management functions
69.4 involving service coordination.

69.5 (b) In developing these recommendations, the commissioner shall consider the
69.6 recommendations of the 2007 Redesigning Case Management Services for Persons
69.7 with Disabilities report and consult with existing stakeholder groups, which include
69.8 representatives of counties, disability and senior advocacy groups, service providers, and
69.9 representatives of agencies which provide contracted case management.

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

69.11 Sec. 8. **COMMISSIONER TO SEEK FEDERAL MATCH.**

69.12 (a) The commissioner of human services shall seek federal financial participation
69.13 for eligible activity related to fiscal years 2010 and 2011 grants to Advocating Change
69.14 Together to establish a statewide self-advocacy network for persons with developmental
69.15 disabilities and for eligible activities under any future grants to the organization.

69.16 (b) The commissioner shall report to the chairs of the senate Health and Human
69.17 Services Budget Division and the house of representatives Health Care and Human
69.18 Services Finance Division by December 15, 2010, with the results of the application for
69.19 federal matching funds.

69.20 **ARTICLE 4**

69.21 **CHILDREN AND FAMILY SERVICES**

69.22 Section 1. Minnesota Statutes 2008, section 119B.025, subdivision 1, is amended to
69.23 read:

69.24 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
69.25 following at all initial child care applications using the universal application:

- 69.26 (1) identity of adults;
69.27 (2) presence of the minor child in the home, if questionable;
69.28 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
69.29 relative caretaker, or the spouses of any of the foregoing;
69.30 (4) age;
69.31 (5) immigration status, if related to eligibility;
69.32 (6) Social Security number, if given;
69.33 (7) income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change.

(c) The commissioner shall develop a redetermination form to redetermine eligibility and a change report form to report changes that minimize paperwork for the county and the participant.

(d) Families have the primary responsibility to verify information. A county must consider the family's circumstances and ability to produce verification when initiating a request for verification. If a family is unable to verify an eligibility factor, the county must request written consent from the family to obtain verification from other sources. A county may not request a specific form of verification if another is more readily available. When verification of an eligibility factor other than income is not available despite the efforts of the county and the family, the county must accept a signed statement from the family attesting to the correctness of the information if one is provided. The county must deny or end assistance to families who refuse or deliberately fail to verify information.

EFFECTIVE DATE. This section is effective October 15, 2010.

Sec. 2. Minnesota Statutes 2008, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for

the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family. Self-employment income must be calculated based on gross receipts less operating expenses. Income must be recalculated when the family's income changes, but no less often than every six months. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, income must be recalculated when the family's income changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

EFFECTIVE DATE. This section is effective October 15, 2010.

Sec. 3. Minnesota Statutes 2008, section 119B.11, subdivision 1, is amended to read:

Subdivision 1. **County contributions required.** (a) In addition to payments from basic sliding fee child care program participants, each county shall contribute from county tax or other sources a ~~fixed local match~~ maintenance of effort equal to its calendar year 1996 required county contribution reduced by the administrative funding loss that would have occurred in state fiscal year 1996 under section 119B.15, except the maintenance of effort for a county must be equal to at least 1.1 percent of the county's basic sliding fee direct services allocation for the previous calendar year and no greater than six percent of the county's basic sliding fee direct services allocation for the previous calendar year. The commissioner shall recover funds from the county as necessary to bring county expenditures into compliance with this subdivision. The commissioner may accept county contributions, including contributions above the ~~fixed local match~~ county maintenance of effort, in order to make state payments.

(b) The commissioner may accept payments from counties to:

(1) fulfill the county contribution as required under subdivision 1;

(2) pay for services authorized under this chapter beyond those paid for with federal or state funds or with the required county contributions; or

(3) pay for child care services in addition to those authorized under this chapter, as authorized under other federal, state, or local statutes or regulations.

(c) The county payments must be deposited in an account in the special revenue fund. Money in this account is appropriated to the commissioner for child care assistance

72.1 under this chapter and other applicable statutes and regulations and is in addition to other
72.2 state and federal appropriations.

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

72.4 Sec. 4. Minnesota Statutes 2008, section 256D.0515, is amended to read:

72.5 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

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

72.8 ~~(1) their gross income meets the federal Food Stamp requirements under United~~
72.9 ~~States Code, title 7, section 2014(c), and is equal to or less than 165 percent of the federal~~
72.10 ~~poverty guidelines for the same family size.~~

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

72.12 Sec. 5. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

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

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

72.28 The county agency shall count the loan value of all other vehicles and apply this
72.29 amount as if it were equity value to the asset limit described in this section. To establish the
72.30 loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide,
72.31 Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook,
72.32 or when the applicant or participant disputes the loan value listed in the guidebook as
72.33 unreasonable given the condition of the particular vehicle, the county agency may require

the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

(2) the value of life insurance policies for members of the assistance unit;

(3) one burial plot per member of an assistance unit;

(4) the value of personal property needed to produce earned income, including tools, implements, farm animals, inventory, business loans, business checking and savings accounts used at least annually and used exclusively for the operation of a self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use is to produce income and if the vehicles are essential for the self-employment business;

(5) the value of personal property not otherwise specified which is commonly used by household members in day-to-day living such as clothing, necessary household furniture, equipment, and other basic maintenance items essential for daily living;

(6) the value of real and personal property owned by a recipient of Supplemental Security Income or Minnesota supplemental aid;

(7) the value of corrective payments, but only for the month in which the payment is received and for the following month;

(8) a mobile home or other vehicle used by an applicant or participant as the applicant's or participant's home;

(9) money in a separate escrow account that is needed to pay real estate taxes or insurance and that is used for this purpose;

(10) money held in escrow to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, business insurance, property rental, property taxes, and other costs that are paid at least annually, but less often than monthly;

(11) monthly assistance payments for the current month's or short-term emergency needs under section 256J.626, subdivision 2;

(12) the value of school loans, grants, or scholarships for the period they are intended to cover;

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective October 1, 2010.

Sec. 6. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

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

EFFECTIVE DATE. This section is effective October 1, 2010.

Sec. 7. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

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

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

(1) age 60 or older;

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

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

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

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

EFFECTIVE DATE. This section is effective October 1, 2010.

Sec. 8. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is amended to read:

Subd. 3. **Hard-to-employ participants.** (a) An assistance unit subject to the time limit in section 256J.42, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) a person who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and the condition severely limits the person's ability to obtain or maintain suitable employment;

(2) a person who:

(i) has been assessed by a vocational specialist or the county agency to be unemployable for purposes of this subdivision; or

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but the condition severely limits the person's ability to obtain or

maintain suitable employment. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person: (A) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

(3) a person who is determined by a qualified professional to be learning disabled, and the condition severely limits the person's ability to obtain or maintain suitable employment. For purposes of the initial approval of a learning disability extension, the determination must have been made or confirmed within the previous 12 months. In the case of a non-English-speaking person: (i) the determination must be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; and (ii) these reports must include a statement of confidence in the results. If a rehabilitation plan for a participant extended as learning disabled is developed or approved by the county agency, the plan must be incorporated into the employment plan. However, a rehabilitation plan does not replace the requirement to develop and comply with an employment plan under section 256J.521; or

(4) a person who has been granted a family violence waiver, and who is complying with an employment plan under section 256J.521, subdivision 3.

(b) For purposes of this ~~section~~ chapter, "severely limits the person's ability to obtain or maintain suitable employment" means:

(1) that a qualified professional has determined that the person's condition prevents the person from working 20 or more hours per week; or

(2) for a person who meets the requirements of paragraph (a), clause (2), item (ii), or clause (3), a qualified professional has determined the person's condition:

(i) significantly restricts the range of employment that the person is able to perform;

or

(ii) significantly interferes with the person's ability to obtain or maintain suitable employment for 20 or more hours per week.

Sec. 9. QUALITY RATING SYSTEM TRAINING, COACHING, CONSULTATION, AND SUPPORTS.

The commissioner of human services shall direct \$500,000 in federal child care development funds used for grants under Minnesota Statutes, section 119B.21, in fiscal year 2011 for the purpose of providing statewide child care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system.

Sec. 10. CHILD CARE ASSISTANCE REDETERMINATION OF ELIGIBILITY
AND INFORMATION VERIFICATION.

ARTICLE 5

Section 1. **[62A.3075] CANCER CHEMOTHERAPY TREATMENT**
COVERAGE.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

Sec. 2. [62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.

78.1 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
78.2 paragraphs (b) to (e) have the meanings given.

78.3 (b) "Autism spectrum disorder" means the following conditions as determined by
78.4 criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of
78.5 Mental Disorders of the American Psychiatric Association:

78.6 (1) autism or autistic disorder;

78.7 (2) Asperger's syndrome; or

78.8 (3) pervasive developmental disorder - not otherwise specified.

78.9 (c) "Board-certified behavior analyst" means an individual certified by the Behavior
78.10 Analyst Certification Board as a board-certified behavior analyst.

78.11 (d) "Evidence-based," for purposes of this section only, is as described in subdivision
78.12 2, paragraph (c), clause (2).

78.13 (e) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

78.14 (f) "Manualized approach" means a self-contained volume, text, or set of
78.15 instructional media, which may include videos or compact discs, that codifies in
78.16 reasonable detail the procedures for implementing treatment.

78.17 (g) "Medical necessity" or "medically necessary care" has the meaning given in
78.18 section 62Q.53, subdivision 2.

78.19 (h) "Mental health professional" has the meaning given in section 245.4871,
78.20 subdivision 27, clauses (1) to (6).

78.21 (i) "Qualified mental health behavioral aide" means a mental health behavioral aide
78.22 as defined in section 256B.0943, subdivision 7.

78.23 (j) "Qualified mental health practitioner" means a mental health practitioner as
78.24 defined in section 245.4871, subdivision 26.

78.25 (k) "Statistically superior outcomes" means a research study in which the probability
78.26 that the results would be obtained under the null hypothesis is less than five percent.

78.27 Subd. 2. **Coverage required.** (a) For coverage requirements to apply, an individual
78.28 must have a diagnosis of autism spectrum disorder made through an evaluation of the
78.29 patient, completed within the six months prior to the start of treatment, which includes
78.30 all of the following:

78.31 (1) a complete medical and psychological evaluation performed by a licensed
78.32 physician and psychologist using empirically validated tools or tests that incorporate
78.33 measures for intellectual functioning, language development, adaptive skills, and
78.34 behavioral problems, which must include:

78.35 (i) a developmental history of the child, focusing on developmental milestones
78.36 and delays;

79.1 (ii) a family history, including whether there are other family members with an
79.2 autism spectrum disorder, developmental disability, fragile X syndrome, or tuberous
79.3 sclerosis;

79.4 (iii) a medical history, including signs of deterioration, seizure activity, brain injury,
79.5 and head circumference;

79.6 (iv) a physical examination completed within the past 12 months;

79.7 (v) an evaluation for intellectual functioning;

79.8 (vi) a lead screening for those children with a developmental disability; and

79.9 (vii) other evaluations and testing as indicated by the medical evaluation, which
79.10 may include neuropsychological testing, occupational therapy, physical therapy, family
79.11 functioning, genetic testing, imaging laboratory tests, and electrophysiological testing;

79.12 (2) a communication assessment conducted by a speech pathologist; and

79.13 (3) a comprehensive hearing test conducted by an audiologist with experience in
79.14 testing very young children.

79.15 (b) A health plan must provide coverage for the diagnosis, evaluation, assessment,
79.16 and medically necessary care of autism spectrum disorders that is evidence-based,
79.17 including but not limited to:

79.18 (1) neurodevelopmental and behavioral health treatments, instruction, and
79.19 management;

79.20 (2) applied behavior analysis and intensive early intervention services, including
79.21 service package models such as intensive early intervention behavior therapy services
79.22 and Lovaas therapy;

79.23 (3) speech therapy;

79.24 (4) occupational therapy;

79.25 (5) physical therapy; and

79.26 (6) prescription medications.

79.27 (c) Coverage required under this section shall include treatment that is in accordance
79.28 with:

79.29 (1) an individualized treatment plan prescribed by the insured's treating physician or
79.30 mental health professional as defined in this section; and

79.31 (2) medically and scientifically accepted evidence that meets the criteria of a
79.32 peer-reviewed, published study that is one of the following:

79.33 (i) a randomized study with adequate statistical power, including a sample size of
79.34 30 or more for each group, that shows statistically superior outcomes to a pill placebo
79.35 group, psychological placebo group, another treatment group, or a wait list control group,

80.1 or that is equivalent to another evidence-based treatment that meets the above standard
80.2 for the specified problem area; or

80.3 (ii) a series of at least three single-case design experiments with clear specification
80.4 of the subjects and with clear specification of the treatment approach that:

80.5 (A) use robust experimental designs;

80.6 (B) show statistically superior outcomes to pill placebo, psychological placebo,
80.7 or another treatment group; and

80.8 (C) either use a manualized approach or are conducted by at least two independent
80.9 investigators or teams; or

80.10 (3) where evidence meeting the standards of this subdivision does not exist for
80.11 the treatment of a diagnosed condition or for an individual matching the demographic
80.12 characteristics for which the evidence is valid, practice guidelines based on consensus
80.13 of Minnesota health care professionals knowledgeable in the treatment of individuals
80.14 with autism spectrum disorders.

80.15 (d) Early intensive behavior therapies that meet the criteria set forth in paragraphs
80.16 (b) and (c) must also meet the following best practices standards:

80.17 (1) the services must be prescribed by a mental health professional as an appropriate
80.18 treatment option for the individual child;

80.19 (2) regular reporting of services provided and the child's progress must be submitted
80.20 to the prescribing mental health professional;

80.21 (3) care must include appropriate parent or legal guardian education and
80.22 involvement;

80.23 (4) the medically prescribed treatment and frequency of services should be
80.24 coordinated between the school and provider for all children up to age 21; and

80.25 (5) services must be provided by a mental health professional or, as appropriate, a
80.26 board-certified behavior analyst, a qualified mental health practitioner, or a qualified
80.27 mental health behavioral aide.

80.28 (e) Providers under this section must work with the commissioner in implementing
80.29 evidence-based practices and, specifically for children under age 21, the Minnesota
80.30 Evidence-Based Practice Database of research-informed practice elements and specific
80.31 constituent practices.

80.32 (f) A health plan company may not refuse to renew or reissue, or otherwise terminate
80.33 or restrict coverage of an individual solely because the individual is diagnosed with an
80.34 autism spectrum disorder.

(g) A health plan company may request an updated treatment plan only once every six months, unless the health plan company and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

Subd. 3. Supervision, delegation of duties, and observation of qualified mental health practitioner, board-certified behavior analyst, or mental health behavioral aide. A mental health professional who uses the services of a qualified mental health practitioner, board-certified behavior analyst, or qualified mental health behavioral aide for the purpose of assisting in the provision of services to patients who have autism spectrum disorder is responsible for functions performed by these service providers. The qualified mental health professional must maintain clinical supervision of services they provide and accept full responsibility for their actions. The services provided must be medically necessary and identified in the child's individual treatment plan. Service providers must document their activities in written progress notes that reflect implementation of the individual treatment plan.

Subd. 4. State health care programs. This section does not affect benefits available under the medical assistance, MinnesotaCare, and general assistance medical care programs, and the state employee group insurance plan offered under sections 43A.22 to 43A.30. These programs and the state employee group insurance plan must maintain current levels of coverage, and section 256B.0644 shall continue to apply. The commissioner shall monitor these services and report to the chairs of the house of representatives and senate standing committees that have jurisdiction over health and human services by February 1, 2011, whether there are gaps in the level of service provided by these programs and the state employee group insurance plan, and the level of service provided by private health plans following enactment of this section.

Subd. 5. No effect on other law. Nothing in this section limits in any way the coverage required under sections 62Q.47 and 62Q.53.

EFFECTIVE DATE. This section is effective August 1, 2010, and applies to coverage offered, issued, sold, renewed, or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after that date.

Sec. 3. Minnesota Statutes 2008, section 62J.38, is amended to read:

62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. Group purchasers shall submit data for the

1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data must distinguish between costs incurred for patient care and administrative costs, including amounts paid to contractors, subcontractors, and other entities for the purpose of managing provider utilization or distributing provider payments. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser

83.1 data collected under this paragraph in accordance with section 62J.321, subdivision 5.

83.2 Workers' compensation insurance plans and automobile insurance plans are exempt from
83.3 complying with this paragraph as it relates to the submission of administrative costs.

83.4 (c) The commissioner may collect information on:

83.5 (1) premiums, benefit levels, managed care procedures, and other features of health
83.6 plan companies;

83.7 (2) prices, provider experience, and other information for services less commonly
83.8 covered by insurance or for which patients commonly face significant out-of-pocket
83.9 expenses; and

83.10 (3) information on health care services not provided through health plan companies,
83.11 including information on prices, costs, expenditures, and utilization.

83.12 (d) All group purchasers shall provide the required data using a uniform format and
83.13 uniform definitions, as prescribed by the commissioner.

83.14 Sec. 4. **[62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.**

83.15 (a) A health plan must cover private duty nursing services as provided under section
83.16 256B.0625, subdivision 7, for persons who are covered under the health plan and require
83.17 private duty nursing services.

83.18 (b) For purposes of this section, a period of private duty nursing services may
83.19 be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing
83.20 requirements that apply under the health plan. Cost-sharing requirements for private duty
83.21 nursing services must not place a greater financial burden on the insured or enrollee than
83.22 those requirements applied by the health plan to other similar services or benefits.

83.23 **EFFECTIVE DATE.** This section is effective July 1, 2010, and applies to health
83.24 plans offered, sold, issued, or renewed on or after that date.

83.25 Sec. 5. Minnesota Statutes 2008, section 62Q.76, subdivision 1, is amended to read:

83.26 Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to ~~62Q.79~~ 62Q.791,
83.27 the terms ~~defined in this section~~ contract, health care provider, dental plan, dental
83.28 organization, dentist, and enrollee have the meanings given them in sections 62Q.733
83.29 and 62Q.76.

83.30 Sec. 6. **[62Q.791] CONTRACTS WITH DENTAL CARE PROVIDERS.**

83.31 (a) Notwithstanding any other provision of law, no contract of any dental
83.32 organization licensed under chapter 62C for provision of dental care services may:

(1) require, directly or indirectly, that a dentist or health care provider provide dental care services to its enrollees at a fee set by the dental organization, unless the services provided are covered dental care services for enrollees under the dental plan or contract; or

(2) prohibit, directly or indirectly, the dentist or health care provider from offering or providing dental care services that are not covered dental care services under the dental plan or contract, on terms and conditions acceptable to the enrollee and the dentist or health care provider. For purposes of this section, "covered dental care services" means dental care services that are expressly covered under the dental plan or contract, including dental care services that are subject to contractual limitations such as deductibles, co-payments, annual maximums, and waiting periods.

(b) When making payment or otherwise adjudicating any claim for dental care services provided to an enrollee, a dental organization or dental plan must clearly identify on an explanation of benefits form or other form of claim resolution the amount, if any, that is the enrollee's responsibility to pay to the enrollee's dentist or health care provider.

(c) This section does not apply to any contract for the provision of dental care services under any public program sponsored or funded by the state or federal government.

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

Sec. 7. [245.6971] ADVISORY GROUP ON STATE-OPERATED SERVICES REDESIGN.

Subdivision 1. **Establishment.** The Advisory Group on State-Operated Services Redesign is established to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency.

Subd. 2. **Duties.** The Advisory Group on State-Operated Services Redesign shall make recommendations to the commissioner and the legislature no later than December 15, 2010, on the following:

(1) transformation needed to improve service delivery and provide a continuum of care, such as transition of current facilities, closure of current facilities, or the development of new models of care;

(2) gaps and barriers to accessing quality care, system inefficiencies, and cost pressures;

(3) services that are best provided by the state and those that are best provided in the community;

(4) an implementation plan to achieve integrated service delivery across the public, private, and nonprofit sectors;

(5) an implementation plan to ensure that individuals with complex chemical and mental health needs receive the appropriate level of care to achieve recovery and wellness; and

(6) financing mechanisms that include all possible revenue sources to maximize federal funding and promote cost efficiencies and sustainability.

Subd. 3. **Membership.** The advisory group shall be composed of the following, who will serve at the pleasure of their appointing authority:

(1) the commissioner of human services or the commissioner's designee, and two additional representatives from the department;

(2) two legislators appointed by the speaker of the house, one from the minority and one from the majority;

(3) two legislators appointed by the senate rules committee, one from the minority and one from the majority;

(4) one representative appointed by AFSCME Council 5;

(5) one representative appointed by the ombudsman for mental health and developmental disabilities;

(6) one representative appointed by the Minnesota Association of Professional Employees;

(7) one representative appointed by the Minnesota Hospital Association;

(8) one representative appointed by the Minnesota Nurses Association;

(9) one representative appointed by NAMI-MN;

(10) one representative appointed by the Mental Health Association of Minnesota;

(11) one representative appointed by the Minnesota Association Of Community Mental Health Programs;

(12) one representative appointed by the Minnesota Dental Association;

(13) three clients or client family members representing different populations receiving services from state-operated services, who are appointed by the commissioner;

(14) one representative appointed by the chair of the state-operated services governing board; and

(15) one representative appointed by the Minnesota Disability Law Center.

Subd. 4. **Administration.** The commissioner shall convene the first meeting of the advisory group and shall provide administrative support and staff.

Subd. 5. **Recommendations.** The advisory group must report its recommendations to the commissioner and to the legislature no later than December 15, 2010.

86.1 Subd. 6. **Expiration.** This section expires January 31, 2011.

86.2 Sec. 8. **[245.6972] LEGISLATIVE APPROVAL REQUIRED.**

86.3 The commissioner of human services shall not redesign or move state-operated
86.4 services programs without specific legislative approval. The commissioner may proceed
86.5 with redesign at the Mankato Crisis Center and the closure of the Community Behavioral
86.6 Health Hospital in Cold Spring.

86.7 Sec. 9. Minnesota Statutes 2009 Supplement, section 252.025, subdivision 7, is
86.8 amended to read:

86.9 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
86.10 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have
86.11 developmental disabilities and exhibit severe behaviors which present a risk to public
86.12 safety. This program is statewide and must provide specialized residential services in
86.13 Cambridge and an array of community-based services with sufficient levels of care and a
86.14 sufficient number of specialists to ensure that individuals referred to the program receive
86.15 the appropriate care. The number of beds at the Cambridge facility may be reorganized
86.16 into two 16-bed facilities, one for individuals with developmental disabilities and one
86.17 for individuals with developmental disabilities and a co-occurring mental illness, with
86.18 the remaining beds converted into transitional intensive treatment foster homes. The
86.19 individuals working in the community-based services under this section are state
86.20 employees supervised by the commissioner of human services. No layoffs shall occur as a
86.21 result of restructuring under this section.

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

86.23 Sec. 10. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

86.24 Subd. 2. **American Indian.** For purposes of services provided under section
86.25 ~~254B.09, subdivision 7~~ 254B.09, subdivision 8, "American Indian" means a person who is
86.26 a member of an Indian tribe, and the commissioner shall use the definitions of "Indian"
86.27 and "Indian tribe" and "Indian organization" provided in Public Law 93-638. For purposes
86.28 of services provided under section ~~254B.09, subdivision 4~~ 254B.09, subdivision 6,
86.29 "American Indian" means a resident of federally recognized tribal lands who is recognized
86.30 as an Indian person by the federally recognized tribal governing body.

86.31 Sec. 11. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency funds appropriated for allocation treatment appropriation shall be placed in a special revenue account. The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated. ~~Six percent of the remaining money must be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The commissioner shall annually divide the money available in the chemical dependency fund that is not held in reserve by counties from a previous allocation, or allocated to the American Indian chemical dependency tribal account. Six percent of the remaining money must be reserved for the nonreservation American Indian chemical dependency allocation for treatment of American Indians by eligible vendors under section 254B.05, subdivision 1. The remainder of the money must be allocated among the counties according to the following formula, using state demographer data and other data sources determined by the commissioner:~~ in the special revenue account must be used according to the requirements in this chapter.

~~(a) For purposes of this formula, American Indians and children under age 14 are subtracted from the population of each county to determine the restricted population.~~

~~(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.~~

~~(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.~~

~~(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.~~

~~(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.~~

~~(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.~~

~~(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.~~

~~(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.~~

~~(i) \$15,000 shall be allocated to each county.~~

~~(j) The remaining funds shall be allocated proportional to the county adjusted population.~~

Sec. 12. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed the lesser of (1) five percent of the first \$50,000, four percent of the next \$50,000, and three percent of the remaining payments for services from the allocation special revenue account according to subdivision 1; or (2) the local agency administrative payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

Sec. 13. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section. ~~If all funds allocated according to section 254B.02 are exhausted by a county and the county has met or exceeded the base level of expenditures under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the costs paid by the state under this section. The commissioner may refuse to pay state funds~~

89.1 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~
89.2 ~~financially responsible for the persons has exhausted its allocation.~~

89.3 Sec. 14. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

89.4 Subd. 4. **Regional treatment centers.** Regional treatment center chemical
89.5 dependency treatment units are eligible vendors. The commissioner may expand the
89.6 capacity of chemical dependency treatment units beyond the capacity funded by direct
89.7 legislative appropriation to serve individuals who are referred for treatment by counties
89.8 and whose treatment will be paid for ~~with a county's allocation under section 254B.02 by~~
89.9 funding under this chapter or other funding sources. Notwithstanding the provisions of
89.10 sections 254B.03 to 254B.041, payment for any person committed at county request to
89.11 a regional treatment center under chapter 253B for chemical dependency treatment and
89.12 determined to be ineligible under the chemical dependency consolidated treatment fund,
89.13 shall become the responsibility of the county.

89.14 Sec. 15. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

89.15 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal
89.16 financial participation collections to ~~the reserve fund under section 254B.02, subdivision 3~~
89.17 a special revenue account. The commissioner shall ~~retain 85~~ allocate 83.86 percent of
89.18 patient payments and third-party payments to the special revenue account and ~~allocate~~
89.19 ~~the collections to the treatment allocation for the county that is financially responsible~~
89.20 ~~for the person. Fifteen 16.14~~ percent of patient and third-party payments must be paid
89.21 to the county financially responsible for the patient. ~~Collections for patient payment and~~
89.22 ~~third-party payment for services provided under section 254B.09 shall be allocated to the~~
89.23 ~~allocation of the tribal unit which placed the person. Collections of federal financial~~
89.24 ~~participation for services provided under section 254B.09 shall be allocated to the tribal~~
89.25 ~~reserve account under section 254B.09, subdivision 5.~~

89.26 Sec. 16. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

89.27 Subd. 8. **Payments to improve services to American Indians.** The commissioner
89.28 may set rates for chemical dependency services to American Indians according to the
89.29 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.
89.30 These rates shall supersede rates set in county purchase of service agreements when
89.31 payments are made on behalf of clients eligible according to Public Law 94-437.

89.32 Sec. 17. **[254B.13] PILOT PROJECTS; CHEMICAL HEALTH CARE.**

90.1 Subdivision 1. **Authorization for pilot projects.** The commissioner of human
90.2 services may approve and implement pilot projects developed under the planning process
90.3 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
90.4 enhance coordination of the delivery of chemical health services required under section
90.5 254B.03.

90.6 Subd. 2. **Program design and implementation.** (a) The commissioner of
90.7 human services and counties participating in the pilot projects shall continue to work in
90.8 partnership to refine and implement the pilot projects initiated under Laws 2009, chapter
90.9 79, article 7, section 26.

90.10 (b) The commissioner and counties participating in the pilot projects shall
90.11 complete the planning phase by June 30, 2010, and, if approved by the commissioner for
90.12 implementation, enter into agreements governing the operation of the pilot projects with
90.13 implementation scheduled no earlier than July 1, 2010.

90.14 Subd. 3. **Program evaluation.** The commissioner of human services shall evaluate
90.15 pilot projects under this section and report the results of the evaluation to the legislative
90.16 committees with jurisdiction over chemical health by June 30, 2013. Evaluation of the
90.17 pilot projects must be based on outcome evaluation criteria negotiated with the projects
90.18 prior to implementation.

90.19 Subd. 4. **Notice of project discontinuation.** Each county's participation in the
90.20 pilot project may be discontinued for any reason by the county or the commissioner of
90.21 human services after 30 days' written notice to the other party. Any unspent funds held
90.22 for the exiting county's pro rata share in the special revenue fund under the authority
90.23 in subdivision 5, paragraph (c), shall be transferred to the general fund following
90.24 discontinuation of the pilot project.

90.25 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in
90.26 this chapter, the commissioner may authorize pilot projects to use chemical dependency
90.27 treatment funds to pay for services:

90.28 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
90.29 (a); and

90.30 (2) by vendors in addition to those authorized under section 254B.05 when not
90.31 providing chemical dependency treatment services.

90.32 (b) State expenditures for chemical dependency services and any other services
90.33 provided by or through the pilot projects must not be greater than chemical dependency
90.34 treatment fund expenditures expected in the absence of the pilot projects. The
90.35 commissioner may restructure the schedule of payments between the state and participating

91.1 counties under the local agency share and division of cost provisions under section
91.2 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the pilot projects.

91.3 (c) To the extent that state fiscal year expenditures within a pilot project region are
91.4 less than expected in the absence of the pilot projects, the commissioner may deposit
91.5 these unexpended funds in the special revenue fund and make these funds available for
91.6 expenditure by the pilot counties the following year. To the extent that treatment and pilot
91.7 project ancillary services expenditures within the pilot project exceed the amount expected
91.8 in the absence of the pilot projects, the pilot counties are responsible for the portion of
91.9 nontreatment expenditures in excess of otherwise expected expenditures.

91.10 (d) The commissioner may waive administrative rule requirements which are
91.11 incompatible with the implementation of the pilot project.

91.12 (e) The commissioner shall not approve or enter into any agreement related to pilot
91.13 projects authorized under this section which puts current or future federal funding at risk.

91.14 Subd. 6. **Duties of county board.** The county board, or other county entity that is
91.15 approved to administer a pilot project, shall:

91.16 (1) administer the pilot project in a manner consistent with the objectives described
91.17 in subdivision 2 and the planning process in subdivision 5;

91.18 (2) ensure that no one is denied chemical dependency treatment services for which
91.19 they would otherwise be eligible under section 254A.03, subdivision 3; and

91.20 (3) provide the commissioner of human services with timely and pertinent
91.21 information as negotiated in agreements governing operation of the pilot projects.

91.22 Sec. 18. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
91.23 to read:

91.24 Subd. 30. **Office of Health Care Inspector General.** (a) The commissioner shall
91.25 create within the Department of Human Services an Office of Health Care Inspector
91.26 General to enhance antifraud activities and to protect the integrity of the state health care
91.27 programs, as well as the health and welfare of the beneficiaries of those programs. The
91.28 Office of Health Care Inspector General must periodically report to the commissioner and
91.29 to the legislature program and management problems and recommendations to correct
91.30 them.

91.31 (b) The duties of the Office of Health Care Inspector General include, but are not
91.32 limited to:

91.33 (1) promoting economy, efficiency, and effectiveness through the elimination of
91.34 waste, fraud, and abuse;

- 92.1 (2) conducting and supervising audits, investigations, inspections, and evaluations
92.2 relating to the state health care programs under chapters 256B, 256D, and 256L;
- 92.3 (3) identifying weaknesses giving rise to opportunities for fraud and abuse in the
92.4 state health care programs and operations and making recommendations to prevent their
92.5 recurrence;
- 92.6 (4) leading and coordinating activities to prevent and detect fraud and abuse in the
92.7 state health care programs and operations;
- 92.8 (5) detecting wrongdoers and abusers of the state health care programs and
92.9 beneficiaries so appropriate remedies may be brought;
- 92.10 (6) keeping the commissioner and the legislature fully and currently informed about
92.11 problems and deficiencies in the administration of the state health care programs and
92.12 operations and about the need for and progress of corrective action;
- 92.13 (7) operating a toll-free hotline to permit individuals to call in suspected fraud,
92.14 waste, or abuse, referring the calls for appropriate action by the agency, and analyzing the
92.15 calls to identify trends and patterns of fraud and abuse needing attention;
- 92.16 (8) developing and reviewing legislative, regulatory, and program proposals to
92.17 reduce vulnerabilities to fraud, waste, and mismanagement; and
- 92.18 (9) recommending changes in program policies, regulations, and laws to improve
92.19 efficiency and effectiveness, and to prevent fraud, waste, abuse, and mismanagement.
- 92.20 (c) Beginning July 1, 2011, the commissioner, in consultation with the Office of
92.21 Health Care Inspector General, shall annually report to the legislature and the governor
92.22 new results from the two ongoing federal Medicaid audits. The commissioner shall report
92.23 (1) the most recent Medicaid Integrity Program (MIP) audit results, with any corrective
92.24 actions needed, and (2) certify the rate of errors determined for the state health care
92.25 programs under chapters 256B, 256D, and 256L, as determined from the most recent
92.26 Payment Error Rate Measurement (PERM) audit results for Minnesota. When the PERM
92.27 audit rate for Minnesota is greater than the national rate for the year or the MIP audit
92.28 determines the need for corrective action, the commissioner shall present a plan to the
92.29 legislature and the governor for the corrective actions and reduction of the error rate
92.30 in the next calendar year.

92.31 Sec. 19. Laws 2009, chapter 79, article 3, section 18, is amended to read:

92.32 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
92.33 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
92.34 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

~~In consultation with community partners, the commissioner of human services~~ The Advisory Group on State-Operated Services Redesign shall develop and recommend an array of community-based services to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center. The community-based services may be provided in facilities with 16 or fewer beds, and must provide the appropriate level of care for the patients being admitted to the facilities. The planning for this transition must be completed by October 1, 2009 2010, with an initial report to the committee chairs of health and human services by November 30, 2009 2010, and a semiannual report on progress until the transition is completed. The commissioner of human services shall solicit interest from stakeholders and potential community partners. The individuals working in the community-based services facilities under this section are state employees supervised by the commissioner of human services. No layoffs shall occur as a result of restructuring under this section.

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

Sec. 20. **NONSUBMISSION OF HEALTH CARE CLAIM BY CLEARINGHOUSE; SIGNIFICANT DISRUPTION.**

(a) A situation shall be considered a significant disruption to normal operations that materially affects the provider's or facility's ability to conduct business in a normal manner and to submit claims on a timely basis under Minnesota Statutes, section 62Q.75, if:

(1) a clearinghouse loses, or otherwise does not submit, a health care claim as required by Minnesota Statutes, section 62J.536; and

(2) the provider or facility can substantiate that it submitted a complete claim to the clearinghouse within provisions stated in contract or six months of the date of service, whichever is less.

(b) This section expires January 1, 2012.

Sec. 21. **REPORT ON HUMAN SERVICES FISCAL NOTES.**

The commissioner of human services shall issue a report to the legislature no later than November 15, 2010, making recommendations for the establishment of a legislative budget office division for the preparation and completion of fiscal notes as required by Minnesota Statutes, section 3.98. The report must include detailed information regarding the necessary financial costs, staff resources, and data protection requirements for a legislative budget office to complete fiscal notes for the Department of Human Services. The report must describe the methods and procedures used by legislatures in other states that ensure the independence and accuracy of fiscal estimates on legislative proposals. The

94.1 report must include proposed bill language for transferring all fiscal note responsibilities
94.2 to an appropriate nonpartisan office within the legislative branch.

94.3 Sec. 22. **REPEALER.**

94.4 Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09,
94.5 subdivisions 4, 5, and 7, and Laws 2009, chapter 79, article 7, section 26, subdivision
94.6 3, are repealed.

94.7 Sec. 23. **EFFECTIVE DATE.**

94.8 Sections 10 to 14 and 22 are effective for claims paid on or after July 1, 2010.

94.9 **ARTICLE 6**

94.10 **DEPARTMENT OF HEALTH**

94.11 Section 1. Minnesota Statutes 2008, section 62D.08, is amended by adding a
94.12 subdivision to read:

94.13 **Subd. 7. Consistent administrative expenses and investment income reporting.**

94.14 (a) Every health maintenance organization must directly allocate administrative expenses
94.15 to specific lines of business or products when such information is available. Remaining
94.16 expenses that cannot be directly allocated must be allocated based on other methods, as
94.17 recommended by the Advisory Group on Administrative Expenses. Health maintenance
94.18 organizations must submit this information, including administrative expenses for dental
94.19 services, using the reporting template provided by the commissioner of health.

94.20 (b) Every health maintenance organization must allocate investment income based
94.21 on cumulative net income over time by business line or product and must submit this
94.22 information, including investment income for dental services, using the reporting template
94.23 provided by the commissioner of health.

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

94.25 Sec. 2. **[62D.31] ADVISORY GROUP ON ADMINISTRATIVE EXPENSES.**

94.26 **Subdivision 1. Establishment.** The Advisory Group on Administrative Expenses
94.27 is established to make recommendations on the development of consistent guidelines
94.28 and reporting requirements, including development of a reporting template, for health
94.29 maintenance organizations and county-based purchasers that participate in publicly
94.30 funded programs.

95.1 Subd. 2. **Membership.** The membership of the advisory group shall be comprised
95.2 of the following, who serve at the pleasure of their appointing authority:

- 95.3 (1) the commissioner of health or the commissioner's designee;
95.4 (2) the commissioner of human services or the commissioner's designee;
95.5 (3) the commissioner of commerce or the commissioner's designee; and
95.6 (4) representatives of health maintenance organizations and county-based purchasers
95.7 appointed by the commissioner of health.

95.8 Subd. 3. **Administration.** The commissioner of health shall convene the first
95.9 meeting of the advisory group by September 1, 2010, and shall provide administrative
95.10 support and staff. The commissioner of health may contract with a consultant to provide
95.11 professional assistance and expertise to the advisory group.

95.12 Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses
95.13 must report its recommendations, including any proposed legislation necessary to
95.14 implement the recommendations, to the commissioner of health and to the chairs and
95.15 ranking minority members of the legislative committees and divisions with jurisdiction
95.16 over health policy and finance by July 1, 2011.

95.17 Subd. 5. **Expiration.** This section expires after submission of the report required
95.18 under subdivision 4 or June 30, 2012, whichever is sooner.

95.19 Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is
95.20 amended to read:

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

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

95.26 (c) "Pharmaceutical electronic data intermediary" means any entity that provides
95.27 the infrastructure to connect computer systems or other electronic devices utilized
95.28 by prescribing practitioners with those used by pharmacies, health plans, third-party
95.29 administrators, and pharmacy benefit managers in order to facilitate the secure
95.30 transmission of electronic prescriptions, refill authorization requests, communications,
95.31 and other prescription-related information between such entities.

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

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

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

- (1) provide clinical decision support;
- (2) support physician order entry;
- (3) capture and query information relevant to health care quality; and
- (4) exchange electronic health information with, and integrate such information from, other sources.

Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is amended to read:

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

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

(b) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers ~~only~~ if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

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

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

(e) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

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

97.3 Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a
97.4 subdivision to read:

97.5 Subd. 6. **State agency information system.** Development of a state agency
97.6 information system necessary to implement this section is subject to the authority of the
97.7 Office of Enterprise Technology in chapter 16E, including, but not limited to:

97.8 (1) evaluation and approval of the system as specified in section 16E.03, subdivisions
97.9 3 and 4;

97.10 (2) review of the system to ensure compliance with security policies, guidelines, and
97.11 standards as specified in section 16E.03, subdivision 7; and

97.12 (3) assurance that the system complies with accessibility standards developed under
97.13 section 16E.03, subdivision 9.

97.14 Sec. 6. **[62J.498] HEALTH INFORMATION EXCHANGE.**

97.15 Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to
97.16 62J.4982:

97.17 (a) "Clinical transaction" means any meaningful use transaction that is not covered
97.18 by section 62J.536.

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

97.20 (c) "Direct health information exchange" means the electronic transmission of
97.21 health-related information through a direct connection between the electronic health
97.22 record systems of health care providers without the use of a health data intermediary.

97.23 (d) "Health care provider" or "provider" means a health care provider or provider as
97.24 defined in section 62J.03, subdivision 8.

97.25 (e) "Health data intermediary" means an entity that provides the infrastructure to
97.26 connect computer systems or other electronic devices used by health care providers,
97.27 laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit
97.28 managers to facilitate the secure transmission of health information, including
97.29 pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not
97.30 include health care providers engaged in a direct health information exchange.

97.31 (f) "Health information exchange" means the electronic transmission of
97.32 health-related information between organizations according to nationally recognized
97.33 standards.

98.1 (g) "Health information exchange service provider" means a health data intermediary
98.2 or health information organization that has been issued a certificate of authority by the
98.3 commissioner under section 62J.4981.

98.4 (h) "Health information organization" means an organization that oversees, governs,
98.5 and facilitates the exchange of health-related information among organizations according
98.6 to nationally recognized standards.

98.7 (i) "HITECH Act" means the Health Information Technology for Economic and
98.8 Clinical Health Act as defined in section 62J.495.

98.9 (j) "Major participating entity" means:

98.10 (1) a participating entity that receives compensation for services that is greater
98.11 than 30 percent of the health information organization's gross annual revenues from the
98.12 health information exchange service provider;

98.13 (2) a participating entity providing administrative, financial, or management services
98.14 to the health information organization, if the total payment for all services provided by the
98.15 participating entity exceeds three percent of the gross revenue of the health information
98.16 organization; and

98.17 (3) a participating entity that nominates or appoints 30 percent or more of the board
98.18 of directors of the health information organization.

98.19 (k) "Meaningful use" means use of certified electronic health record technology that
98.20 includes e-prescribing, and is connected in a manner that provides for the electronic
98.21 exchange of health information and used for the submission of clinical quality measures
98.22 as established by the Center for Medicare and Medicaid Services and the Minnesota
98.23 Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH
98.24 Act.

98.25 (l) "Meaningful use transaction" means an electronic transaction that a health care
98.26 provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare
98.27 penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

98.28 (m) "Participating entity" means any of the following persons, health care providers,
98.29 companies, or other organizations with which a health information organization or health
98.30 data intermediary has contracts or other agreements for the provision of health information
98.31 exchange service providers:

98.32 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home
98.33 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise
98.34 licensed under the laws of this state or registered with the commissioner;

98.35 (2) a health care provider, and any other health care professional otherwise licensed
98.36 under the laws of this state or registered with the commissioner;

99.1 (3) a group, professional corporation, or other organization that provides the
99.2 services of individuals or entities identified in clause (2), including but not limited to a
99.3 medical clinic, a medical group, a home health care agency, an urgent care center, and
99.4 an emergent care center;

99.5 (4) a health plan as defined in section 62A.011, subdivision 3; and

99.6 (5) a state agency as defined in section 13.02, subdivision 17.

99.7 (n) "Reciprocal agreement" means an arrangement in which two or more health
99.8 information exchange service providers agree to share in-kind services and resources to
99.9 allow for the pass-through of meaningful use transactions.

99.10 (o) "State-certified health data intermediary" means a health data intermediary that:

99.11 (1) provides a subset of the meaningful use transaction capabilities necessary for
99.12 hospitals and providers to achieve meaningful use of electronic health records;

99.13 (2) is not exclusively engaged in the exchange of meaningful use transactions
99.14 covered by section 62J.536; and

99.15 (3) has been issued a certificate of authority to operate in Minnesota.

99.16 (p) "State-certified health information organization" means a nonprofit health
99.17 information organization that provides transaction capabilities necessary to fully support
99.18 clinical transactions required for meaningful use of electronic health records that has been
99.19 issued a certificate of authority to operate in Minnesota.

99.20 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall
99.21 protect the public interest on matters pertaining to health information exchange. The
99.22 commissioner shall:

99.23 (1) review and act on applications from health data intermediaries and health
99.24 information organizations for certificates of authority to operate in Minnesota;

99.25 (2) provide ongoing monitoring to ensure compliance with criteria established under
99.26 sections 62J.498 to 62J.4982;

99.27 (3) respond to public complaints related to health information exchange services;

99.28 (4) take enforcement actions as necessary, including the imposition of fines,
99.29 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

99.30 (5) provide a biannual report on the status of health information exchange services
99.31 that includes but is not limited to:

99.32 (i) recommendations on actions necessary to ensure that health information exchange
99.33 services are adequate to meet the needs of Minnesota citizens and providers statewide;

99.34 (ii) recommendations on enforcement actions to ensure that health information
99.35 exchange service providers act in the public interest without causing disruption in health
99.36 information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall make all portions of the application classified as public data available to the public at least ten days in advance of the hearing. The applicant shall participate in the hearing by presenting an application overview and responding to questions from interested parties;

(2) make available all feedback and recommendations from the hearing available to the public prior to issuing a certificate of authority; and

(3) consult with hospitals, physicians, and other professionals eligible to receive meaningful use incentive payments or are subject to penalties as established in the HITECH Act, and their respective statewide associations, prior to issuing a certificate of authority.

(c)(1) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(2) The commissioner may disclose data classified as protected nonpublic or confidential under this paragraph if disclosing the data will protect the health or safety of patients.

(d) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 7. [62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. Authority to require organizations to apply. The commissioner shall require an entity providing health information exchange services to apply for a

certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information organization whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. Certificate of authority for health data intermediaries. (a) A health data intermediary that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use must be registered with the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) can interoperate with at least one state-certified health information organization;

(2) can provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;

(3) has a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and

(4) holds reciprocal agreements with at least one state-certified health information organization to enable access to record locator services to find patient data, and for the transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements established in subdivision 5.

Subd. 3. Certificate of authority for health information organizations. (a) A health information organization that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

102.1 (b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do
102.2 so may apply for a certificate of authority to establish and operate a health information
102.3 organization under this section. No person shall establish or operate a health information
102.4 organization in this state, or sell or offer to sell, or solicit offers to purchase or receive
102.5 advance or periodic consideration in conjunction with a health information organization
102.6 or health information contract unless the organization has a certificate of authority under
102.7 this section.

102.8 (c) In issuing the certificate of authority, the commissioner shall determine whether
102.9 the applicant for the certificate of authority has demonstrated that the applicant meets
102.10 the following minimum criteria:

102.11 (1) the entity is a legally established, nonprofit organization;

102.12 (2) has appropriate insurance, including liability insurance, for the operation of the
102.13 health information organization is in place and sufficient to protect the interest of the
102.14 public and participating entities;

102.15 (3) has strategic and operational plans that clearly address how the organization will
102.16 expand technical capacity of the health information organization to support providers in
102.17 achieving meaningful use of electronic health records over time;

102.18 (4) the entity addresses the parameters to be used with participating entities and
102.19 other health information organizations for meaningful use transactions, compliance with
102.20 Minnesota law, and interstate health information exchange in trust agreements;

102.21 (5) the entity's board of directors is comprised of members that broadly represent the
102.22 health information organization's participating entities and consumers;

102.23 (6) the entity maintains a professional staff responsible to the board of directors with
102.24 the capacity to ensure accountability to the organization's mission;

102.25 (7) the entity is compliant with criteria established under the Health Information
102.26 Exchange Accreditation Program of the Electronic Healthcare Network Accreditation
102.27 Commission (EHNAC) or equivalent criteria established by the commissioner;

102.28 (8) the entity maintains a record locator service as defined in section 144.291,
102.29 subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293,
102.30 subdivision 8, when conducting meaningful use transactions;

102.31 (9) the organization demonstrates interoperability with all other state-certified health
102.32 information organizations using nationally recognized standards;

102.33 (10) the organization demonstrates compliance with all privacy and security
102.34 requirements required by state and federal law; and

103.1 (11) the organization uses financial policies and procedures consistent with generally
103.2 accepted accounting principles and has an independent audit of the organization's
103.3 financials on an annual basis.

103.4 (d) Health information organizations that have obtained a certificate of authority
103.5 must:

103.6 (1) meet the requirements established for connecting to the Nationwide Health
103.7 Information Network (NHIN) within the federally mandated timeline or within a time
103.8 frame established by the commissioner and published in the State Register. If the state
103.9 timeline for implementation varies from the federal timeline, the State Register notice
103.10 shall include an explanation for the variation;

103.11 (2) annually submit strategic and operational plans for review by the commissioner
103.12 that address:

103.13 (i) increasing adoption rates to include a sufficient number of participating entities to
103.14 achieve financial sustainability; and

103.15 (ii) progress in achieving objectives included in previously submitted strategic
103.16 and operational plans across the following domains: business and technical operations,
103.17 technical infrastructure, legal and policy issues, finance, and organizational governance;

103.18 (3) develop and maintain a business plan that addresses:

103.19 (i) plans for ensuring the necessary capacity to support meaningful use transactions;

103.20 (ii) approach for attaining financial sustainability, including public and private
103.21 financing strategies, and rate structures;

103.22 (iii) rates of adoption, utilization, and transaction volume, and mechanisms to
103.23 support health information exchange; and

103.24 (iv) an explanation of methods employed to address the needs of community clinics,
103.25 critical access hospitals, and free clinics in accessing health information exchange services;

103.26 (4) annually submit a rate plan outlining fee structures for health information
103.27 exchange services for approval by the commissioner. The commissioner shall approve the
103.28 rate plan if it:

103.29 (i) distributes costs equitably among users of health information services;

103.30 (ii) provides predictable costs for participating entities;

103.31 (iii) covers all costs associated with conducting the full range of meaningful use
103.32 clinical transactions, including access to health information retrieved through other
103.33 state-certified health information exchange service providers; and

103.34 (iv) provides for a predictable revenue stream for the health information organization
103.35 and generates sufficient resources to maintain operating costs and develop technical
103.36 infrastructure necessary to serve the public interest;

104.1 (5) enter into reciprocal agreements with all other state-certified health information
104.2 organizations to enable access to record locator services to find patient data, and
104.3 transmission and receipt of meaningful use transactions consistent with the format and
104.4 content required by national standards established by Centers for Medicare and Medicaid
104.5 Services. Reciprocal agreements must meet the requirements in subdivision 5; and
104.6 (6) comply with additional requirements for the certification or recertification of
104.7 health information organizations that may be established by the commissioner.

104.8 **Subd. 4. Application for certificate of authority for health information exchange**
104.9 **service providers.** (a) Each application for a certificate of authority shall be in a form
104.10 prescribed by the commissioner and verified by an officer or authorized representative of
104.11 the applicant. Each application shall include the following:

104.12 (1) a copy of the basic organizational document, if any, of the applicant and of
104.13 each major participating entity, such as the articles of incorporation, or other applicable
104.14 documents, and all amendments to it;

104.15 (2) a list of the names, addresses, and official positions of the following:

104.16 (i) all members of the board of directors and the principal officers and, if applicable,
104.17 shareholders of the applicant organization; and

104.18 (ii) all members of the board of directors and the principal officers of each major
104.19 participating entity and, if applicable, each shareholder beneficially owning more than ten
104.20 percent of any voting stock of the major participating entity;

104.21 (3) the name and address of each participating entity and the agreed-upon duration
104.22 of each contract or agreement if applicable;

104.23 (4) a copy of each standard agreement or contract intended to bind the participating
104.24 entities and the health information organization. Contractual provisions shall be consistent
104.25 with the purposes of this section in regard to the services to be performed under the
104.26 standard agreement or contract, the manner in which payment for services is determined,
104.27 the nature and extent of responsibilities to be retained by the health information
104.28 organization, and contractual termination provisions;

104.29 (5) a copy of each contract intended to bind major participating entities and the
104.30 health information organization. Contract information filed with the commissioner under
104.31 this section shall be nonpublic as defined in section 13.02, subdivision 9;

104.32 (6) a statement generally describing the health information organization, its health
104.33 information exchange contracts, facilities, and personnel, including a statement describing
104.34 the manner in which the applicant proposes to provide participants with comprehensive
104.35 health information exchange services;

(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;

(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;

(9) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(10) a description of the complaint procedures to be used as required under this section;

(11) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(12) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(13) a copy of the conflict of interest policy that applies to all members of the board of directors and the principal officers of the health information organization; and

(14) other information as the commissioner may reasonably require to be provided.

(b) Thirty days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Ninety days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. Reciprocal agreements between health information exchange entities.

(a) Reciprocal agreements between two health information organizations or between a

health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of transactions necessary to achieve meaningful use;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use.

(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.

Subd. 6. State participation in health information exchange. A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency and necessary for meaningful use by the participating entities of the other health information service providers.

Sec. 8. [62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. Penalties and enforcement. (a) The commissioner may, for any violation of statute or rule applicable to a health information exchange service provider,

107.1 levy an administrative penalty in an amount up to \$25,000 for each violation. In
107.2 determining the level of an administrative penalty, the commissioner shall consider the
107.3 following factors:

107.4 (1) the number of participating entities affected by the violation;
107.5 (2) the effect of the violation on participating entities' access to health information
107.6 exchange services;
107.7 (3) if only one participating entity is affected, the effect of the violation on the
107.8 patients of that entity;
107.9 (4) whether the violation is an isolated incident or part of a pattern of violations;
107.10 (5) the economic benefits derived by the health information organization or a health
107.11 data intermediary by virtue of the violation;
107.12 (6) whether the violation hindered or facilitated an individual's ability to obtain
107.13 health care;
107.14 (7) whether the violation was intentional;
107.15 (8) whether the violation was beyond the direct control of the health information
107.16 exchange service provider;
107.17 (9) any history of prior compliance with the provisions of this section, including
107.18 violations;
107.19 (10) whether and to what extent the health information exchange service provider
107.20 attempted to correct previous violations;
107.21 (11) how the health information exchange service provider responded to technical
107.22 assistance from the commissioner provided in the context of a compliance effort; and
107.23 (12) the financial condition of the health information exchange service provider
107.24 including, but not limited to, whether the health information exchange service provider
107.25 had financial difficulties that affected its ability to comply or whether the imposition of an
107.26 administrative monetary penalty would jeopardize the ability of the health information
107.27 exchange service provider to continue to deliver health information exchange services.

107.28 Reasonable notice in writing shall be given to the health information exchange
107.29 service provider of the intent to levy the penalty and the reasons for them. A health
107.30 information exchange service provider may have 15 days within which to contest whether
107.31 the finding of facts constitute a violation of this section and section 62J.4981, according to
107.32 the contested case and judicial review provisions of sections 14.57 to 14.69.

107.33 (b) If the commissioner has reason to believe that a violation of this section or
107.34 section 62J.4981 has occurred or is likely, the commissioner may confer with the persons
107.35 involved before commencing action under subdivision 2. The commissioner may notify
107.36 the health information exchange service provider and the representatives, or other persons

who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information exchange service provider or a representative of a health information exchange service provider to cease and desist from engaging in any act or practice in violation of this section and section 62J.4981.

(d) Within 20 days after service of the order to cease and desist, a health information exchange service provider may contest whether the finding of facts constitutes a violation of this section and section 62J.4981 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a health data intermediary or health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information exchange service provider is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information exchange service provider is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information exchange service provider is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information exchange service provider has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information exchange service provider, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

109.1 (6) the continued operation of the health information exchange service provider
109.2 would be hazardous to its participating entities or the patients served by the participating
109.3 entities; or

109.4 (7) the health information exchange service provider has otherwise failed to
109.5 substantially comply with section 62J.4981 or with any other statute or administrative
109.6 rule applicable to health information exchange service providers, or has submitted false
109.7 information in any report required under sections 62J.498 to 62J.4982.

109.8 (b) A certificate of authority shall be suspended or revoked only after meeting the
109.9 requirements of subdivision 3.

109.10 (c) If the certificate of authority of a health information exchange service provider is
109.11 suspended, the health information exchange service provider shall not, during the period
109.12 of suspension, enroll any additional participating entities, and shall not engage in any
109.13 advertising or solicitation.

109.14 (d) If the certificate of authority of a health information exchange service provider is
109.15 revoked, the organization shall proceed, immediately following the effective date of the
109.16 order of revocation, to wind up its affairs and shall conduct no further business except as
109.17 necessary to the orderly conclusion of the affairs of the organization. The organization
109.18 shall engage in no further advertising or solicitation. The commissioner may, by written
109.19 order, permit further operation of the organization as the commissioner finds to be in the
109.20 best interest of participating entities, to the end that participating entities will be given the
109.21 greatest practical opportunity to access continuing health information exchange services.

109.22 Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a)
109.23 When the commissioner has cause to believe that grounds for the denial, suspension,
109.24 or revocation of a certificate of authority exists, the commissioner shall notify the
109.25 health information exchange service provider in writing stating the grounds for denial,
109.26 suspension, or revocation and setting a time within 20 days for a hearing on the matter.

109.27 (b) After a hearing before the commissioner at which the health information
109.28 exchange service provider may respond to the grounds for denial, suspension, or
109.29 revocation, or upon the failure of the health information exchange service provider to
109.30 appear at the hearing, the commissioner shall take action as deemed necessary and shall
109.31 issue written findings that shall be mailed to the health information exchange service
109.32 provider.

109.33 (c) If suspension, revocation, or an administrative penalty is proposed according
109.34 to this section, the commissioner must deliver, or send by certified mail with return
109.35 receipt requested, to the health information exchange service provider written notice of

110.1 the commissioner's intent to impose a penalty. This notice of proposed determination
110.2 must include:

110.3 (1) a reference to the statutory basis for the penalty;

110.4 (2) a description of the findings of fact regarding the violations with respect to
110.5 which the penalty is proposed;

110.6 (3) the nature and amount of the proposed penalty;

110.7 (4) any circumstances described in subdivision 1, paragraph (a), that were considered
110.8 in determining the amount of the proposed penalty;

110.9 (5) instructions for responding to the notice, including a statement of the health
110.10 information exchange service provider's right to a contested case proceeding and a
110.11 statement that failure to request a contested case proceeding within 30 calendar days
110.12 permits the imposition of the proposed penalty; and

110.13 (6) the address to which the contested case proceeding request must be sent.

110.14 Subd. 4. **Coordination.** (a) To the extent possible when implementing sections
110.15 62J.498 to 62J.4982, the commissioner shall seek the advice of the Minnesota e-Health
110.16 Advisory Committee, in the review and update of criteria for the certification and
110.17 recertification of health information exchange service providers.

110.18 (b) By January 1, 2011, the commissioner shall report to the governor and the
110.19 chairs of the senate and house of representatives committees having jurisdiction over
110.20 health information policy issues on the status of the health information exchange in
110.21 Minnesota and provide recommendations on further action necessary to facilitate the
110.22 secure electronic movement of health information among health providers that will enable
110.23 Minnesota providers and hospitals to meet meaningful use exchange requirements.

110.24 Subd. 5. **Fees and monetary penalties.** (a) Every health information exchange
110.25 service provider subject to this section and section 62J.4981 shall be assessed fees as
110.26 follows:

110.27 (1) filing an application for certificate of authority to operate as a health information
110.28 organization, \$10,500;

110.29 (2) filing an application for certificate of authority to operate as a health data
110.30 intermediary, \$7,000;

110.31 (3) annual health information organization certificate fee, \$14,000;

110.32 (4) annual health data intermediary certificate fee, \$7,000; and

110.33 (5) fees for other filings, as specified by rule.

110.34 (b) Administrative monetary penalties imposed under this subdivision shall be
110.35 deposited into a revolving fund and are appropriated to the commissioner for the purposes
110.36 of sections 62J.498 to 62J.4982.

111.1 Sec. 9. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

111.2 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
111.3 community providers. The criteria for essential community provider designation shall be
111.4 the following:

111.5 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
111.6 with medical care for uninsured persons and high-risk and special needs populations,
111.7 underserved, and other special needs populations; and

111.8 (2) a commitment to serve low-income and underserved populations by meeting the
111.9 following requirements:

111.10 (i) has nonprofit status in accordance with chapter 317A;

111.11 (ii) has tax exempt status in accordance with the Internal Revenue Service Code,
111.12 section 501(c)(3);

111.13 (iii) charges for services on a sliding fee schedule based on current poverty income
111.14 guidelines; and

111.15 (iv) does not restrict access or services because of a client's financial limitation;

111.16 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
111.17 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
111.18 government, an Indian health service unit, or a community health board as defined in
111.19 chapter 145A;

111.20 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
111.21 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
111.22 conditions; ~~or~~

111.23 (5) a sole community hospital. For these rural hospitals, the essential community
111.24 provider designation applies to all health services provided, including both inpatient and
111.25 outpatient services. For purposes of this section, "sole community hospital" means a
111.26 rural hospital that:

111.27 (i) is eligible to be classified as a sole community hospital according to Code
111.28 of Federal Regulations, title 42, section 412.92, or is located in a community with a
111.29 population of less than 5,000 and located more than 25 miles from a like hospital currently
111.30 providing acute short-term services;

111.31 (ii) has experienced net operating income losses in two of the previous three
111.32 most recent consecutive hospital fiscal years for which audited financial information is
111.33 available; and

111.34 (iii) consists of 40 or fewer licensed beds; or

111.35 (6) a birth center licensed under section 144.615.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Sec. 10. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. The local or state registrar shall forward this amount to the commissioner of management and budget for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of management and budget that the assets in that fund exceed \$20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of \$10 for each certified birth record. The local or state registrar shall forward this amount to the commissioner of finance for deposit in the general fund for the Minnesota Birth Defects Information System established under section 144.2215. This surcharge shall not be charged under those circumstances in which no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 11. **[144.615] BIRTH CENTERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given them.

(b) "Birth center" means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy.

(c) "CABC" means the Commission for the Accreditation of Birth Centers.

(d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be established, operated, or maintained in the state without first obtaining a license from the commissioner of health according to this section.

(b) A license issued under this section is not transferable or assignable and is subject to suspension or revocation at any time for failure to comply with this section.

(c) A birth center licensed under this section shall not assert, represent, offer, provide, or imply that the center is or may render care or services other than the services it is permitted to render within the scope of the license or the accreditation issued.

(d) The license must be conspicuously posted in an area where patients are admitted.

Subd. 3. **Temporary license.** For new birth centers planning to begin operations after January 1, 2011, the commissioner may issue a temporary license to the birth center that is valid for a period of six months from the date of issuance. The birth center must submit to the commissioner an application and applicable fee for licensure as required under subdivision 4. The application must include the information required in subdivision 4, clauses (1) to (3) and (5) to (7), and documentation that the birth center has submitted an application for accreditation to the CABC. Upon receipt of accreditation from the CABC, the birth center must submit to the commissioner the information required in subdivision 4, clause (4), and the applicable fee under subdivision 8. The commissioner shall issue a new license.

Subd. 4. **Application.** An application for a license to operate a birth center and the applicable fee under subdivision 8 must be submitted to the commissioner on a form provided by the commissioner and must contain:

(1) the name of the applicant;

(2) the site location of the birth center;

(3) the name of the person in charge of the center;

(4) documentation that the accreditation described under subdivision 6 has been issued, including the effective date and the expiration date of the accreditation, and the date of the last site visit by the CABC;

(5) the number of patients the birth center is capable of serving at a given time;

(6) the names and license numbers, if applicable, of the health care professionals on staff at the birth center; and

(7) any other information the commissioner deems necessary.

114.1 Subd. 5. **Suspension, revocation, and refusal to renew.** The commissioner may
114.2 refuse to grant or renew, or may suspend or revoke, a license on any of the grounds
114.3 described under section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or
114.4 upon the loss of accreditation by the CABC. The applicant or licensee is entitled to notice
114.5 and a hearing as described under section 144.55, subdivision 7, and a new license may be
114.6 issued after proper inspection of the birth center has been conducted.

114.7 Subd. 6. **Standards for licensure.** (a) To be eligible for licensure under this
114.8 section, a birth center must be accredited by the CABC or must obtain accreditation
114.9 within six months of the date of the application for licensure. If the birth center loses its
114.10 accreditation, the birth center must immediately notify the commissioner.

114.11 (b) The center must have procedures in place specifying criteria by which risk status
114.12 will be established and applied to each woman at admission and during labor.

114.13 (c) Upon request, the birth center shall provide the commissioner of health with any
114.14 material submitted by the birth center to the CABC as part of the accreditation process,
114.15 including the accreditation application, the self-evaluation report, the accreditation
114.16 decision letter from the CABC, and any reports from the CABC following a site visit.

114.17 Subd. 7. **Limitations of services.** (a) The following limitations apply to the services
114.18 performed at a birth center:

114.19 (1) surgical procedures must be limited to those normally accomplished during an
114.20 uncomplicated birth, including episiotomy and repair;

114.21 (2) no abortions may be administered; and

114.22 (3) no general or regional anesthesia may be administered.

114.23 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth
114.24 center if the administration of the anesthetic is performed within the scope of practice of a
114.25 health care professional.

114.26 Subd. 8. **Fees.** (a) The biennial license fee for a birth center is \$365.

114.27 (b) The temporary license fee is \$365.

114.28 (c) Fees shall be collected and deposited according to section 144.122.

114.29 Subd. 9. **Renewal.** (a) Except as provided in paragraph (b), a license issued under
114.30 this section expires two years from the date of issue.

114.31 (b) A temporary license issued under subdivision 3 expires six months from the date
114.32 of issue, and may be renewed for one additional six-month period.

114.33 (c) An application for renewal shall be submitted at least 60 days prior to expiration
114.34 of the license on forms prescribed by the commissioner of health.

114.35 Subd. 10. **Records.** All health records maintained on each client by a birth center
114.36 are subject to sections 144.292 to 144.298.

Subd. 11. **Report.** (a) The commissioner of health, in consultation with the commissioner of human services and representatives of the licensed birth centers, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Minnesota Hospital Association, and the Minnesota Ambulance Association, shall evaluate the quality of care and outcomes for services provided in licensed birth centers, including, but not limited to, the utilization of services provided at a birth center, the outcomes of care provided to both mothers and newborns, and the numbers of transfers to other health care facilities that are required and the reasons for the transfers. The commissioner shall work with the birth centers to establish a process to gather and analyze the data within protocols that protect the confidentiality of patient identification.

(b) The commissioner of health shall report the findings of the evaluation to the legislature by January 15, 2014.

Sec. 12. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

Sec. 13. Minnesota Statutes 2008, section 144.9504, is amended by adding a subdivision to read:

Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner must revise clinical and case management guidelines to include recommendations

116.1 for protective health actions and follow-up services when a child's blood lead level
116.2 exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be
116.3 implemented to the extent possible using available resources.

116.4 (b) In revising the clinical and case management guidelines for blood lead levels
116.5 greater than five micrograms of lead per deciliter of blood under this subdivision,
116.6 the commissioner of health must consult with a statewide organization representing
116.7 physicians, the public health department of Minneapolis and other public health
116.8 departments, and a nonprofit organization with expertise in lead abatement.

116.9 Sec. 14. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

116.10 Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility
116.11 which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a
116.12 facility or that part of a facility which is required to be licensed under any law of this state
116.13 which provides for the licensure of nursing homes.

116.14 Sec. 15. Minnesota Statutes 2008, section 144E.37, is amended to read:

116.15 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

116.16 The ~~board~~ commissioner of health shall establish a comprehensive advanced
116.17 life-support educational program to train rural medical personnel, including physicians,
116.18 physician assistants, nurses, and allied health care providers, in a team approach to
116.19 anticipate, recognize, and treat life-threatening emergencies before serious injury or
116.20 cardiac arrest occurs.

116.21 **EFFECTIVE DATE.** This section is effective July 1, 2010.

116.22 Sec. 16. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
116.23 **REDUCTION; REPORTING REQUIREMENTS.**

116.24 (a) Minnesota health plans and county-based purchasing plans may complete an
116.25 inventory of existing data collection and reporting requirements for health plans and
116.26 county-based purchasing plans and submit to the commissioners of health and human
116.27 services a list of data, documentation, and reports that:

116.28 (1) are collected from the same health plan or county-based purchasing plan more
116.29 than once;

116.30 (2) are collected directly from the health plan or county-based purchasing plan but
116.31 are available to the state agencies from other sources;

116.32 (3) are not currently being used by state agencies; or

(4) collect similar information more than once in different formats, at different times, or by more than one state agency.

(b) The report to the commissioners may also identify the percentage of health plan and county-based purchasing plan administrative time and expense attributed to fulfilling reporting requirements and include recommendations regarding ways to reduce duplicative reporting requirements.

(c) Upon receipt, the commissioners shall submit the inventory and recommendations to the chairs of the appropriate legislative committees, along with their comments and recommendations as to whether any action should be taken by the legislature to establish a consolidated and streamlined reporting system under which data, reports, and documentation are collected only once and only when needed for the state agencies to fulfill their duties under law and applicable regulations.

Sec. 17. **APPLICATION PROCESS FOR HEALTH INFORMATION EXCHANGE.**

To the extent that the commissioner of health applies for additional federal funding to support the commissioner's responsibilities of developing and maintaining state level health information exchange under section 3013 of the HITECH Act, the commissioner of health shall ensure that applications are made through an open process that provides health information exchange service providers equal opportunity to receive funding.

Sec. 18. **TRANSFER.**

The powers and duties of the Emergency Medical Services Regulatory Board with respect to the comprehensive advanced life-support educational program under Minnesota Statutes, section 144E.37, are transferred to the commissioner of health under Minnesota Statutes, section 15.039.

EFFECTIVE DATE. This section is effective July 1, 2010.

Sec. 19. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 144E.37, as Minnesota Statutes, section 144.6062, and make all necessary changes in statutory cross-references in Minnesota Statutes and Minnesota Rules.

EFFECTIVE DATE. This section is effective July 1, 2010.

ARTICLE 7

HEALTH CARE REFORM

Section 1. [62E.20] RELATIONSHIP TO TEMPORARY FEDERAL HIGH-RISK POOL.

Subdivision 1. Definitions. (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Association" means the Minnesota Comprehensive Health Association.

(c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, including any federal regulations adopted under it.

(d) "Federal qualified high-risk pool" means an arrangement established by the federal secretary of health and human services that meets the requirements of the federal law.

Subd. 2. Timing of this section. This section applies beginning as of the date the temporary federal qualified high risk health pool created under the federal law begins to provide coverage in this state.

Subd. 3. Maintenance of effort. The assessments made by the comprehensive health association on its member insurers must comply with the maintenance of effort requirement contained in paragraph (b), clause (3), of the federal law, to the extent that requirement applies to assessments made by the association.

Subd. 4. Coordination with federal law. Upon the date a federal qualified high-risk pool begins to provide coverage in this state, the comprehensive health association must not enroll new enrollees, notwithstanding section 62E.14 or other law to the contrary. If the lack of new enrollees would otherwise lead to noncompliance with subdivision 3, the association shall reduce the premiums to levels below those otherwise required under section 62E.08, to the extent necessary to comply with subdivision 3.

Subd. 5. Coordination with state health care programs. The commissioner of human services, in consultation with the commissioner of commerce and the Minnesota Comprehensive Health Association, shall coordinate enrollment between medical assistance, MinnesotaCare, the federal qualified high-risk pool, and the Minnesota Comprehensive Health Association, to ensure that:

(1) applicants for coverage through the federal qualified high-risk pool, or through the Minnesota Comprehensive Health Association to the extent the association is enrolling new members, are referred to the medical assistance or MinnesotaCare programs if they are determined to be potentially eligible for coverage through those programs; and

119.1 (2) applicants for coverage under medical assistance or MinnesotaCare who are
119.2 determined not to be eligible for those programs are provided information about coverage
119.3 through the federal qualified high-risk pool and the Minnesota Comprehensive Health
119.4 Association.

119.5 Sec. 2. Minnesota Statutes 2008, section 62J.07, subdivision 2, is amended to read:

119.6 Subd. 2. **Membership.** The Legislative Commission on Health Care Access
119.7 consists of ~~five~~ seven members of the senate appointed under the rules of the senate and
119.8 ~~five~~ seven members of the house of representatives appointed under the rules of the house
119.9 of representatives. The Legislative Commission on Health Care Access must include ~~three~~
119.10 five members of the majority party and two members of the minority party in each house.

119.11 Sec. 3. Minnesota Statutes 2008, section 62J.07, is amended by adding a subdivision to
119.12 read:

119.13 Subd. 5. **Federal health care reform.** (a) The Legislative Commission on
119.14 Health Care Access shall analyze options and make recommendations regarding the
119.15 implementation of provisions of the Patient Protection and Affordable Health Care Act,
119.16 Public Law 111-148, and the health care reform provisions in the Health Care and
119.17 Education Reconciliation Act of 2010, Public Law 111-152, including:

119.18 (1) development of accountable care organizations;

119.19 (2) health insurance reform, including options related to coverage, purchasing,
119.20 exchange development, and coverage for high-risk individuals; and

119.21 (3) other provisions that will require changes in state law.

119.22 (b) Before finalizing and submitting federal applications for pilot projects authorized
119.23 under federal health care reform, the governor and state agencies shall seek review and
119.24 advice from the commission.

119.25 (c) The commission may create and make appointments to work groups to assist the
119.26 commission in its work. Work group members may include legislators, representatives
119.27 of businesses and nonprofit agencies impacted by federal health care reform, academic
119.28 experts, and consumer representatives.

119.29 Sec. 4. Minnesota Statutes 2008, section 62U.05, is amended to read:

119.30 **62U.05 PROVIDER PRICING FOR BASKETS OF CARE; ACCOUNTABLE**
119.31 **CARE ORGANIZATIONS.**

119.32 Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner
119.33 of health shall establish uniform definitions for baskets of care beginning with a minimum

of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care must incorporate a patient-directed, decision-making support model.

(d) By January 1, 2012, the commissioner shall establish uniform definitions for the total cost of providing all necessary services to a patient through an accountable care organization meeting the standards specified in section 3022 of the Patient Protection and Affordable Care Act, Public Law 111-148, and shall develop a standard method and format for accountable care organizations to use for submitting package prices for the total cost of care. This method must be published in the State Register and must be made available to all providers.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1. Beginning July 1, 2012, accountable care organizations may establish package prices for the total cost of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section, and beginning July 1, 2012, no accountable care organization that has established a package price for the total cost of care under this section, shall vary the payment amount that the provider or organization accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

121.1 Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall
121.2 establish quality measurements for the defined baskets of care by December 31, 2009.
121.3 The commissioner shall establish quality measures for the total cost of care for services
121.4 delivered through an accountable care organization by June 30, 2012. The commissioner
121.5 may contract with an organization that works to improve health care quality to make
121.6 recommendations about the use of existing measures or establishing new measures where
121.7 no measures currently exist.

121.8 (b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall
121.9 publish comparative price and quality information on the baskets of care in a manner
121.10 that is easily accessible and understandable to the public, as this information becomes
121.11 available. Beginning January 1, 2013, the commissioner or the commissioner's designee
121.12 shall publish comparative price and quality information on the total cost of care for
121.13 services delivered through an accountable care organization in a manner that is easily
121.14 accessible and understandable to the public, as this information becomes available.

121.15 Sec. 5. Minnesota Statutes 2008, section 256B.0754, is amended by adding a
121.16 subdivision to read:

121.17 Subd. 3. **Accountable care organizations.** By July 1, 2012, the commissioner of
121.18 human services shall deliver services to enrollees in state health care programs through
121.19 accountable care organizations, and shall provide incentive payments to accountable care
121.20 organizations that meet or exceed annual quality and performance targets. Accountable
121.21 care organizations and incentive payments must meet the standards specified in the Patient
121.22 Protection and Affordable Care Act, Public Law 111-148.

121.23 Sec. 6. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

121.24 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
121.25 medical assistance coverage of health home services for eligible individuals with chronic
121.26 conditions who select a designated provider, a team of health care professionals, or a
121.27 health team as the individual's health home.

121.28 (b) The commissioner shall implement this section in compliance with the
121.29 requirements of the state option to provide health homes for enrollees with chronic
121.30 conditions, as provided under the Patient Protection and Affordable Care Act, Public
121.31 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
121.32 provided in that act.

122.1 Subd. 2. **Eligible individual.** An individual is eligible for health home services
122.2 under this section if the individual is eligible for medical assistance under this chapter
122.3 and has at least:

- 122.4 (1) two chronic conditions;
122.5 (2) one chronic condition and is at risk of having a second chronic condition; or
122.6 (3) one serious and persistent mental health condition.

122.7 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
122.8 timely high-quality services that are provided by a health home. These services include:

- 122.9 (1) comprehensive care management;
122.10 (2) care coordination and health promotion;
122.11 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
122.12 to other settings;
122.13 (4) patient and family support, including authorized representatives;
122.14 (5) referral to community and social support services, if relevant; and
122.15 (6) use of health information technology to link services, as feasible and appropriate.

122.16 (b) The commissioner shall maximize the number and type of services
122.17 included in this subdivision to the extent permissible under federal law, including
122.18 physician, outpatient, mental health treatment, and rehabilitation services necessary for
122.19 comprehensive transitional care following hospitalization.

122.20 Subd. 4. **Health teams.** The commissioner shall establish health teams to support
122.21 the patient-centered health home and provide the services described in subdivision 3 to
122.22 individuals eligible under subdivision 2. The commissioner shall apply for grants or
122.23 contracts as provided under section 3502 of the Patient Protection and Affordable Care
122.24 Act to establish health teams and provide capitated payments to primary care providers.
122.25 For purposes of this section, "health teams" means community-based, interdisciplinary,
122.26 inter-professional teams of health care providers that support primary care practices.
122.27 These providers may include medical specialists, nurses, advanced practice registered
122.28 nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers,
122.29 doctors of chiropractic, licensed complementary and alternative medicine practitioners,
122.30 and physician's assistants.

122.31 Subd. 5. **Payments.** The commissioner shall make payments to each health home
122.32 and each health team for the provision of health home services to each eligible individual
122.33 with chronic conditions that selects the health home as a provider.

122.34 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
122.35 the requirements and payment methods for health homes and health teams developed
122.36 under this section are consistent with the requirements and payment methods for health

123.1 care homes established under sections 256B.0751 and 256B.0753. The commissioner may
123.2 modify requirements and payment methods under sections 256B.0751 and 256B.0753 in
123.3 order to be consistent with federal health home requirements and payment methods.

123.4 Subd. 7. **State plan amendment.** The commissioner shall submit a state plan
123.5 amendment to implement this section to the federal Centers for Medicare and Medicaid
123.6 Services by January 1, 2011.

123.7 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
123.8 approval, whichever is later.

123.9 Sec. 7. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS**
123.10 **AND GRANTS.**

123.11 (a) The commissioner of human services shall seek to participate in the following
123.12 demonstration projects, or apply for the following grants, as described in the federal
123.13 Patient Protection and Affordable Care Act, Public Law 111-148:

123.14 (1) the demonstration project to evaluate integrated care around a hospitalization,
123.15 Public Law 111-148, section 2704;

123.16 (2) the Medicaid global payment system demonstration project, Public Law 111-148,
123.17 section 2705;

123.18 (3) the pediatric accountable care organization demonstration project, Public Law
123.19 111-148, section 2706;

123.20 (4) the Medicaid emergency psychiatric demonstration project, Public Law 111-148,
123.21 section 2707; and

123.22 (5) grants to provide incentives for prevention of chronic diseases in Medicaid,
123.23 Public Law 111-148, section 4108.

123.24 (b) The commissioner of human services shall report to the chairs and ranking
123.25 minority members of the house of representatives and senate committees or divisions with
123.26 jurisdiction over health care policy and finance on the status of the demonstration project
123.27 and grant applications. If the state is accepted as a demonstration project participant, or is
123.28 awarded a grant, the commissioner shall notify the chairs and ranking minority members
123.29 of those committees or divisions of any legislative changes necessary to implement the
123.30 demonstration projects or grants.

123.31 Sec. 8. **HEALTH CARE REFORM TASK FORCE.**

123.32 Subdivision 1. **Task force.** (a) The governor shall convene a Health Care
123.33 Reform Task Force to advise and assist the governor and the legislature regarding state
123.34 implementation of federal health care reform legislation. For purposes of this section,

124.1 "federal health care reform legislation" means the Patient Protection and Affordable Care
124.2 Act, Public Law 111-148, and the health care reform provisions in the Health Care and
124.3 Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:

124.4 (1) two legislators from the house of representatives appointed by the speaker and
124.5 two legislators from the senate appointed by the Subcommittee on Committees of the
124.6 Committee on Rules and Administration;

124.7 (2) two representatives appointed by the governor to represent the governor and
124.8 state agencies;

124.9 (3) three persons appointed by the governor who have demonstrated leadership in
124.10 health care organizations, health plan companies, or health care trade or professional
124.11 associations;

124.12 (4) three persons appointed by the governor who have demonstrated leadership in
124.13 employer and group purchaser activities related to health system improvement of whom at
124.14 least two must be from a labor organization; and

124.15 (5) five persons appointed by the governor who have demonstrated expertise in the
124.16 areas of health care financing, access, and quality.

124.17 The governor is exempt from the requirements of the open appointments process
124.18 for purposes of appointing task force members. Members shall be appointed for one-year
124.19 terms and may be reappointed.

124.20 (b) The Department of Health, Department of Human Services, and Department of
124.21 Commerce shall provide staff support to the task force. The task force may accept outside
124.22 resources to help support its efforts.

124.23 (c) Task force members must be appointed by July 1, 2010. The task force must hold
124.24 its first meeting by July 15, 2010.

124.25 Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and
124.26 present to the legislature and the governor a preliminary report and recommendations on
124.27 state implementation of federal health care reform legislation. The report must include
124.28 recommendations for state law and program changes necessary to comply with the federal
124.29 health care reform legislation, and also recommendations for implementing provisions of
124.30 the federal legislation that are optional for states. In developing recommendations, the task
124.31 force shall consider the extent to which an approach maximizes federal funding to the state.

124.32 (b) The task force, in consultation with the governor and the legislature, shall also
124.33 establish timelines and criteria for future reports on state implementation of the federal
124.34 health care reform legislation.

Sec. 9. **AMERICAN HEALTH BENEFIT EXCHANGE; PLANNING PROVISIONS.**

Subdivision 1. Federal planning grants. The commissioners of commerce, health, and human services shall jointly or separately apply to the federal secretary of health and human services for one or more planning and establishment grants, including renewal grants, authorized under section 1311 of the Patient Protection and Affordable Care Act, Public Law 111-148, including any future amendments of that provision, relating to state creation of American Health Benefit Exchanges.

Subd. 2. Consideration of early creation and operation of exchange. (a) The commissioners referenced in subdivision 1 shall analyze the advantages and disadvantages to the state of planning to have a state health insurance exchange, similar to an American Health Benefit Exchange referenced in subdivision 1, begin prior to the federal deadline of January 1, 2014.

(b) The commissioners shall provide a written report to the legislature on the results of the analysis required under paragraph (a) no later than December 15, 2010. The written report must comply with Minnesota Statutes, sections 3.195 and 3.197.

Sec. 10. **STATE FISCAL IMPACT OF FEDERAL REFORM.**

The commissioner of human services, in consultation with the commissioners of health and commerce, must report to the legislature by January 1, 2011, the additional costs and savings to the state in fiscal years 2011 through 2015 imposed under implementation of the Federal Patient Protection and Affordable Care Act.

ARTICLE 8

PUBLIC HEALTH

Section 1. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is amended to read:

Subd. 3. Establishment fees; definitions. (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening

126.1 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
126.2 that may be required.

126.3 (b) All food and beverage service establishments, except special event food stands,
126.4 and all hotels, motels, lodging establishments, public pools, and resorts shall pay an
126.5 annual base fee of \$150.

126.6 (c) A special event food stand shall pay a flat fee of \$50 annually. "Special event
126.7 food stand" means a fee category where food is prepared or served in conjunction with
126.8 celebrations, county fairs, or special events from a special event food stand as defined
126.9 in section 157.15.

126.10 (d) In addition to the base fee in paragraph (b), each food and beverage service
126.11 establishment, other than a special event food stand, and each hotel, motel, lodging
126.12 establishment, public pool, and resort shall pay an additional annual fee for each fee
126.13 category, additional food service, or required additional inspection specified in this
126.14 paragraph:

126.15 (1) Limited food menu selection, \$60. "Limited food menu selection" means a fee
126.16 category that provides one or more of the following:

- 126.17 (i) prepackaged food that receives heat treatment and is served in the package;
- 126.18 (ii) frozen pizza that is heated and served;
- 126.19 (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;
- 126.20 (iv) soft drinks, coffee, or nonalcoholic beverages; or
- 126.21 (v) cleaning for eating, drinking, or cooking utensils, when the only food served
126.22 is prepared off site.

126.23 (2) Small establishment, including boarding establishments, \$120. "Small
126.24 establishment" means a fee category that has no salad bar and meets one or more of
126.25 the following:

- 126.26 (i) possesses food service equipment that consists of no more than a deep fat fryer, a
126.27 grill, two hot holding containers, and one or more microwave ovens;
- 126.28 (ii) serves dipped ice cream or soft serve frozen desserts;
- 126.29 (iii) serves breakfast in an owner-occupied bed and breakfast establishment;
- 126.30 (iv) is a boarding establishment; or
- 126.31 (v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum
126.32 patron seating capacity of not more than 50.

126.33 (3) Medium establishment, \$310. "Medium establishment" means a fee category
126.34 that meets one or more of the following:

- 126.35 (i) possesses food service equipment that includes a range, oven, steam table, salad
126.36 bar, or salad preparation area;

127.1 (ii) possesses food service equipment that includes more than one deep fat fryer,
127.2 one grill, or two hot holding containers; or

127.3 (iii) is an establishment where food is prepared at one location and served at one or
127.4 more separate locations.

127.5 Establishments meeting criteria in clause (2), item (v), are not included in this fee
127.6 category.

127.7 (4) Large establishment, \$540. "Large establishment" means either:

127.8 (i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a
127.9 medium establishment, (B) seats more than 175 people, and (C) offers the full menu
127.10 selection an average of five or more days a week during the weeks of operation; or

127.11 (ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium
127.12 establishment, and (B) prepares and serves 500 or more meals per day.

127.13 (5) Other food and beverage service, including food carts, mobile food units,
127.14 seasonal temporary food stands, and seasonal permanent food stands, \$60.

127.15 (6) Beer or wine table service, \$60. "Beer or wine table service" means a fee
127.16 category where the only alcoholic beverage service is beer or wine, served to customers
127.17 seated at tables.

127.18 (7) Alcoholic beverage service, other than beer or wine table service, \$165.

127.19 "Alcohol beverage service, other than beer or wine table service" means a fee
127.20 category where alcoholic mixed drinks are served or where beer or wine are served from
127.21 a bar.

127.22 (8) Lodging per sleeping accommodation unit, \$10, including hotels, motels,
127.23 lodging establishments, and resorts, up to a maximum of \$1,000. "Lodging per sleeping
127.24 accommodation unit" means a fee category including the number of guest rooms, cottages,
127.25 or other rental units of a hotel, motel, lodging establishment, or resort; or the number of
127.26 beds in a dormitory.

127.27 (9) First public pool, \$325; each additional public pool, \$175. "Public pool" means a
127.28 fee category that has the meaning given in section 144.1222, subdivision 4.

127.29 (10) First spa, \$175; each additional spa, \$100. "Spa pool" means a fee category that
127.30 has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

127.31 (11) Private sewer or water, \$60. "Individual private water" means a fee category
127.32 with a water supply other than a community public water supply as defined in Minnesota
127.33 Rules, chapter 4720. "Individual private sewer" means a fee category with an individual
127.34 sewage treatment system which uses subsurface treatment and disposal.

(12) Additional food service, \$150. "Additional food service" means a location at a food service establishment, other than the primary food preparation and service area, used to prepare or serve food to the public.

(13) Additional inspection fee, \$360. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility school lunch programs when required by the Richard B. Russell National School Lunch Act.

(e) A fee for review of construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units. The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	limited food menu	\$275
	small establishment	\$400
	medium establishment	\$450
	large food establishment	\$500
	additional food service	\$150
	food cart	\$250
Transient food service	seasonal permanent food stand	\$250
	seasonal temporary food stand	\$250
	mobile food unit	\$350
	beer or wine table service	\$150
Alcohol	alcohol service from bar	\$250
	less than 25 rooms	\$375
Lodging	25 to less than 100 rooms	\$400
	100 rooms or more	\$500
	less than five cabins	\$350
	five to less than ten cabins	\$400
	ten cabins or more	\$450

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, resorts, seasonal food stands, and mobile food units are extensively remodeled, a fee must be submitted with the remodeling plans. The fee for this construction plan review is as follows:

Service Area	Type	Fee
Food	limited food menu	\$250
	small establishment	\$300
	medium establishment	\$350
	large food establishment	\$400
	additional food service	\$150
Transient food service	food cart	\$250
	seasonal permanent food stand	\$250

129.1		seasonal temporary food stand	\$250
129.2		mobile food unit	\$250
129.3	Alcohol	beer or wine table service	\$150
129.4		alcohol service from bar	\$250
129.5	Lodging	less than 25 rooms	\$250
129.6		25 to less than 100 rooms	\$300
129.7		100 rooms or more	\$450
129.8		less than five cabins	\$250
129.9		five to less than ten cabins	\$350
129.10		ten cabins or more	\$400

129.11 (g) Special event food stands are not required to submit construction or remodeling
129.12 plans for review.

129.13 (h) Youth camps shall pay an annual single fee for food and lodging as follows:

129.14 (1) camps with up to 99 campers, \$325;

129.15 (2) camps with 100 to 199 campers, \$550; and

129.16 (3) camps with 200 or more campers, \$750.

129.17 (i) A youth camp which pays fees under paragraph (d) is not required to pay fees
129.18 under paragraph (h).

129.19 Sec. 2. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is
129.20 amended to read:

129.21 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)

129.22 The following fees are required for manufactured home parks and recreational camping

129.23 areas licensed under this chapter. Recreational camping areas and manufactured home

129.24 parks shall pay the highest applicable base fee under paragraph ~~(c)~~ (b). The license fee

129.25 for new operators of a manufactured home park or recreational camping area previously

129.26 licensed under this chapter for the same calendar year is one-half of the appropriate annual

129.27 license fee, plus any penalty that may be required. The license fee for operators opening

129.28 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty

129.29 that may be required.

129.30 (b) All manufactured home parks and recreational camping areas shall pay the
129.31 following annual base fee:

129.32 (1) a manufactured home park, \$150; and

129.33 (2) a recreational camping area with:

129.34 (i) 24 or less sites, \$50;

129.35 (ii) 25 to 99 sites, \$212; and

129.36 (iii) 100 or more sites, \$300.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay \$4 for each licensed site. This paragraph does not apply to special event recreational camping areas ~~or to~~. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, \$60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, \$375;

(2) for initial construction of 25 to 99 sites, \$400; and

(3) for initial construction of 100 or more sites, \$500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, \$250;

(2) for expansion of 25 to 99 sites, \$300; and

(3) for expansion of 100 or more sites, \$450.

Sec. 3. FOOD SUPPORT FOR CHILDREN WITH SEVERE ALLERGIES.

The commissioner of human services must seek a federal waiver from the federal Department of Agriculture, Food and Nutrition Service, for the supplemental nutrition assistance program, to increase the income eligibility requirements to 375 percent of the federal poverty guidelines, in order to cover nutritional food products required to treat or manage severe food allergies, including allergies to wheat and gluten, for infants and children who have been diagnosed with life-threatening severe food allergies.

ARTICLE 9

HUMAN SERVICES FORECAST ADJUSTMENTS

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 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, from the general fund or any 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 "2010" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2010. The figure "2011" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2011.

	<u>2010</u>	<u>2011</u>
<u>General</u>	\$ (109,876,000)	\$ (28,344,000)
<u>Health Care Access</u>	99,654,000	276,500,000
<u>Federal TANF</u>	(9,830,000)	15,133,000
<u>Total</u>	\$ (20,052,000)	\$ 263,289,000

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subdivision 1. Total Appropriation \$ (20,052,000) \$ 263,289,000

Appropriations by Fund

	<u>2010</u>	<u>2011</u>
<u>General</u>	(109,876,000)	(28,344,000)
<u>Health Care Access</u>	99,654,000	276,500,000
<u>Federal TANF</u>	(9,830,000)	15,133,000

Subd. 2. Revenue and Pass-Through

Federal TANF 390,000 (251,000)

Subd. 3. Children and Economic Assistance Grants

<u>General Fund</u>	4,489,000	(4,140,000)
<u>Federal TANF</u>	(10,220,000)	15,384,000

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

(a) MFIP Grants

H.F. No. 2614, 1st Engrossment - 86th Legislative Session (2009-2010) [H2614-1]

132.1	<u>General Fund</u>	<u>7,916,000</u>	<u>(14,481,000)</u>
132.2	<u>TANF Fund</u>	<u>(10,220,000)</u>	<u>15,384,000</u>
132.3	<u>(b) MFIP Child Care Assistance Grants</u>	<u>(7,832,000)</u>	<u>2,579,000</u>
132.4	<u>(c) General Assistance Grants</u>	<u>875,000</u>	<u>1,339,000</u>
132.5	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>2,454,000</u>	<u>3,843,000</u>
132.6	<u>(e) Group Residential Housing Grants</u>	<u>1,076,000</u>	<u>2,580,000</u>
132.7	<u>Subd. 4. Basic Health Care Grants</u>		
132.8	<u>General Fund</u>	<u>(62,770,000)</u>	<u>29,192,000</u>
132.9	<u>TANF Fund</u>	<u>99,654,000</u>	<u>276,500,000</u>
132.10	<u>The amounts that may be spent from this</u>		
132.11	<u>appropriation are as follows:</u>		
132.12	<u>(a) MinnesotaCare Grants</u>		
132.13	<u>Health Care Access</u>		
132.14	<u>Fund</u>	<u>99,654,000</u>	<u>276,500,000</u>
132.15	<u>(b) Medical Assistance Basic Health Care –</u>		
132.16	<u>Families and Children</u>	<u>1,165,000</u>	<u>24,146,000</u>
132.17	<u>(c) Medical Assistance Basic Health Care –</u>		
132.18	<u>Elderly and Disabled</u>	<u>(63,935,000)</u>	<u>5,046,000</u>
132.19	<u>Subd. 5. Continuing Care Grants</u>	<u>(51,595,000)</u>	<u>(53,396,000)</u>
132.20	<u>The amounts that may be spent from this</u>		
132.21	<u>appropriation are as follows:</u>		
132.22	<u>(a) Medical Assistance Long-Term Care</u>		
132.23	<u>Facilities</u>	<u>(3,774,000)</u>	<u>(8,275,000)</u>
132.24	<u>(b) Medical Assistance Long-Term Care</u>		
132.25	<u>Waivers</u>	<u>(27,710,000)</u>	<u>(22,452,000)</u>
132.26	<u>(c) Chemical Dependency Entitlement Grants</u>	<u>(20,111,000)</u>	<u>(22,669,000)</u>

132.27 **Sec. 3. EFFECTIVE DATE.**

132.28 Sections 1 and 2 are effective the day following final enactment.

ARTICLE 10

HUMAN SERVICES CONTINGENT APPROPRIATIONS

Section 1. SUMMARY OF HUMAN SERVICES APPROPRIATIONS.

133.1 The amounts shown in this section summarize direct appropriations, by fund, made
133.2 in this bill.

133.3		<u>2010</u>		<u>2011</u>	<u>Total</u>
133.4	<u>General</u>	\$	<u>-0-</u>	\$ <u>13,383,000</u>	<u>13,383,000</u>
133.5	<u>Health Care Access</u>		<u>-0-</u>	<u>686,000</u>	<u>686,000</u>
133.6	<u>Total</u>	\$	<u>-0-</u>	\$ <u>14,069,000</u>	<u>14,069,000</u>

133.7 Sec. 2. HEALTH AND HUMAN SERVICES CONTINGENT APPROPRIATIONS.

133.8 (a) The sums shown in the columns marked "Appropriations" are added to the
133.9 appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter
133.10 173, article 2, to the agency and for the purposes specified in this bill. The appropriations
133.11 are from the general fund, or another named fund, and are available for the fiscal years
133.12 indicated for each purpose. The figures "2010" and "2011" used in this bill mean that the
133.13 addition to or subtraction from the appropriation listed under them is available for the
133.14 fiscal year ending June 30, 2010, or June 30, 2011, respectively.

133.15 (b) Upon enactment of the extension of the enhanced federal medical assistance
133.16 percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the
133.17 president's budget for federal fiscal year 2011 or contained in House Resolution 2847,
133.18 the federal "Jobs for Main Street Act, 2010," or contained in House Resolution 4213,
133.19 "American Workers, State, and Business Relief Act of 2010," or subsequent federal
133.20 legislation, the appropriations identified in section 3 shall be made for fiscal year 2011.

133.21		<u>APPROPRIATIONS</u>
133.22		<u>Available for the Year</u>
133.23		<u>Ending June 30</u>
133.24		<u>2010</u> <u>2011</u>

133.25 Sec. 3. COMMISSIONER OF HUMAN
133.26 SERVICES

133.27 Subdivision 1. Total Appropriation \$ -0- \$ 14,069,000

133.28	<u>Appropriations by Fund</u>		
133.29		<u>2010</u>	<u>2011</u>
133.30	<u>General</u>	<u>-0-</u>	<u>13,383,000</u>
133.31	<u>Health Care Access</u>	<u>-0-</u>	<u>686,000</u>

133.32 The appropriations for each purpose are
133.33 shown in the following subdivisions.

133.34 Subd. 2. Basic Health Care Grants

134.1	<u>(a) MinnesotaCare Grants</u>	<u>-0-</u>	<u>686,000</u>
134.2	<u>This appropriation is from the health care</u>		
134.3	<u>access fund.</u>		
134.4	<u>(b) Medical Assistance Basic Health Care</u>		
134.5	<u>Grants - Families and Children</u>	<u>-0-</u>	<u>6,297,000</u>
134.6	<u>(c) Medical Assistance Basic Health Care</u>		
134.7	<u>Grants - Elderly and Disabled</u>	<u>-0-</u>	<u>3,697,000</u>
134.8	<u>Subd. 3. Continuing Care Grants</u>		
134.9	<u>(a) Medical Assistance - Long-Term Care</u>		
134.10	<u>Facilities Grants</u>	<u>-0-</u>	<u>2,486,000</u>
134.11	<u>(b) Medical Assistance Grants - Long-Term</u>		
134.12	<u>Care Waivers and Home Care Grants</u>	<u>-0-</u>	<u>547,000</u>
134.13	<u>(c) Chemical Dependency Entitlement Grants</u>	<u>-0-</u>	<u>356,000</u>

134.14 Sec. 4. Minnesota Statutes 2009 Supplement, section 144.0724, subdivision 11,
134.15 is amended to read:

134.16 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance
134.17 payment of long-term care services, a recipient must be determined, using assessments
134.18 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

134.19 (1) the person needs the assistance of another person or constant supervision to begin
134.20 and complete at least four of the following activities of living: bathing, bed mobility,
134.21 dressing, eating, grooming, toileting, transferring, and walking;

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

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

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

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

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

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

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

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

135.11 (c) The assessment used to establish medical assistance payment for long-term care
135.12 services provided under sections 256B.0915 and 256B.49 and alternative care payment
135.13 for services provided under section 256B.0913 must be the most recent face-to-face
135.14 assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred
135.15 no more than 60 calendar days before the effective date of medical assistance eligibility
135.16 for payment of long-term care services.

135.17 **EFFECTIVE DATE.** This section is effective July 1, 2011.

135.18 Sec. 5. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
135.19 to read:

135.20 **Subd. 4a. Division of costs for medical assistance services.** Notwithstanding
135.21 subdivision 4, for chemical dependency services provided on or after October 1, 2008, and
135.22 reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

135.23 Sec. 6. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to
135.24 read:

135.25 **Subd. 22. Hospice care.** Medical assistance covers hospice care services under
135.26 Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient
135.27 age 21 or under who elects to receive hospice services does not waive coverage for
135.28 services that are related to the treatment of the condition for which a diagnosis of terminal
135.29 illness has been made.

135.30 **EFFECTIVE DATE.** This section is effective retroactive from March 23, 2010.

135.31 Sec. 7. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 1a,
135.32 is amended to read:

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

136.2 (a) "Long-term care consultation services" means:

136.3 (1) assistance in identifying services needed to maintain an individual in the most
136.4 inclusive environment;

136.5 (2) providing recommendations on cost-effective community services that are
136.6 available to the individual;

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

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

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

136.13 (6) federally mandated screening to determine the need for a institutional level of
136.14 care under section 256B.0911, ~~subdivision 4, paragraph (a)~~ subdivision 4a;

136.15 (7) determination of home and community-based waiver service eligibility including
136.16 level of care determination for individuals who need an institutional level of care as
136.17 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including
136.18 state plan home care services identified in section 256B.0625, subdivisions 6, 7, and
136.19 19, paragraphs (a) and (c), based on assessment and support plan development with
136.20 appropriate referrals;

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

136.23 (9) assistance to transition people back to community settings after facility
136.24 admission.

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

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

136.31 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
136.32 plans administering long-term care consultation assessment and support planning services.

136.33 Sec. 8. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

136.34 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall
136.35 be responsible for a monthly transfer payment of \$1,500,000, due before noon on the

15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of \$500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be \$2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately ~~\$3,400,000, plus any available federal matching funds,~~ \$6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to \$566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be \$434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be \$566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be \$434,688.

Sec. 9. Minnesota Statutes 2008, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is

138.1 approved. This exemption applies for 12 months. This paragraph expires June 30, 2010.
138.2 If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this
138.3 provision will expire on the date when it is no longer subject to section 5001 of Public Law
138.4 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

138.5 Sec. 10. Laws 2005, First Special Session chapter 4, article 8, section 66, as amended
138.6 by Laws 2009, chapter 173, article 3, section 24, the effective date, is amended to read:

138.7 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2009, ~~and~~ upon federal
138.8 approval and on the date when it is no longer subject to the maintenance of effort
138.9 requirements of section 5001 of Public Law 111-5. The commissioner of human services
138.10 shall notify the revisor of statutes of that date. Paragraph (e) is effective September 1,
138.11 2006.

138.12 Sec. 11. Laws 2009, chapter 79, article 5, section 17, the effective date, is amended to
138.13 read:

138.14 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
138.15 approval, ~~whichever is later~~ and on the date when it is no longer subject to the maintenance
138.16 of effort requirements of section 5001 of Public Law 111-5. The commissioner of human
138.17 services shall notify the revisor of statutes of that date.

138.18 Sec. 12. Laws 2009, chapter 79, article 5, section 18, the effective date, is amended to
138.19 read:

138.20 **EFFECTIVE DATE.** This section is effective ~~January 1, 2011~~ upon federal
138.21 approval and on the date when it is no longer subject to the maintenance of effort
138.22 requirements of section 5001 of Public Law 111-5. The commissioner of human services
138.23 shall notify the revisor of statutes when federal approval is obtained.

138.24 Sec. 13. Laws 2009, chapter 79, article 5, section 22, the effective date, is amended to
138.25 read:

138.26 **EFFECTIVE DATE.** This section is effective for periods of ineligibility established
138.27 on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.
138.28 If it is in violation of that section, then it shall be effective on the date when it is no longer
138.29 subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The
138.30 commissioner of human services shall notify the revisor of statutes of that date.

Sec. 14. Laws 2009, chapter 173, article 1, section 17, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for pooled trust accounts established on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5. If it is in violation of that section, then it shall be effective on the date when it is no longer subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

ARTICLE 11

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. SUMMARY OF APPROPRIATIONS.

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	<u>2010</u>	<u>2011</u>	<u>Total</u>
<u>General</u>	<u>\$ (10,141,000)</u>	<u>\$ (107,438,000)</u>	<u>\$ (117,579,000)</u>
<u>State Government Special Revenue</u>	<u>2,002,000</u>	<u>(275,000)</u>	<u>1,727,000</u>
<u>Health Care Access</u>	<u>(1,094,000)</u>	<u>72,459,000</u>	<u>71,365,000</u>
<u>Federal TANF</u>	<u>(7,500,000)</u>	<u>35,418,000</u>	<u>27,918,000</u>
<u>Total</u>	<u>\$ (16,733,000)</u>	<u>\$ 163,000</u>	<u>\$ (16,570,000)</u>

Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2010, are effective the day following final enactment unless a different effective date is explicit.

<u>APPROPRIATIONS</u> <u>Available for the Year</u> <u>Ending June 30</u>	
<u>2010</u>	<u>2011</u>

140.1	Sec. 3. <u>COMMISSIONER OF HUMAN</u>		
140.2	<u>SERVICES</u>		
140.3	<u>Subdivision 1. Total Appropriation</u>	<u>\$ (16,667,000)</u>	<u>\$ (4,971,000)</u>
140.4	<u>Appropriations by Fund</u>		
140.5		<u>2010</u>	<u>2011</u>
140.6	<u>General</u>	<u>(8,075,000)</u>	<u>(112,631,000)</u>
140.7	<u>State Government</u>		
140.8	<u>Special Revenue</u>	<u>(8,000)</u>	<u>(16,000)</u>
140.9	<u>Health Care Access</u>	<u>(1,094,000)</u>	<u>72,259,000</u>
140.10	<u>Federal TANF</u>	<u>(7,500,000)</u>	<u>35,418,000</u>
140.11	<u>Working Family Credit Expenditures to</u>		
140.12	<u>be Claimed for TANF/MOE. For fiscal year</u>		
140.13	<u>2011, the commissioner may count \$38,000</u>		
140.14	<u>of working family credit expenditures as</u>		
140.15	<u>TANF/MOE. Notwithstanding any provision</u>		
140.16	<u>to the contrary, this rider expires June 30,</u>		
140.17	<u>2013.</u>		
140.18	<u>TANF Financing and Maintenance of</u>		
140.19	<u>Effort.</u> <u>The commissioner of human</u>		
140.20	<u>services, with the approval of the</u>		
140.21	<u>commissioner of management and budget,</u>		
140.22	<u>and after notification of the chairs of the</u>		
140.23	<u>relevant senate budget division and house of</u>		
140.24	<u>representatives finance division, may adjust</u>		
140.25	<u>the amount of TANF transfers between the</u>		
140.26	<u>MFIP transition year child care assistance</u>		
140.27	<u>program and MFIP grant programs within the</u>		
140.28	<u>fiscal year, and within the current biennium</u>		
140.29	<u>and the biennium ending June 30, 2013,</u>		
140.30	<u>to ensure that state and federal match and</u>		
140.31	<u>maintenance of effort requirements are</u>		
140.32	<u>met. These transfers and amounts must be</u>		
140.33	<u>reported to the chairs of the senate and house</u>		
140.34	<u>of representatives Finance Committees, the</u>		
140.35	<u>senate Health and Human Services Budget</u>		
140.36	<u>Division, the house of representatives Health</u>		
140.37	<u>Care and Human Services Finance Division,</u>		

141.1	<u>and Early Childhood Finance and Policy</u>		
141.2	<u>Division by December 1 of each fiscal</u>		
141.3	<u>year. Notwithstanding any provision to the</u>		
141.4	<u>contrary, this rider expires June 30, 2013.</u>		
141.5	<u>The appropriation reductions for each</u>		
141.6	<u>purpose are shown in the following</u>		
141.7	<u>subdivisions.</u>		
141.8	<u>Subd. 2. Agency Management; Financial</u>		
141.9	<u>Operations</u>	<u>(8,000)</u>	<u>(16,000)</u>
141.10	<u>This appropriation reduction is from the state</u>		
141.11	<u>government special revenue fund.</u>		
141.12	<u>Subd. 3. Revenue and Pass-Through Revenue</u>		
141.13	<u>Expenditures</u>	<u>(7,500,000)</u>	<u>35,500,000</u>
141.14	<u>TANF Funding for the Working Family</u>		
141.15	<u>Tax Credit.</u> <u>In addition to the amounts</u>		
141.16	<u>specified in Minnesota Statutes, section</u>		
141.17	<u>290.0671, subdivision 6, \$18,722,000</u>		
141.18	<u>of TANF funds in fiscal year 2010 and</u>		
141.19	<u>\$18,689,000 of TANF funds in fiscal year</u>		
141.20	<u>2011 are appropriated to the commissioner</u>		
141.21	<u>of human services to reimburse the cost of</u>		
141.22	<u>the working family tax credit for eligible</u>		
141.23	<u>families. Beginning January 1, 2011, the</u>		
141.24	<u>commissioner shall reimburse the general</u>		
141.25	<u>fund on a monthly basis according to a</u>		
141.26	<u>schedule based on the pattern of working</u>		
141.27	<u>family credit expenditures through June 20,</u>		
141.28	<u>2011. This rider is effective upon enactment.</u>		
141.29	<u>Subd. 4. Children and Economic Assistance</u>		
141.30	<u>Grants</u>		
141.31	<u>(a) MFIP and Diversionary Work Program</u>		
141.32	<u>Grants</u>	<u>-0-</u>	<u>(2,033,000)</u>
141.33	<u>This appropriation reduces the general</u>		
141.34	<u>fund appropriation by \$5,691,000 and</u>		

142.1	<u>increases the federal TANF appropriation by</u>		
142.2	<u>\$3,658,000.</u>		
142.3	<u>(b) Support Services Grants</u>	<u>-0-</u>	<u>(7,646,000)</u>
142.4	<u>Supported Work.</u> <u>The fiscal year 2011</u>		
142.5	<u>TANF appropriation to the commissioner of</u>		
142.6	<u>human services for supported work for MFIP</u>		
142.7	<u>recipients is reduced by \$4,000,000. This</u>		
142.8	<u>reduction is onetime.</u>		
142.9	<u>Base Adjustment.</u> <u>The federal TANF base</u>		
142.10	<u>shall be increased by \$2,642,000 for fiscal</u>		
142.11	<u>years 2012 and 2013.</u>		
142.12	<u>(c) MFIP Child Care Assistance Grants</u>	<u>-0-</u>	<u>(38,000)</u>
142.13	<u>This appropriation reduces the general</u>		
142.14	<u>fund appropriation by \$4,000,000 and</u>		
142.15	<u>increases the federal TANF appropriation by</u>		
142.16	<u>\$3,962,000.</u>		
142.17	<u>(d) Basic Sliding Fee Child Care Assistance</u>		
142.18	<u>Grants</u>	<u>-0-</u>	<u>(7,500,000)</u>
142.19	<u>This appropriation reduces the fiscal</u>		
142.20	<u>year 2011 general fund appropriation by</u>		
142.21	<u>\$7,500,000 and carries over and expends, in</u>		
142.22	<u>fiscal year 2011, \$7,500,000 of the TANF</u>		
142.23	<u>funds transferred in fiscal year 2010, which</u>		
142.24	<u>reflect the child care and development</u>		
142.25	<u>fund unexpended balance for the basic</u>		
142.26	<u>sliding fee child care assistance program</u>		
142.27	<u>under Minnesota Statutes, section 119B.03.</u>		
142.28	<u>The commissioner shall ensure that all</u>		
142.29	<u>the funds are expended according to the</u>		
142.30	<u>federal child care and development fund</u>		
142.31	<u>regulations relating to TANF transfers. This</u>		
142.32	<u>appropriation is onetime.</u>		
142.33	<u>(e) Children and Community Services Grants</u>	<u>-0-</u>	<u>(9,900,000)</u>

143.1	<u>Children and Community Services Grant</u>		
143.2	<u>Reduction.</u> The fiscal year 2011 general		
143.3	<u>fund appropriation to the commissioner</u>		
143.4	<u>of human services for the children and</u>		
143.5	<u>community services grants under Minnesota</u>		
143.6	<u>Statutes, section 256M.40, is reduced by</u>		
143.7	<u>\$9,900,000. This reduction is ongoing and is</u>		
143.8	<u>subtracted from the base.</u>		
143.9	<u>(f) Children's Mental Health Grants</u>	<u>-0-</u>	<u>(8,028,000)</u>
143.10	<u>(1) The general fund appropriation for</u>		
143.11	<u>respite care services for children with</u>		
143.12	<u>severe emotional disturbance who are at</u>		
143.13	<u>risk of out-of-home placement is reduced</u>		
143.14	<u>by \$1,024,000 for fiscal year 2011. This</u>		
143.15	<u>reduction is onetime.</u>		
143.16	<u>(2) The general fund appropriation for</u>		
143.17	<u>children's early intervention services is</u>		
143.18	<u>reduced by \$1,024,000 for fiscal year 2011.</u>		
143.19	<u>This reduction is onetime.</u>		
143.20	<u>(3) The general fund appropriation for</u>		
143.21	<u>children's capacity school-based services is</u>		
143.22	<u>reduced by \$4,777,000 for fiscal year 2011.</u>		
143.23	<u>(4) The general fund appropriation for</u>		
143.24	<u>children's mental health targeted case</u>		
143.25	<u>management grants is reduced by \$1,210,000</u>		
143.26	<u>for fiscal year 2011.</u>		
143.27	<u>Base adjustment.</u> The general fund base		
143.28	<u>is increased by \$2,048,000 in each of fiscal</u>		
143.29	<u>years 2012 and 2013.</u>		
143.30	<u>(g) Other Children and Economic Assistance</u>		
143.31	<u>Grants</u>	<u>290,000</u>	<u>63,000</u>
143.32	<u>Subd. 5. Children and Economic Assistance</u>		
143.33	<u>Management</u>		
143.34	<u>(a) Children and Economic Assistance</u>		
143.35	<u>Administration</u>	<u>-0-</u>	<u>-0-</u>

144.1	<u>The general fund appropriation is reduced by</u>		
144.2	<u>\$172,000 in fiscal year 2010 and by \$176,000</u>		
144.3	<u>in fiscal year 2011.</u>		
144.4	<u>The federal TANF appropriation is increased</u>		
144.5	<u>by \$172,000 in fiscal year 2010 and by</u>		
144.6	<u>\$176,000 in fiscal year 2011. The TANF</u>		
144.7	<u>fund base shall be reduced by \$700,000 in</u>		
144.8	<u>fiscal years 2012 and 2013.</u>		
144.9	<u>(b) Children and Economic Assistance</u>		
144.10	<u>Operations</u>	<u>(1,580,000)</u>	<u>(1,692,000)</u>
144.11	<u>The general fund appropriation is reduced</u>		
144.12	<u>by \$1,408,000 in fiscal year 2010 and by</u>		
144.13	<u>\$1,534,000 in fiscal year 2011. The general</u>		
144.14	<u>fund base is reduced by \$26,000 in each of</u>		
144.15	<u>fiscal years 2012 and 2013.</u>		
144.16	<u>\$74,000 in fiscal year 2011 is appropriated</u>		
144.17	<u>from the health care access fund. This</u>		
144.18	<u>appropriation is onetime.</u>		
144.19	<u>The federal TANF appropriation is reduced</u>		
144.20	<u>by \$172,000 in fiscal year 2010 and by</u>		
144.21	<u>\$232,000 in fiscal year 2011.</u>		
144.22	<u>Subd. 6. Basic Health Care Grants</u>		
144.23	<u>(a) MinnesotaCare Grants</u>	<u>-0-</u>	<u>(67,549,000)</u>
144.24	<u>This appropriation reduction is from the</u>		
144.25	<u>health care access fund.</u>		
144.26	<u>(b) Medical Assistance Basic Health Care</u>		
144.27	<u>Grants - Families and Children</u>	<u>-0-</u>	<u>(1,108,000)</u>
144.28	<u>(c) Medical Assistance Basic Health Care</u>		
144.29	<u>Grants - Elderly and Disabled</u>	<u>-0-</u>	<u>(2,817,000)</u>
144.30	<u>(d) General Assistance Medical Care Grants</u>	<u>-0-</u>	<u>(52,614,000)</u>
144.31	<u>Funding Reduction; Coordinated Care</u>		
144.32	<u>Delivery Systems.</u> The appropriation for		
144.33	payments to coordinated care delivery		
144.34	systems in Laws 2010, chapter 200, article		

145.1	<u>2, section 2, subdivision 4, paragraph (d), is</u>		
145.2	<u>reduced by \$20,000,000 in fiscal year 2011.</u>		
145.3	<u>(e) Medical Assistance; Adults Without</u>		
145.4	<u>Children</u>	<u>-0-</u>	<u>144,114,000</u>
145.5	<u>Of this appropriation, \$142,768,000 is from</u>		
145.6	<u>the health care access fund.</u>		
145.7	<u>(f) Other Health Care Grants</u>	<u>-0-</u>	<u>(1,831,000)</u>
145.8	<u>Of this appropriation, the general fund is</u>		
145.9	<u>increased by \$19,000 and the health care</u>		
145.10	<u>access fund appropriation is reduced by</u>		
145.11	<u>\$1,850,000. This appropriation is onetime.</u>		
145.12	<u>COBRA Carryforward. Unexpended</u>		
145.13	<u>funds appropriated in fiscal year 2010 for</u>		
145.14	<u>COBRA grants under Laws 2009, chapter</u>		
145.15	<u>79, article 5, section 78, do not cancel and</u>		
145.16	<u>are available to the commissioner of human</u>		
145.17	<u>services for fiscal year 2011 COBRA grant</u>		
145.18	<u>expenditures. Up to \$110,000 of the fiscal</u>		
145.19	<u>year 2011 appropriation for COBRA grants</u>		
145.20	<u>provided in Laws 2009, chapter 79, article</u>		
145.21	<u>13, section 3, subdivision 6, may be used</u>		
145.22	<u>by the commissioner of human services for</u>		
145.23	<u>costs related to administration of the COBRA</u>		
145.24	<u>grants.</u>		
145.25	<u>Transfer.</u> The commissioner shall transfer		
145.26	<u>\$19,000 to the commissioner of commerce</u>		
145.27	<u>for regulation of Minnesota Statutes, section</u>		
145.28	<u>62A.3075.</u>		
145.29	<u>Subd. 7. Health Care Management</u>		
145.30	<u>(a) Health Care Administration</u>	<u>(2,853,000)</u>	<u>(4,683,000)</u>
145.31	<u>For fiscal year 2011 the health care access</u>		
145.32	<u>fund appropriation is increased by \$250,000</u>		
145.33	<u>and the general fund appropriation is reduced</u>		
145.34	<u>by \$4,633,000.</u>		

146.1 **Fiscal Note Report.** \$50,000 in fiscal
146.2 year 2011 is from the general fund for the
146.3 completion of the human services fiscal note
146.4 report in article 5.

146.5 **Reduction in Appropriation.** The base
146.6 funding under the current law forecast used
146.7 to calculate the state appropriation for the
146.8 medical assistance program is reduced by
146.9 one percent for the 2012-2013 biennium.
146.10 This reduction is subject to federal approval
146.11 of the intensive care management program
146.12 authorized under Minnesota Statutes, section
146.13 256B.0755, and is ongoing and shall apply
146.14 to future bienniums, or for as long as the
146.15 intensive care management program is
146.16 determined to be cost-effective by the
146.17 commissioner of human services.

146.18 **PACE Implementation Funding.** For fiscal
146.19 year 2011, \$145,000 is appropriated from
146.20 the general fund to the commissioner of
146.21 human services to complete the actuarial and
146.22 administrative work necessary to begin the
146.23 operation of PACE under Minnesota Statutes,
146.24 section 256B.69, subdivision 23, paragraph
146.25 (e). Base level funding for this activity shall
146.26 be \$130,000 in fiscal year 2012 and \$0 in
146.27 fiscal year 2013.

146.28 **Minnesota Senior Health Options**
146.29 **Reimbursement.** Effective July 1, 2011,
146.30 federal administrative reimbursement
146.31 resulting from the Minnesota senior
146.32 health options project is appropriated
146.33 to the commissioner for this activity.
146.34 Notwithstanding any contrary provision, this
146.35 provision expires June 30, 2013.

147.1 **Health Care Inspector General.** \$120,000
147.2 from the general fund in fiscal year 2011
147.3 is for the Office of Health Care Inspector
147.4 General, established under Minnesota
147.5 Statutes, section 256.01, subdivision 30.

147.6 **Fiscal and Actuarial Analysis.** \$250,000
147.7 from the general fund is for the fiscal and
147.8 actuarial analysis of 2010 House File No.
147.9 135 and 2010 Senate File No. 118. This
147.10 appropriation is onetime.

147.11 **Utilization Review.** Effective July 1,
147.12 2011, federal administrative reimbursement
147.13 resulting from prior authorization and
147.14 inpatient admission certification by a
147.15 professional review organization shall be
147.16 dedicated to, and is appropriated to, the
147.17 commissioner for these activities. A portion
147.18 of these funds must be used for activities to
147.19 decrease unnecessary pharmaceutical costs
147.20 in medical assistance. Notwithstanding any
147.21 contrary provision, this provision expires
147.22 June 30, 2013.

147.23 **Base Adjustment.** The health care access
147.24 fund base is reduced by \$50,000 in each of
147.25 fiscal years 2012 and 2013.

147.26 The general fund base is reduced by \$516,000
147.27 in each of fiscal years 2012 and 2013.

147.28 **(b) Health Care Operations**

147.29 Appropriations by Fund

147.30	<u>General</u>	<u>-0-</u>	<u>64,000</u>
147.31	<u>Health Care Access</u>	<u>(1,094,000)</u>	<u>(1,234,000)</u>

147.32 **Base Adjustment.** The health care access
147.33 fund base for health care operations is
147.34 reduced by \$1,272,000 in fiscal year 2012

148.1 and \$1,337,000 in fiscal year 2013. The
 148.2 general fund appropriation is onetime.
 148.3 Subd. 8. **Continuing Care Grants**
 148.4 (a) **Aging and Adult Services Grants** (154,000) (139,000)
 148.5 This reduction is onetime and must not be
 148.6 applied to the base.
 148.7 **Community Service Development**
 148.8 **Reduction.** The appropriation in Laws
 148.9 2009, chapter 79, article 13, section 3,
 148.10 subdivision 8, paragraph (a), for community
 148.11 service development grants, as amended by
 148.12 Laws 2009, chapter 173, article 2, section
 148.13 1, subdivision 8, paragraph (a), is reduced
 148.14 by \$154,000 in fiscal year 2011. The
 148.15 appropriation base is reduced by \$139,000
 148.16 for fiscal year 2012 and \$0 for fiscal year
 148.17 2013. Notwithstanding any law or rule to
 148.18 the contrary, this provision expires June 30,
 148.19 2012.
 148.20 (b) **Medical Assistance Long-Term Care**
 148.21 **Facilities Grants** -0- 551,000
 148.22 (c) **Medical Assistance Long-Term Care**
 148.23 **Waivers and Home Care Grants** -0- (2,747,000)
 148.24 **Manage Growth in Traumatic Brain**
 148.25 **Injury and Community Alternatives for**
 148.26 **Disabled Individuals' Waivers.** During
 148.27 the fiscal year beginning July 1, 2010, the
 148.28 commissioner shall allocate money for home
 148.29 and community-based waiver programs
 148.30 under Minnesota Statutes, section 256B.49,
 148.31 to ensure a reduction in state spending that is
 148.32 equivalent to limiting the caseload growth
 148.33 of the traumatic brain injury waiver to six
 148.34 allocations per month and the community
 148.35 alternatives for disabled individuals waiver

149.1 to 60 allocations per month. The limits do not
 149.2 apply: (1) when there is an approved plan for
 149.3 nursing facility bed closures for individuals
 149.4 under age 65 who require relocation due to
 149.5 the bed closure; (2) to fiscal year 2009 waiver
 149.6 allocations delayed due to unallotment; or (3)
 149.7 to transfers authorized by the commissioner
 149.8 from the personal care assistance program
 149.9 of individuals having a home care rating of
 149.10 CS, MT, or HL. Priorities for the allocation
 149.11 of funds must be for individuals anticipated
 149.12 to be discharged from institutional settings or
 149.13 who are at imminent risk of a placement in
 149.14 an institutional setting.

149.15 **Manage Growth in the Developmental**
 149.16 **Disability (DD) Waiver.** The commissioner
 149.17 shall manage the growth in the developmental
 149.18 disability waiver by limiting the allocations
 149.19 included in the November 2010 forecast to
 149.20 six additional diversion allocations each
 149.21 month for the calendar year that begins on
 149.22 January 1, 2011. Additional allocations must
 149.23 be made available for transfers authorized
 149.24 by the commissioner from the personal care
 149.25 assistance program of individuals having a
 149.26 home care rating of CS, MT, or HL. This
 149.27 provision is effective through December 31,
 149.28 2011.

149.29 <u>(d) Adult Mental Health Grants</u>	<u>(3,500,000)</u>	<u>(9,903,000)</u>
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149.30 **Compulsive Gambling Special Revenue**
 149.31 **Account.** \$149,000 for fiscal year 2010
 149.32 and \$27,000 for fiscal year 2011 from
 149.33 the compulsive gambling special revenue
 149.34 account established under Minnesota
 149.35 Statutes, section 245.982, must be transferred

150.1 and deposited into the general fund by June
150.2 30 of each respective fiscal year.

150.3 **Compulsive Gambling Lottery Prize Fund**

150.4 **Appropriation.** The lottery prize fund
150.5 appropriation for compulsive gambling, is
150.6 reduced by \$80,000 in fiscal year 2010 and
150.7 \$79,000 in fiscal year 2011. This is a onetime
150.8 reduction.

150.9 **Adult Mental Health.** (1) The general
150.10 fund appropriation for adult mental health
150.11 evidence-based practices, including but not
150.12 limited to, assertive community treatment
150.13 and integrated dual diagnosis treatment
150.14 services, is reduced by \$750,000 for fiscal
150.15 year 2011. This reduction is onetime.

150.16 (2) The general fund appropriation for
150.17 mental health grants to increase availability
150.18 of culturally specific adult mental health
150.19 services is reduced by \$300,000 for fiscal
150.20 year 2011. This reduction is onetime.

150.21 (3) The general fund appropriation for
150.22 grants to community hospitals to provide
150.23 alternatives to residential treatment center
150.24 mental health programs is reduced by
150.25 \$2,653,000 for fiscal year 2011. This
150.26 reduction is onetime.

150.27 (4) The general fund appropriation for grants
150.28 to counties for adult mental health services is
150.29 reduced by \$6,200,000 for fiscal year 2011,
150.30 and \$6,000,000 in each of fiscal years 2012
150.31 and 2013.

150.32 (5) Of the fiscal year 2010 general fund
150.33 appropriation for grants to counties for
150.34 housing with support services for adults
150.35 with serious and persistent mental illness,

151.1 \$3,300,000 is canceled and returned to the
 151.2 general fund.

151.3 (6) Of the fiscal year 2010 general
 151.4 fund appropriation for additional crisis
 151.5 intervention team training for law
 151.6 enforcement, \$200,000 is canceled and
 151.7 returned to the general fund.

151.8 **Base adjustment.** The general fund base
 151.9 is increased by \$3,903,000 in each of fiscal
 151.10 years 2012 and 2013.

151.11 <u>(e) Chemical Dependency Entitlement Grants</u>	<u>-0-</u>	<u>(3,986,000)</u>
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151.12 <u>(f) Chemical Dependency Nonentitlement</u>		
151.13 <u>Grants</u>	<u>(389,000)</u>	<u>-0-</u>

151.14 **Chemical Health.** Of the fiscal year 2010
 151.15 general fund appropriation to Mother's First
 151.16 and the Native American Program, \$389,000
 151.17 is canceled and returned to the general fund.

151.18 <u>(g) Other Continuing Care Grants</u>	<u>-0-</u>	<u>100,000</u>
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151.19 **Intermediate Care Facilities for the**
 151.20 **Developmentally Disabled Payment Rates.**
 151.21 \$36,000 is appropriated from the general
 151.22 fund in fiscal year 2011 and \$4,000 in fiscal
 151.23 year 2012 to increase payment rates for an
 151.24 ICF/MR licensed for six beds and located in
 151.25 Kandiyohi County to serve persons with high
 151.26 behavioral needs. The payment rate increase
 151.27 shall be effective for services provided from
 151.28 July 1, 2010, through June 30, 2011. These
 151.29 appropriations are onetime.

151.30 **Region 10 Quality Assurance Commission.**
 151.31 \$100,000 is appropriated from the general
 151.32 fund in fiscal year 2011 to the commissioner
 151.33 of human services for the purposes
 151.34 of the Region 10 Quality Assurance

152.1 Commission under Minnesota Statutes,
152.2 section 256B.0951. This appropriation is
152.3 onetime.

152.4 Subd. 9. **Continuing Care Management** 111,000 101,000

152.5 **PACE Implementation Funding.** For fiscal
152.6 year 2011, \$111,000 is appropriated from
152.7 the general fund to the commissioner of
152.8 human services to complete the actuarial
152.9 and administrative work necessary to begin
152.10 the operation of PACE under Minnesota
152.11 Statutes, section 256B.69, subdivision 23,
152.12 paragraph (e). Base level funding for this
152.13 activity shall be \$101,000 in fiscal year 2012
152.14 and \$0 in fiscal year 2013. For fiscal year
152.15 2013 and beyond, the commissioner must
152.16 work with stakeholders to develop financing
152.17 mechanisms to complete the actuarial
152.18 and administrative costs of PACE. The
152.19 commissioner shall inform the chairs and
152.20 ranking minority members of the legislative
152.21 committee with jurisdiction over health care
152.22 funding by January 15, 2011, on progress to
152.23 develop financing mechanisms.

152.24 Subd. 10. **State-Operated Services**

152.25 **Obsolete Laundry Depreciation Account.**
152.26 \$669,000, or the balance, whichever is
152.27 greater, must be transferred from the
152.28 state-operated services laundry depreciation
152.29 account in the special revenue fund and
152.30 deposited into the general fund by June 30,
152.31 2010.

152.32 **State-operated Services Programs.** Of
152.33 the fiscal year 2011 appropriation for
152.34 the Minnesota sex offender program,
152.35 \$12,600,000 is transferred to state-operated

153.1	<u>services to maintain the METO program and</u>		
153.2	<u>other residential adult mental health services.</u>		
153.3	<u>Subd. 11. Adult Mental Health Services</u>	<u>-0-</u>	<u>12,600,000</u>
153.4	<u>This appropriation is onetime and does not</u>		
153.5	<u>affect the agency's base.</u>		
153.6	<u>Subd. 12. Minnesota Sex Offender Services</u>	<u>-0-</u>	<u>(12,600,000)</u>
153.7	<u>This appropriation is onetime and does not</u>		
153.8	<u>affect the agency's base.</u>		
153.9	<u>Subd. 13. Contingent Appropriations</u>		
153.10	<u>Reductions</u>		
153.11	<u>Upon enactment of the extension of</u>		
153.12	<u>the enhanced federal medical assistance</u>		
153.13	<u>percentage (FMAP) under Public Law 111-5</u>		
153.14	<u>to June 30, 2011, that is contained in the</u>		
153.15	<u>president's budget for federal fiscal year 2011</u>		
153.16	<u>or contained in House Resolution 2847, the</u>		
153.17	<u>federal "Jobs for Main Street Act of 2010," or</u>		
153.18	<u>subsequent federal legislation, the reductions</u>		
153.19	<u>identified in each clause shall be made to</u>		
153.20	<u>the specified general fund appropriations</u>		
153.21	<u>for fiscal year 2011. These contingent</u>		
153.22	<u>reductions, if implemented, are in addition</u>		
153.23	<u>to the reductions specified in subdivision 6,</u>		
153.24	<u>paragraphs (a), (b), and (c), and subdivision</u>		
153.25	<u>8, paragraphs (c) and (d), respectively.</u>		
153.26	<u>(1) MinnesotaCare Grants</u>	<u>-0-</u>	<u>(9,200,000)</u>
153.27	<u>(2) Medical Assistance Basic Health Care Grants</u>		
153.28	<u>- Families and Children</u>	<u>-0-</u>	<u>(109,662,500)</u>
153.29	<u>(3) Medical Assistance Basic Health Care Grants</u>		
153.30	<u>- Elderly and Disabled</u>	<u>-0-</u>	<u>(110,437,500)</u>
153.31	<u>(4) Medical Assistance Long-Term Care Facilities</u>		
153.32	<u>Grants</u>	<u>-0-</u>	<u>(51,925,000)</u>
153.33	<u>(5) Medical Assistance Long-Term Care Waivers</u>		
153.34	<u>and Home Care Grants</u>	<u>-0-</u>	<u>(115,475,000)</u>

154.1	Sec. 4. <u>COMMISSIONER OF HEALTH</u>			
154.2	<u>APPROPRIATIONS</u>			
154.3	<u>Available for the Year</u>			
154.4	<u>Ending June 30</u>			
154.5	<u>2010</u>		<u>2011</u>	
154.6	Subdivision 1. <u>Total Appropriation</u>	\$	<u>(2,992,000)</u>	\$ <u>5,325,000</u>
154.7	<u>Appropriations by Fund</u>			
154.8		<u>2010</u>	<u>2011</u>	
154.9	<u>General</u>	<u>(2,392,000)</u>	<u>5,384,000</u>	
154.10	<u>State Government</u>			
154.11	<u>Special Revenue</u>	<u>(600,000)</u>	<u>(259,000)</u>	
154.12	<u>Health Care Access</u>			
154.13	<u>Fund</u>	<u>-0-</u>	<u>200,000</u>	
154.14	Subd. 2. <u>Community and Family Health</u>		<u>(221,000)</u>	<u>(21,000)</u>
154.15	<u>Grant for Memory Care Clinic. \$100,000</u>			
154.16	<u>from the general fund in fiscal year 2011</u>			
154.17	<u>is for a grant to a nonprofit, multispecialty</u>			
154.18	<u>clinic located in the city of St. Cloud that</u>			
154.19	<u>provides early identification, diagnosis, and</u>			
154.20	<u>treatment of memory loss, and information</u>			
154.21	<u>and support for family members who care for</u>			
154.22	<u>persons with memory impairment. In order</u>			
154.23	<u>to receive the grant, the clinic must certify to</u>			
154.24	<u>the commissioner that it has a commitment</u>			
154.25	<u>from a private foundation to provide a 50</u>			
154.26	<u>percent match of the grant amount. This</u>			
154.27	<u>appropriation is onetime.</u>			
154.28	<u>Statewide Health Improvement Program.</u>			
154.29	<u>\$8,500,000 from the health care access</u>			
154.30	<u>fund in fiscal year 2012 and \$8,500,000 in</u>			
154.31	<u>fiscal year 2013 is for the statewide health</u>			
154.32	<u>improvement program under Minnesota</u>			
154.33	<u>Statutes, section 145.986. These additions</u>			
154.34	<u>are onetime.</u>			

155.1 **Base adjustment.** The general fund base is
155.2 reduced by \$132,000 in each of fiscal years
155.3 2012 and 2013.

155.4 **Subd. 3. Policy, Quality, and Compliance**

155.5	<u>Appropriations by Fund</u>		
155.6		<u>2010</u>	<u>2011</u>
155.7	<u>General</u>	<u>(1,797,000)</u>	<u>5,210,000</u>
155.8	<u>State Government</u>		
155.9	<u>Special Revenue</u>	<u>(600,000)</u>	<u>(268,000)</u>
155.10	<u>Health Care Access</u>		
155.11	<u>Fund</u>	<u>-0-</u>	<u>200,000</u>

155.12 Of this appropriation, \$74,000 in fiscal
155.13 year 2011 is to restore unallotments for the
155.14 Office of Unlicensed Complementary and
155.15 Alternative Health Care Practice.

155.16 **Health Care Reform.** Funds appropriated
155.17 in Laws 2008, chapter 358, article 5, section
155.18 4, subdivision 3, for health reform activities
155.19 to implement Laws 2008, chapter 358,
155.20 article 4, are available until expended.
155.21 Notwithstanding any contrary provision in
155.22 this article, this provision shall not expire.

155.23 **Health Care Reform Task Force.** \$200,000
155.24 from the general fund is for expenses related
155.25 to the Health Care Reform Task Force
155.26 established under article 7, section 8.

155.27 **Autism Coverage Study.** \$50,000 in
155.28 fiscal year 2011 is appropriated to the
155.29 commissioner of health to monitor the gaps
155.30 in the level of service provided by state
155.31 health programs, the state employee group
155.32 insurance plan, and private health plans for
155.33 autism spectrum disorder. This appropriation
155.34 is onetime.

155.35 **Rural Hospital Capital Improvement**

155.36 **Grants.** Of the general fund reductions in

156.1 fiscal year 2010, \$1,755,000 is for the rural
156.2 hospital capital improvement grant program.

156.3 **Health Information Exchange Oversight.**
156.4 Of the state government special revenue fund
156.5 appropriations, \$104,000 in fiscal year 2011
156.6 is for the duties required under Minnesota
156.7 Statutes, sections 62J.498 to 62J.4982.

156.8 **Birth Centers.** Of the state government
156.9 special revenue fund appropriations, \$9,000
156.10 is for licensing birth centers under Minnesota
156.11 Statutes, section 144.651. Base funding shall
156.12 be \$7,000 in fiscal year 2012 and \$7,000 in
156.13 fiscal year 2013.

156.14 **Advisory Group on Administrative**
156.15 **Expenses.** Of the general fund appropriation,
156.16 \$40,000 in fiscal year 2011 is for the advisory
156.17 group established under Minnesota Statutes,
156.18 section 62D.31.

156.19 **Community Clinic Grants.** Of this
156.20 appropriation, \$2,500,000 in fiscal
156.21 year 2011 is for the commissioner to
156.22 provide community clinic grants under
156.23 Minnesota Statutes, section 145.9268. This
156.24 appropriation is onetime. In awarding grants
156.25 using this funding, the commissioner shall
156.26 give priority to proposals that seek to serve
156.27 medically underserved areas of the state that
156.28 are not served by a coordinated care delivery
156.29 system established under Minnesota Statutes,
156.30 section 256D.031, subdivision 6.

156.31 **Federally Qualified Health Center**
156.32 **Subsidies.** Of this appropriation, \$2,500,000
156.33 in fiscal year 2011 is for the commissioner to
156.34 increase subsidies to federally qualified health
156.35 centers provided under Minnesota Statutes,

157.1 section 145.9269. This appropriation is
157.2 onetime. In awarding subsidies using this
157.3 funding, the commissioner shall give priority
157.4 to federally qualified health centers that serve
157.5 medically underserved areas of the state that
157.6 are not served by a coordinated care delivery
157.7 system established under Minnesota Statutes,
157.8 section 256D.031, subdivision 6.

157.9 **Base Level Adjustment.** The general
157.10 fund base is reduced by \$5,134,000 in each
157.11 of fiscal years 2012 and 2013. The state
157.12 government special revenue fund base is
157.13 increased by \$365,000 in each of fiscal years
157.14 2012 and 2013.

157.15	<u>Subd. 4. Health Protection</u>	<u>(374,000)</u>	<u>295,000</u>
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157.16 **Lead Base Grant Program.** Of the general
157.17 fund reduction, \$25,000 in fiscal year 2010
157.18 and fiscal year 2011 is for the elimination
157.19 of state funding for the temporary lead-safe
157.20 housing base grant program.

157.21 **Birth Defects Information System.** Of
157.22 the general fund appropriation, \$500,000 in
157.23 fiscal year 2011 is for the Minnesota Birth
157.24 Defects Information System established
157.25 under Minnesota Statutes, section 144.2215.

157.26 **Base Adjustment.** The general fund base is
157.27 reduced by \$99,000 in each of fiscal years
157.28 2012 and 2013.

157.29	<u>Subd. 5. Administrative Support Services</u>	<u>-0-</u>	<u>(100,000)</u>
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157.30 **Sec. 5. **HEALTH-RELATED BOARDS****

157.31	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>2,900,000</u>	<u>\$</u>	<u>-0-</u>
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157.32 In fiscal year 2010, \$591,000 shall be
157.33 transferred from the state government special

158.1 revenue fund to the general fund. In fiscal
 158.2 year 2011, \$442,000 shall be transferred from
 158.3 the state government special revenue fund
 158.4 to the general fund. These transfers are in
 158.5 addition to those made in Laws 2009, chapter
 158.6 79, article 13, section 5, as amended by Laws
 158.7 2009, chapter 173, article 2, section 3.

158.8 The transfers in this section are onetime in
 158.9 the fiscal year 2010-2011 biennium.

158.10 Subd. 2. **Board of Nursing Home**
 158.11 **Administrators**

2,610,000

-0-

158.12 **Administrative Services Unit; Transfer.**

158.13 This appropriation is from the state
 158.14 government special revenue fund in fiscal
 158.15 year 2010 to the administrative services
 158.16 unit. Upon request for a transfer from a
 158.17 health-related board, the administrative
 158.18 services unit is authorized to transfer
 158.19 money from this appropriation to the board
 158.20 with the approval of the commissioner of
 158.21 management and budget. This appropriation
 158.22 does not cancel. Any unencumbered and
 158.23 unspent balances remain available for these
 158.24 expenditures in subsequent fiscal years. The
 158.25 administrative services unit must report to
 158.26 the legislature a detailed spending report
 158.27 by September 1, 2011, on the uses of these
 158.28 appropriated funds.

158.29 Sec. 6. **EMERGENCY MEDICAL SERVICES**
 158.30 **BOARD**

361,000

(133,000)

158.31 This appropriation must be applied to
 158.32 emergency medical services grant programs.
 158.33 Reductions from the general fund must be
 158.34 applied to the board's operating budget and
 158.35 must not be applied to grant programs.

159.1	<u>Longevity Award and Incentive Program</u>	(19,000)	(19,000)
159.2	<u>Emergency Medical Services Relief</u>		
159.3	<u>Transfer. \$10,000 in fiscal year 2010</u>		
159.4	<u>and \$24,000 in fiscal year 2011 shall be</u>		
159.5	<u>transferred to the general fund from the</u>		
159.6	<u>portion of the emergency medical services</u>		
159.7	<u>relief account in the special revenue fund</u>		
159.8	<u>otherwise designated for distribution by</u>		
159.9	<u>the Emergency Medical Services Board</u>		
159.10	<u>under Minnesota Statutes, section 169.686,</u>		
159.11	<u>subdivision 3. These transfers are onetime in</u>		
159.12	<u>the 2010-2011 biennium.</u>		
159.13	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>		
159.14	<u>HEALTH AND DEVELOPMENTAL</u>		
159.15	<u>DISABILITIES</u>	\$ (31,000)	\$ (50,000)
159.16	Sec. 8. <u>OMBUDSPERSON FOR FAMILIES</u>	\$ (4,000)	\$ (8,000)
159.17	Sec. 9. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:		
159.18	Subd. 7. Medical professional liability insurance. (a) <u>Within the limit of funds</u>		
159.19	<u>appropriated for this program,</u> the administrative services unit must purchase medical		
159.20	professional liability insurance, if available, for a health care provider who is registered in		
159.21	accordance with subdivision 4 and who is not otherwise covered by a medical professional		
159.22	liability insurance policy or self-insured plan either personally or through another facility		
159.23	or employer. <u>The administrative services unit is authorized to prorate payments or</u>		
159.24	<u>otherwise limit the number of participants in the program if the costs of the insurance for</u>		
159.25	<u>eligible providers exceed the funds appropriated for the program.</u>		
159.26	(b) Coverage purchased under this subdivision must be limited to the provision of		
159.27	health care services performed by the provider for which the provider does not receive		
159.28	direct monetary compensation.		
159.29	<u>EFFECTIVE DATE. This section is effective the day following final enactment.</u>		
159.30	Sec. 10. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by		
159.31	Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:		
159.32	Subdivision 1. Total Appropriation	\$ 5,225,451,000	\$ 6,002,864,000

160.1	Appropriations by Fund		
160.2		2010	2011
160.3	General	4,375,689,000	5,209,765,000
160.4	State Government		
160.5	Special Revenue	565,000	565,000
160.6	Health Care Access	450,662,000	527,411,000
160.7	Federal TANF	286,770,000	263,458,000
160.8	Lottery Prize	1,665,000	1,665,000
160.9	Federal Fund	110,000,000	0

160.10 **Receipts for Systems Projects.**

160.11 Appropriations and federal receipts for

160.12 information systems projects for MAXIS,

160.13 PRISM, MMIS, and SSIS must be deposited

160.14 in the state system account authorized in

160.15 Minnesota Statutes, section 256.014. Money

160.16 appropriated for computer projects approved

160.17 by the Minnesota Office of Enterprise

160.18 Technology, funded by the legislature, and

160.19 approved by the commissioner of finance,

160.20 may be transferred from one project to

160.21 another and from development to operations

160.22 as the commissioner of human services

160.23 considers necessary, except that any transfers

160.24 to one project that exceed \$1,000,000 or

160.25 multiple transfers to one project that exceed

160.26 \$1,000,000 in total require the express

160.27 approval of the legislature. The preceding

160.28 requirement for legislative approval does not

160.29 apply to transfers made to establish a project's

160.30 initial operating budget each year; instead,

160.31 the requirements of section 11, subdivision

160.32 2, of this article apply to those transfers. Any

160.33 unexpended balance in the appropriation

160.34 for these projects does not cancel but is

160.35 available for ongoing development and

160.36 operations. Any computer project with a

160.37 total cost exceeding \$1,000,000, including,

161.1 but not limited to, a replacement for the
161.2 proposed HealthMatch system, shall not be
161.3 commenced without the express approval of
161.4 the legislature.

161.5 **HealthMatch Systems Project.** In fiscal
161.6 year 2010, \$3,054,000 shall be transferred
161.7 from the HealthMatch account in the state
161.8 systems account in the special revenue fund
161.9 to the general fund.

161.10 **Nonfederal Share Transfers.** The
161.11 nonfederal share of activities for which
161.12 federal administrative reimbursement is
161.13 appropriated to the commissioner may be
161.14 transferred to the special revenue fund.

161.15 **TANF Maintenance of Effort.**

161.16 (a) In order to meet the basic maintenance
161.17 of effort (MOE) requirements of the TANF
161.18 block grant specified under Code of Federal
161.19 Regulations, title 45, section 263.1, the
161.20 commissioner may only report nonfederal
161.21 money expended for allowable activities
161.22 listed in the following clauses as TANF/MOE
161.23 expenditures:

161.24 (1) MFIP cash, diversionary work program,
161.25 and food assistance benefits under Minnesota
161.26 Statutes, chapter 256J;

161.27 (2) the child care assistance programs
161.28 under Minnesota Statutes, sections 119B.03
161.29 and 119B.05, and county child care
161.30 administrative costs under Minnesota
161.31 Statutes, section 119B.15;

161.32 (3) state and county MFIP administrative
161.33 costs under Minnesota Statutes, chapters
161.34 256J and 256K;

162.1 (4) state, county, and tribal MFIP
162.2 employment services under Minnesota
162.3 Statutes, chapters 256J and 256K;
162.4 (5) expenditures made on behalf of
162.5 noncitizen MFIP recipients who qualify
162.6 for the medical assistance without federal
162.7 financial participation program under
162.8 Minnesota Statutes, section 256B.06,
162.9 subdivision 4, paragraphs (d), (e), and (j);
162.10 ~~and~~
162.11 (6) qualifying working family credit
162.12 expenditures under Minnesota Statutes,
162.13 section 290.0671-; and
162.14 (7) qualifying Minnesota education credit
162.15 expenditures under Minnesota Statutes,
162.16 section 290.0674.
162.17 (b) The commissioner shall ensure that
162.18 sufficient qualified nonfederal expenditures
162.19 are made each year to meet the state's
162.20 TANF/MOE requirements. For the activities
162.21 listed in paragraph (a), clauses (2) to
162.22 (6), the commissioner may only report
162.23 expenditures that are excluded from the
162.24 definition of assistance under Code of
162.25 Federal Regulations, title 45, section 260.31.
162.26 (c) For fiscal years beginning with state
162.27 fiscal year 2003, the commissioner shall
162.28 ensure that the maintenance of effort used
162.29 by the commissioner of finance for the
162.30 February and November forecasts required
162.31 under Minnesota Statutes, section 16A.103,
162.32 contains expenditures under paragraph (a),
162.33 clause (1), equal to at least 16 percent of
162.34 the total required under Code of Federal
162.35 Regulations, title 45, section 263.1.

163.1 (d) For the federal fiscal years beginning on
163.2 or after October 1, 2007, the commissioner
163.3 may not claim an amount of TANF/MOE in
163.4 excess of the 75 percent standard in Code
163.5 of Federal Regulations, title 45, section
163.6 263.1(a)(2), except:

163.7 (1) to the extent necessary to meet the 80
163.8 percent standard under Code of Federal
163.9 Regulations, title 45, section 263.1(a)(1),
163.10 if it is determined by the commissioner
163.11 that the state will not meet the TANF work
163.12 participation target rate for the current year;
163.13 (2) to provide any additional amounts
163.14 under Code of Federal Regulations, title 45,
163.15 section 264.5, that relate to replacement of
163.16 TANF funds due to the operation of TANF
163.17 penalties; and

163.18 (3) to provide any additional amounts that
163.19 may contribute to avoiding or reducing
163.20 TANF work participation penalties through
163.21 the operation of the excess MOE provisions
163.22 of Code of Federal Regulations, title 45,
163.23 section 261.43 (a)(2).

163.24 For the purposes of clauses (1) to (3),
163.25 the commissioner may supplement the
163.26 MOE claim with working family credit
163.27 expenditures to the extent such expenditures
163.28 or other qualified expenditures are otherwise
163.29 available after considering the expenditures
163.30 allowed in this section.

163.31 (e) Minnesota Statutes, section 256.011,
163.32 subdivision 3, which requires that federal
163.33 grants or aids secured or obtained under that
163.34 subdivision be used to reduce any direct

164.1 appropriations provided by law, do not apply
164.2 if the grants or aids are federal TANF funds.
164.3 (f) Notwithstanding any contrary provision
164.4 in this article, this provision expires June 30,
164.5 2013.

164.6 **Working Family Credit Expenditures as**
164.7 **TANF/MOE.** The commissioner may claim
164.8 as TANF/MOE up to \$6,707,000 per year of
164.9 working family credit expenditures for fiscal
164.10 year 2010 through fiscal year 2011.

164.11 **Working Family Credit Expenditures**
164.12 **to be Claimed for TANF/MOE.** The
164.13 commissioner may count the following
164.14 amounts of working family credit expenditure
164.15 as TANF/MOE:

164.16 (1) fiscal year 2010, ~~\$50,973,000~~
164.17 \$50,897,000;

164.18 (2) fiscal year 2011, ~~\$53,793,000~~
164.19 \$54,243,000;

164.20 (3) fiscal year 2012, ~~\$23,516,000~~
164.21 \$23,345,000; and

164.22 (4) fiscal year 2013, ~~\$16,808,000~~
164.23 \$16,585,000.

164.24 Notwithstanding any contrary provision in
164.25 this article, this rider expires June 30, 2013.

164.26 **Food Stamps Employment and Training.**

164.27 (a) The commissioner shall apply for and
164.28 claim the maximum allowable federal
164.29 matching funds under United States Code,
164.30 title 7, section 2025, paragraph (h), for
164.31 state expenditures made on behalf of family
164.32 stabilization services participants voluntarily
164.33 engaged in food stamp employment and
164.34 training activities, where appropriate.

165.1 (b) Notwithstanding Minnesota Statutes,
165.2 sections 256D.051, subdivisions 1a, 6b,
165.3 and 6c, and 256J.626, federal food stamps
165.4 employment and training funds received
165.5 as reimbursement of MFIP consolidated
165.6 fund grant expenditures for diversionary
165.7 work program participants and child
165.8 care assistance program expenditures for
165.9 two-parent families must be deposited in the
165.10 general fund. The amount of funds must be
165.11 limited to \$3,350,000 in fiscal year 2010
165.12 and \$4,440,000 in fiscal years 2011 through
165.13 2013, contingent on approval by the federal
165.14 Food and Nutrition Service.

165.15 (c) Consistent with the receipt of these federal
165.16 funds, the commissioner may adjust the
165.17 level of working family credit expenditures
165.18 claimed as TANF maintenance of effort.
165.19 Notwithstanding any contrary provision in
165.20 this article, this rider expires June 30, 2013.

165.21 **ARRA Food Support Administration.**
165.22 The funds available for food support
165.23 administration under the American Recovery
165.24 and Reinvestment Act (ARRA) of 2009
165.25 are appropriated to the commissioner
165.26 to pay actual costs of implementing the
165.27 food support benefit increases, increased
165.28 eligibility determinations, and outreach. Of
165.29 these funds, 20 percent shall be allocated
165.30 to the commissioner and 80 percent shall
165.31 be allocated to counties. The commissioner
165.32 shall allocate the county portion based on
165.33 caseload. Reimbursement shall be based on
165.34 actual costs reported by counties through
165.35 existing processes. Tribal reimbursement
165.36 must be made from the state portion based

166.1 on a caseload factor equivalent to that of a
166.2 county.

166.3 **ARRA Food Support Benefit Increases.**

166.4 The funds provided for food support benefit
166.5 increases under the Supplemental Nutrition
166.6 Assistance Program provisions of the
166.7 American Recovery and Reinvestment Act
166.8 (ARRA) of 2009 must be used for benefit
166.9 increases beginning July 1, 2009.

166.10 **Emergency Fund for the TANF Program.**

166.11 TANF Emergency Contingency funds
166.12 available under the American Recovery
166.13 and Reinvestment Act of 2009 (Public Law
166.14 111-5) are appropriated to the commissioner.
166.15 The commissioner must request TANF
166.16 Emergency Contingency funds from the
166.17 Secretary of the Department of Health
166.18 and Human Services to the extent the
166.19 commissioner meets or expects to meet the
166.20 requirements of section 403(c) of the Social
166.21 Security Act. The commissioner must seek
166.22 to maximize such grants. The funds received
166.23 must be used as appropriated. Each county
166.24 must maintain the county's current level of
166.25 emergency assistance funding under the
166.26 MFIP consolidated fund and use the funds
166.27 under this paragraph to supplement existing
166.28 emergency assistance funding levels.

166.29 Sec. 11. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by
166.30 Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

166.31 Subd. 3. **Revenue and Pass-Through Revenue**
166.32 **Expenditures**

68,337,000	70,505,000
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166.33 This appropriation is from the federal TANF
166.34 fund.

167.1 **TANF Transfer to Federal Child Care**
167.2 **and Development Fund.** The following
167.3 TANF fund amounts are appropriated to the
167.4 commissioner for the purposes of MFIP and
167.5 transition year child care under Minnesota
167.6 Statutes, section 119B.05:

- 167.7 (1) fiscal year 2010, ~~\$6,531,000~~ \$862,000;
- 167.8 (2) fiscal year 2011, ~~\$10,241,000~~ \$978,000;
- 167.9 (3) fiscal year 2012, ~~\$10,826,000~~ \$0; and
- 167.10 (4) fiscal year 2013, ~~\$4,046,000~~ \$0.

167.11 The commissioner shall authorize the
167.12 transfer of sufficient TANF funds to the
167.13 federal child care and development fund to
167.14 meet this appropriation and shall ensure that
167.15 all transferred funds are expended according
167.16 to federal child care and development fund
167.17 regulations.

167.18 Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
167.19 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

167.20 Subd. 4. **Children and Economic Assistance**
167.21 **Grants**

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

167.24 **(a) MFIP/DWP Grants**

167.25	Appropriations by Fund		
167.26	General	63,205,000	89,033,000
167.27	Federal TANF	100,818,000	84,538,000

167.28 **(b) Support Services Grants**

167.29	Appropriations by Fund		
167.30	General	8,715,000	12,498,000
167.31	Federal TANF	116,557,000	107,457,000

167.32 **MFIP Consolidated Fund.** The MFIP
167.33 consolidated fund TANF appropriation is

168.1 reduced by \$1,854,000 in fiscal year 2010
168.2 and fiscal year 2011.

168.3 Notwithstanding Minnesota Statutes, section
168.4 256J.626, subdivision 8, paragraph (b), the
168.5 commissioner shall reduce proportionately
168.6 the reimbursement to counties for
168.7 administrative expenses.

168.8 **Subsidized Employment Funding Through**

168.9 **ARRA.** The commissioner is authorized to
168.10 apply for TANF emergency fund grants for
168.11 subsidized employment activities. Growth
168.12 in expenditures for subsidized employment
168.13 within the supported work program and the
168.14 MFIP consolidated fund over the amount
168.15 expended in the calendar quarters in the
168.16 TANF emergency fund base year shall be
168.17 used to leverage the TANF emergency fund
168.18 grants for subsidized employment and to
168.19 fund supported work. The commissioner
168.20 shall develop procedures to maximize
168.21 reimbursement of these expenditures over the
168.22 TANF emergency fund base year quarters,
168.23 and may contract directly with employers
168.24 and providers to maximize these TANF
168.25 emergency fund grants.

168.26 **Supported Work.** Of the TANF
168.27 appropriation, \$4,700,000 in fiscal year 2010
168.28 and \$4,700,000 in fiscal year 2011 are to the
168.29 commissioner for supported work for MFIP
168.30 recipients and is available until expended.
168.31 Supported work includes paid transitional
168.32 work experience and a continuum of
168.33 employment assistance, including outreach
168.34 and recruitment, program orientation
168.35 and intake, testing and assessment, job

169.1 development and marketing, preworksite
169.2 training, supported worksite experience,
169.3 job coaching, and postplacement follow-up,
169.4 in addition to extensive case management
169.5 and referral services. This is a onetime
169.6 appropriation.

169.7 **Base Adjustment.** The general fund base
169.8 is reduced by \$3,783,000 in each of fiscal
169.9 years 2012 and 2013. The TANF fund base
169.10 is increased by \$5,004,000 in each of fiscal
169.11 years 2012 and 2013.

169.12 **Integrated Services Program Funding.**
169.13 The TANF appropriation for integrated
169.14 services program funding is \$1,250,000 in
169.15 fiscal year 2010 and \$0 in fiscal year 2011
169.16 and the base for fiscal years 2012 and 2013
169.17 is \$0.

169.18 **TANF Emergency Fund; Nonrecurrent**
169.19 **Short-Term Benefits.** (1) TANF emergency
169.20 contingency fund grants received due to
169.21 increases in expenditures for nonrecurrent
169.22 short-term benefits must be used to offset the
169.23 increase in these expenditures for counties
169.24 under the MFIP consolidated fund, under
169.25 Minnesota Statutes, section 256J.626,
169.26 and the diversionary work program. The
169.27 commissioner shall develop procedures
169.28 to maximize reimbursement of these
169.29 expenditures over the TANF emergency fund
169.30 base year quarters. Growth in expenditures
169.31 for the diversionary work program over the
169.32 amount expended in the calendar quarters in
169.33 the TANF emergency fund base year shall be
169.34 used to leverage these funds.

170.1 (2) To the extent that the commissioner
170.2 can claim eligible tax credit growth as
170.3 nonrecurrent short-term benefits, the
170.4 commissioner shall use those funds to
170.5 leverage the increased expenditures in clause
170.6 (1).

170.7 (3) TANF emergency funds for nonrecurrent
170.8 short-term benefits received in excess of the
170.9 amounts necessary for clauses (1) and (2)
170.10 shall be used to reimburse the general fund
170.11 for the costs of eligible tax credits in fiscal
170.12 year 2011. The amount of such funds shall
170.13 not exceed \$28,000,000.

170.14	(c) MFIP Child Care Assistance Grants	61,171,000	65,214,000
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170.15 **Acceleration of ARRA Child Care and**
170.16 **Development Fund Expenditure.** The
170.17 commissioner must liquidate all child care
170.18 and development money available under
170.19 the American Recovery and Reinvestment
170.20 Act (ARRA) of 2009, Public Law 111-5,
170.21 by September 30, 2010. In order to expend
170.22 those funds by September 30, 2010, the
170.23 commissioner may redesignate and expend
170.24 the ARRA child care and development funds
170.25 appropriated in fiscal year 2011 for purposes
170.26 under this section for related purposes that
170.27 will allow liquidation by September 30,
170.28 2010. Child care and development funds
170.29 otherwise available to the commissioner
170.30 for those related purposes shall be used to
170.31 fund the purposes from which the ARRA
170.32 child care and development funds had been
170.33 redesignated.

170.34 **School Readiness Service Agreements.**
170.35 \$400,000 in fiscal year 2010 and \$400,000

171.1 in fiscal year 2011 are from the federal
171.2 TANF fund to the commissioner of human
171.3 services consistent with federal regulations
171.4 for the purpose of school readiness service
171.5 agreements under Minnesota Statutes,
171.6 section 119B.231. This is a onetime
171.7 appropriation. Any unexpended balance the
171.8 first year is available in the second year.

171.9	(d) Basic Sliding Fee Child Care Assistance		
171.10	Grants	40,100,000	45,092,000

171.11 **School Readiness Service Agreements.**
171.12 \$257,000 in fiscal year 2010 and \$257,000
171.13 in fiscal year 2011 are from the general
171.14 fund for the purpose of school readiness
171.15 service agreements under Minnesota
171.16 Statutes, section 119B.231. This is a onetime
171.17 appropriation. Any unexpended balance the
171.18 first year is available in the second year.

171.19 **Child Care Development Fund**
171.20 **Unexpended Balance.** In addition to
171.21 the amount provided in this section, the
171.22 commissioner shall expend \$5,244,000 in
171.23 fiscal year 2010 from the federal child care
171.24 development fund unexpended balance
171.25 for basic sliding fee child care under
171.26 Minnesota Statutes, section 119B.03. The
171.27 commissioner shall ensure that all child
171.28 care and development funds are expended
171.29 according to the federal child care and
171.30 development fund regulations.

171.31 **Basic Sliding Fee.** \$4,000,000 in fiscal year
171.32 2010 and \$4,000,000 in fiscal year 2011 are
171.33 from the federal child care development
171.34 funds received from the American Recovery
171.35 and Reinvestment Act of 2009, Public
171.36 Law 111-5, to the commissioner of human

172.1 services consistent with federal regulations
172.2 for the purpose of basic sliding fee child care
172.3 assistance under Minnesota Statutes, section
172.4 119B.03. This is a onetime appropriation.
172.5 Any unexpended balance the first year is
172.6 available in the second year.

172.7 **Basic Sliding Fee Allocation for Calendar**
172.8 **Year 2010.** Notwithstanding Minnesota
172.9 Statutes, section 119B.03, subdivision 6,
172.10 in calendar year 2010, basic sliding fee
172.11 funds shall be distributed according to
172.12 this provision. Funds shall be allocated
172.13 first in amounts equal to each county's
172.14 guaranteed floor, according to Minnesota
172.15 Statutes, section 119B.03, subdivision 8,
172.16 with any remaining available funds allocated
172.17 according to the following formula:

172.18 (a) Up to one-fourth of the funds shall be
172.19 allocated in proportion to the number of
172.20 families participating in the transition year
172.21 child care program as reported during and
172.22 averaged over the most recent six months
172.23 completed at the time of the notice of
172.24 allocation. Funds in excess of the amount
172.25 necessary to serve all families in this category
172.26 shall be allocated according to paragraph (d).

172.27 (b) Up to three-fourths of the funds shall
172.28 be allocated in proportion to the average
172.29 of each county's most recent six months of
172.30 reported waiting list as defined in Minnesota
172.31 Statutes, section 119B.03, subdivision 2, and
172.32 the reinstatement list of those families whose
172.33 assistance was terminated with the approval
172.34 of the commissioner under Minnesota Rules,
172.35 part 3400.0183, subpart 1. Funds in excess

173.1 of the amount necessary to serve all families
173.2 in this category shall be allocated according
173.3 to paragraph (d).

173.4 (c) The amount necessary to serve all families
173.5 in paragraphs (a) and (b) shall be calculated
173.6 based on the basic sliding fee average cost of
173.7 care per family in the county with the highest
173.8 cost in the most recently completed calendar
173.9 year.

173.10 (d) Funds in excess of the amount necessary
173.11 to serve all families in paragraphs (a) and
173.12 (b) shall be allocated in proportion to each
173.13 county's total expenditures for the basic
173.14 sliding fee child care program reported
173.15 during the most recent fiscal year completed
173.16 at the time of the notice of allocation. To
173.17 the extent that funds are available, and
173.18 notwithstanding Minnesota Statutes, section
173.19 119B.03, subdivision 8, for the period
173.20 January 1, 2011, to December 31, 2011, each
173.21 county's guaranteed floor must be equal to its
173.22 original calendar year 2010 allocation.

173.23 **Base Adjustment.** The general fund base is
173.24 decreased by \$257,000 in each of fiscal years
173.25 2012 and 2013.

173.26	(e) Child Care Development Grants	1,487,000	1,487,000
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173.27 **Family, friends, and neighbor grants.**
173.28 \$375,000 in fiscal year 2010 and \$375,000
173.29 in fiscal year 2011 are from the child
173.30 care development fund required targeted
173.31 quality funds for quality expansion and
173.32 infant/toddler from the American Recovery
173.33 and Reinvestment Act of 2009, Public
173.34 Law 111-5, to the commissioner of human
173.35 services for family, friends, and neighbor

174.1 grants under Minnesota Statutes, section
174.2 119B.232. This appropriation may be used
174.3 on programs receiving family, friends, and
174.4 neighbor grant funds as of June 30, 2009,
174.5 or on new programs or projects. This is a
174.6 onetime appropriation. Any unexpended
174.7 balance the first year is available in the
174.8 second year.

174.9 **Voluntary quality rating system training,**
174.10 **coaching, consultation, and supports.**
174.11 \$633,000 in fiscal year 2010 and \$633,000
174.12 in fiscal year 2011 are from the federal child
174.13 care development fund required targeted
174.14 quality funds for quality expansion and
174.15 infant/toddler from the American Recovery
174.16 and Reinvestment Act of 2009, Public
174.17 Law 111-5, to the commissioner of human
174.18 services consistent with federal regulations
174.19 for the purpose of providing grants to provide
174.20 statewide child-care provider training,
174.21 coaching, consultation, and supports to
174.22 prepare for the voluntary Minnesota quality
174.23 rating system rating tool. This is a onetime
174.24 appropriation. Any unexpended balance the
174.25 first year is available in the second year.

174.26 **Voluntary quality rating system.** \$184,000
174.27 in fiscal year 2010 and \$1,200,000 in fiscal
174.28 year 2011 are from the federal child care
174.29 development fund required targeted funds for
174.30 quality expansion and infant/toddler from the
174.31 American Recovery and Reinvestment Act of
174.32 2009, Public Law 111-5, to the commissioner
174.33 of human services consistent with federal
174.34 regulations for the purpose of implementing
174.35 the voluntary Parent Aware quality star
174.36 rating system pilot in coordination with the

175.1 Minnesota Early Learning Foundation. The
175.2 appropriation for the first year is to complete
175.3 and promote the voluntary Parent Aware
175.4 quality rating system pilot program through
175.5 June 30, 2010, and the appropriation for
175.6 the second year is to continue the voluntary
175.7 Minnesota quality rating system pilot
175.8 through June 30, 2011. This is a onetime
175.9 appropriation. Any unexpended balance the
175.10 first year is available in the second year.

175.11 **(f) Child Support Enforcement Grants** 3,705,000 3,705,000

175.12 **(g) Children's Services Grants**

175.13	Appropriations by Fund		
175.14	General	48,333,000	50,498,000
175.15	Federal TANF	340,000	240,000

175.16 **Base Adjustment.** The general fund base is
175.17 decreased by \$5,371,000 in fiscal year 2012
175.18 and decreased \$5,371,000 in fiscal year 2013.

175.19 **Privatized Adoption Grants.** Federal
175.20 reimbursement for privatized adoption grant
175.21 and foster care recruitment grant expenditures
175.22 is appropriated to the commissioner for
175.23 adoption grants and foster care and adoption
175.24 administrative purposes.

175.25 **Adoption Assistance Incentive Grants.**
175.26 Federal funds available during fiscal year
175.27 2010 and fiscal year 2011 for the adoption
175.28 incentive grants are appropriated to the
175.29 commissioner for postadoption services
175.30 including parent support groups.

175.31 **Adoption Assistance and Relative Custody**
175.32 **Assistance.** The commissioner may transfer
175.33 unencumbered appropriation balances for
175.34 adoption assistance and relative custody

176.1 assistance between fiscal years and between
176.2 programs.

176.3	(h) Children and Community Services Grants	67,663,000	67,542,000
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176.4 **Targeted Case Management Temporary**
176.5 **Funding Adjustment.** The commissioner
176.6 shall recover from each county and tribe
176.7 receiving a targeted case management
176.8 temporary funding payment in fiscal year
176.9 2008 an amount equal to that payment. The
176.10 commissioner shall recover one-half of the
176.11 funds by February 1, 2010, and the remainder
176.12 by February 1, 2011. At the commissioner's
176.13 discretion and at the request of a county
176.14 or tribe, the commissioner may revise
176.15 the payment schedule, but full payment
176.16 must not be delayed beyond May 1, 2011.
176.17 The commissioner may use the recovery
176.18 procedure under Minnesota Statutes, section
176.19 256.017, to recover the funds. Recovered
176.20 funds must be deposited into the general
176.21 fund.

176.22	(i) General Assistance Grants	48,215,000	48,608,000
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176.23 **General Assistance Standard.** The
176.24 commissioner shall set the monthly standard
176.25 of assistance for general assistance units
176.26 consisting of an adult recipient who is
176.27 childless and unmarried or living apart
176.28 from parents or a legal guardian at \$203.
176.29 The commissioner may reduce this amount
176.30 according to Laws 1997, chapter 85, article
176.31 3, section 54.

176.32 **Emergency General Assistance.** The
176.33 amount appropriated for emergency general
176.34 assistance funds is limited to no more
176.35 than \$7,889,812 in fiscal year 2010 and

177.1	\$7,889,812 in fiscal year 2011. Funds		
177.2	to counties must be allocated by the		
177.3	commissioner using the allocation method		
177.4	specified in Minnesota Statutes, section		
177.5	256D.06.		
177.6	(j) Minnesota Supplemental Aid Grants	33,930,000	35,191,000
177.7	Emergency Minnesota Supplemental		
177.8	Aid Funds. The amount appropriated for		
177.9	emergency Minnesota supplemental aid		
177.10	funds is limited to no more than \$1,100,000		
177.11	in fiscal year 2010 and \$1,100,000 in fiscal		
177.12	year 2011. Funds to counties must be		
177.13	allocated by the commissioner using the		
177.14	allocation method specified in Minnesota		
177.15	Statutes, section 256D.46.		
177.16	(k) Group Residential Housing Grants	111,778,000	114,034,000
177.17	Group Residential Housing Costs		
177.18	Refinanced. (a) Effective July 1, 2011, the		
177.19	commissioner shall increase the home and		
177.20	community-based service rates and county		
177.21	allocations provided to programs for persons		
177.22	with disabilities established under section		
177.23	1915(c) of the Social Security Act to the		
177.24	extent that these programs will be paying		
177.25	for the costs above the rate established		
177.26	in Minnesota Statutes, section 256I.05,		
177.27	subdivision 1.		
177.28	(b) For persons receiving services under		
177.29	Minnesota Statutes, section 245A.02, who		
177.30	reside in licensed adult foster care beds		
177.31	for which a difficulty of care payment		
177.32	was being made under Minnesota Statutes,		
177.33	section 256I.05, subdivision 1c, paragraph		
177.34	(b), counties may request an exception to		
177.35	the individual's service authorization not to		

178.1 exceed the difference between the client's
178.2 monthly service expenditures plus the
178.3 amount of the difficulty of care payment.

178.4	(l) Children's Mental Health Grants	16,885,000	16,882,000
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178.5 **Funding Usage.** Up to 75 percent of a fiscal
178.6 year's appropriation for children's mental
178.7 health grants may be used to fund allocations
178.8 in that portion of the fiscal year ending
178.9 December 31.

178.10	(m) Other Children and Economic Assistance		
178.11	Grants	16,047,000	15,339,000

178.12 **Fraud Prevention Grants.** Of this
178.13 appropriation, \$228,000 in fiscal year 2010
178.14 and ~~\$228,000~~ \$379,000 in fiscal year 2011
178.15 is to the commissioner for fraud prevention
178.16 grants to counties.

178.17 **Homeless and Runaway Youth.** \$218,000
178.18 in fiscal year 2010 is for the Runaway
178.19 and Homeless Youth Act under Minnesota
178.20 Statutes, section 256K.45. Funds shall be
178.21 spent in each area of the continuum of care
178.22 to ensure that programs are meeting the
178.23 greatest need. Any unexpended balance in
178.24 the first year is available in the second year.
178.25 Beginning July 1, 2011, the base is increased
178.26 by \$119,000 each year.

178.27 **ARRA Homeless Youth Funds.** To the
178.28 extent permitted under federal law, the
178.29 commissioner shall designate \$2,500,000
178.30 of the Homeless Prevention and Rapid
178.31 Re-Housing Program funds provided under
178.32 the American Recovery and Reinvestment
178.33 Act of 2009, Public Law 111-5, for agencies
178.34 providing homelessness prevention and rapid
178.35 rehousing services to youth.

179.1 **Supportive Housing Services.** \$1,500,000
179.2 each year is for supportive services under
179.3 Minnesota Statutes, section 256K.26. This is
179.4 a onetime appropriation.

179.5 **Community Action Grants.** Community
179.6 action grants are reduced one time by
179.7 \$1,794,000 each year. This reduction is due
179.8 to the availability of federal funds under the
179.9 American Recovery and Reinvestment Act.

179.10 **Base Adjustment.** The general fund base
179.11 is increased by ~~\$773,000~~ \$903,000 in fiscal
179.12 year 2012 and ~~\$773,000~~ \$413,000 in fiscal
179.13 year 2013.

179.14 **Federal ARRA Funds for Existing**
179.15 **Programs.** ~~(a)~~ (1) Federal funds received by
179.16 the commissioner for the emergency food
179.17 and shelter program from the American
179.18 Recovery and Reinvestment Act of 2009,
179.19 Public Law 111-5, but not previously
179.20 approved by the legislature are appropriated
179.21 to the commissioner for the purposes of the
179.22 grant program.

179.23 ~~(b)~~ (2) Federal funds received by the
179.24 commissioner for the emergency shelter
179.25 grant program including the Homelessness
179.26 Prevention and Rapid Re-Housing
179.27 Program from the American Recovery and
179.28 Reinvestment Act of 2009, Public Law
179.29 111-5, are appropriated to the commissioner
179.30 for the purposes of the grant programs.

179.31 ~~(c)~~ (3) Federal funds received by the
179.32 commissioner for the emergency food
179.33 assistance program from the American
179.34 Recovery and Reinvestment Act of 2009,
179.35 Public Law 111-5, are appropriated to the

180.1 commissioner for the purposes of the grant
180.2 program.

180.3 ~~(d)~~ (4) Federal funds received by the
180.4 commissioner for senior congregate meals
180.5 and senior home-delivered meals from the
180.6 American Recovery and Reinvestment Act
180.7 of 2009, Public Law 111-5, are appropriated
180.8 to the commissioner for the Minnesota Board
180.9 on Aging, for purposes of the grant programs.

180.10 ~~(e)~~ (5) Federal funds received by the
180.11 commissioner for the community services
180.12 block grant program from the American
180.13 Recovery and Reinvestment Act of 2009,
180.14 Public Law 111-5, are appropriated to the
180.15 commissioner for the purposes of the grant
180.16 program.

180.17 **Long-Term Homeless Supportive**
180.18 **Service Fund Appropriation.** To the
180.19 extent permitted under federal law, the
180.20 commissioner shall designate \$3,000,000
180.21 of the Homelessness Prevention and Rapid
180.22 Re-Housing Program funds provided under
180.23 the American Recovery and Reinvestment
180.24 Act of 2009, Public Law, 111-5, to the
180.25 long-term homeless service fund under
180.26 Minnesota Statutes, section 256K.26. This
180.27 appropriation shall become available by July
180.28 1, 2009. This paragraph is effective the day
180.29 following final enactment.

180.30 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
180.31 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

180.32 Subd. 8. **Continuing Care Grants**

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

181.1	(a) Aging and Adult Services Grants	13,499,000	15,805,000
181.2	Base Adjustment. The general fund base is		
181.3	increased by \$5,751,000 in fiscal year 2012		
181.4	and \$6,705,000 in fiscal year 2013.		
181.5	Information and Assistance		
181.6	Reimbursement. Federal administrative		
181.7	reimbursement obtained from information		
181.8	and assistance services provided by the		
181.9	Senior LinkAge or Disability Linkage lines		
181.10	to people who are identified as eligible for		
181.11	medical assistance shall be appropriated to		
181.12	the commissioner for this activity.		
181.13	Community Service Development Grant		
181.14	Reduction. Funding for community service		
181.15	development grants must be reduced by		
181.16	\$260,000 for fiscal year 2010; \$284,000 in		
181.17	fiscal year 2011; \$43,000 in fiscal year 2012;		
181.18	and \$43,000 in fiscal year 2013. Base level		
181.19	funding shall be restored in fiscal year 2014.		
181.20	Community Service Development Grant		
181.21	Community Initiative. Funding for		
181.22	community service development grants shall		
181.23	be used to offset the cost of aging support		
181.24	grants. Base level funding shall be restored		
181.25	in fiscal year 2014.		
181.26	Senior Nutrition Use of Federal Funds.		
181.27	For fiscal year 2010, general fund grants		
181.28	for home-delivered meals and congregate		
181.29	dining shall be reduced by \$500,000. The		
181.30	commissioner must replace these general		
181.31	fund reductions with equal amounts from		
181.32	federal funding for senior nutrition from the		
181.33	American Recovery and Reinvestment Act		
181.34	of 2009.		

182.1	(b) Alternative Care Grants	50,234,000	48,576,000
182.2	Base Adjustment. The general fund base is		
182.3			
182.4			
182.5	Alternative Care Transfer. Any money		
182.6			
182.7			
182.8			
182.9			
182.10	(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
182.11			
182.12	(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000
182.13			
182.14	Manage Growth in TBI and CADI		
182.15	Waivers. During the fiscal years beginning		
182.16			
182.17			
182.18			
182.19			
182.20			
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182.22			
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183.1 anticipated to be discharged from institutional
183.2 settings or who are at imminent risk of a
183.3 placement in an institutional setting.

183.4 **Manage Growth in ~~DD~~ Developmental**
183.5 **Disability Waiver.** The commissioner
183.6 shall manage the growth in the DD waiver
183.7 by limiting the allocations included in the
183.8 February 2009 forecast to 15 additional
183.9 diversion allocations each month for the
183.10 calendar years that begin on January 1, 2010,
183.11 and January 1, 2011. Additional allocations
183.12 must be made available for transfers
183.13 authorized by the commissioner from the
183.14 personal care program of individuals having
183.15 a home care rating of "CS," "MT," or "HL."

183.16 **Adjustment to Lead Agency Waiver**
183.17 **Allocations.** Prior to the availability of the
183.18 alternative license defined in Minnesota
183.19 Statutes, section 245A.11, subdivision 8,
183.20 the commissioner shall reduce lead agency
183.21 waiver allocations for the purposes of
183.22 implementing a moratorium on corporate
183.23 foster care.

183.24 **Alternatives to Personal Care Assistance**
183.25 **Services.** Base level funding of \$3,237,000
183.26 in fiscal year 2012 and \$4,856,000 in
183.27 fiscal year 2013 is to implement alternative
183.28 services to personal care assistance services
183.29 for persons with mental health and other
183.30 behavioral challenges who can benefit
183.31 from other services that more appropriately
183.32 meet their needs and assist them in living
183.33 independently in the community. These
183.34 services may include, but not be limited to, a
183.35 1915(i) state plan option.

184.1 (e) Mental Health Grants

184.2	Appropriations by Fund		
184.3	General	77,739,000	77,739,000
184.4	Health Care Access	750,000	750,000
184.5	Lottery Prize	1,508,000	1,508,000

184.6 **Funding Usage.** Up to 75 percent of a fiscal
184.7 year's appropriation for adult mental health
184.8 grants may be used to fund allocations in that
184.9 portion of the fiscal year ending December
184.10 31.

184.11	(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
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184.12	(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000
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184.13 **Payments for Substance Abuse Treatment.**

184.14 For services provided during fiscal years
184.15 2010 and 2011, county-negotiated rates
184.16 and provider claims to the consolidated
184.17 chemical dependency fund must not exceed
184.18 the lesser of: (1) rates charged for these
184.19 services on January 1, 2009; or (2) 160
184.20 percent of the average rate on January 1,
184.21 2009, for each group of vendors with similar
184.22 attributes. For services provided in fiscal
184.23 years 2012 and 2013, ~~the statewide average~~
184.24 ~~rates aggregate payment~~ under the new
184.25 rate methodology to be developed under
184.26 Minnesota Statutes, section 254B.12, must
184.27 not exceed the ~~average rates charged for~~
184.28 ~~these services on January 1, 2009, plus a~~
184.29 ~~state share increase of \$3,787,000 for fiscal~~
184.30 ~~year 2012 and \$5,023,000 for fiscal year~~
184.31 ~~2013~~ projected aggregate payment under
184.32 the rates in effect for fiscal year 2010 minus
184.33 1.25 percent. Notwithstanding any provision
184.34 to the contrary in this article, this provision
184.35 expires on June 30, 2013.

185.1 **Chemical Dependency Special Revenue**
185.2 **Account.** For fiscal year 2010, \$750,000
185.3 must be transferred from the consolidated
185.4 chemical dependency treatment fund
185.5 administrative account and deposited into the
185.6 general fund.

185.7 **County CD Share of MA Costs for**
185.8 **ARRA Compliance.** Notwithstanding the
185.9 provisions of Minnesota Statutes, chapter
185.10 254B, for chemical dependency services
185.11 provided during the period October 1, 2008,
185.12 to December 31, 2010, and reimbursed by
185.13 medical assistance at the enhanced federal
185.14 matching rate provided under the American
185.15 Recovery and Reinvestment Act of 2009, the
185.16 county share is 30 percent of the nonfederal
185.17 share. This provision is effective the day
185.18 following final enactment.

185.19	(h) Chemical Dependency Nonentitlement		
185.20	Grants	1,729,000	1,729,000

185.21	(i) Other Continuing Care Grants	19,201,000	17,528,000
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185.22 **Base Adjustment.** The general fund base is
185.23 increased by \$2,639,000 in fiscal year 2012
185.24 and increased by \$3,854,000 in fiscal year
185.25 2013.

185.26 **Technology Grants.** \$650,000 in fiscal
185.27 year 2010 and \$1,000,000 in fiscal year
185.28 2011 are for technology grants, case
185.29 consultation, evaluation, and consumer
185.30 information grants related to developing and
185.31 supporting alternatives to shift-staff foster
185.32 care residential service models.

185.33 **Other Continuing Care Grants; HIV**
185.34 **Grants.** Money appropriated for the HIV
185.35 drug and insurance grant program in fiscal

186.1 year 2010 may be used in either year of the
186.2 biennium.

186.3 **Quality Assurance Commission.** Effective
186.4 July 1, 2009, state funding for the quality
186.5 assurance commission under Minnesota
186.6 Statutes, section 256B.0951, is canceled.

186.7 Sec. 14. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by
186.8 Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

186.9 Subd. 8. Board of Nursing Home		
186.10 Administrators	1,211,000	1,023,000

186.11 **Administrative Services Unit - Operating**
186.12 **Costs.** Of this appropriation, \$524,000
186.13 in fiscal year 2010 and \$526,000 in
186.14 fiscal year 2011 are for operating costs
186.15 of the administrative services unit. The
186.16 administrative services unit may receive
186.17 and expend reimbursements for services
186.18 performed by other agencies.

186.19 **Administrative Services Unit - Retirement**
186.20 **Costs.** Of this appropriation in fiscal year
186.21 2010, \$201,000 is for onetime retirement
186.22 costs in the health-related boards. This
186.23 funding may be transferred to the health
186.24 boards incurring those costs for their
186.25 payment. These funds are available either
186.26 year of the biennium.

186.27 **Administrative Services Unit - Volunteer**
186.28 **Health Care Provider Program.** Of this
186.29 appropriation, \$79,000 in fiscal year 2010
186.30 and \$89,000 in fiscal year 2011 are to pay
186.31 for medical professional liability coverage
186.32 required under Minnesota Statutes, section
186.33 214.40.

187.1 **Administrative Services Unit - Contested**
187.2 **Cases and Other Legal Proceedings.** Of
187.3 this appropriation, \$200,000 in fiscal year
187.4 2010 and \$200,000 in fiscal year 2011 are
187.5 for costs of contested case hearings and other
187.6 unanticipated costs of legal proceedings
187.7 involving health-related boards funded
187.8 under this section and for unforeseen
187.9 expenditures of an urgent nature. Upon
187.10 certification of a health-related board to the
187.11 administrative services unit that the costs
187.12 will be incurred and that there is insufficient
187.13 money available to pay for the costs out of
187.14 money currently available to that board, the
187.15 administrative services unit is authorized
187.16 to transfer money from this appropriation
187.17 to the board for payment of those costs
187.18 with the approval of the commissioner of
187.19 finance. This appropriation does not cancel.
187.20 Any unencumbered and unspent balances
187.21 remain available for these expenditures in
187.22 subsequent fiscal years. The boards receiving
187.23 funds under this section shall include these
187.24 amounts when setting fees to cover their
187.25 costs.

187.26 Sec. 15. **CANCELLATIONS.**

187.27 The remaining balance from Laws 2008, chapter 358, article 5, section 4, subdivision
187.28 3, appropriation for Section 125 employer incentives, is canceled.

187.29 Sec. 16. **TRANSFERS.**

187.30 The commissioner of management and budget shall transfer from the general fund to
187.31 the health care access fund \$38,475,000 in fiscal year 2011, \$14,758,000 in fiscal year
187.32 2012, and \$35,058,000 in fiscal year 2013.

188.1 **EFFECTIVE DATE.** This section is effective upon federal approval of the
188.2 amendments to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056,
188.3 subdivision 4.

188.4 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**
188.5 All uncodified language contained in this article expires on June 30, 2011, unless a
188.6 different expiration date is explicit.

188.7 Sec. 18. **EFFECTIVE DATE.**
188.8 The provisions in this article are effective July 1, 2010, unless a different effective
188.9 date is explicit.

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Article locations in H2614-1

ARTICLE 1	DHS LICENSING	Page.Ln 2.9
ARTICLE 2	HEALTH CARE	Page.Ln 12.26
ARTICLE 3	CONTINUING CARE	Page.Ln 57.28
ARTICLE 4	CHILDREN AND FAMILY SERVICES	Page.Ln 69.20
ARTICLE 5	MISCELLANEOUS	Page.Ln 77.9
ARTICLE 6	DEPARTMENT OF HEALTH	Page.Ln 94.9
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ARTICLE 8	PUBLIC HEALTH	Page.Ln 125.22
ARTICLE 9	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 131.1
ARTICLE 10	HUMAN SERVICES CONTINGENT APPROPRIATIONS	Page.Ln 132.29
ARTICLE 11	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 139.8

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subd. 2. **County adjustment; maximum allocation.** The commissioner shall determine the state money used by each county in fiscal year 1986, using all state data sources. If available records do not provide specific chemical dependency expenditures for every county, the commissioner shall determine the amount of state money using estimates based on available data. In state fiscal year 1988, a county must not be allocated more than 150 percent of the state money spent by or on behalf of the county in fiscal year 1986 for chemical dependency treatment services eligible for payment under section 254B.05 but not including expenditures made for persons eligible for placement under section 254B.09, subdivision 6. The allocation maximums must be increased by 25 percent each year. After fiscal year 1992, there must be no allocation maximum. The commissioner shall reallocate the excess over the maximum to counties allocated less than the fiscal year 1986 state money, using the following process:

(a) The allocation is divided by 1986 state expenditures to determine percentage of prior expenditure, and counties are ranked by percentage of prior expenditure less expenditures for persons eligible for placement under section 254B.09, subdivision 6.

(b) The allocation of the lowest ranked county is raised to the same percentage of prior expenditure as the second lowest ranked county. The allocation of these two counties is then raised to the percentage of prior expenditures of the third lowest ranked county.

(c) The operations under paragraph (b) are repeated with each county by ranking until the money in excess of the allocation maximum has been allocated.

Subd. 3. **Reserve account.** The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, at the end of each biennium, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Subd. 4. **Allocation spending limits.** Money allocated according to subdivision 1 and section 254B.09, subdivision 4, is available for payments for up to two years. The commissioner shall deduct payments from the most recent year allocation in which money is available. Allocations under this section that are not used within two years must be reallocated to the reserve account for payments under subdivision 3. Allocations under section 254B.09, subdivision 4, that are not used within two years must be reallocated for payments under section 254B.09, subdivision 5.

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subd. 4. **Tribal allocation.** Eighty-five percent of the American Indian chemical dependency tribal account must be allocated to the federally recognized American Indian tribal governing bodies that have entered into an agreement under subdivision 2 as follows: \$10,000 must be allocated to each governing body and the remainder must be allocated in direct proportion to the population of the reservation according to the most recently available estimates from the federal Bureau of Indian Affairs. When a tribal governing body has not entered into an agreement with the commissioner under subdivision 2, the county may use funds allocated to the reservation to pay for chemical dependency services for a current resident of the county and of the reservation.

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Subd. 5. **Tribal reserve account.** The commissioner shall reserve 15 percent of the American Indian chemical dependency tribal account. The reserve must be allocated to those tribal units that have used all money allocated under subdivision 4 according to agreements made under subdivision 2 and to counties submitting invoices for American Indians under subdivision 1 when all money allocated under subdivision 4 has been used. An American Indian tribal governing body or a county submitting invoices under subdivision 1 may receive not more than 30 percent of the reserve account in a year. The commissioner may refuse to make reserve payments for persons not eligible under section 254B.04, subdivision 1, if the tribal governing body responsible for treatment placement has exhausted its allocation. Money must be allocated as invoices are received.

Subd. 7. **Nonreservation Indian account.** The nonreservation American Indian chemical dependency allocation must be held in reserve by the commissioner in an account for treatment of Indians not residing on lands of a reservation receiving money under subdivision 4. This money must be used to pay for services certified by county invoice to have been provided to an American Indian eligible recipient. Money allocated under this subdivision may be used for payments on behalf of American Indian county residents only if, in addition to other placement standards, the county certifies that the placement was appropriate to the cultural orientation of the client. Any funds for treatment of nonreservation Indians remaining at the end of a fiscal year shall be reallocated under section 254B.02.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

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

(2) who is a resident of Minnesota; and

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

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

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

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

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

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

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(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

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

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

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

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

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

(6) are eligible under paragraph (k);

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

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

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

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

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

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

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial

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months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

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

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

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

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 5. **Certain county agencies to pay state for county share.** The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a

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pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

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(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

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Laws 2009, chapter 79, article 7, section 26, subdivision 3

Sec. 26. STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT PROJECT.

Subd. 3. **Report.** The Department of Human Services shall evaluate the efficacy and feasibility of the pilot projects and report the results of that evaluation to the legislative committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot projects may occur only if the department's report finds the pilot projects effective.

Laws 2010, chapter 200, article 1, section 12 Subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9,

Sec. 12. [256D.031] GENERAL ASSISTANCE MEDICAL CARE.

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

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

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of \$1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

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

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

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

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

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human

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Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare-certified rehabilitation agencies;
- (4) prescription drugs;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations;
- (7) hearing aids;
- (8) prosthetic devices, if not covered by veterans benefits;
- (9) laboratory and x-ray services;
- (10) physicians' services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services;
- (15) mental health services covered under chapter 256B;
- (16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for

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inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(18) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(19) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) \$25 for nonemergency visits to a hospital-based emergency room; and

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 5. Payment rates and contract modification; April 1, 2010, to May 31, 2010. (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater than 1.3 percent of net

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patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

(2) establish a process to monitor enrollment and ensure the quality of care provided; and

(3) in cooperation with counties, coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner

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deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system.

(a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

(c) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(d) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

Subd. 8. Temporary uncompensated care pool. (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to November 30, 2010.

(c) The aggregated payment amounts for each hospital must be calculated as a percentage of the total calculated amount for all hospitals.

(d) Distributions from the uncompensated care pool for each hospital must be determined by multiplying the factor in paragraph (c) by the amount of money in the uncompensated care pool that is available for the six-month period.

(e) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(f) Outpatient prescription drugs are not eligible for payment under this subdivision.

Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

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Sec. 18. **DRUG REBATE PROGRAM.**

The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph (cc), and 256D.03.

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

Laws 2010, chapter 200, article 1, section 19

Sec. 19. **TRANSITIONAL MINNESOTACARE PHASEOUT.**

For any applicant or recipient who meets the requirements of Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), before April 1, 2010, and who is not exempt under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (f), the commissioner of human services shall continue the process of enrolling the recipient in MinnesotaCare as required under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), and, upon the completion of enrollment, the recipient shall receive services under MinnesotaCare in accordance with Minnesota Statutes, section 256L.03. County agencies shall continue to perform all duties necessary to administer the MinnesotaCare program ongoing for individuals enrolled in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), including the redetermination of MinnesotaCare eligibility at renewal.

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