

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; 144.293, subdivision 4; 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; 256.969, subdivision 21; 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.03, subdivision 3b; 256D.0515; 256I.05, by adding a subdivision; 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.04, subdivision 7; 256L.05, by adding a subdivision; 256L.07, subdivision 1, 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; 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, subdivisions 5a, 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 8, sections 2; 51; 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, subdivisions 6, 7, 8; 13, subdivision 1b; 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. (a) If the commissioner does not set aside a disqualification of an individual under section 245C.22~~  
(a) An individual 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 following a reconsideration decision issued under section 245C.23, 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 following a reconsideration decision.** (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~~ following a reconsideration decision under section 245C.23, 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 the disqualification of an~~ A disqualified 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 following a reconsideration determination under section 245C.23, 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~~ of the reconsideration decision. 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 a disqualification that is~~ (b) When an individual is disqualified based on a maltreatment determination, the scope of the contested case hearing under paragraph (a) must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) Rules adopted under this chapter may not preclude an employee in a contested case hearing for a disqualification from submitting evidence concerning information gathered under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, ~~which has not been set aside under sections 245C.22 and~~ following a reconsideration decision under section 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 under sections 245C.22 and 245C.23~~ and the individual remains disqualified following a reconsideration decision, 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:

7.1 Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative  
7.2 reconsideration is not applicable in family assessments since no determination concerning  
7.3 maltreatment is made. For investigations, except as provided under paragraph (e), an  
7.4 individual or facility that the commissioner of human services, a local social service  
7.5 agency, or the commissioner of education determines has maltreated a child, an interested  
7.6 person acting on behalf of the child, regardless of the determination, who contests  
7.7 the investigating agency's final determination regarding maltreatment, may request the  
7.8 investigating agency to reconsider its final determination regarding maltreatment. The  
7.9 request for reconsideration must be submitted in writing to the investigating agency within  
7.10 15 calendar days after receipt of notice of the final determination regarding maltreatment  
7.11 or, if the request is made by an interested person who is not entitled to notice, within  
7.12 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the  
7.13 request for reconsideration must be postmarked and sent to the investigating agency  
7.14 within 15 calendar days of the individual's or facility's receipt of the final determination. If  
7.15 the request for reconsideration is made by personal service, it must be received by the  
7.16 investigating agency within 15 calendar days after the individual's or facility's receipt of the  
7.17 final determination. Effective January 1, 2002, an individual who was determined to have  
7.18 maltreated a child under this section and who was disqualified on the basis of serious or  
7.19 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration  
7.20 of the maltreatment determination and the disqualification. The request for reconsideration  
7.21 of the maltreatment determination and the disqualification must be submitted within 30  
7.22 calendar days of the individual's receipt of the notice of disqualification under sections  
7.23 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment  
7.24 determination and the disqualification must be postmarked and sent to the investigating  
7.25 agency within 30 calendar days of the individual's receipt of the maltreatment  
7.26 determination and notice of disqualification. If the request for reconsideration is made by  
7.27 personal service, it must be received by the investigating agency within 30 calendar days  
7.28 after the individual's receipt of the notice of disqualification.

7.29 (b) Except as provided under paragraphs (e) and (f), if the investigating agency  
7.30 denies the request or fails to act upon the request within 15 working days after receiving  
7.31 the request for reconsideration, the person or facility entitled to a fair hearing under section  
7.32 256.045 may submit to the commissioner of human services or the commissioner of  
7.33 education a written request for a hearing under that section. Section 256.045 also governs  
7.34 hearings requested to contest a final determination of the commissioner of education. For  
7.35 reports involving maltreatment of a child in a facility, an interested person acting on behalf  
7.36 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 under sections 245C.21 to 245C.27~~ and the individual remains disqualified following a reconsideration decision, 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

13.1 involved in the electronic exchange of health records between the entities for the delivery  
13.2 of patient care.

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

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

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

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

13.15 (g) "Patient" means a natural person who has received health care services from a  
13.16 provider for treatment or examination of a medical, psychiatric, or mental condition, the  
13.17 surviving spouse and parents of a deceased patient, or a person the patient appoints in  
13.18 writing as a representative, including a health care agent acting according to chapter 145C,  
13.19 unless the authority of the agent has been limited by the principal in the principal's health  
13.20 care directive. Except for minors who have received health care services under sections  
13.21 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a  
13.22 person acting as a parent or guardian in the absence of a parent or guardian.

13.23 (h) "Provider" means:

13.24 (1) any person who furnishes health care services and is regulated to furnish the  
13.25 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A,  
13.26 151, 153, or 153A;

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

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

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

13.30 (5) an unlicensed mental health practitioner regulated under sections 148B.60 to  
13.31 148B.71.

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

13.35 (j) "Related health care entity" means an affiliate, as defined in section 144.6521,  
13.36 subdivision 3, paragraph (b), of the provider releasing the health records, including, but

14.1 not limited to, affiliates of providers participating in a coordinated care delivery system  
14.2 established under section 256D.031, subdivision 6.

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

14.5 Subd. 30. **Review and evaluation of ongoing studies.** The commissioner  
14.6 shall review all ongoing studies, reports, and program evaluations completed by the  
14.7 Department of Human Services for state fiscal years 2006 through 2010. For each item,  
14.8 the commissioner shall report the legislature's appropriation for that work, if any, and the  
14.9 actual reported cost of the completed work by the Department of Human Services. The  
14.10 commissioner shall make recommendations to the legislature about which studies, reports,  
14.11 and program evaluations required by law on an ongoing basis are duplicative, unnecessary,  
14.12 or obsolete. The commissioner shall repeat this review every five fiscal years.

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

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

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

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

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

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

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

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

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

~~(f)~~ (g) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of

the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

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

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

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

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



preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after 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, through June 30, 2013, 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, through December 31, 2013, to reflect this reduction.

Sec. 5. Minnesota Statutes 2008, section 256.969, subdivision 21, is amended to read:

Subd. 21. **Mental health or chemical dependency admissions; rates.** (a) Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity.

Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

(b) Payment rates for fee-for-service medical assistance admissions occurring on or after July 1, 2011, through June 30, 2013, for diagnosis-related groups admissions related to children's mental health specified by the commissioner, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than a total of \$7,200,000 per fiscal year, including state and federal shares. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall adjust rates paid to a prepaid health plan under contract with the commissioner on a temporary basis to reflect payments provided in this paragraph, and prepaid health plans are required to increase rates to providers under contract on a temporary basis to reflect payments provided in this paragraph.

**EFFECTIVE DATE.** This section is effective July 1, 2011.

Sec. 6. Minnesota Statutes 2008, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

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

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; ~~and~~

20.1 (6) drugs; and

20.2 (7) medical supplies.

20.3 (b) Rate changes under this chapter and chapters 256D and 256L do not affect  
20.4 contract payments under this subdivision unless specifically identified.

20.5 (c) The commissioner may not utilize volume purchase through competitive bidding  
20.6 and negotiation for special transportation services under the provisions of chapter 16C.

20.7 Sec. 7. Minnesota Statutes 2008, section 256B.055, is amended by adding a  
20.8 subdivision to read:

20.9 Subd. 15. **Adults without children.** Medical assistance may be paid for a person  
20.10 who is:

20.11 (1) at least age 21 and under age 65;

20.12 (2) not pregnant;

20.13 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII  
20.14 of the Social Security Act;

20.15 (4) not an adult in a family with children as defined in section 256L.01, subdivision  
20.16 3a; and

20.17 (5) not described in another subdivision of this section.

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

20.20 Sec. 8. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

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

20.26 (b) To be eligible for medical assistance, families and children may have an income  
20.27 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,  
20.28 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,  
20.29 1996, shall be increased by three percent.

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

20.32 (d) In computing income to determine eligibility of persons under paragraphs (a)  
20.33 to (c) and (e) who are not residents of long-term care facilities, the commissioner shall  
20.34 disregard increases in income as required by Public Law Numbers 94-566, section 503;

21.1 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration  
21.2 unusual medical expense payments are considered income to the recipient.

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

21.6 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal  
21.7 approval.

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

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

21.19 Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to  
21.20 read:

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

21.32 Sec. 11. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to  
21.33 read:

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

22.10 Sec. 12. Minnesota Statutes 2008, section 256B.0625, is amended by adding a  
22.11 subdivision to read:

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

22.15 Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9,  
22.16 is amended to read:

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

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

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

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

22.22 (3) limited exams;

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

22.24 (5) periapical x-rays;

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

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

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

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

22.33 (9) posterior fillings, all at the amalgam rate;

22.34 (10) anterior fillings;

23.1 (11) endodontics, limited to root canals on the anterior and premolars only, and  
23.2 molar root canal therapy as deemed medically necessary for patients that are at high risk  
23.3 of osteonecrosis from molar extractions;

23.4 (12) removable prostheses, each dental arch limited to one every six years; including:  
23.5 (i) relines of full dentures once every six years per dental arch;  
23.6 (ii) repair of acrylic bases of full dentures and acrylic partial dentures, limited to one  
23.7 per year; and  
23.8 (iii) adding a maximum of two denture teeth and two wrought wire clasps per year to  
23.9 partial dentures per dental arch;

23.10 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of  
23.11 abscesses;

23.12 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~

23.13 (15) full-mouth ~~debridement~~ periodontal scaling and root planing, limited to one  
23.14 every five years; and

23.15 (16) moderate sedation, deep sedation, and general anesthesia, limited to when  
23.16 provided by an oral maxillofacial surgeon who is board-certified, or actively participating  
23.17 in the American Board of Oral and Maxillofacial Surgery certification process, when  
23.18 medically necessary to allow the surgical management of acute oral and maxillofacial  
23.19 pathology which cannot be accomplished safely with local anesthesia alone and would  
23.20 otherwise require operating room services.

23.21 (c) In addition to the services specified in paragraph (b), medical assistance  
23.22 covers the following services for adults, if provided in an outpatient hospital setting or  
23.23 freestanding ambulatory surgical center as part of outpatient dental surgery:

23.24 (1) periodontics, limited to periodontal scaling and root planing once every two  
23.25 years;

23.26 (2) general anesthesia; and

23.27 (3) full-mouth survey once every ~~five~~ two years.

23.28 (d) Medical assistance covers dental services for children that are medically  
23.29 necessary. The following guidelines apply:

23.30 (1) posterior fillings are paid at the amalgam rate;

23.31 (2) application of sealants once every five years per permanent molar; and

23.32 (3) application of fluoride varnish once every six months.

23.33 Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e,  
23.34 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~~ 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~~ 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. 15. 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 face-to-face 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. 16. 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. 17. 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. 18. 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:

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

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

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

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

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

Sec. 19. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 20. Minnesota Statutes 2008, section 256B.0644, as amended by Laws 2010, chapter 200, article 1, section 6, is amended to read:

**256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE 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. 21. 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. 22. **[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 January 1, 2011. 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 July 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. 23. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a,  
is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section  
and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year  
basis beginning January 1, 1996. Managed care contracts which were in effect on June  
30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995  
through December 31, 1995 at the same terms that were in effect on June 30, 1995. The  
commissioner may issue separate contracts with requirements specific to services to  
medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons  
pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms  
of its contract with the commissioner. Requirements applicable to managed care programs  
under chapters 256B, 256D, and 256L, established after the effective date of a contract  
with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner  
shall withhold five percent of managed care plan payments under this section and  
county-based purchasing plan's payment rate under section 256B.692 for the prepaid  
medical assistance and general assistance medical care programs pending completion of  
performance targets. Each performance target must be quantifiable, objective, measurable,  
and reasonably attainable, except in the case of a performance target based on a federal  
or state law or rule. Criteria for assessment of each performance target must be outlined  
in writing prior to the contract effective date. The managed care plan must demonstrate,  
to the commissioner's satisfaction, that the data submitted regarding attainment of  
the performance target is accurate. The commissioner shall periodically change the  
administrative measures used as performance targets in order to improve plan performance  
across a broader range of administrative services. The performance targets must include  
measurement of plan efforts to contain spending on health care services and administrative

activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold four percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(h) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no

sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and prepaid general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(k) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(l) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(m) Effective for services rendered on or after January 1, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the managed care plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the managed care plan's emergency room utilization rate for state health care program enrollees for calendar year 2009.

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

36.1           Subd. 5k. **Payment rate modification.** For services rendered on or after July 1,  
36.2 2011, the total payment made to managed care and county-based purchasing plans under  
36.3 the medical assistance program and under MinnesotaCare for families with children shall  
36.4 be increased by 1.4 percent.

36.5           **EFFECTIVE DATE.** This section is effective July 1, 2011.

36.6           Sec. 25. Minnesota Statutes 2008, section 256B.69, is amended by adding a  
36.7 subdivision to read:

36.8           Subd. 5l. **Payment reduction.** For services rendered on or after January 1, 2011,  
36.9 the total payment made to managed care plans for providing covered services under  
36.10 the medical assistance and MinnesotaCare programs is reduced by one percent. This  
36.11 provision excludes payments for nursing home services, home and community-based  
36.12 waivers, home care services covered under section 256B.0651, subdivision 2, payments to  
36.13 demonstration projects for persons with disabilities, and mental health services added as  
36.14 covered benefits after December 31, 2007.

36.15           Sec. 26. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by  
36.16 Laws 2010, chapter 200, article 1, section 10, is amended to read:

36.17           Subd. 20. **Ombudsperson.** (a) The commissioner shall designate an ombudsperson  
36.18 to advocate for persons required to enroll in prepaid health plans under this section. The  
36.19 ombudsperson shall advocate for recipients enrolled in prepaid health plans through  
36.20 complaint and appeal procedures and ensure that necessary medical services are provided  
36.21 either by the prepaid health plan directly or by referral to appropriate social services. At  
36.22 the time of enrollment in a prepaid health plan, the local agency shall inform recipients  
36.23 about the ombudsperson program and their right to a resolution of a complaint by the  
36.24 prepaid health plan if they experience a problem with the plan or its providers.

36.25           ~~(b) The commissioner shall designate an ombudsperson to advocate for persons~~  
36.26 ~~enrolled in a care coordination delivery system under section 256D.031. The~~  
36.27 ~~ombudsperson shall advocate for recipients enrolled in a care coordination delivery~~  
36.28 ~~system through the state appeal process and assist enrollees in accessing necessary~~  
36.29 ~~medical services through the care coordination delivery systems directly or by referral to~~  
36.30 ~~appropriate services. At the time of enrollment in a care coordination delivery system, the~~  
36.31 ~~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. 27. 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. 28. 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.

Sec. 29. Minnesota Statutes 2008, section 256B.75, is amended to read:

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

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal

maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

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

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

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

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

- 39.1           (1) 2014: 50 percent of costs;
- 39.2           (2) 2015: 60 percent of costs;
- 39.3           (3) 2016: 70 percent of costs;
- 39.4           (4) 2017: 80 percent of costs;
- 39.5           (5) 2018: 90 percent of costs; and
- 39.6           (6) 2019 and thereafter: 100 percent of costs.

39.7           Sec. 30. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is  
39.8 amended to read:

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

39.12           (1) payment for level one Centers for Medicare and Medicaid Services' common  
39.13 procedural coding system codes titled "office and other outpatient services," "preventive  
39.14 medicine new and established patient," "delivery, antepartum, and postpartum care,"  
39.15 "critical care," cesarean delivery and pharmacologic management provided to psychiatric  
39.16 patients, and level three codes for enhanced services for prenatal high risk, shall be paid  
39.17 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June  
39.18 30, 1992. If the rate on any procedure code within these categories is different than the  
39.19 rate that would have been paid under the methodology in section 256B.74, subdivision 2,  
39.20 then the larger rate shall be paid;

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

39.23           (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th  
39.24 percentile of 1989, less the percent in aggregate necessary to equal the above increases  
39.25 except that payment rates for home health agency services shall be the rates in effect  
39.26 on September 30, 1992.

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

39.32           (c) Effective for services rendered on or after July 1, 2009, payment rates for  
39.33 physician and professional services shall be reduced by five percent over the rates in  
39.34 effect on June 30, 2009. This reduction does not apply to office or other outpatient visits,  
39.35 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. 31. 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. 32. 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. 33. 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.

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

(d) A provider who has been terminated or not designated under this section may appeal only through the contested hearing process as defined in section 14.02, subdivision

3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after notification of termination or nondesignation.

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

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

Sec. 34. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

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

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

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

Sec. 35. **[256B.767] MEDICARE PAYMENT LIMIT.**

Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

Sec. 36. **[256B.768] FEE-FOR-SERVICE PAYMENT INCREASE.**

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

45.5 Sec. 37. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as  
45.6 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

45.7 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,  
45.8 the general assistance medical care program shall be administered according to section  
45.9 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,  
45.10 which shall continue to be administered under this section and funded under section  
45.11 256D.031, subdivision 9, beginning June 1, 2010.

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

45.14 (1) are covered under the medical assistance program as described in section  
45.15 256B.0625, subdivisions 13 and 13d; and

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

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

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

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

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

45.27 Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care  
45.28 applicants and recipients must cooperate with the state and local agency to identify  
45.29 potentially liable third-party payors and assist the state in obtaining third-party payments.  
45.30 Cooperation includes identifying any third party who may be liable for care and services  
45.31 provided under this chapter to the applicant, recipient, or any other family member for  
45.32 whom application is made and providing relevant information to assist the state in pursuing  
45.33 a potentially liable third party. ~~General assistance medical care applicants and recipients~~  
45.34 ~~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.

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

Sec. 39. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of 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. 40. 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 July 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision to read:

**Subd. 3c. Supplemental hospital coverage.** (a) 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.

**EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. 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. 43. Minnesota Statutes 2008, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** ~~(a) The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.~~

~~(b) Effective July 1, 2009,~~ The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are above 75 percent and equal to or less than 250 percent of the federal poverty guidelines.

**EFFECTIVE DATE.** This section is effective January 1, 2011, or upon implementation of medical assistance for adults without children under Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, whichever is later.

Sec. 44. 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. 45. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner.

(c) ~~Beginning January 1, 2008, Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income decreases to 75 percent of the federal poverty guidelines or less, or increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons~~

disenrolled under this subdivision due to income above the income limits, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits. Persons disenrolled under this subdivision due to income at or above 75 percent of the federal poverty guidelines shall have eligibility redetermined for medical assistance under section 256B.055, subdivision 15.

~~(b)~~ (d) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a \$500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c)~~ (e) Notwithstanding paragraphs (a) and ~~(b)~~ (d), parents are not eligible for MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period of eligibility.

**EFFECTIVE DATE.** This section is effective January 1, 2011, or upon implementation of medical assistance for adults without children under Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, whichever is later.

Sec. 46. 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.

52.1 **EFFECTIVE DATE.** This section is effective April 1, 2011.

52.2 Sec. 47. Minnesota Statutes 2009 Supplement, section 256L.11, subdivision 1, is  
52.3 amended to read:

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

52.7 (b) Effective for services provided on or after July 1, 2009, total payments for basic  
52.8 care services shall be reduced by three percent, in accordance with section 256B.766.  
52.9 Payments made to managed care and county-based purchasing plans shall be reduced for  
52.10 services provided on or after October 1, 2009, to reflect this reduction.

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

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

52.21 Sec. 48. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

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

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

Sec. 49. 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 July 1, 2011, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 50. 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).

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

Sec. 51. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:

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

Sec. 52. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

Subd. 5. **Expiration.** This section, with the exception of subdivision 4, expires ~~December 31, 2010~~ August 31, 2011. Subdivision 4 expires February 28, 2012.

Sec. 53. Laws 2010, chapter 200, article 1, section 12, subdivision 6, is amended to read:

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). 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 to 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 within 25 miles of the individual's community of residence, 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) A hospital must provide access to cost-effective outpatient services available in its service area. The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with federally qualified health centers and 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.



57.1 (e) A coordinated care delivery system must:

57.2 (1) provide the covered services required under paragraph (a) to recipients enrolled  
57.3 in the coordinated care delivery system, and comply with the requirements of subdivision  
57.4 4, paragraphs (b) to (g);

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

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

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

57.13 (f) The hospital may require a recipient to designate a primary care provider or  
57.14 a primary care clinic. The hospital may limit the delivery of services to a network of  
57.15 providers who have contracted with the hospital to deliver services in accordance with  
57.16 this subdivision, and require a recipient to seek services only within this network. The  
57.17 hospital may also require a referral to a provider before the service is eligible for payment.  
57.18 A coordinated care delivery system is not required to provide payment to a provider who  
57.19 is not employed by or under contract with the system for services provided to a recipient  
57.20 enrolled in the system, ~~except in cases of an emergency. For purposes of this section,~~  
57.21 ~~emergency services are defined in accordance with Code of Federal Regulations, title~~  
57.22 ~~42, section 438.114 (a).~~

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

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

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

57.34 (j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2,  
57.35 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. 54. 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.

~~(e)~~ (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. 55. 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 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. Payments from the pool must also be distributed, within the limits of the available appropriation, to ambulance services licensed under chapter 144E that respond to a request for an emergency ambulance call or interfacility transfer for a general assistance medical care enrollee, if the call or transfer originates from a location more than 25 miles from the health care facility that receives the enrollee.

(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~~ December 31, 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.

Sec. 56. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to read:

60.1           **EFFECTIVE DATE.** This section is effective for services rendered on or after April  
60.2 1, 2010, except that subdivision 3, paragraph (e), regarding MinnesotaCare eligibility, and  
60.3 subdivision 4 are effective June 1, 2010.

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

60.5           Sec. 57. Laws 2010, chapter 200, article 1, section 13, subdivision 1b, is amended to  
60.6 read:

60.7           Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September  
60.8 1, 2006, county agencies shall enroll single adults and households with no children  
60.9 formerly enrolled in general assistance medical care in MinnesotaCare according to  
60.10 Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies  
60.11 shall perform all duties necessary to administer the MinnesotaCare program ongoing for  
60.12 these enrollees, including the redetermination of MinnesotaCare eligibility at renewal,  
60.13 through January 1, 2011, or implementation of medical assistance for adults without  
60.14 children under section 256B.055, subdivision 15, whichever is later.

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

60.16           Sec. 58. Laws 2010, chapter 200, article 1, section 16, is amended to read:

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

60.19           Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective  
60.20 date of coverage shall be the first day of the month following termination from medical  
60.21 assistance for families and individuals who are eligible for MinnesotaCare and who  
60.22 submitted a written request for retroactive MinnesotaCare coverage with a completed  
60.23 application within 30 days of the mailing of notification of termination from medical  
60.24 assistance. The applicant must provide all required verifications within 30 days of the  
60.25 written request for verification. For retroactive coverage, premiums must be paid in full  
60.26 for any retroactive month, current month, and next month within 30 days of the premium  
60.27 billing. General assistance medical care recipients may qualify for retroactive coverage  
60.28 under this subdivision at six-month renewal.

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

60.30           Sec. 59. Laws 2010, chapter 200, article 1, section 21, is amended to read:

60.31           Sec. 21. **REPEALER.**



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

62.2 Sec. 61. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

62.3 Subd. 8. **Transfers**

62.4 The commissioner must transfer \$29,538,000  
62.5 in fiscal year 2010 and \$18,462,000 in fiscal  
62.6 year 2011 from the health care access fund to  
62.7 the general fund. This is a onetime transfer.

62.8 The commissioner must transfer \$4,800,000  
62.9 from the consolidated chemical dependency  
62.10 treatment fund to the general fund by June  
62.11 30, 2010.

62.12 **Compulsive Gambling ~~Special Revenue~~**

62.13 **Administration.** The lottery prize fund  
62.14 appropriation for compulsive gambling  
62.15 administration is reduced by \$6,000 for fiscal  
62.16 year 2010 and \$4,000 for fiscal year 2011  
62.17 ~~must be transferred from the lottery prize~~  
62.18 ~~fund appropriation for compulsive gambling~~  
62.19 ~~administration to the general fund by June~~  
62.20 ~~30 of each respective fiscal year. These are~~  
62.21 onetime reductions.

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

62.23 Sec. 62. **EARLY EXPANSION.**

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

62.27 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal  
62.28 approval.

62.29 Sec. 63. **FISCAL AND ACTUARIAL ANALYSIS.**

62.30 The commissioner of human services shall offer a request for proposal and accept  
62.31 bids for the completion of a complete fiscal and actuarial analysis of 2010 House File 135

and 2010 Senate File 118. The commissioner shall report this analysis to the chairs of the health and human services finance and policy divisions in the house of representatives and senate no later than December 15, 2010.

Sec. 64. **REPEALER; TRANSFER.**

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

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

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

**EFFECTIVE DATE.** Paragraphs (a) and (b) are 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, and all remaining unspent appropriations for the program established by Laws 2010, chapter 200, are transferred to the health care access fund. Paragraph (c) 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.

**ARTICLE 3**

**CONTINUING CARE**

Section 1. Minnesota Statutes 2009 Supplement, section 252.27, subdivision 2a, 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. [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.

67.1        Sec. 3. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

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

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

67.6            (2) is at least 16 but less than 65 years of age;

67.7            (3) meets the asset limits in paragraph (c); and

67.8            (4) ~~effective November 1, 2003~~, pays a premium and other obligations under  
67.9 paragraph (e).

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

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

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

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

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

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

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

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

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

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

67.34            (e)(1) A person whose earned and unearned income is equal to or greater than 100  
67.35 percent of federal poverty guidelines for the applicable family size must pay a premium  
67.36 to be eligible for medical assistance under this subdivision. The premium shall be based

on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

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

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

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

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

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

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

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

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums

as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

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

**EFFECTIVE DATE.** The amendments to paragraph (e) are effective July 1, 2011. The amendments to all other paragraphs in this section are effective January 1, 2011.

Sec. 4. Minnesota Statutes 2009 Supplement, section 256B.0915, subdivision 3a, is amended to read:

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

(b) The monthly limit for the cost of waived services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with (1) no dependencies in activities of daily living, (2) only one dependency in bathing, dressing, grooming, or walking, or (3) a dependency score of less than three if eating is the only dependency, shall be the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A effective on October 1, 2008, per month for all new participants enrolled in the program

on or after July 1, 2009. This monthly limit shall be applied to all other participants who meet this criteria at reassessment.

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 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. 5. 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:

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

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

Sec. 6. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,

the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner 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~~ year 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. Effective December 31, 2010, enrollment and operation of the MnDHO program in effect during calendar year 2010 must close. The commissioner may reopen the program provided all applicable conditions of this section are met. 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~~ prior to any further implementation or expansion.

(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. 7. Laws 2009, chapter 79, article 8, section 51, the effective date, is amended to read:

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

Sec. 8. **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, quality assurance, host county concurrence requirements, county of financial responsibility provisions, and waiver compliance; and

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

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

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

75.7 **Sec. 9. COMMISSIONER TO SEEK FEDERAL MATCH.**

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

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

75.16      Sec. 10. ICF/MR RATE INCREASE.

75.17 The daily rate at an intermediate care facility for the developmentally disabled  
75.18 located in Clearwater County and classified as a Class A facility with 15 beds shall be  
75.19 increased from \$112.73 to \$138.23 beginning July 1, 2010.

75.20 ARTICLE 4

75.21 **CHILDREN AND FAMILY SERVICES**

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

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

75.26 (1) identity of adults;

75.27 (2) presence of the minor child in the home, if questionable;

75.28 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible  
75.29 relative caretaker, or the spouses of any of the foregoing;

75.30 (4) age;

75.31 (5) immigration status, if related to eligibility;

75.32 (6) Social Security number, if given;

- 76.1 (7) income;
- 76.2 (8) spousal support and child support payments made to persons outside the
- 76.3 household;
- 76.4 (9) residence; and
- 76.5 (10) inconsistent information, if related to eligibility.

76.6 (b) If a family did not use the universal application or child care addendum to apply

76.7 for child care assistance, the family must complete the universal application or child care

76.8 addendum at its next eligibility redetermination and the county must verify the factors

76.9 listed in paragraph (a) as part of that redetermination. Once a family has completed a

76.10 universal application or child care addendum, the county shall use the redetermination

76.11 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility

76.12 must be redetermined at least every six months. For a family where at least one parent is

76.13 under the age of 21, does not have a high school or general equivalency diploma, and is a

76.14 student in a school district or another similar program that provides or arranges for child

76.15 care, as well as parenting, social services, career and employment supports, and academic

76.16 support to achieve high school graduation, the redetermination of eligibility shall be

76.17 deferred beyond six months, but not to exceed 12 months, to the end of the student's

76.18 school year. If a family reports a change in an eligibility factor before the family's next

76.19 regularly scheduled redetermination, the county must recalculate eligibility without

76.20 requiring verification of any eligibility factor that did not change.

76.21 (c) The commissioner shall develop a redetermination form to redetermine eligibility

76.22 and a change report form to report changes that minimize paperwork for the county and

76.23 the participant.

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

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

76.26 Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant

76.27 family is the current monthly income of the family multiplied by 12 or the income for

76.28 the 12-month period immediately preceding the date of application, or income calculated

76.29 by the method which provides the most accurate assessment of income available to the

76.30 family. Self-employment income must be calculated based on gross receipts less operating

76.31 expenses. Income must be recalculated when the family's income changes, but no less

76.32 often than every six months. For a family where at least one parent is under the age

76.33 of 21, does not have a high school or general equivalency diploma, and is a student in

76.34 a school district or another similar program that provides or arranges for child care,

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

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

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

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

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

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

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

**EFFECTIVE DATE.** This section is effective November 1, 2010.

Sec. 5. Minnesota Statutes 2008, section 256I.05, is amended by adding a subdivision to read:

**Subd. 1n. Supplemental rate; Mahnomen County.** Notwithstanding the provisions of this section, beginning July 1, 2009, a county agency shall negotiate a supplemental service rate in addition to the rate specified in subdivision 1, not to exceed \$753 per month or the existing rate, including any legislative authorized inflationary adjustments, for a group residential provider located in Mahnomen County that operates a 28-bed facility providing 24-hour care to individuals who are homeless, disabled, chemically dependent, mentally ill, or chronically homeless.

Sec. 6. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

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

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

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. To establish the

79.1 loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide,  
79.2 Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook,  
79.3 or when the applicant or participant disputes the loan value listed in the guidebook as  
79.4 unreasonable given the condition of the particular vehicle, the county agency may require  
79.5 the applicant or participant document the loan value by securing a written statement from  
79.6 a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer  
79.7 would pay to purchase the vehicle. The county agency shall reimburse the applicant or  
79.8 participant for the cost of a written statement that documents a lower loan value;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

80.14 **EFFECTIVE DATE.** This section is effective March 1, 2011.

80.15 Sec. 7. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

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

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

80.26 Sec. 8. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

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



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

81.3 (1) age 60 or older;

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

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

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

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

81.24 **EFFECTIVE DATE.** This section is effective February 1, 2011.

81.25 Sec. 9. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is  
81.26 amended to read:

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

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

81.34 (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. 10. QUALITY RATING SYSTEM TRAINING, COACHING,**  
**CONSULTATION, AND SUPPORTS.**

**Sec. 11. 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.

84.1 or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after  
84.2 that date. Paragraph (b) is effective the day following final enactment.

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

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

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

84.9 (1) autism or autistic disorder;

84.10 (2) Asperger's syndrome; or

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

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

84.14 (d) "Evidence-based," for purposes of this section only, is as described in subdivision  
84.15 2, paragraph (c), clause (2).

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

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

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

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

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

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

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

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

84.34 (1) a complete medical and psychological evaluation performed by a licensed  
84.35 physician and psychologist using empirically validated tools or tests that incorporate

85.1 measures for intellectual functioning, language development, adaptive skills, and  
85.2 behavioral problems, which must include:

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

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

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

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

85.11 (v) an evaluation for intellectual functioning;

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

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

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

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

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

85.22 (1) neurodevelopmental and behavioral health treatments, instruction, and  
85.23 management;

85.24 (2) applied behavior analysis and intensive early intervention services, including  
85.25 service package models such as intensive early intervention behavior therapy services  
85.26 and Lovaas therapy;

85.27 (3) speech therapy;

85.28 (4) occupational therapy;

85.29 (5) physical therapy; and

85.30 (6) prescription medications.

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

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

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

86.1           (i) a randomized study with adequate statistical power, including a sample size of  
86.2           30 or more for each group, that shows statistically superior outcomes to a pill placebo  
86.3           group, psychological placebo group, another treatment group, or a wait list control group,  
86.4           or that is equivalent to another evidence-based treatment that meets the above standard  
86.5           for the specified problem area; or  
86.6           (ii) a series of at least three single-case design experiments with clear specification  
86.7           of the subjects and with clear specification of the treatment approach that:  
86.8                 (A) use robust experimental designs;  
86.9                 (B) show statistically superior outcomes to pill placebo, psychological placebo,  
86.10            or another treatment group; and  
86.11                 (C) either use a manualized approach or are conducted by at least two independent  
86.12            investigators or teams; or  
86.13                 (3) where evidence meeting the standards of this subdivision does not exist for  
86.14            the treatment of a diagnosed condition or for an individual matching the demographic  
86.15            characteristics for which the evidence is valid, practice guidelines based on consensus  
86.16            of Minnesota health care professionals knowledgeable in the treatment of individuals  
86.17            with autism spectrum disorders.  
86.18            (d) Early intensive behavior therapies that meet the criteria set forth in paragraphs  
86.19            (b) and (c) must also meet the following best practices standards:  
86.20                 (1) the services must be prescribed by a mental health professional as an appropriate  
86.21            treatment option for the individual child;  
86.22                 (2) regular reporting of services provided and the child's progress must be submitted  
86.23            to the prescribing mental health professional;  
86.24                 (3) care must include appropriate parent or legal guardian education and  
86.25            involvement;  
86.26                 (4) the medically prescribed treatment and frequency of services should be  
86.27            coordinated between the school and provider for all children up to age 21; and  
86.28                 (5) services must be provided by a mental health professional or, as appropriate, a  
86.29            board-certified behavior analyst, a qualified mental health practitioner, or a qualified  
86.30            mental health behavioral aide.  
86.31            (e) Providers under this section must work with the commissioner in implementing  
86.32            evidence-based practices and, specifically for children under age 21, the Minnesota  
86.33            Evidence-Based Practice Database of research-informed practice elements and specific  
86.34            constituent practices.

(f) A health plan company may not refuse to renew or reissue, or otherwise terminate or restrict coverage of an individual solely because the individual is diagnosed with an 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 data collected under this paragraph in accordance with section 62J.321, subdivision 5.

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

(c) The commissioner may collect information on:

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

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

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

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

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

(a) Private duty nursing services, as provided under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4, shall be provided by a health plan company for persons who require private duty nursing services and who are concurrently covered by a health plan, as defined in section 62Q.01, and enrolled in medical assistance under chapter 256B.

(b) For purposes of this section, a period of private duty nursing services may be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing requirements that apply under the health plan. Cost-sharing requirements for private duty nursing services must not place a greater financial burden on the insured or enrollee than those requirements applied by the health plan to other similar services or benefits. Nothing in this section is intended to prevent a health plan company from requiring prior authorization by the health plan company for services required under 256B.0625, subdivision 7, or using contracted providers under the applicable provisions of the plan.

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

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

Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to ~~62Q.79~~ 62Q.791, the terms ~~defined in this section~~ contract, health care provider, dental plan, dental

90.1 organization, dentist, and enrollee have the meanings given them in sections 62Q.733  
90.2 and 62Q.76.

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

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

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

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

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

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

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

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

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

90.31       Subd. 2. **Duties.** The Advisory Group on State-Operated Services Redesign shall  
90.32 make recommendations to the commissioner and the legislature no later than December  
90.33 15, 2010, on the following:

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

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

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

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

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

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

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

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

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

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

91.23          (4) one representative appointed by AFSCME Council 5;

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

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

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

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

91.30          (9) one representative appointed by NAMI-MN;

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

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

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

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

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

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

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

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

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

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

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

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

92.16          Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop  
92.17   by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have  
92.18   developmental disabilities and exhibit severe behaviors which present a risk to public  
92.19   safety. This program is statewide and must provide specialized residential services in  
92.20   Cambridge and an array of community-based services with sufficient levels of care and a  
92.21   sufficient number of specialists to ensure that individuals referred to the program receive  
92.22   the appropriate care. The number of beds at the Cambridge facility may be reorganized  
92.23   into two 16-bed facilities, one for individuals with developmental disabilities and one for  
92.24   individuals with developmental disabilities and a co-occurring mental illness. Remaining  
92.25   beds shall be converted into community-based transitional intensive treatment foster  
92.26   homes in the Cambridge area and staffed by state employees. The individuals working  
92.27   in the community-based services under this section are state employees supervised by  
92.28   the commissioner of human services. No layoffs shall occur as a result of restructuring  
92.29   under this section.

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

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

92.32          Subd. 2. **American Indian.** For purposes of services provided under section  
92.33   ~~254B.09, subdivision 7~~ 254B.09, subdivision 8, "American Indian" means a person who is

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

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~~

94.1 ~~investment program, general assistance, and medical assistance and divided by the county~~  
94.2 ~~restricted population to determine county per capita months of covered service eligibility.~~

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

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

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

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

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

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

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

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

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

94.29 Subd. 4. **Division of costs.** Except for services provided by a county under  
94.30 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,  
94.31 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for  
94.32 ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services  
94.33 provided to persons eligible for medical assistance under chapter 256B and general  
94.34 assistance medical care under chapter 256D. Counties may use the indigent hospitalization

95.1 levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent  
95.2 of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost  
95.3 of payment and collections, must be distributed to the county that paid for a portion of  
95.4 the treatment under this section. ~~If all funds allocated according to section 254B.02 are~~  
95.5 ~~exhausted by a county and the county has met or exceeded the base level of expenditures~~  
95.6 ~~under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the~~  
95.7 ~~costs paid by the state under this section. The commissioner may refuse to pay state funds~~  
95.8 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~  
95.9 ~~financially responsible for the persons has exhausted its allocation.~~

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

95.11 Subd. 4. **Regional treatment centers.** Regional treatment center chemical  
95.12 dependency treatment units are eligible vendors. The commissioner may expand the  
95.13 capacity of chemical dependency treatment units beyond the capacity funded by direct  
95.14 legislative appropriation to serve individuals who are referred for treatment by counties  
95.15 and whose treatment will be paid for ~~with a county's allocation under section 254B.02 by~~  
95.16 funding under this chapter or other funding sources. Notwithstanding the provisions of  
95.17 sections 254B.03 to 254B.041, payment for any person committed at county request to  
95.18 a regional treatment center under chapter 253B for chemical dependency treatment and  
95.19 determined to be ineligible under the chemical dependency consolidated treatment fund,  
95.20 shall become the responsibility of the county.

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

95.22 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal  
95.23 financial participation collections to ~~the reserve fund under section 254B.02, subdivision 3~~  
95.24 a special revenue account. The commissioner shall ~~retain 85~~ allocate 83.86 percent of  
95.25 patient payments and third-party payments to the special revenue account and ~~allocate~~  
95.26 ~~the collections to the treatment allocation for the county that is financially responsible~~  
95.27 ~~for the person. Fifteen 16.14 percent of patient and third-party payments must be paid~~  
95.28 ~~to the county financially responsible for the patient. Collections for patient payment and~~  
95.29 ~~third-party payment for services provided under section 254B.09 shall be allocated to the~~  
95.30 ~~allocation of the tribal unit which placed the person. Collections of federal financial~~  
95.31 ~~participation for services provided under section 254B.09 shall be allocated to the tribal~~  
95.32 ~~reserve account under section 254B.09, subdivision 5.~~

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

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

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

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

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

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

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

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

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

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



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

(b) State expenditures for chemical dependency services and any other services provided by or through the pilot projects must not be greater than chemical dependency treatment fund expenditures expected in the absence of the pilot projects. The commissioner may restructure the schedule of payments between the state and participating counties under the local agency share and division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the pilot projects.

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

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

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

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

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

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

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

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

**Subd. 30. Office of Health Care Inspector General.** (a) The commissioner shall create within the Department of Human Services an Office of Health Care Inspector General to enhance antifraud activities and to protect the integrity of the state health care programs, as well as the health and welfare of the beneficiaries of those programs. The Office of Health Care Inspector General must periodically report to the commissioner and

98.1 to the legislature program and management problems and recommendations to correct  
98.2 them.

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

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

98.7 (2) conducting and supervising audits, investigations, inspections, and evaluations  
98.8 relating to the state health care programs under chapters 256B, 256D, and 256L;

98.9 (3) identifying weaknesses giving rise to opportunities for fraud and abuse in the  
98.10 state health care programs and operations and making recommendations to prevent their  
98.11 recurrence;

98.12 (4) leading and coordinating activities to prevent and detect fraud and abuse in the  
98.13 state health care programs and operations;

98.14 (5) detecting wrongdoers and abusers of the state health care programs and  
98.15 beneficiaries so appropriate remedies may be brought;

98.16 (6) keeping the commissioner and the legislature fully and currently informed about  
98.17 problems and deficiencies in the administration of the state health care programs and  
98.18 operations and about the need for and progress of corrective action;

98.19 (7) operating a toll-free hotline to permit individuals to call in suspected fraud,  
98.20 waste, or abuse, referring the calls for appropriate action by the agency, and analyzing the  
98.21 calls to identify trends and patterns of fraud and abuse needing attention;

98.22 (8) developing and reviewing legislative, regulatory, and program proposals to  
98.23 reduce vulnerabilities to fraud, waste, and mismanagement; and

98.24 (9) recommending changes in program policies, regulations, and laws to improve  
98.25 efficiency and effectiveness, and to prevent fraud, waste, abuse, and mismanagement.

98.26 (c) Beginning July 1, 2011, the commissioner, in consultation with the Office of  
98.27 Health Care Inspector General, shall annually report to the legislature and the governor  
98.28 new results from the two ongoing federal Medicaid audits. The commissioner shall report

98.29 (1) the most recent Medicaid Integrity Program (MIP) audit results, with any corrective  
98.30 actions needed, and (2) certify the rate of errors determined for the state health care

98.31 programs under chapters 256B, 256D, and 256L, as determined from the most recent

98.32 Payment Error Rate Measurement (PERM) audit results for Minnesota. When the PERM  
98.33 audit rate for Minnesota is greater than the national rate for the year or the MIP audit

98.34 determines the need for corrective action, the commissioner shall present a plan to the

98.35 legislature and the governor for the corrective actions and reduction of the error rate

98.36 in the next calendar year.

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

**Sec. 18. REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE 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~~ 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 management and budget shall issue a report to the legislature no later than November 15, 2010, making recommendations for improving the preparation and delivery of fiscal notes under Minnesota Statutes, section 3.98, relating to human services. The report shall consider: (1) the establishment of an independent fiscal

100.1 note office in the human services department and (2) transferring the responsibility for  
100.2 preparing human services fiscal notes to the legislature. The report must include detailed  
100.3 information regarding the financial costs, staff resources, training, access to information,  
100.4 and data protection issues relative to the preparation of human services fiscal notes. The  
100.5 report shall describe methods and procedures used by other states to insure independence  
100.6 and accuracy of fiscal estimates on legislative proposals for changes in human services.

100.7            Sec. 22. **REPEALER.**

100.8 Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09,  
100.9 subdivisions 4, 5, and 7, and Laws 2009, chapter 79, article 7, section 26, subdivision  
100.10 3, are repealed.

100.11      **Sec. 23. EFFECTIVE DATE.**

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

## 100.13 ARTICLE 6

## 100.14 DEPARTMENT OF HEALTH

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

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

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

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

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

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

100.30        Subdivision 1. **Establishment.** The Advisory Group on Administrative Expenses  
100.31        is established to make recommendations on the development of consistent guidelines

101.1 and reporting requirements, including development of a reporting template, for health  
101.2 maintenance organizations and county-based purchasers that participate in publicly  
101.3 funded programs.

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

101.6 (1) the commissioner of health or the commissioner's designee;  
101.7 (2) the commissioner of human services or the commissioner's designee;  
101.8 (3) the commissioner of commerce or the commissioner's designee; and  
101.9 (4) representatives of health maintenance organizations and county-based purchasers  
101.10 appointed by the commissioner of health.

101.11 Subd. 3. **Administration.** The commissioner of health shall convene the first  
101.12 meeting of the advisory group by September 1, 2010, and shall provide administrative  
101.13 support and staff. The commissioner of health may contract with a consultant to provide  
101.14 professional assistance and expertise to the advisory group.

101.15 Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses  
101.16 must report its recommendations, including any proposed legislation necessary to  
101.17 implement the recommendations, to the commissioner of health and to the chairs and  
101.18 ranking minority members of the legislative committees and divisions with jurisdiction  
101.19 over health policy and finance by July 1, 2011.

101.20 Subd. 5. **Expiration.** This section expires after submission of the report required  
101.21 under subdivision 4 or June 30, 2012, whichever is sooner.

101.22 Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is  
101.23 amended to read:

101.24 Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an  
101.25 electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH  
101.26 Act to meet the standards and implementation specifications adopted under section 3004  
101.27 as applicable.

101.28 (b) "Commissioner" means the commissioner of health.

101.29 (c) "Pharmaceutical electronic data intermediary" means any entity that provides  
101.30 the infrastructure to connect computer systems or other electronic devices utilized  
101.31 by prescribing practitioners with those used by pharmacies, health plans, third-party  
101.32 administrators, and pharmacy benefit managers in order to facilitate the secure  
101.33 transmission of electronic prescriptions, refill authorization requests, communications,  
101.34 and other prescription-related information between such entities.

102.1 (d) "HITECH Act" means the Health Information Technology for Economic and  
102.2 Clinical Health Act in division A, title XIII and division B, title IV of the American  
102.3 Recovery and Reinvestment Act of 2009, including federal regulations adopted under  
102.4 that act.

102.5 (e) "Interoperable electronic health record" means an electronic health record that  
102.6 securely exchanges health information with another electronic health record system that  
102.7 meets requirements specified in subdivision 3, and national requirements for certification  
102.8 under the HITECH Act.

102.9 (f) "Qualified electronic health record" means an electronic record of health-related  
102.10 information on an individual that includes patient demographic and clinical health  
102.11 information and has the capacity to:

102.12 (1) provide clinical decision support;

102.13 (2) support physician order entry;

102.14 (3) capture and query information relevant to health care quality; and

102.15 (4) exchange electronic health information with, and integrate such information  
102.16 from, other sources.

102.17 Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is  
102.18 amended to read:

102.19 Subd. 3. **Interoperable electronic health record requirements.** To meet the  
102.20 requirements of subdivision 1, hospitals and health care providers must meet the following  
102.21 criteria when implementing an interoperable electronic health records system within their  
102.22 hospital system or clinical practice setting.

102.23 (a) The electronic health record must be a qualified electronic health record.

102.24 (b) The electronic health record must be certified by the Office of the National  
102.25 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and  
102.26 health care providers ~~only~~ if a certified electronic health record product for the provider's  
102.27 particular practice setting is available. This criterion shall be considered met if a hospital  
102.28 or health care provider is using an electronic health records system that has been certified  
102.29 within the last three years, even if a more current version of the system has been certified  
102.30 within the three-year period.

102.31 (c) The electronic health record must meet the standards established according to  
102.32 section 3004 of the HITECH Act as applicable.

102.33 (d) The electronic health record must have the ability to generate information on  
102.34 clinical quality measures and other measures reported under sections 4101, 4102, and  
102.35 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.

~~(e)~~ (f) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 6. **State agency information system.** Development of a state agency information system necessary to implement this section is subject to the authority of the Office of Enterprise Technology in chapter 16E, including, but not limited to:

(1) evaluation and approval of the system as specified in section 16E.03, subdivisions 3 and 4;

(2) review of the system to ensure compliance with security policies, guidelines, and standards as specified in section 16E.03, subdivision 7; and

(3) assurance that the system complies with accessibility standards developed under section 16E.03, subdivision 9.

Sec. 6. **[62J.498] HEALTH INFORMATION EXCHANGE.**

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical transaction" means any meaningful use transaction that is not covered by section 62J.536.

(b) "Commissioner" means the commissioner of health.

(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not include health care providers engaged in a direct health information exchange.

104.1        (f) "Health information exchange" means the electronic transmission of  
104.2 health-related information between organizations according to nationally recognized  
104.3 standards.

104.4        (g) "Health information exchange service provider" means a health data intermediary  
104.5 or health information organization that has been issued a certificate of authority by the  
104.6 commissioner under section 62J.4981.

104.7        (h) "Health information organization" means an organization that oversees, governs,  
104.8 and facilitates the exchange of health-related information among organizations according  
104.9 to nationally recognized standards.

104.10       (i) "HITECH Act" means the Health Information Technology for Economic and  
104.11 Clinical Health Act as defined in section 62J.495.

104.12       (j) "Major participating entity" means:

104.13       (1) a participating entity that receives compensation for services that is greater  
104.14 than 30 percent of the health information organization's gross annual revenues from the  
104.15 health information exchange service provider;

104.16       (2) a participating entity providing administrative, financial, or management services  
104.17 to the health information organization, if the total payment for all services provided by the  
104.18 participating entity exceeds three percent of the gross revenue of the health information  
104.19 organization; and

104.20       (3) a participating entity that nominates or appoints 30 percent or more of the board  
104.21 of directors of the health information organization.

104.22       (k) "Meaningful use" means use of certified electronic health record technology that  
104.23 includes e-prescribing, and is connected in a manner that provides for the electronic  
104.24 exchange of health information and used for the submission of clinical quality measures  
104.25 as established by the Center for Medicare and Medicaid Services and the Minnesota  
104.26 Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH  
104.27 Act.

104.28       (l) "Meaningful use transaction" means an electronic transaction that a health care  
104.29 provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare  
104.30 penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

104.31       (m) "Participating entity" means any of the following persons, health care providers,  
104.32 companies, or other organizations with which a health information organization or health  
104.33 data intermediary has contracts or other agreements for the provision of health information  
104.34 exchange service providers:



(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(n) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of meaningful use transactions.

(o) "State-certified health data intermediary" means a health data intermediary that:

(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;

(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and

(3) has been issued a certificate of authority to operate in Minnesota.

(p) "State-certified health information organization" means a nonprofit health information organization that provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that has been issued a certificate of authority to operate in Minnesota.

**Subd. 2. Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biannual report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health 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

108.1 transmission of clinical transactions necessary for meaningful use of electronic health  
108.2 records must obtain a certificate of authority from the commissioner and demonstrate  
108.3 compliance with the criteria in paragraph (c).

108.4 (b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do  
108.5 so may apply for a certificate of authority to establish and operate a health information  
108.6 organization under this section. No person shall establish or operate a health information  
108.7 organization in this state, or sell or offer to sell, or solicit offers to purchase or receive  
108.8 advance or periodic consideration in conjunction with a health information organization  
108.9 or health information contract unless the organization has a certificate of authority under  
108.10 this section.

108.11 (c) In issuing the certificate of authority, the commissioner shall determine whether  
108.12 the applicant for the certificate of authority has demonstrated that the applicant meets  
108.13 the following minimum criteria:

108.14 (1) the entity is a legally established, nonprofit organization;

108.15 (2) has appropriate insurance, including liability insurance, for the operation of the  
108.16 health information organization is in place and sufficient to protect the interest of the  
108.17 public and participating entities;

108.18 (3) has strategic and operational plans that clearly address how the organization will  
108.19 expand technical capacity of the health information organization to support providers in  
108.20 achieving meaningful use of electronic health records over time;

108.21 (4) the entity addresses the parameters to be used with participating entities and  
108.22 other health information organizations for meaningful use transactions, compliance with  
108.23 Minnesota law, and interstate health information exchange in trust agreements;

108.24 (5) the entity's board of directors is comprised of members that broadly represent the  
108.25 health information organization's participating entities and consumers;

108.26 (6) the entity maintains a professional staff responsible to the board of directors with  
108.27 the capacity to ensure accountability to the organization's mission;

108.28 (7) the entity is compliant with criteria established under the Health Information  
108.29 Exchange Accreditation Program of the Electronic Healthcare Network Accreditation  
108.30 Commission (EHNAC) or equivalent criteria established by the commissioner;

108.31 (8) the entity maintains a record locator service as defined in section 144.291,  
108.32 subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293,  
108.33 subdivision 8, when conducting meaningful use transactions;

108.34 (9) the organization demonstrates interoperability with all other state-certified health  
108.35 information organizations using nationally recognized standards;

109.1           (10) the organization demonstrates compliance with all privacy and security  
109.2 requirements required by state and federal law; and

109.3           (11) the organization uses financial policies and procedures consistent with generally  
109.4 accepted accounting principles and has an independent audit of the organization's  
109.5 financials on an annual basis.

109.6           (d) Health information organizations that have obtained a certificate of authority  
109.7 must:

109.8           (1) meet the requirements established for connecting to the Nationwide Health  
109.9 Information Network (NHIN) within the federally mandated timeline or within a time  
109.10 frame established by the commissioner and published in the State Register. If the state  
109.11 timeline for implementation varies from the federal timeline, the State Register notice  
109.12 shall include an explanation for the variation;

109.13           (2) annually submit strategic and operational plans for review by the commissioner  
109.14 that address:

109.15           (i) increasing adoption rates to include a sufficient number of participating entities to  
109.16 achieve financial sustainability; and

109.17           (ii) progress in achieving objectives included in previously submitted strategic  
109.18 and operational plans across the following domains: business and technical operations,  
109.19 technical infrastructure, legal and policy issues, finance, and organizational governance;

109.20           (3) develop and maintain a business plan that addresses:

109.21           (i) plans for ensuring the necessary capacity to support meaningful use transactions;

109.22           (ii) approach for attaining financial sustainability, including public and private  
109.23 financing strategies, and rate structures;

109.24           (iii) rates of adoption, utilization, and transaction volume, and mechanisms to  
109.25 support health information exchange; and

109.26           (iv) an explanation of methods employed to address the needs of community clinics,  
109.27 critical access hospitals, and free clinics in accessing health information exchange services;

109.28           (4) annually submit a rate plan outlining fee structures for health information  
109.29 exchange services for approval by the commissioner. The commissioner shall approve the  
109.30 rate plan if it:

109.31           (i) distributes costs equitably among users of health information services;

109.32           (ii) provides predictable costs for participating entities;

109.33           (iii) covers all costs associated with conducting the full range of meaningful use  
109.34 clinical transactions, including access to health information retrieved through other  
109.35 state-certified health information exchange service providers; and

(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;

(5) enter into reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and 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 in subdivision 5; and

(6) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

**Subd. 4. Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following:

(1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;

(6) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing

111.1 the manner in which the applicant proposes to provide participants with comprehensive  
111.2 health information exchange services;

111.3 (7) financial statements showing the applicant's assets, liabilities, and sources  
111.4 of financial support, including a copy of the applicant's most recent certified financial  
111.5 statement;

111.6 (8) strategic and operational plans that specifically address how the organization  
111.7 will expand technical capacity of the health information organization to support providers  
111.8 in achieving meaningful use of electronic health records over time, a description of  
111.9 the proposed method of marketing the services, a schedule of proposed charges, and a  
111.10 financial plan that includes a three-year projection of the expenses and income and other  
111.11 sources of future capital;

111.12 (9) a statement reasonably describing the geographic area or areas to be served and  
111.13 the type or types of participants to be served;

111.14 (10) a description of the complaint procedures to be used as required under this  
111.15 section;

111.16 (11) a description of the mechanism by which participating entities will have an  
111.17 opportunity to participate in matters of policy and operation;

111.18 (12) a copy of any pertinent agreements between the health information organization  
111.19 and insurers, including liability insurers, demonstrating coverage is in place;

111.20 (13) a copy of the conflict of interest policy that applies to all members of the board  
111.21 of directors and the principal officers of the health information organization; and

111.22 (14) other information as the commissioner may reasonably require to be provided.

111.23 (b) Thirty days after the receipt of the application for a certificate of authority,  
111.24 the commissioner shall determine whether or not the application submitted meets the  
111.25 requirements for completion in paragraph (a), and notify the applicant of any further  
111.26 information required for the application to be processed.

111.27 (c) Ninety days after the receipt of a complete application for a certificate of  
111.28 authority, the commissioner shall issue a certificate of authority to the applicant if the  
111.29 commissioner determines that the applicant meets the minimum criteria requirements  
111.30 of subdivision 2 for health data intermediaries or subdivision 3 for health information  
111.31 organizations. If the commissioner determines that the applicant is not qualified, the  
111.32 commissioner shall notify the applicant and specify the reasons for disqualification.

111.33 (d) Upon being granted a certificate of authority to operate as a health information  
111.34 organization, the organization must operate in compliance with the provisions of this  
111.35 section. Noncompliance may result in the imposition of a fine or the suspension or  
111.36 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, levy an administrative penalty in an amount up to \$25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

- (1) the number of participating entities affected by the violation;
  - (2) the effect of the violation on participating entities' access to health information exchange services;
  - (3) if only one participating entity is affected, the effect of the violation on the patients of that entity;
  - (4) whether the violation is an isolated incident or part of a pattern of violations;
  - (5) the economic benefits derived by the health information organization or a health data intermediary by virtue of the violation;
  - (6) whether the violation hindered or facilitated an individual's ability to obtain health care;
  - (7) whether the violation was intentional;
  - (8) whether the violation was beyond the direct control of the health information exchange service provider;
  - (9) any history of prior compliance with the provisions of this section, including violations;
  - (10) whether and to what extent the health information exchange service provider attempted to correct previous violations;
  - (11) how the health information exchange service provider responded to technical assistance from the commissioner provided in the context of a compliance effort; and
  - (12) the financial condition of the health information exchange service provider including, but not limited to, whether the health information exchange service provider had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information exchange service provider to continue to deliver health information exchange services.
- Reasonable notice in writing shall be given to the health information exchange service provider of the intent to levy the penalty and the reasons for them. A health information exchange service provider may have 15 days within which to contest whether the finding of facts constitute 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.
- (b) If the commissioner has reason to believe that a violation of this section or section 62J.4981 has occurred or is likely, the commissioner may confer with the persons

involved before commencing action under subdivision 2. The commissioner may notify 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;

(6) the continued operation of the health information exchange service provider would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information exchange service provider has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information exchange service provider is suspended, the health information exchange service provider shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information exchange service provider is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

**Subd. 3. Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exists, the commissioner shall notify the health information exchange service provider in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information exchange service provider may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings that shall be mailed to the health information exchange service provider.

(c) If suspension, revocation, or an administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information exchange service provider written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

- (1) a reference to the statutory basis for the penalty;
- (2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;
- (3) the nature and amount of the proposed penalty;
- (4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;
- (5) instructions for responding to the notice, including a statement of the health information exchange service provider's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and
- (6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** (a) To the extent possible when implementing sections 62J.498 to 62J.4982, the commissioner shall seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers.

(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of the health information exchange in Minnesota and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.

Subd. 5. **Fees and monetary penalties.** (a) Every health information exchange service provider subject to this section and section 62J.4981 shall be assessed fees as follows:

- (1) filing an application for certificate of authority to operate as a health information organization, \$10,500;
- (2) filing an application for certificate of authority to operate as a health data intermediary, \$7,000;
- (3) annual health information organization certificate fee, \$14,000;
- (4) annual health data intermediary certificate fee, \$7,000; and
- (5) fees for other filings, as specified by rule.

117.1        (b) Administrative monetary penalties imposed under this subdivision shall be  
117.2        deposited into a revolving fund and are appropriated to the commissioner for the purposes  
117.3        of sections 62J.498 to 62J.4982.

117.4        Sec. 9. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

117.5        Subdivision 1. **Designation.** (a) The commissioner shall designate essential  
117.6        community providers. The criteria for essential community provider designation shall be  
117.7        the following:

117.8        (1) a demonstrated ability to integrate applicable supportive and stabilizing services  
117.9        with medical care for uninsured persons and high-risk and special needs populations,  
117.10       underserved, and other special needs populations; and

117.11       (2) a commitment to serve low-income and underserved populations by meeting the  
117.12       following requirements:

117.13       (i) has nonprofit status in accordance with chapter 317A;

117.14       (ii) has tax exempt status in accordance with the Internal Revenue Service Code,  
117.15       section 501(c)(3);

117.16       (iii) charges for services on a sliding fee schedule based on current poverty income  
117.17       guidelines; and

117.18       (iv) does not restrict access or services because of a client's financial limitation;

117.19       (3) status as a local government unit as defined in section 62D.02, subdivision 11, a  
117.20       hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal  
117.21       government, an Indian health service unit, or a community health board as defined in  
117.22       chapter 145A;

117.23       (4) a former state hospital that specializes in the treatment of cerebral palsy, spina  
117.24       bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling  
117.25       conditions; ~~or~~

117.26       (5) a sole community hospital. For these rural hospitals, the essential community  
117.27       provider designation applies to all health services provided, including both inpatient and  
117.28       outpatient services. For purposes of this section, "sole community hospital" means a  
117.29       rural hospital that:

117.30       (i) is eligible to be classified as a sole community hospital according to Code  
117.31       of Federal Regulations, title 42, section 412.92, or is located in a community with a  
117.32       population of less than 5,000 and located more than 25 miles from a like hospital currently  
117.33       providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds; or  
(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. Minnesota Statutes 2008, section 144.293, subdivision 4, is amended to read:

Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for one year or for a ~~lesser~~ period specified in the consent or for a different period provided by law.

Sec. 12. **[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.

Subd. 5. **Suspension, revocation, and refusal to renew.** The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the grounds described under section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or upon the loss of accreditation by the CABC. The applicant or licensee is entitled to notice and a hearing as described under section 144.55, subdivision 7, and a new license may be issued after proper inspection of the birth center has been conducted.

Subd. 6. **Standards for licensure.** (a) To be eligible for licensure under this section, a birth center must be accredited by the CABC or must obtain accreditation within six months of the date of the application for licensure. If the birth center loses its accreditation, the birth center must immediately notify the commissioner.

(b) The center must have procedures in place specifying criteria by which risk status will be established and applied to each woman at admission and during labor.

(c) Upon request, the birth center shall provide the commissioner of health with any material submitted by the birth center to the CABC as part of the accreditation process, including the accreditation application, the self-evaluation report, the accreditation decision letter from the CABC, and any reports from the CABC following a site visit.

Subd. 7. **Limitations of services.** (a) The following limitations apply to the services performed at a birth center:

(1) surgical procedures must be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair;

(2) no abortions may be administered; and

(3) no general or regional anesthesia may be administered.



(b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of a health care professional.

Subd. 8. **Fees.** (a) The biennial license fee for a birth center is \$365.

(b) The temporary license fee is \$365.

(c) Fees shall be collected and deposited according to section 144.122.

Subd. 9. **Renewal.** (a) Except as provided in paragraph (b), a license issued under this section expires two years from the date of issue.

(b) A temporary license issued under subdivision 3 expires six months from the date of issue, and may be renewed for one additional six-month period.

(c) An application for renewal shall be submitted at least 60 days prior to expiration of the license on forms prescribed by the commissioner of health.

Subd. 10. **Records.** All health records maintained on each client by a birth center 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. 13. 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

122.1 mental health treatment on an outpatient basis or in a community support program or other  
122.2 community-based program. "Resident" means a person who is admitted to a nonacute care  
122.3 facility including extended care facilities, nursing homes, and boarding care homes for  
122.4 care required because of prolonged mental or physical illness or disability, recovery from  
122.5 injury or disease, or advancing age. For purposes of all subdivisions except subdivisions  
122.6 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board  
122.7 and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised  
122.8 living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates  
122.9 a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

122.10 Sec. 14. Minnesota Statutes 2008, section 144.9504, is amended by adding a  
122.11 subdivision to read:

122.12 Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner  
122.13 must revise clinical and case management guidelines to include recommendations  
122.14 for protective health actions and follow-up services when a child's blood lead level  
122.15 exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be  
122.16 implemented to the extent possible using available resources.

122.17 (b) In revising the clinical and case management guidelines for blood lead levels  
122.18 greater than five micrograms of lead per deciliter of blood under this subdivision,  
122.19 the commissioner of health must consult with a statewide organization representing  
122.20 physicians, the public health department of Minneapolis and other public health  
122.21 departments, and a nonprofit organization with expertise in lead abatement.

122.22 Sec. 15. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

122.23 Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility  
122.24 which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a  
122.25 facility or that part of a facility which is required to be licensed under any law of this state  
122.26 which provides for the licensure of nursing homes.

122.27 Sec. 16. Minnesota Statutes 2008, section 144E.37, is amended to read:

122.28 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

122.29 The ~~board~~ commissioner of health shall establish a comprehensive advanced  
122.30 life-support educational program to train rural medical personnel, including physicians,  
122.31 physician assistants, nurses, and allied health care providers, in a team approach to  
122.32 anticipate, recognize, and treat life-threatening emergencies before serious injury or  
122.33 cardiac arrest occurs.

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

Sec. 17. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST  
REDUCTION; REPORTING REQUIREMENTS.**

(a) Minnesota health plans and county-based purchasing plans may complete an inventory of existing data collection and reporting requirements for health plans and county-based purchasing plans and submit to the commissioners of health and human services a list of data, documentation, and reports that:

(1) are collected from the same health plan or county-based purchasing plan more than once;

(2) are collected directly from the health plan or county-based purchasing plan but are available to the state agencies from other sources;

(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. 18. **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. 19. **TRANSFER.**

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

124.7 The revisor of statutes shall renumber Minnesota Statutes, section 144E.37, as  
124.8 Minnesota Statutes, section 144.6062, and make all necessary changes in statutory  
124.9 cross-references in Minnesota Statutes and Minnesota Rules.

## ARTICLE 7

124.13 Section 1. **[62E.20] RELATIONSHIP TO TEMPORARY FEDERAL HIGH-RISK**  
124.14 **POOL.**

124.17 (b) "Association" means the Minnesota Comprehensive Health Association.

124.21 (d) "Federal qualified high-risk pool" means an arrangement established by the  
124.22 federal secretary of health and human services that meets the requirements of the federal  
124.23 law.

124.27 Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive  
124.28 health association on its member insurers must comply with the maintenance of effort  
124.29 requirement contained in paragraph (b), clause (3), of the federal law, to the extent that  
124.30 requirement applies to assessments made by the association.

125.1 assistance, MinnesotaCare, the federal qualified high-risk pool, and the Minnesota  
125.2 Comprehensive Health Association, to ensure that:

125.3 (1) applicants for coverage through the federal qualified high-risk pool, or through  
125.4 the Minnesota Comprehensive Health Association to the extent the association is enrolling  
125.5 new members, are referred to the medical assistance or MinnesotaCare programs if they  
125.6 are determined to be potentially eligible for coverage through those programs; and

125.7 (2) applicants for coverage under medical assistance or MinnesotaCare who are  
125.8 determined not to be eligible for those programs are provided information about coverage  
125.9 through the federal qualified high-risk pool and the Minnesota Comprehensive Health  
125.10 Association.

125.11 Sec. 2. Minnesota Statutes 2008, section 62J.07, subdivision 2, is amended to read:

125.12 Subd. 2. **Membership.** The Legislative Commission on Health Care Access  
125.13 consists of ~~five~~ seven members of the senate appointed under the rules of the senate and  
125.14 ~~five~~ seven members of the house of representatives appointed under the rules of the house  
125.15 of representatives. The Legislative Commission on Health Care Access must include ~~three~~  
125.16 five members of the majority party and two members of the minority party in each house.

125.17 Sec. 3. Minnesota Statutes 2008, section 62J.07, is amended by adding a subdivision to  
125.18 read:

125.19 Subd. 5. **Federal health care reform.** (a) The Legislative Commission on  
125.20 Health Care Access shall analyze options and make recommendations regarding the  
125.21 implementation of provisions of the Patient Protection and Affordable Health Care Act,  
125.22 Public Law 111-148, and the health care reform provisions in the Health Care and  
125.23 Education Reconciliation Act of 2010, Public Law 111-152, including:

125.24 (1) development of accountable care organizations;

125.25 (2) health insurance reform, including options related to coverage, purchasing,  
125.26 exchange development, and coverage for high-risk individuals; and

125.27 (3) other provisions that will require changes in state law.

125.28 (b) Before finalizing and submitting federal applications for pilot projects authorized  
125.29 under federal health care reform, the governor and state agencies shall seek review and  
125.30 advice from the commission.

125.31 (c) The commission may create and make appointments to work groups to assist the  
125.32 commission in its work. Work group members may include legislators, representatives  
125.33 of businesses and nonprofit agencies impacted by federal health care reform, academic  
125.34 experts, and consumer representatives.

Sec. 4. Minnesota Statutes 2008, section 62U.05, is amended to read:

**62U.05 PROVIDER PRICING FOR BASKETS OF CARE; ACCOUNTABLE CARE ORGANIZATIONS.**

Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner 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

127.1 not apply to services paid for by Medicare, state public health care programs through  
127.2 fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile  
127.3 insurance. This paragraph does not affect the right of a provider to provide charity care  
127.4 or care for a reduced price due to financial hardship of the patient or due to the patient  
127.5 being a relative or friend of the provider.

127.6 Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall  
127.7 establish quality measurements for the defined baskets of care by December 31, 2009.  
127.8 The commissioner shall establish quality measures for the total cost of care for services  
127.9 delivered through an accountable care organization by June 30, 2012. The commissioner  
127.10 may contract with an organization that works to improve health care quality to make  
127.11 recommendations about the use of existing measures or establishing new measures where  
127.12 no measures currently exist.

127.13 (b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall  
127.14 publish comparative price and quality information on the baskets of care in a manner  
127.15 that is easily accessible and understandable to the public, as this information becomes  
127.16 available. Beginning January 1, 2013, the commissioner or the commissioner's designee  
127.17 shall publish comparative price and quality information on the total cost of care for  
127.18 services delivered through an accountable care organization in a manner that is easily  
127.19 accessible and understandable to the public, as this information becomes available.

127.20 Sec. 5. Minnesota Statutes 2008, section 256B.0754, is amended by adding a  
127.21 subdivision to read:

127.22 Subd. 3. **Accountable care organizations.** By July 1, 2012, the commissioner of  
127.23 human services shall deliver services to enrollees in state health care programs through  
127.24 accountable care organizations, and shall provide incentive payments to accountable care  
127.25 organizations that meet or exceed annual quality and performance targets. Accountable  
127.26 care organizations and incentive payments must meet the standards specified in the Patient  
127.27 Protection and Affordable Care Act, Public Law 111-148. Prescription drug coverage  
127.28 must not be provided through accountable care organizations and must instead be provided  
127.29 through a delivery method that qualifies for federal prescription drug rebates.

127.30 Sec. 6. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

127.31 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide  
127.32 medical assistance coverage of health home services for eligible individuals with chronic  
127.33 conditions who select a designated provider, a team of health care professionals, or a  
127.34 health team as the individual's health home.

128.1        (b) The commissioner shall implement this section in compliance with the  
128.2 requirements of the state option to provide health homes for enrollees with chronic  
128.3 conditions, as provided under the Patient Protection and Affordable Care Act, Public  
128.4 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning  
128.5 provided in that act.

128.6        Subd. 2. **Eligible individual.** An individual is eligible for health home services  
128.7 under this section if the individual is eligible for medical assistance under this chapter  
128.8 and has at least:

- 128.9        (1) two chronic conditions;  
128.10       (2) one chronic condition and is at risk of having a second chronic condition; or  
128.11       (3) one serious and persistent mental health condition.

128.12       Subd. 3. **Health home services.** (a) Health home services means comprehensive and  
128.13 timely high-quality services that are provided by a health home. These services include:

- 128.14       (1) comprehensive care management;  
128.15       (2) care coordination and health promotion;  
128.16       (3) comprehensive transitional care, including appropriate follow-up, from inpatient  
128.17 to other settings;  
128.18       (4) patient and family support, including authorized representatives;  
128.19       (5) referral to community and social support services, if relevant; and  
128.20       (6) use of health information technology to link services, as feasible and appropriate.

128.21       (b) The commissioner shall maximize the number and type of services  
128.22 included in this subdivision to the extent permissible under federal law, including  
128.23 physician, outpatient, mental health treatment, and rehabilitation services necessary for  
128.24 comprehensive transitional care following hospitalization.

128.25       Subd. 4. **Health teams.** The commissioner shall establish health teams to support  
128.26 the patient-centered health home and provide the services described in subdivision 3 to  
128.27 individuals eligible under subdivision 2. The commissioner shall apply for grants or  
128.28 contracts as provided under section 3502 of the Patient Protection and Affordable Care  
128.29 Act to establish health teams and provide capitated payments to primary care providers.  
128.30 For purposes of this section, "health teams" means community-based, interdisciplinary,  
128.31 inter-professional teams of health care providers that support primary care practices.  
128.32 These providers may include medical specialists, nurses, advanced practice registered  
128.33 nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers,  
128.34 doctors of chiropractic, licensed complementary and alternative medicine practitioners,  
128.35 and physician's assistants.



Subd. 5. **Payments.** The commissioner shall make payments to each health home and each health team for the provision of health home services to each eligible individual with chronic conditions that selects the health home as a provider.

Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for health homes and health teams developed under this section are consistent with the requirements and payment methods for health care homes established under sections 256B.0751 and 256B.0753. The commissioner may modify requirements and payment methods under sections 256B.0751 and 256B.0753 in order to be consistent with federal health home requirements and payment methods.

Subd. 7. **State plan amendment.** The commissioner shall submit a state plan amendment to implement this section to the federal Centers for Medicare and Medicaid Services by January 1, 2011.

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

Sec. 7. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS AND GRANTS.**

(a) The commissioner of human services shall seek to participate in the following demonstration projects, or apply for the following grants, as described in the federal Patient Protection and Affordable Care Act, Public Law 111-148:

(1) the demonstration project to evaluate integrated care around a hospitalization, Public Law 111-148, section 2704;

(2) the Medicaid global payment system demonstration project, Public Law 111-148, section 2705;

(3) the pediatric accountable care organization demonstration project, Public Law 111-148, section 2706;

(4) the Medicaid emergency psychiatric demonstration project, Public Law 111-148, section 2707; and

(5) grants to provide incentives for prevention of chronic diseases in Medicaid, Public Law 111-148, section 4108.

(b) The commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees or divisions with jurisdiction over health care policy and finance on the status of the demonstration project and grant applications. If the state is accepted as a demonstration project participant, or is awarded a grant, the commissioner shall notify the chairs and ranking minority members

130.1 of those committees or divisions of any legislative changes necessary to implement the  
130.2 demonstration projects or grants.

130.3 Sec. 8. **HEALTH CARE REFORM TASK FORCE.**

130.4 Subdivision 1. **Task force.** (a) The governor shall convene a Health Care  
130.5 Reform Task Force to advise and assist the governor and the legislature regarding state  
130.6 implementation of federal health care reform legislation. For purposes of this section,  
130.7 "federal health care reform legislation" means the Patient Protection and Affordable Care  
130.8 Act, Public Law 111-148, and the health care reform provisions in the Health Care and  
130.9 Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:

130.10 (1) two legislators from the house of representatives appointed by the speaker and  
130.11 two legislators from the senate appointed by the Subcommittee on Committees of the  
130.12 Committee on Rules and Administration;

130.13 (2) two representatives appointed by the governor to represent the governor and  
130.14 state agencies;

130.15 (3) three persons appointed by the governor who have demonstrated leadership in  
130.16 health care organizations, health plan companies, or health care trade or professional  
130.17 associations;

130.18 (4) three persons appointed by the governor who have demonstrated leadership in  
130.19 employer and group purchaser activities related to health system improvement of whom  
130.20 two must be from a labor organization and one from the business community; and

130.21 (5) five persons appointed by the governor who have demonstrated expertise in the  
130.22 areas of health care financing, access, and quality.

130.23 The governor is exempt from the requirements of the open appointments process  
130.24 for purposes of appointing task force members. Members shall be appointed for one-year  
130.25 terms and may be reappointed.

130.26 (b) The Department of Health, Department of Human Services, and Department of  
130.27 Commerce shall provide staff support to the task force. The task force may accept outside  
130.28 resources to help support its efforts.

130.29 (c) Task force members must be appointed by July 1, 2010. The task force must hold  
130.30 its first meeting by July 15, 2010.

130.31 Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and  
130.32 present to the legislature and the governor a preliminary report and recommendations on  
130.33 state implementation of federal health care reform legislation. The report must include  
130.34 recommendations for state law and program changes necessary to comply with the federal  
130.35 health care reform legislation, and also recommendations for implementing provisions of

the federal legislation that are optional for states. In developing recommendations, the task force shall consider the extent to which an approach maximizes federal funding to the state.

(b) The task force, in consultation with the governor and the legislature, shall also establish timelines and criteria for future reports on state implementation of the federal 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

132.1 service establishments must pay the highest applicable fee under paragraph (d), clause  
132.2 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable  
132.3 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously  
132.4 licensed under this chapter for the same calendar year is one-half of the appropriate annual  
132.5 license fee, plus any penalty that may be required. The license fee for operators opening  
132.6 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty  
132.7 that may be required.

132.8 (b) All food and beverage service establishments, except special event food stands,  
132.9 and all hotels, motels, lodging establishments, public pools, and resorts shall pay an  
132.10 annual base fee of \$150.

132.11 (c) A special event food stand shall pay a flat fee of \$50 annually. "Special event  
132.12 food stand" means a fee category where food is prepared or served in conjunction with  
132.13 celebrations, county fairs, or special events from a special event food stand as defined  
132.14 in section 157.15.

132.15 (d) In addition to the base fee in paragraph (b), each food and beverage service  
132.16 establishment, other than a special event food stand, and each hotel, motel, lodging  
132.17 establishment, public pool, and resort shall pay an additional annual fee for each fee  
132.18 category, additional food service, or required additional inspection specified in this  
132.19 paragraph:

132.20 (1) Limited food menu selection, \$60. "Limited food menu selection" means a fee  
132.21 category that provides one or more of the following:

- 132.22 (i) prepackaged food that receives heat treatment and is served in the package;
- 132.23 (ii) frozen pizza that is heated and served;
- 132.24 (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;
- 132.25 (iv) soft drinks, coffee, or nonalcoholic beverages; or
- 132.26 (v) cleaning for eating, drinking, or cooking utensils, when the only food served  
132.27 is prepared off site.

132.28 (2) Small establishment, including boarding establishments, \$120. "Small  
132.29 establishment" means a fee category that has no salad bar and meets one or more of  
132.30 the following:

- 132.31 (i) possesses food service equipment that consists of no more than a deep fat fryer, a  
132.32 grill, two hot holding containers, and one or more microwave ovens;
- 132.33 (ii) serves dipped ice cream or soft serve frozen desserts;
- 132.34 (iii) serves breakfast in an owner-occupied bed and breakfast establishment;
- 132.35 (iv) is a boarding establishment; or

133.1 (v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum  
133.2 patron seating capacity of not more than 50.

133.3 (3) Medium establishment, \$310. "Medium establishment" means a fee category  
133.4 that meets one or more of the following:

133.5 (i) possesses food service equipment that includes a range, oven, steam table, salad  
133.6 bar, or salad preparation area;

133.7 (ii) possesses food service equipment that includes more than one deep fat fryer,  
133.8 one grill, or two hot holding containers; or

133.9 (iii) is an establishment where food is prepared at one location and served at one or  
133.10 more separate locations.

133.11 Establishments meeting criteria in clause (2), item (v), are not included in this fee  
133.12 category.

133.13 (4) Large establishment, \$540. "Large establishment" means either:

133.14 (i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a  
133.15 medium establishment, (B) seats more than 175 people, and (C) offers the full menu  
133.16 selection an average of five or more days a week during the weeks of operation; or

133.17 (ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium  
133.18 establishment, and (B) prepares and serves 500 or more meals per day.

133.19 (5) Other food and beverage service, including food carts, mobile food units,  
133.20 seasonal temporary food stands, and seasonal permanent food stands, \$60.

133.21 (6) Beer or wine table service, \$60. "Beer or wine table service" means a fee  
133.22 category where the only alcoholic beverage service is beer or wine, served to customers  
133.23 seated at tables.

133.24 (7) Alcoholic beverage service, other than beer or wine table service, \$165.

133.25 "Alcohol beverage service, other than beer or wine table service" means a fee  
133.26 category where alcoholic mixed drinks are served or where beer or wine are served from  
133.27 a bar.

133.28 (8) Lodging per sleeping accommodation unit, \$10, including hotels, motels,  
133.29 lodging establishments, and resorts, up to a maximum of \$1,000. "Lodging per sleeping  
133.30 accommodation unit" means a fee category including the number of guest rooms, cottages,  
133.31 or other rental units of a hotel, motel, lodging establishment, or resort; or the number of  
133.32 beds in a dormitory.

133.33 (9) First public pool, \$325; each additional public pool, \$175. "Public pool" means a  
133.34 fee category that has the meaning given in section 144.1222, subdivision 4.

133.35 (10) First spa, \$175; each additional spa, \$100. "Spa pool" means a fee category that  
133.36 has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, \$60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with an individual sewage treatment system which uses subsurface treatment and disposal.

(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 |
| Transient food service | food cart                     | \$250 |
|                        | seasonal permanent food stand | \$250 |
|                        | seasonal temporary food stand | \$250 |
|                        | mobile food unit              | \$350 |
| Alcohol                | beer or wine table service    | \$150 |
|                        | alcohol service from bar      | \$250 |
| Lodging                | less than 25 rooms            | \$375 |
|                        | 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 |

|        |                        |                               |       |
|--------|------------------------|-------------------------------|-------|
| 135.1  |                        | medium establishment          | \$350 |
| 135.2  |                        | large food establishment      | \$400 |
| 135.3  |                        | additional food service       | \$150 |
| 135.4  | Transient food service | food cart                     | \$250 |
| 135.5  |                        | seasonal permanent food stand | \$250 |
| 135.6  |                        | seasonal temporary food stand | \$250 |
| 135.7  |                        | mobile food unit              | \$250 |
| 135.8  | Alcohol                | beer or wine table service    | \$150 |
| 135.9  |                        | alcohol service from bar      | \$250 |
| 135.10 | Lodging                | less than 25 rooms            | \$250 |
| 135.11 |                        | 25 to less than 100 rooms     | \$300 |
| 135.12 |                        | 100 rooms or more             | \$450 |
| 135.13 |                        | less than five cabins         | \$250 |
| 135.14 |                        | five to less than ten cabins  | \$350 |
| 135.15 |                        | ten cabins or more            | \$400 |

135.16 (g) Special event food stands are not required to submit construction or remodeling  
135.17 plans for review.

135.18 (h) Youth camps shall pay an annual single fee for food and lodging as follows:

135.19 (1) camps with up to 99 campers, \$325;

135.20 (2) camps with 100 to 199 campers, \$550; and

135.21 (3) camps with 200 or more campers, \$750.

135.22 (i) A youth camp which pays fees under paragraph (d) is not required to pay fees  
135.23 under paragraph (h).

135.24 Sec. 2. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is  
135.25 amended to read:

135.26 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)

135.27 The following fees are required for manufactured home parks and recreational camping

135.28 areas licensed under this chapter. Recreational camping areas and manufactured home

135.29 parks shall pay the highest applicable base fee under paragraph ~~(e)~~ (b). The license fee

135.30 for new operators of a manufactured home park or recreational camping area previously

135.31 licensed under this chapter for the same calendar year is one-half of the appropriate annual

135.32 license fee, plus any penalty that may be required. The license fee for operators opening

135.33 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty

135.34 that may be required.

135.35 (b) All manufactured home parks and recreational camping areas shall pay the  
135.36 following annual base fee:

135.37 (1) a manufactured home park, \$150; and

136.1 (2) a recreational camping area with:

136.2 (i) 24 or less sites, \$50;

136.3 (ii) 25 to 99 sites, \$212; and

136.4 (iii) 100 or more sites, \$300.

136.5 In addition to the base fee, manufactured home parks and recreational camping areas shall  
136.6 pay \$4 for each licensed site. This paragraph does not apply to special event recreational  
136.7 camping areas ~~or to~~. Operators of a manufactured home park or a recreational camping  
136.8 area also licensed under section 157.16 for the same location shall pay only one base fee,  
136.9 whichever is the highest of the base fees found in this section or section 157.16.

136.10 (c) In addition to the fee in paragraph (b), each manufactured home park or  
136.11 recreational camping area shall pay an additional annual fee for each fee category  
136.12 specified in this paragraph:

136.13 (1) Manufactured home parks and recreational camping areas with public swimming  
136.14 pools and spas shall pay the appropriate fees specified in section 157.16.

136.15 (2) Individual private sewer or water, \$60. "Individual private water" means a fee  
136.16 category with a water supply other than a community public water supply as defined in  
136.17 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a  
136.18 subsurface sewage treatment system which uses subsurface treatment and disposal.

136.19 (d) The following fees must accompany a plan review application for initial  
136.20 construction of a manufactured home park or recreational camping area:

136.21 (1) for initial construction of less than 25 sites, \$375;

136.22 (2) for initial construction of 25 to 99 sites, \$400; and

136.23 (3) for initial construction of 100 or more sites, \$500.

136.24 (e) The following fees must accompany a plan review application when an existing  
136.25 manufactured home park or recreational camping area is expanded:

136.26 (1) for expansion of less than 25 sites, \$250;

136.27 (2) for expansion of 25 to 99 sites, \$300; and

136.28 (3) for expansion of 100 or more sites, \$450.

136.29 **Sec. 3. FOOD SUPPORT FOR CHILDREN WITH SEVERE ALLERGIES.**

136.30 The commissioner of human services must seek a federal waiver from the federal  
136.31 Department of Agriculture, Food and Nutrition Service, for the supplemental nutrition  
136.32 assistance program, to increase the income eligibility requirements to 375 percent of the  
136.33 federal poverty guidelines, in order to cover nutritional food products required to treat  
136.34 or manage severe food allergies, including allergies to wheat and gluten, for infants and  
136.35 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            |
| <b><u>Total</u></b>       | <b>\$ (20,052,000)</b> | <b>\$ 263,289,000</b> |

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, 2nd Engrossment - 86th Legislative Session (2009-2010) [H2614-2]**

|        |                                                          |                     |                     |
|--------|----------------------------------------------------------|---------------------|---------------------|
| 138.1  | <u>General Fund</u>                                      | <u>7,916,000</u>    | <u>(14,481,000)</u> |
| 138.2  | <u>TANF Fund</u>                                         | <u>(10,220,000)</u> | <u>15,384,000</u>   |
| 138.3  | <b><u>(b) MFIP Child Care Assistance Grants</u></b>      | <u>(7,832,000)</u>  | <u>2,579,000</u>    |
| 138.4  | <b><u>(c) General Assistance Grants</u></b>              | <u>875,000</u>      | <u>1,339,000</u>    |
| 138.5  | <b><u>(d) Minnesota Supplemental Aid Grants</u></b>      | <u>2,454,000</u>    | <u>3,843,000</u>    |
| 138.6  | <b><u>(e) Group Residential Housing Grants</u></b>       | <u>1,076,000</u>    | <u>2,580,000</u>    |
| 138.7  | <b><u>Subd. 4. Basic Health Care Grants</u></b>          |                     |                     |
| 138.8  | <u>General Fund</u>                                      | <u>(62,770,000)</u> | <u>29,192,000</u>   |
| 138.9  | <u>TANF Fund</u>                                         | <u>99,654,000</u>   | <u>276,500,000</u>  |
| 138.10 | <u>The amounts that may be spent from this</u>           |                     |                     |
| 138.11 | <u>appropriation are as follows:</u>                     |                     |                     |
| 138.12 | <b><u>(a) MinnesotaCare Grants</u></b>                   |                     |                     |
| 138.13 | <u>Health Care Access</u>                                |                     |                     |
| 138.14 | <u>Fund</u>                                              | <u>99,654,000</u>   | <u>276,500,000</u>  |
| 138.15 | <b><u>(b) Medical Assistance Basic Health Care –</u></b> |                     |                     |
| 138.16 | <b><u>Families and Children</u></b>                      | <u>1,165,000</u>    | <u>24,146,000</u>   |
| 138.17 | <b><u>(c) Medical Assistance Basic Health Care –</u></b> |                     |                     |
| 138.18 | <b><u>Elderly and Disabled</u></b>                       | <u>(63,935,000)</u> | <u>5,046,000</u>    |
| 138.19 | <b><u>Subd. 5. Continuing Care Grants</u></b>            | <u>(51,595,000)</u> | <u>(53,396,000)</u> |
| 138.20 | <u>The amounts that may be spent from this</u>           |                     |                     |
| 138.21 | <u>appropriation are as follows:</u>                     |                     |                     |
| 138.22 | <b><u>(a) Medical Assistance Long-Term Care</u></b>      |                     |                     |
| 138.23 | <b><u>Facilities</u></b>                                 | <u>(3,774,000)</u>  | <u>(8,275,000)</u>  |
| 138.24 | <b><u>(b) Medical Assistance Long-Term Care</u></b>      |                     |                     |
| 138.25 | <b><u>Waivers</u></b>                                    | <u>(27,710,000)</u> | <u>(22,452,000)</u> |
| 138.26 | <b><u>(c) Chemical Dependency Entitlement Grants</u></b> | <u>(20,111,000)</u> | <u>(22,669,000)</u> |

138.27      **Sec. 3. EFFECTIVE DATE.**

138.28 Sections 1 and 2 are effective the day following final enactment.

## ARTICLE 10

## HUMAN SERVICES CONTINGENT APPROPRIATIONS

138.31 Section 1. **SUMMARY OF HUMAN SERVICES APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this bill.

|                           | <u>2010</u> | <u>2011</u>   | <u>Total</u>  |
|---------------------------|-------------|---------------|---------------|
| <u>General</u>            | \$ -0-      | \$ 13,383,000 | \$ 13,383,000 |
| <u>Health Care Access</u> | -0-         | 686,000       | 686,000       |
| <u>Total</u>              | \$ -0-      | \$ 14,069,000 | \$ 14,069,000 |

Sec. 2. **HEALTH AND HUMAN SERVICES CONTINGENT APPROPRIATIONS.**

(a) The sums shown in the columns marked "Appropriations" are added to the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agency and for the purposes specified in this bill. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this bill 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.

(b) Upon enactment of the extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the president's budget for federal fiscal year 2011 or contained in House Resolution 2847, the federal "Jobs for Main Street Act, 2010," or contained in House Resolution 4213, "American Workers, State, and Business Relief Act of 2010," or subsequent federal legislation, the appropriations identified in section 3 shall be made for fiscal year 2011.

**APPROPRIATIONS**  
**Available for the Year**  
**Ending June 30**  
**2010**                      **2011**

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**                      \$                      -0-                      \$                      **14,069,000**

| <u>Appropriations by Fund</u> |             |             |
|-------------------------------|-------------|-------------|
|                               | <u>2010</u> | <u>2011</u> |
| <u>General</u>                | -0-         | 13,383,000  |
| <u>Health Care Access</u>     | -0-         | 686,000     |

The appropriations for each purpose are shown in the following subdivisions.

Subd. 2. **Basic Health Care Grants**

|        |                                                   |            |                  |
|--------|---------------------------------------------------|------------|------------------|
| 140.1  | <u>(a) MinnesotaCare Grants</u>                   | <u>-0-</u> | <u>686,000</u>   |
| 140.2  | <u>This appropriation is from the health care</u> |            |                  |
| 140.3  | <u>access fund.</u>                               |            |                  |
| 140.4  | <u>(b) Medical Assistance Basic Health Care</u>   |            |                  |
| 140.5  | <u>Grants - Families and Children</u>             | <u>-0-</u> | <u>6,297,000</u> |
| 140.6  | <u>(c) Medical Assistance Basic Health Care</u>   |            |                  |
| 140.7  | <u>Grants - Elderly and Disabled</u>              | <u>-0-</u> | <u>3,697,000</u> |
| 140.8  | <u>Subd. 3. Continuing Care Grants</u>            |            |                  |
| 140.9  | <u>(a) Medical Assistance - Long-Term Care</u>    |            |                  |
| 140.10 | <u>Facilities Grants</u>                          | <u>-0-</u> | <u>2,486,000</u> |
| 140.11 | <u>(b) Medical Assistance Grants - Long-Term</u>  |            |                  |
| 140.12 | <u>Care Waivers and Home Care Grants</u>          | <u>-0-</u> | <u>547,000</u>   |
| 140.13 | <u>(c) Chemical Dependency Entitlement Grants</u> | <u>-0-</u> | <u>356,000</u>   |

140.14       Sec. 4. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision  
140.15 to read:

140.16           Subd. 4a. Division of costs for medical assistance services. Notwithstanding  
140.17 subdivision 4, for chemical dependency services provided on or after October 1, 2008, and  
140.18 reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

140.19       Sec. 5. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to  
140.20 read:

140.21           Subd. 22. **Hospice care.** Medical assistance covers hospice care services under  
140.22 Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient  
140.23 age 21 or under who elects to receive hospice services does not waive coverage for  
140.24 services that are related to the treatment of the condition for which a diagnosis of terminal  
140.25 illness has been made.

140.26           **EFFECTIVE DATE.** This section is effective retroactive from March 23, 2010.

140.27       Sec. 6. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 1a,  
140.28 is amended to read:

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

140.30           (a) "Long-term care consultation services" means:

140.31           (1) assistance in identifying services needed to maintain an individual in the most  
140.32 inclusive environment;

141.1 (2) providing recommendations on cost-effective community services that are  
141.2 available to the individual;

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

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

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

141.9 (6) federally mandated screening to determine the need for a institutional level of  
141.10 care under section 256B.0911, ~~subdivision 4, paragraph (a)~~ subdivision 4a;

141.11 (7) determination of home and community-based waiver service eligibility including  
141.12 level of care determination for individuals who need an institutional level of care as  
141.13 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including  
141.14 state plan home care services identified in section 256B.0625, subdivisions 6, 7, and  
141.15 19, paragraphs (a) and (c), based on assessment and support plan development with  
141.16 appropriate referrals;

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

141.19 (9) assistance to transition people back to community settings after facility  
141.20 admission.

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

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

141.27 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health  
141.28 plans administering long-term care consultation assessment and support planning services.

141.29 Sec. 7. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

141.30 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall  
141.31 be responsible for a monthly transfer payment of \$1,500,000, due before noon on the  
141.32 15th of each month and the University of Minnesota shall be responsible for a monthly  
141.33 transfer payment of \$500,000 due before noon on the 15th of each month, beginning July  
141.34 15, 1995. These sums shall be part of the designated governmental unit's portion of the  
141.35 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. 8. 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 approved. This exemption applies for 12 months. This paragraph expires June 30, 2010. If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this provision will expire on the date when it is no longer subject to section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

143.1       Sec. 9. Laws 2005, First Special Session chapter 4, article 8, section 66, as amended by  
143.2       Laws 2009, chapter 173, article 3, section 24, the effective date, is amended to read:

143.3               **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2009, ~~and~~ upon federal  
143.4       approval and on the date when it is no longer subject to the maintenance of effort  
143.5       requirements of section 5001 of Public Law 111-5. The commissioner of human services  
143.6       shall notify the revisor of statutes of that date. Paragraph (e) is effective September 1,  
143.7       2006.

143.8       Sec. 10. Laws 2009, chapter 79, article 5, section 17, the effective date, is amended to  
143.9       read:

143.10              **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal  
143.11       approval, ~~whichever is later~~ and on the date when it is no longer subject to the maintenance  
143.12       of effort requirements of section 5001 of Public Law 111-5. The commissioner of human  
143.13       services shall notify the revisor of statutes of that date.

143.14       Sec. 11. Laws 2009, chapter 79, article 5, section 18, the effective date, is amended to  
143.15       read:

143.16              **EFFECTIVE DATE.** This section is effective ~~January 1, 2011~~ upon federal  
143.17       approval and on the date when it is no longer subject to the maintenance of effort  
143.18       requirements of section 5001 of Public Law 111-5. The commissioner of human services  
143.19       shall notify the revisor of statutes when federal approval is obtained.

143.20       Sec. 12. Laws 2009, chapter 79, article 5, section 22, the effective date, is amended to  
143.21       read:

143.22              **EFFECTIVE DATE.** This section is effective for periods of ineligibility established  
143.23       on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.  
143.24       If it is in violation of that section, then it shall be effective on the date when it is no longer  
143.25       subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The  
143.26       commissioner of human services shall notify the revisor of statutes of that date.

143.27       Sec. 13. Laws 2009, chapter 79, article 8, section 2, the effective date, is amended to  
143.28       read:

143.29              **EFFECTIVE DATE.** The section is effective ~~January~~ July 1, 2011.

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>\$ (10,071,000)</u> | <u>\$ (92,097,000)</u> | <u>\$ (102,168,000)</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>71,245,000</u>      | <u>70,151,000</u>       |
| <u>Federal TANF</u>                     | <u>20,500,000</u>      | <u>11,500,000</u>      | <u>32,000,000</u>       |
| <u>Total</u>                            | <u>\$ 11,337,000</u>   | <u>\$ (9,627,000)</u>  | <u>1,710,000</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><br><u>Available for the Year</u><br><u>Ending June 30</u> |             |
|---------------------------------------------------------------------------------|-------------|
| <u>2010</u>                                                                     | <u>2011</u> |



|        |                                                       |                        |                       |
|--------|-------------------------------------------------------|------------------------|-----------------------|
| 145.1  | Sec. 3. <u>COMMISSIONER OF HUMAN</u>                  |                        |                       |
| 145.2  | <u>SERVICES</u>                                       |                        |                       |
| 145.3  | <u>Subdivision 1. Total Appropriation</u>             | <u>\$ (16,667,000)</u> | <u>\$ (4,971,000)</u> |
| 145.4  | <u>Appropriations by Fund</u>                         |                        |                       |
| 145.5  |                                                       | <u>2010</u>            | <u>2011</u>           |
| 145.6  | <u>General</u>                                        | <u>(8,005,000)</u>     | <u>(97,189,000)</u>   |
| 145.7  | <u>State Government</u>                               |                        |                       |
| 145.8  | <u>Special Revenue</u>                                | <u>(8,000)</u>         | <u>(16,000)</u>       |
| 145.9  | <u>Health Care Access</u>                             | <u>(1,094,000)</u>     | <u>71,045,000</u>     |
| 145.10 | <u>Federal TANF</u>                                   | <u>20,500,000</u>      | <u>11,500,000</u>     |
| 145.11 | <u>Working Family Credit Expenditures to</u>          |                        |                       |
| 145.12 | <u>be Claimed for TANF/MOE. For fiscal year</u>       |                        |                       |
| 145.13 | <u>2011, the commissioner may count \$38,000</u>      |                        |                       |
| 145.14 | <u>of working family credit expenditures as</u>       |                        |                       |
| 145.15 | <u>TANF/MOE. Notwithstanding any provision</u>        |                        |                       |
| 145.16 | <u>to the contrary, this rider expires June 30,</u>   |                        |                       |
| 145.17 | <u>2013.</u>                                          |                        |                       |
| 145.18 | <u>TANF Financing and Maintenance of</u>              |                        |                       |
| 145.19 | <u>Effort. The commissioner of human</u>              |                        |                       |
| 145.20 | <u>services, with the approval of the</u>             |                        |                       |
| 145.21 | <u>commissioner of management and budget,</u>         |                        |                       |
| 145.22 | <u>and after notification of the chairs of the</u>    |                        |                       |
| 145.23 | <u>relevant senate budget division and house of</u>   |                        |                       |
| 145.24 | <u>representatives finance division, may adjust</u>   |                        |                       |
| 145.25 | <u>the amount of TANF transfers between the</u>       |                        |                       |
| 145.26 | <u>MFIP transition year child care assistance</u>     |                        |                       |
| 145.27 | <u>program and MFIP grant programs within the</u>     |                        |                       |
| 145.28 | <u>fiscal year, and within the current biennium</u>   |                        |                       |
| 145.29 | <u>and the biennium ending June 30, 2013,</u>         |                        |                       |
| 145.30 | <u>to ensure that state and federal match and</u>     |                        |                       |
| 145.31 | <u>maintenance of effort requirements are</u>         |                        |                       |
| 145.32 | <u>met. These transfers and amounts must be</u>       |                        |                       |
| 145.33 | <u>reported to the chairs of the senate and house</u> |                        |                       |
| 145.34 | <u>of representatives Finance Committees, the</u>     |                        |                       |
| 145.35 | <u>senate Health and Human Services Budget</u>        |                        |                       |
| 145.36 | <u>Division, the house of representatives Health</u>  |                        |                       |
| 145.37 | <u>Care and Human Services Finance Division,</u>      |                        |                       |

|        |                                                         |                   |                   |
|--------|---------------------------------------------------------|-------------------|-------------------|
| 146.1  | <u>and Early Childhood Finance and Policy</u>           |                   |                   |
| 146.2  | <u>Division by December 1 of each fiscal</u>            |                   |                   |
| 146.3  | <u>year. Notwithstanding any provision to the</u>       |                   |                   |
| 146.4  | <u>contrary, this rider expires June 30, 2013.</u>      |                   |                   |
| 146.5  | <u>The appropriation reductions for each</u>            |                   |                   |
| 146.6  | <u>purpose are shown in the following</u>               |                   |                   |
| 146.7  | <u>subdivisions.</u>                                    |                   |                   |
| 146.8  | <b><u>SNAP Enhanced Administrative Funding.</u></b>     |                   |                   |
| 146.9  | <u>The funds available for administration</u>           |                   |                   |
| 146.10 | <u>of the Supplemental Nutrition Assistance</u>         |                   |                   |
| 146.11 | <u>Program under the Department of Defense</u>          |                   |                   |
| 146.12 | <u>Appropriations Act of 2010, Public</u>               |                   |                   |
| 146.13 | <u>Law 111-118, are appropriated to the</u>             |                   |                   |
| 146.14 | <u>commissioner to pay the actual costs</u>             |                   |                   |
| 146.15 | <u>of providing for increased eligibility</u>           |                   |                   |
| 146.16 | <u>determinations, caseload-related cost, timely</u>    |                   |                   |
| 146.17 | <u>application processing, and quality control.</u>     |                   |                   |
| 146.18 | <u>Of these funds, 20 percent shall be allocated</u>    |                   |                   |
| 146.19 | <u>to the commissioner and 80 percent shall</u>         |                   |                   |
| 146.20 | <u>be allocated to counties. The commissioner</u>       |                   |                   |
| 146.21 | <u>shall allocate the county portion based</u>          |                   |                   |
| 146.22 | <u>on recent caseload. Reimbursement shall</u>          |                   |                   |
| 146.23 | <u>be based on actual costs reported by</u>             |                   |                   |
| 146.24 | <u>counties through existing processes. Tribal</u>      |                   |                   |
| 146.25 | <u>reimbursement must be made from the state</u>        |                   |                   |
| 146.26 | <u>portion, based on a caseload factor equivalent</u>   |                   |                   |
| 146.27 | <u>to that of a county.</u>                             |                   |                   |
| 146.28 | <b><u>Subd. 2. Agency Management; Financial</u></b>     |                   |                   |
| 146.29 | <b><u>Operations</u></b>                                | <u>(8,000)</u>    | <u>(16,000)</u>   |
| 146.30 | <u>This appropriation reduction is from the state</u>   |                   |                   |
| 146.31 | <u>government special revenue fund.</u>                 |                   |                   |
| 146.32 | <b><u>Subd. 3. Revenue and Pass-Through Revenue</u></b> |                   |                   |
| 146.33 | <b><u>Expenditures</u></b>                              | <u>20,672,000</u> | <u>21,402,000</u> |
| 146.34 | <b><u>TANF Funding for the Working Family</u></b>       |                   |                   |
| 146.35 | <b><u>Tax Credit.</u></b> In addition to the amounts    |                   |                   |

147.1 specified in Minnesota Statutes, section  
147.2 290.0671, subdivision 6, \$18,722,000  
147.3 of TANF funds in fiscal year 2010 and  
147.4 \$18,957,000 of TANF funds in fiscal year  
147.5 2011 are appropriated to the commissioner  
147.6 of human services to reimburse the general  
147.7 fund for the cost of the working family tax  
147.8 credit for eligible families, with respect to  
147.9 the amounts appropriated for fiscal year  
147.10 2010, the commissioner shall reimburse  
147.11 the general fund by June 30, 2010, with  
147.12 respect to the funds appropriated for fiscal  
147.13 year 2011, beginning January 1, 2011, the  
147.14 commissioner shall reimburse the general  
147.15 fund on a monthly basis according to a  
147.16 schedule based on the pattern of working  
147.17 family credit expenditures through June 30,  
147.18 2011. This rider is effective upon enactment.

147.19 Subd. 4. **Children and Economic Assistance**  
147.20 **Grants**

147.21 (a) **MFIP and Diversionary Work Program**  
147.22 **Grants** -0- (2,024,000)

147.23 This appropriation reduction is from the  
147.24 federal TANF fund.

147.25 (b) **Support Services Grants** -0- (7,646,000)

147.26 **Supported Work.** The fiscal year 2011  
147.27 TANF appropriation to the commissioner  
147.28 of human services for supported work for  
147.29 MFIP recipients is reduced by \$4,000,000.  
147.30 This reduction is onetime. \$4,000,000 of  
147.31 the amounts earned in the TANF emergency  
147.32 fund (TEF) subsidized employment  
147.33 category under the American Recovery and  
147.34 Reinvestment Act (ARRA) of 2009, Public  
147.35 Law 111-5, are available for reimbursement

|        |                                                            |            |                    |
|--------|------------------------------------------------------------|------------|--------------------|
| 148.1  | <u>in the working family credit in fiscal year</u>         |            |                    |
| 148.2  | <u>2011.</u>                                               |            |                    |
| 148.3  | <b><u>Base Adjustment.</u></b> The federal TANF base       |            |                    |
| 148.4  | <u>shall be increased by \$2,642,000 for fiscal</u>        |            |                    |
| 148.5  | <u>years 2012 and 2013.</u>                                |            |                    |
| 148.6  | <b><u>(c) MFIP Child Care Assistance Grants</u></b>        | <u>-0-</u> | <u>(38,000)</u>    |
| 148.7  | <b><u>(d) Basic Sliding Fee Child Care Assistance</u></b>  |            |                    |
| 148.8  | <b><u>Grants</u></b>                                       | <u>-0-</u> | <u>(7,500,000)</u> |
| 148.9  | <u>This appropriation reduces the fiscal</u>               |            |                    |
| 148.10 | <u>year 2011 general fund appropriation by</u>             |            |                    |
| 148.11 | <u>\$7,500,000 and carries over and expends, in</u>        |            |                    |
| 148.12 | <u>fiscal year 2011, \$7,500,000 of the TANF</u>           |            |                    |
| 148.13 | <u>funds transferred in fiscal year 2010, which</u>        |            |                    |
| 148.14 | <u>reflect the child care and development</u>              |            |                    |
| 148.15 | <u>fund unexpended balance for the basic</u>               |            |                    |
| 148.16 | <u>sliding fee child care assistance program</u>           |            |                    |
| 148.17 | <u>under Minnesota Statutes, section 119B.03.</u>          |            |                    |
| 148.18 | <u>The commissioner shall ensure that all</u>              |            |                    |
| 148.19 | <u>the funds are expended according to the</u>             |            |                    |
| 148.20 | <u>federal child care and development fund</u>             |            |                    |
| 148.21 | <u>regulations relating to TANF transfers. This</u>        |            |                    |
| 148.22 | <u>appropriation is onetime.</u>                           |            |                    |
| 148.23 | <b><u>(e) Children and Community Services Grants</u></b>   | <u>-0-</u> | <u>(5,900,000)</u> |
| 148.24 | <b><u>Children and Community Services Grant</u></b>        |            |                    |
| 148.25 | <b><u>Reduction.</u></b> The fiscal year 2011 general fund |            |                    |
| 148.26 | <u>appropriation to the commissioner of human</u>          |            |                    |
| 148.27 | <u>services for the children and community</u>             |            |                    |
| 148.28 | <u>services grants under Minnesota Statutes,</u>           |            |                    |
| 148.29 | <u>section 256M.40, is reduced by \$5,900,000.</u>         |            |                    |
| 148.30 | <u>The ongoing reduction must be \$9,900,000</u>           |            |                    |
| 148.31 | <u>in each of fiscal years 2012 and 2013.</u>              |            |                    |
| 148.32 | <b><u>(f) Children's Mental Health Grants</u></b>          | <u>-0-</u> | <u>(5,980,000)</u> |

|        |                                                          |                    |                     |
|--------|----------------------------------------------------------|--------------------|---------------------|
| 149.1  | <u>(1) The general fund appropriation for</u>            |                    |                     |
| 149.2  | <u>children's capacity school-based services is</u>      |                    |                     |
| 149.3  | <u>reduced by \$4,777,000 for fiscal year 2011.</u>      |                    |                     |
| 149.4  | <u>(2) The general fund appropriation for</u>            |                    |                     |
| 149.5  | <u>children's mental health targeted case</u>            |                    |                     |
| 149.6  | <u>management grants is reduced by \$1,210,000</u>       |                    |                     |
| 149.7  | <u>for fiscal year 2011.</u>                             |                    |                     |
| 149.8  | <b><u>Base adjustment.</u></b> The general fund base     |                    |                     |
| 149.9  | is increased by \$2,048,000 in each of fiscal            |                    |                     |
| 149.10 | years 2012 and 2013.                                     |                    |                     |
| 149.11 | <b><u>(g) Other Children and Economic Assistance</u></b> |                    |                     |
| 149.12 | <b><u>Grants</u></b>                                     | <u>290,000</u>     | <u>63,000</u>       |
| 149.13 | <b><u>Subd. 5. Children and Economic Assistance</u></b>  |                    |                     |
| 149.14 | <b><u>Management</u></b>                                 |                    |                     |
| 149.15 | <b><u>(a) Children and Economic Assistance</u></b>       |                    |                     |
| 149.16 | <b><u>Administration</u></b>                             | <u>-0-</u>         | <u>-0-</u>          |
| 149.17 | <u>The TANF fund base shall be reduced by</u>            |                    |                     |
| 149.18 | <u>\$700,000 in fiscal years 2012 and 2013.</u>          |                    |                     |
| 149.19 | <b><u>(b) Children and Economic Assistance</u></b>       |                    |                     |
| 149.20 | <b><u>Operations</u></b>                                 | <u>(1,580,000)</u> | <u>(1,613,000)</u>  |
| 149.21 | <u>The federal TANF fund appropriation is</u>            |                    |                     |
| 149.22 | <u>reduced by \$172,000 in fiscal year 2010 and</u>      |                    |                     |
| 149.23 | <u>\$176,000 in fiscal year 2011.</u>                    |                    |                     |
| 149.24 | <u>The general fund appropriation is reduced</u>         |                    |                     |
| 149.25 | <u>by \$1,408,000 in fiscal year 2010 and by</u>         |                    |                     |
| 149.26 | <u>\$1,534,000 in fiscal year 2011. The general</u>      |                    |                     |
| 149.27 | <u>fund base is reduced by \$26,000 in each of</u>       |                    |                     |
| 149.28 | <u>fiscal years 2012 and 2013.</u>                       |                    |                     |
| 149.29 | <u>\$74,000 in fiscal year 2011 is appropriated</u>      |                    |                     |
| 149.30 | <u>from the health care access fund. This</u>            |                    |                     |
| 149.31 | <u>appropriation is onetime.</u>                         |                    |                     |
| 149.32 | <b><u>Subd. 6. Basic Health Care Grants</u></b>          |                    |                     |
| 149.33 | <b><u>(a) MinnesotaCare Grants</u></b>                   | <u>-0-</u>         | <u>(68,763,000)</u> |

|        |                                                        |            |                    |
|--------|--------------------------------------------------------|------------|--------------------|
| 150.1  | <u>This appropriation reduction is from the</u>        |            |                    |
| 150.2  | <u>health care access fund.</u>                        |            |                    |
| 150.3  | <b><u>(b) Medical Assistance Basic Health Care</u></b> |            |                    |
| 150.4  | <b><u>Grants - Families and Children</u></b>           | <u>-0-</u> | <u>(7,101,000)</u> |
| 150.5  | <b><u>(c) Medical Assistance Basic Health Care</u></b> |            |                    |
| 150.6  | <b><u>Grants - Elderly and Disabled</u></b>            | <u>-0-</u> | <u>(9,167,000)</u> |
| 150.7  | <b><u>MnDHO Transition. \$250,000 is</u></b>           |            |                    |
| 150.8  | <u>appropriated from the general fund in fiscal</u>    |            |                    |
| 150.9  | <u>year 2011 to the commissioner of human</u>          |            |                    |
| 150.10 | <u>services to be made available to county</u>         |            |                    |
| 150.11 | <u>agencies to assist in the proactive transition</u>  |            |                    |
| 150.12 | <u>of the approximately 1,290 current MnDHO</u>        |            |                    |
| 150.13 | <u>members to the fee-for-service Medicaid</u>         |            |                    |
| 150.14 | <u>program or another managed care option by</u>       |            |                    |
| 150.15 | <u>January 1, 2011. County agencies shall work</u>     |            |                    |
| 150.16 | <u>with the Department of Human Services,</u>          |            |                    |
| 150.17 | <u>health plans, and MnDHO members and</u>             |            |                    |
| 150.18 | <u>their legal representatives to develop and</u>      |            |                    |
| 150.19 | <u>implement transition plans that include:</u>        |            |                    |
| 150.20 | <u>(1) identification of service needs of MnDHO</u>    |            |                    |
| 150.21 | <u>members based on the current assessment or</u>      |            |                    |
| 150.22 | <u>through the completion of a new assessment;</u>     |            |                    |
| 150.23 | <u>(2) identification of services currently</u>        |            |                    |
| 150.24 | <u>provided to MnDHO members and which</u>             |            |                    |
| 150.25 | <u>of those services will continue to be</u>           |            |                    |
| 150.26 | <u>reimbursable through fee-for-service or</u>         |            |                    |
| 150.27 | <u>another managed care option under the</u>           |            |                    |
| 150.28 | <u>Medicaid state plan or a Title XIX home and</u>     |            |                    |
| 150.29 | <u>community-based waiver program;</u>                 |            |                    |
| 150.30 | <u>(3) identification of service providers who do</u>  |            |                    |
| 150.31 | <u>not have a contract with the county or who</u>      |            |                    |
| 150.32 | <u>are currently reimbursed at a different rate</u>    |            |                    |
| 150.33 | <u>than the county-contracted rate; and</u>            |            |                    |
| 150.34 | <u>(4) development of an individual service</u>        |            |                    |
| 150.35 | <u>plan that is within allowable home and</u>          |            |                    |

|        |                                                          |            |                     |
|--------|----------------------------------------------------------|------------|---------------------|
| 151.1  | <u>community-based service waiver funding</u>            |            |                     |
| 151.2  | <u>limits.</u>                                           |            |                     |
| 151.3  | <b><u>(d) General Assistance Medical Care Grants</u></b> | <u>-0-</u> | <u>(52,614,000)</u> |
| 151.4  | <b><u>Funding Reduction; Coordinated Care</u></b>        |            |                     |
| 151.5  | <b><u>Delivery Systems.</u></b> The appropriation for    |            |                     |
| 151.6  | <u>payments to coordinated care delivery</u>             |            |                     |
| 151.7  | <u>systems in Laws 2010, chapter 200, article</u>        |            |                     |
| 151.8  | <u>2, section 2, subdivision 4, paragraph (d), is</u>    |            |                     |
| 151.9  | <u>reduced by \$20,000,000 in fiscal year 2011.</u>      |            |                     |
| 151.10 | <b><u>(e) Medical Assistance; Adults Without</u></b>     |            |                     |
| 151.11 | <b><u>Children</u></b>                                   | <u>-0-</u> | <u>142,768,000</u>  |
| 151.12 | <u>Of this appropriation, \$142,768,000 is from</u>      |            |                     |
| 151.13 | <u>the health care access fund.</u>                      |            |                     |
| 151.14 | <b><u>(f) Other Health Care Grants</u></b>               | <u>-0-</u> | <u>(1,831,000)</u>  |
| 151.15 | <u>Of this appropriation, the general fund is</u>        |            |                     |
| 151.16 | <u>increased by \$19,000 and the health care</u>         |            |                     |
| 151.17 | <u>access fund appropriation is reduced by</u>           |            |                     |
| 151.18 | <u>\$1,850,000. This appropriation is onetime.</u>       |            |                     |
| 151.19 | <b><u>COBRA Carryforward.</u></b> Unexpended             |            |                     |
| 151.20 | <u>funds appropriated in fiscal year 2010 for</u>        |            |                     |
| 151.21 | <u>COBRA grants under Laws 2009, chapter</u>             |            |                     |
| 151.22 | <u>79, article 5, section 78, do not cancel and</u>      |            |                     |
| 151.23 | <u>are available to the commissioner of human</u>        |            |                     |
| 151.24 | <u>services for fiscal year 2011 COBRA grant</u>         |            |                     |
| 151.25 | <u>expenditures. Up to \$110,000 of the fiscal</u>       |            |                     |
| 151.26 | <u>year 2011 appropriation for COBRA grants</u>          |            |                     |
| 151.27 | <u>provided in Laws 2009, chapter 79, article</u>        |            |                     |
| 151.28 | <u>13, section 3, subdivision 6, may be used</u>         |            |                     |
| 151.29 | <u>by the commissioner of human services for</u>         |            |                     |
| 151.30 | <u>costs related to administration of the COBRA</u>      |            |                     |
| 151.31 | <u>grants.</u>                                           |            |                     |
| 151.32 | <b><u>Transfer.</u></b> The commissioner shall transfer  |            |                     |
| 151.33 | <u>\$19,000 to the commissioner of commerce</u>          |            |                     |

152.1 for regulation of Minnesota Statutes, section  
152.2 62A.3075.

152.3 Subd. 7. **Health Care Management**

152.4 (a) **Health Care Administration** (2,998,000) (4,468,000)

152.5 For fiscal year 2011 the health care access  
152.6 fund appropriation is increased by \$250,000  
152.7 and the general fund appropriation is reduced  
152.8 by \$4,633,000.

152.9 **PACE Implementation Funding.** For fiscal  
152.10 year 2011, \$145,000 is appropriated from  
152.11 the general fund to the commissioner of  
152.12 human services to complete the actuarial and  
152.13 administrative work necessary to begin the  
152.14 operation of PACE under Minnesota Statutes,  
152.15 section 256B.69, subdivision 23, paragraph  
152.16 (e). Base level funding for this activity shall  
152.17 be \$130,000 in fiscal year 2012 and \$0 in  
152.18 fiscal year 2013.

152.19 **Minnesota Senior Health Options**

152.20 **Reimbursement.** Effective July 1, 2011,  
152.21 federal administrative reimbursement  
152.22 resulting from the Minnesota senior  
152.23 health options project is appropriated  
152.24 to the commissioner for this activity.

152.25 Notwithstanding any contrary provision, this  
152.26 provision expires June 30, 2013.

152.27 **Health Care Inspector General.** \$120,000  
152.28 from the general fund in fiscal year 2011  
152.29 is for the Office of Health Care Inspector  
152.30 General, established under Minnesota  
152.31 Statutes, section 256.01, subdivision 30.

152.32 **Fiscal and Actuarial Analysis.** \$250,000  
152.33 from the general fund is for the fiscal and  
152.34 actuarial analysis of 2010 House File No.



153.1 135 and 2010 Senate File No. 118. This  
153.2 appropriation is onetime.

153.3 **Utilization Review.** Effective July 1,  
153.4 2011, federal administrative reimbursement  
153.5 resulting from prior authorization and  
153.6 inpatient admission certification by a  
153.7 professional review organization shall be  
153.8 dedicated to, and is appropriated to, the  
153.9 commissioner for these activities. A portion  
153.10 of these funds must be used for activities to  
153.11 decrease unnecessary pharmaceutical costs  
153.12 in medical assistance. Notwithstanding any  
153.13 contrary provision, this provision expires  
153.14 June 30, 2013.

153.15 **Base Adjustment.** The health care access  
153.16 fund base is reduced by \$50,000 in each of  
153.17 fiscal years 2012 and 2013.

153.18 The general fund base is reduced by \$516,000  
153.19 in each of fiscal years 2012 and 2013.

153.20 **(b) Health Care Operations**

|        |                               |                    |                    |
|--------|-------------------------------|--------------------|--------------------|
| 153.21 | <u>Appropriations by Fund</u> |                    |                    |
| 153.22 | <u>General</u>                | <u>-0-</u>         | <u>44,000</u>      |
| 153.23 | <u>Health Care Access</u>     | <u>(1,094,000)</u> | <u>(1,234,000)</u> |

153.24 **Base Adjustment.** The health care access  
153.25 fund base for health care operations is  
153.26 reduced by \$1,272,000 in fiscal year 2012  
153.27 and \$1,337,000 in fiscal year 2013. The  
153.28 general fund appropriation is onetime.

153.29 **Subd. 8. Continuing Care Grants**

|        |                                                   |            |                  |
|--------|---------------------------------------------------|------------|------------------|
| 153.30 | <b><u>(a) Aging and Adult Services Grants</u></b> | <u>-0-</u> | <u>(154,000)</u> |
|--------|---------------------------------------------------|------------|------------------|

153.31 This reduction is onetime and must not be  
153.32 applied to the base.

153.33 **Community Service Development**

153.34 **Reduction.** The appropriation in Laws

154.1 2009, chapter 79, article 13, section 3,  
154.2 subdivision 8, paragraph (a), for community  
154.3 service development grants, as amended by  
154.4 Laws 2009, chapter 173, article 2, section  
154.5 1, subdivision 8, paragraph (a), is reduced  
154.6 by \$154,000 in fiscal year 2011. The  
154.7 appropriation base is reduced by \$139,000  
154.8 for fiscal year 2012 and \$0 for fiscal year  
154.9 2013. Notwithstanding any law or rule to  
154.10 the contrary, this provision expires June 30,  
154.11 2012.

154.12 **(b) Medical Assistance Long-Term Care**  
154.13 **Facilities Grants**

-0-

683,000

154.14 **Clearwater County; ICF/MR Payment**

154.15 **Rate.** \$84,000 is appropriated in fiscal  
154.16 year 2011 from the general fund to the  
154.17 commissioner of human services for the  
154.18 purposes of the Clearwater County facility  
154.19 ICF/MR rate increase in article 3. This  
154.20 appropriation is onetime.

154.21 **Kandiyohi County; ICF/MR Payment**

154.22 **Rate.** \$36,000 is appropriated from the  
154.23 general fund in fiscal year 2011 and \$4,000  
154.24 in fiscal year 2012 to increase payment rates  
154.25 for an ICF/MR licensed for six beds and  
154.26 located in Kandiyohi County to serve persons  
154.27 with high behavioral needs. The payment  
154.28 rate increase shall be effective for services  
154.29 provided from July 1, 2010, through June 30,  
154.30 2011. These appropriations are onetime.

154.31 **Crisis Center Services.** Of this

154.32 appropriation, \$400,000 in fiscal year  
154.33 2011 is to a community collaborative to  
154.34 continue crisis center services provided in  
154.35 the Mankato area.

155.1 **Group Residential Housing; Mahnomen**

155.2 **County.** \$48,000 is appropriated from  
155.3 the general fund in fiscal year 2011 to the  
155.4 commissioner of human services for the  
155.5 purposes of Minnesota Statutes, section  
155.6 256I.05, subdivision 1n. This appropriation  
155.7 is onetime.

155.8 **(c) Medical Assistance Long-Term Care**  
155.9 **Waivers and Home Care Grants**

-0- (2,747,000)

155.10 **Manage Growth in Traumatic Brain**

155.11 **Injury and Community Alternatives for**

155.12 **Disabled Individuals' Waivers.** During  
155.13 the fiscal year beginning July 1, 2010, the  
155.14 commissioner shall allocate money for home  
155.15 and community-based waiver programs  
155.16 under Minnesota Statutes, section 256B.49,  
155.17 to ensure a reduction in state spending that is  
155.18 equivalent to limiting the caseload growth  
155.19 of the traumatic brain injury waiver to six  
155.20 allocations per month and the community  
155.21 alternatives for disabled individuals waiver  
155.22 to 60 allocations per month. The limits do not  
155.23 apply: (1) when there is an approved plan for  
155.24 nursing facility bed closures for individuals  
155.25 under age 65 who require relocation due to  
155.26 the bed closure; (2) to fiscal year 2009 waiver  
155.27 allocations delayed due to unallotment; or (3)  
155.28 to transfers authorized by the commissioner  
155.29 from the personal care assistance program  
155.30 of individuals having a home care rating of  
155.31 CS, MT, or HL. Priorities for the allocation  
155.32 of funds must be for individuals anticipated  
155.33 to be discharged from institutional settings or  
155.34 who are at imminent risk of a placement in  
155.35 an institutional setting.

156.1 **Manage Growth in the Developmental**

156.2 **Disability (DD) Waiver.** The commissioner  
156.3 shall manage the growth in the developmental  
156.4 disability waiver by limiting the allocations  
156.5 included in the November 2010 forecast to  
156.6 six additional diversion allocations each  
156.7 month for the calendar year that begins on  
156.8 January 1, 2011. Additional allocations must  
156.9 be made available for transfers authorized  
156.10 by the commissioner from the personal care  
156.11 assistance program of individuals having a  
156.12 home care rating of CS, MT, or HL. This  
156.13 provision is effective through December 31,  
156.14 2011.

156.15 **(d) Adult Mental Health Grants** (3,500,000) (9,903,000)

156.16 **Compulsive Gambling Special Revenue**

156.17 **Account.** \$149,000 for fiscal year 2010  
156.18 and \$27,000 for fiscal year 2011 from  
156.19 the compulsive gambling special revenue  
156.20 account established under Minnesota  
156.21 Statutes, section 245.982, must be transferred  
156.22 and deposited into the general fund by June  
156.23 30 of each respective fiscal year.

156.24 **Compulsive Gambling Lottery Prize Fund**

156.25 **Appropriation.** The lottery prize fund  
156.26 appropriation for compulsive gambling, is  
156.27 reduced by \$80,000 in fiscal year 2010 and  
156.28 \$79,000 in fiscal year 2011. This is a onetime  
156.29 reduction.

156.30 **Adult Mental Health.** (1) The general  
156.31 fund appropriation for adult mental health  
156.32 evidence-based practices, including but not  
156.33 limited to, assertive community treatment  
156.34 and integrated dual diagnosis treatment

157.1 services, is reduced by \$750,000 for fiscal  
157.2 year 2011. This reduction is onetime.

157.3 (2) The general fund appropriation for  
157.4 mental health grants to increase availability  
157.5 of culturally specific adult mental health  
157.6 services is reduced by \$300,000 for fiscal  
157.7 year 2011. This reduction is onetime.

157.8 (3) The general fund appropriation for  
157.9 grants to community hospitals to provide  
157.10 alternatives to residential treatment center  
157.11 mental health programs is reduced by  
157.12 \$2,653,000 for fiscal year 2011. This  
157.13 reduction is onetime.

157.14 (4) The general fund appropriation for grants  
157.15 to counties for adult mental health services is  
157.16 reduced by \$6,200,000 for fiscal year 2011,  
157.17 and \$6,000,000 in each of fiscal years 2012  
157.18 and 2013.

157.19 (5) Of the fiscal year 2010 general fund  
157.20 appropriation for grants to counties for  
157.21 housing with support services for adults  
157.22 with serious and persistent mental illness,  
157.23 \$3,300,000 is canceled and returned to the  
157.24 general fund.

157.25 (6) Of the fiscal year 2010 general  
157.26 fund appropriation for additional crisis  
157.27 intervention team training for law  
157.28 enforcement, \$200,000 is canceled and  
157.29 returned to the general fund.

157.30 **Base adjustment.** The general fund base  
157.31 is increased by \$3,903,000 in each of fiscal  
157.32 years 2012 and 2013.

157.33 **(e) Chemical Dependency Entitlement Grants** -0- (3,986,000)

|        |                                                        |                  |                |
|--------|--------------------------------------------------------|------------------|----------------|
| 158.1  | <u>(f) Chemical Dependency Nonentitlement</u>          |                  |                |
| 158.2  | <u>Grants</u>                                          | <u>(389,000)</u> | <u>-0-</u>     |
| 158.3  | <u>Chemical Health. Of the fiscal year 2010</u>        |                  |                |
| 158.4  | <u>general fund appropriation to Mother's First</u>    |                  |                |
| 158.5  | <u>and the Native American Program, \$389,000</u>      |                  |                |
| 158.6  | <u>is canceled and returned to the general fund.</u>   |                  |                |
| 158.7  | <u>(g) Other Continuing Care Grants</u>                | <u>-0-</u>       | <u>100,000</u> |
| 158.8  | <u>Region 10 Quality Assurance Commission.</u>         |                  |                |
| 158.9  | <u>\$100,000 is appropriated from the general</u>      |                  |                |
| 158.10 | <u>fund in fiscal year 2011 to the commissioner</u>    |                  |                |
| 158.11 | <u>of human services for the purposes</u>              |                  |                |
| 158.12 | <u>of the Region 10 Quality Assurance</u>              |                  |                |
| 158.13 | <u>Commission under Minnesota Statutes,</u>            |                  |                |
| 158.14 | <u>section 256B.0951. This appropriation is</u>        |                  |                |
| 158.15 | <u>onetime.</u>                                        |                  |                |
| 158.16 | <u>Subd. 9. Continuing Care Management</u>             | <u>-0-</u>       | <u>111,000</u> |
| 158.17 | <u>PACE Implementation Funding. For fiscal</u>         |                  |                |
| 158.18 | <u>year 2011, \$111,000 is appropriated from</u>       |                  |                |
| 158.19 | <u>the general fund to the commissioner of</u>         |                  |                |
| 158.20 | <u>human services to complete the actuarial</u>        |                  |                |
| 158.21 | <u>and administrative work necessary to begin</u>      |                  |                |
| 158.22 | <u>the operation of PACE under Minnesota</u>           |                  |                |
| 158.23 | <u>Statutes, section 256B.69, subdivision 23,</u>      |                  |                |
| 158.24 | <u>paragraph (e). Base level funding for this</u>      |                  |                |
| 158.25 | <u>activity shall be \$101,000 in fiscal year 2012</u> |                  |                |
| 158.26 | <u>and \$0 in fiscal year 2013. For fiscal year</u>    |                  |                |
| 158.27 | <u>2013 and beyond, the commissioner must</u>          |                  |                |
| 158.28 | <u>work with stakeholders to develop financing</u>     |                  |                |
| 158.29 | <u>mechanisms to complete the actuarial</u>            |                  |                |
| 158.30 | <u>and administrative costs of PACE. The</u>           |                  |                |
| 158.31 | <u>commissioner shall inform the chairs and</u>        |                  |                |
| 158.32 | <u>ranking minority members of the legislative</u>     |                  |                |
| 158.33 | <u>committee with jurisdiction over health care</u>    |                  |                |
| 158.34 | <u>funding by January 15, 2011, on progress to</u>     |                  |                |
| 158.35 | <u>develop financing mechanisms.</u>                   |                  |                |

159.1 Subd. 10. State-Operated Services

159.2 Obsolete Laundry Depreciation Account.

159.3 \$669,000, or the balance, whichever is  
 159.4 greater, must be transferred from the  
 159.5 state-operated services laundry depreciation  
 159.6 account in the special revenue fund and  
 159.7 deposited into the general fund by June 30,  
 159.8 2010.

159.9 State-Operated Services. Of this  
 159.10 appropriation, \$12,854,000 in fiscal year  
 159.11 2011 is for the commissioner to maintain  
 159.12 dental clinics, the METO program, and other  
 159.13 residential adult mental health services.

|        |                                               |            |                   |
|--------|-----------------------------------------------|------------|-------------------|
| 159.14 | <u>Subd. 11. Adult Mental Health Services</u> | <u>-0-</u> | <u>12,854,000</u> |
|--------|-----------------------------------------------|------------|-------------------|

159.15 This appropriation is onetime and does not  
 159.16 affect the agency's base.

159.17 Subd. 12. Contingent Appropriations  
 159.18 Reductions

159.19 Upon enactment of the extension of  
 159.20 the enhanced federal medical assistance  
 159.21 percentage (FMAP) under Public Law 111-5  
 159.22 to June 30, 2011, that is contained in the  
 159.23 president's budget for federal fiscal year 2011  
 159.24 or contained in House Resolution 2847, the  
 159.25 federal "Jobs for Main Street Act of 2010," or  
 159.26 subsequent federal legislation, the reductions  
 159.27 identified in each clause shall be made to  
 159.28 the specified general fund appropriations  
 159.29 for fiscal year 2011. These contingent  
 159.30 reductions, if implemented, are in addition  
 159.31 to the reductions specified in subdivision 6,  
 159.32 paragraphs (a), (b), and (c), and subdivision  
 159.33 8, paragraphs (c) and (d), respectively.

|        |                                 |            |                    |
|--------|---------------------------------|------------|--------------------|
| 159.34 | <u>(1) MinnesotaCare Grants</u> | <u>-0-</u> | <u>(9,200,000)</u> |
|--------|---------------------------------|------------|--------------------|

|       |                                                         |            |                      |
|-------|---------------------------------------------------------|------------|----------------------|
| 160.1 | <u>(2) Medical Assistance Basic Health Care Grants</u>  |            |                      |
| 160.2 | <u>- Families and Children</u>                          | <u>-0-</u> | <u>(109,662,500)</u> |
| 160.3 | <u>(3) Medical Assistance Basic Health Care Grants</u>  |            |                      |
| 160.4 | <u>- Elderly and Disabled</u>                           | <u>-0-</u> | <u>(110,437,500)</u> |
| 160.5 | <u>(4) Medical Assistance Long-Term Care Facilities</u> |            |                      |
| 160.6 | <u>Grants</u>                                           | <u>-0-</u> | <u>(51,925,000)</u>  |
| 160.7 | <u>(5) Medical Assistance Long-Term Care Waivers</u>    |            |                      |
| 160.8 | <u>and Home Care Grants</u>                             | <u>-0-</u> | <u>(115,475,000)</u> |

160.9     Sec. 4. COMMISSIONER OF HEALTH

|        |  |                               |
|--------|--|-------------------------------|
| 160.10 |  | <u>APPROPRIATIONS</u>         |
| 160.11 |  | <u>Available for the Year</u> |
| 160.12 |  | <u>Ending June 30</u>         |
| 160.13 |  | <u>2010</u> <u>2011</u>       |

|        |                                           |           |                    |           |                  |
|--------|-------------------------------------------|-----------|--------------------|-----------|------------------|
| 160.14 | <u>Subdivision 1. Total Appropriation</u> | <u>\$</u> | <u>(2,992,000)</u> | <u>\$</u> | <u>5,224,000</u> |
|--------|-------------------------------------------|-----------|--------------------|-----------|------------------|

|        |                               |                    |                  |
|--------|-------------------------------|--------------------|------------------|
| 160.15 | <u>Appropriations by Fund</u> |                    |                  |
| 160.16 |                               | <u>2010</u>        | <u>2011</u>      |
| 160.17 | <u>General</u>                | <u>(2,392,000)</u> | <u>5,283,000</u> |
| 160.18 | <u>State Government</u>       |                    |                  |
| 160.19 | <u>Special Revenue</u>        | <u>(600,000)</u>   | <u>(259,000)</u> |
| 160.20 | <u>Health Care Access</u>     |                    |                  |
| 160.21 | <u>Fund</u>                   | <u>-0-</u>         | <u>200,000</u>   |

|        |                                             |                  |                  |
|--------|---------------------------------------------|------------------|------------------|
| 160.22 | <u>Subd. 2. Community and Family Health</u> | <u>(221,000)</u> | <u>(121,000)</u> |
|--------|---------------------------------------------|------------------|------------------|

160.23     Statewide Health Improvement Program.

160.24     \$8,500,000 from the health care access  
160.25     fund in fiscal year 2012 and \$8,500,000 in  
160.26     fiscal year 2013 is for the statewide health  
160.27     improvement program under Minnesota  
160.28     Statutes, section 145.986. These additions  
160.29     are onetime.

160.30     Base adjustment. The general fund base is  
160.31     reduced by \$132,000 in each of fiscal years  
160.32     2012 and 2013.

160.33     Subd. 3. Policy, Quality, and Compliance

|        |                               |                    |                  |
|--------|-------------------------------|--------------------|------------------|
| 160.34 | <u>Appropriations by Fund</u> |                    |                  |
| 160.35 |                               | <u>2010</u>        | <u>2011</u>      |
| 160.36 | <u>General</u>                | <u>(1,797,000)</u> | <u>5,209,000</u> |



|       |                           |                  |                  |
|-------|---------------------------|------------------|------------------|
| 161.1 | <u>State Government</u>   |                  |                  |
| 161.2 | <u>Special Revenue</u>    | <u>(600,000)</u> | <u>(268,000)</u> |
| 161.3 | <u>Health Care Access</u> |                  |                  |
| 161.4 | <u>Fund</u>               | <u>-0-</u>       | <u>200,000</u>   |

161.5 Of this appropriation, \$74,000 in fiscal  
161.6 year 2011 is to restore unallotments for the  
161.7 Office of Unlicensed Complementary and  
161.8 Alternative Health Care Practice.

161.9 **Health Care Reform.** Funds appropriated  
161.10 in Laws 2008, chapter 358, article 5, section  
161.11 4, subdivision 3, for health reform activities  
161.12 to implement Laws 2008, chapter 358,  
161.13 article 4, are available until expended.  
161.14 Notwithstanding any contrary provision in  
161.15 this article, this provision shall not expire.

161.16 **Health Care Reform Task Force.** \$200,000  
161.17 from the general fund is for expenses related  
161.18 to the Health Care Reform Task Force  
161.19 established under article 7, section 8.

161.20 **Autism Coverage Study.** \$50,000 in  
161.21 fiscal year 2011 is appropriated to the  
161.22 commissioner of health to monitor the gaps  
161.23 in the level of service provided by state  
161.24 health programs, the state employee group  
161.25 insurance plan, and private health plans for  
161.26 autism spectrum disorder. This appropriation  
161.27 is onetime.

161.28 **Rural Hospital Capital Improvement**  
161.29 **Grants.** Of the general fund reductions in  
161.30 fiscal year 2010, \$1,755,000 is for the rural  
161.31 hospital capital improvement grant program.

161.32 **Health Information Exchange Oversight.**  
161.33 Of the state government special revenue fund  
161.34 appropriations, \$104,000 in fiscal year 2011

162.1 is for the duties required under Minnesota  
162.2 Statutes, sections 62J.498 to 62J.4982.

162.3 **Birth Centers.** Of the state government  
162.4 special revenue fund appropriations, \$9,000  
162.5 is for licensing birth centers under Minnesota  
162.6 Statutes, section 144.651. Base funding shall  
162.7 be \$7,000 in fiscal year 2012 and \$7,000 in  
162.8 fiscal year 2013.

162.9 **Advisory Group on Administrative**  
162.10 **Expenses.** Of the general fund appropriation,  
162.11 \$40,000 in fiscal year 2011 is for the advisory  
162.12 group established under Minnesota Statutes,  
162.13 section 62D.31.

162.14 **Community Clinic Grants.** Of this  
162.15 appropriation, \$2,500,000 in fiscal  
162.16 year 2011 is for the commissioner to  
162.17 provide community clinic grants under  
162.18 Minnesota Statutes, section 145.9268. This  
162.19 appropriation is onetime. In awarding grants  
162.20 using this funding, the commissioner shall  
162.21 give priority to proposals that seek to serve  
162.22 medically underserved areas of the state that  
162.23 are not served by a coordinated care delivery  
162.24 system established under Minnesota Statutes,  
162.25 section 256D.031, subdivision 6.

162.26 **Federally Qualified Health Center**  
162.27 **Subsidies.** Of this appropriation, \$2,500,000  
162.28 in fiscal year 2011 is for the commissioner to  
162.29 increase subsidies to federally qualified health  
162.30 centers provided under Minnesota Statutes,  
162.31 section 145.9269. This appropriation is  
162.32 onetime. In awarding subsidies using this  
162.33 funding, the commissioner shall give priority  
162.34 to federally qualified health centers that serve  
162.35 medically underserved areas of the state that

|        |                                                                |                     |                 |
|--------|----------------------------------------------------------------|---------------------|-----------------|
| 163.1  | <u>are not served by a coordinated care delivery</u>           |                     |                 |
| 163.2  | <u>system established under Minnesota Statutes,</u>            |                     |                 |
| 163.3  | <u>section 256D.031, subdivision 6.</u>                        |                     |                 |
| 163.4  | <b><u>Base Level Adjustment.</u></b> <u>The general</u>        |                     |                 |
| 163.5  | <u>fund base is reduced by \$5,134,000 in each</u>             |                     |                 |
| 163.6  | <u>of fiscal years 2012 and 2013. The state</u>                |                     |                 |
| 163.7  | <u>government special revenue fund base is</u>                 |                     |                 |
| 163.8  | <u>increased by \$365,000 in each of fiscal years</u>          |                     |                 |
| 163.9  | <u>2012 and 2013.</u>                                          |                     |                 |
| 163.10 | <u>Subd. 4. <b>Health Protection</b></u>                       | <u>(374,000)</u>    | <u>295,000</u>  |
| 163.11 | <b><u>Lead Base Grant Program.</u></b> <u>Of the general</u>   |                     |                 |
| 163.12 | <u>fund reduction, \$25,000 in fiscal year 2010</u>            |                     |                 |
| 163.13 | <u>and fiscal year 2011 is for the elimination</u>             |                     |                 |
| 163.14 | <u>of state funding for the temporary lead-safe</u>            |                     |                 |
| 163.15 | <u>housing base grant program.</u>                             |                     |                 |
| 163.16 | <b><u>Birth Defects Information System.</u></b> <u>Of</u>      |                     |                 |
| 163.17 | <u>the general fund appropriation, \$500,000 in</u>            |                     |                 |
| 163.18 | <u>fiscal year 2011 is for the Minnesota Birth</u>             |                     |                 |
| 163.19 | <u>Defects Information System established</u>                  |                     |                 |
| 163.20 | <u>under Minnesota Statutes, section 144.2215.</u>             |                     |                 |
| 163.21 | <b><u>Base Adjustment.</u></b> <u>The general fund base is</u> |                     |                 |
| 163.22 | <u>reduced by \$99,000 in each of fiscal years</u>             |                     |                 |
| 163.23 | <u>2012 and 2013.</u>                                          |                     |                 |
| 163.24 | <u>Subd. 5. <b>Administrative Support Services</b></u>         | <u>-0-</u>          | <u>(91,000)</u> |
| 163.25 | <u>Sec. 5. <b>HEALTH-RELATED BOARDS</b></u>                    |                     |                 |
| 163.26 | <u>Subdivision 1. <b>Total Appropriation</b></u>               | <u>\$ 2,610,000</u> | <u>\$ -0-</u>   |
| 163.27 | <u>In fiscal year 2010, \$591,000 shall be</u>                 |                     |                 |
| 163.28 | <u>transferred from the state government special</u>           |                     |                 |
| 163.29 | <u>revenue fund to the general fund. In fiscal</u>             |                     |                 |
| 163.30 | <u>year 2011, \$442,000 shall be transferred from</u>          |                     |                 |
| 163.31 | <u>the state government special revenue fund</u>               |                     |                 |
| 163.32 | <u>to the general fund. These transfers are in</u>             |                     |                 |
| 163.33 | <u>addition to those made in Laws 2009, chapter</u>            |                     |                 |

|        |                                                       |                  |                  |
|--------|-------------------------------------------------------|------------------|------------------|
| 164.1  | <u>79, article 13, section 5, as amended by Laws</u>  |                  |                  |
| 164.2  | <u>2009, chapter 173, article 2, section 3.</u>       |                  |                  |
| 164.3  | <u>The transfers in this section are onetime in</u>   |                  |                  |
| 164.4  | <u>the fiscal year 2010-2011 biennium.</u>            |                  |                  |
| 164.5  | <u>Subd. 2. <b>Board of Nursing Home</b></u>          |                  |                  |
| 164.6  | <u><b>Administrators</b></u>                          | <u>2,610,000</u> | <u>-0-</u>       |
| 164.7  | <u><b>Administrative Services Unit; Transfer.</b></u> |                  |                  |
| 164.8  | <u>This appropriation is from the state</u>           |                  |                  |
| 164.9  | <u>government special revenue fund in fiscal</u>      |                  |                  |
| 164.10 | <u>year 2010 to the administrative services</u>       |                  |                  |
| 164.11 | <u>unit. Upon request for a transfer from a</u>       |                  |                  |
| 164.12 | <u>health-related board, the administrative</u>       |                  |                  |
| 164.13 | <u>services unit is authorized to transfer</u>        |                  |                  |
| 164.14 | <u>money from this appropriation to the board</u>     |                  |                  |
| 164.15 | <u>with the approval of the commissioner of</u>       |                  |                  |
| 164.16 | <u>management and budget. This appropriation</u>      |                  |                  |
| 164.17 | <u>does not cancel. Any unencumbered and</u>          |                  |                  |
| 164.18 | <u>unspent balances remain available for these</u>    |                  |                  |
| 164.19 | <u>expenditures in subsequent fiscal years. The</u>   |                  |                  |
| 164.20 | <u>administrative services unit must report to</u>    |                  |                  |
| 164.21 | <u>the legislature a detailed spending report</u>     |                  |                  |
| 164.22 | <u>by September 1, 2011, on the uses of these</u>     |                  |                  |
| 164.23 | <u>appropriated funds.</u>                            |                  |                  |
| 164.24 | <u>Sec. 6. <b>EMERGENCY MEDICAL SERVICES</b></u>      |                  |                  |
| 164.25 | <u><b>BOARD</b></u>                                   | <u>361,000</u>   | <u>(133,000)</u> |
| 164.26 | <u>This appropriation must be applied to</u>          |                  |                  |
| 164.27 | <u>emergency medical services grant programs.</u>     |                  |                  |
| 164.28 | <u>Reductions from the general fund must be</u>       |                  |                  |
| 164.29 | <u>applied to the board's operating budget and</u>    |                  |                  |
| 164.30 | <u>must not be applied to grant programs.</u>         |                  |                  |
| 164.31 | <u><b>Longevity Award and Incentive Program</b></u>   | <u>(19,000)</u>  | <u>(19,000)</u>  |
| 164.32 | <u><b>Emergency Medical Services Relief</b></u>       |                  |                  |
| 164.33 | <u><b>Transfer.</b> \$10,000 in fiscal year 2010</u>  |                  |                  |
| 164.34 | <u>and \$24,000 in fiscal year 2011 shall be</u>      |                  |                  |
| 164.35 | <u>transferred to the general fund from the</u>       |                  |                  |

165.1 portion of the emergency medical services  
165.2 relief account in the special revenue fund  
165.3 otherwise designated for distribution by  
165.4 the Emergency Medical Services Board  
165.5 under Minnesota Statutes, section 169.686,  
165.6 subdivision 3. These transfers are onetime in  
165.7 the 2010-2011 biennium.

|        |                                            |                  |                        |                                         |
|--------|--------------------------------------------|------------------|------------------------|-----------------------------------------|
| 165.8  | Sec. 7. <b><u>OMBUDSMAN FOR MENTAL</u></b> |                  |                        |                                         |
| 165.9  | <b><u>HEALTH AND DEVELOPMENTAL</u></b>     |                  |                        |                                         |
| 165.10 | <b><u>DISABILITIES</u></b>                 | <b><u>\$</u></b> | <b><u>(31,000)</u></b> | <b><u>\$</u></b> <b><u>(50,000)</u></b> |

|        |                                                 |                  |                       |                                        |
|--------|-------------------------------------------------|------------------|-----------------------|----------------------------------------|
| 165.11 | Sec. 8. <b><u>OMBUDSPERSON FOR FAMILIES</u></b> | <b><u>\$</u></b> | <b><u>(4,000)</u></b> | <b><u>\$</u></b> <b><u>(8,000)</u></b> |
|--------|-------------------------------------------------|------------------|-----------------------|----------------------------------------|

|        |                                                |                  |                   |                                         |
|--------|------------------------------------------------|------------------|-------------------|-----------------------------------------|
| 165.12 | Sec. 9. <b><u>MINNESOTA MANAGEMENT AND</u></b> |                  |                   |                                         |
| 165.13 | <b><u>BUDGET</u></b>                           | <b><u>\$</u></b> | <b><u>-0-</u></b> | <b><u>\$</u></b> <b><u>\$50,000</u></b> |

165.14 **Fiscal Note Report.** \$50,000 in fiscal year  
165.15 2012 is to the commissioner of Minnesota  
165.16 Management and Budget from the general  
165.17 fund for the completion of the human  
165.18 services fiscal note report in article 5.

165.19       Sec. 10. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

165.20           Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds  
165.21 appropriated for this program, the administrative services unit must purchase medical  
165.22 professional liability insurance, if available, for a health care provider who is registered in  
165.23 accordance with subdivision 4 and who is not otherwise covered by a medical professional  
165.24 liability insurance policy or self-insured plan either personally or through another facility  
165.25 or employer. The administrative services unit is authorized to prorate payments or  
165.26 otherwise limit the number of participants in the program if the costs of the insurance for  
165.27 eligible providers exceed the funds appropriated for the program.

165.28           (b) Coverage purchased under this subdivision must be limited to the provision of  
165.29 health care services performed by the provider for which the provider does not receive  
165.30 direct monetary compensation.

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

166.1       Sec. 11. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by  
166.2       Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

166.3       Subdivision 1. **Total Appropriation**                               \$    5,225,451,000   \$    6,002,864,000

|        |                        |               |               |
|--------|------------------------|---------------|---------------|
| 166.4  | Appropriations by Fund |               |               |
| 166.5  |                        | 2010          | 2011          |
| 166.6  | General                | 4,375,689,000 | 5,209,765,000 |
| 166.7  | State Government       |               |               |
| 166.8  | Special Revenue        | 565,000       | 565,000       |
| 166.9  | Health Care Access     | 450,662,000   | 527,411,000   |
| 166.10 | Federal TANF           | 286,770,000   | 263,458,000   |
| 166.11 | Lottery Prize          | 1,665,000     | 1,665,000     |
| 166.12 | Federal Fund           | 110,000,000   | 0             |

166.13   **Receipts for Systems Projects.**

166.14   Appropriations and federal receipts for

166.15   information systems projects for MAXIS,

166.16   PRISM, MMIS, and SSIS must be deposited

166.17   in the state system account authorized in

166.18   Minnesota Statutes, section 256.014. Money

166.19   appropriated for computer projects approved

166.20   by the Minnesota Office of Enterprise

166.21   Technology, funded by the legislature, and

166.22   approved by the commissioner of finance,

166.23   may be transferred from one project to

166.24   another and from development to operations

166.25   as the commissioner of human services

166.26   considers necessary, except that any transfers

166.27   to one project that exceed \$1,000,000 or

166.28   multiple transfers to one project that exceed

166.29   \$1,000,000 in total require the express

166.30   approval of the legislature. The preceding

166.31   requirement for legislative approval does not

166.32   apply to transfers made to establish a project's

166.33   initial operating budget each year; instead,

166.34   the requirements of section 11, subdivision

166.35   2, of this article apply to those transfers. Any

166.36   unexpended balance in the appropriation

166.37   for these projects does not cancel but is

167.1 available for ongoing development and  
167.2 operations. Any computer project with a  
167.3 total cost exceeding \$1,000,000, including,  
167.4 but not limited to, a replacement for the  
167.5 proposed HealthMatch system, shall not be  
167.6 commenced without the express approval of  
167.7 the legislature.

167.8 **HealthMatch Systems Project.** In fiscal  
167.9 year 2010, \$3,054,000 shall be transferred  
167.10 from the HealthMatch account in the state  
167.11 systems account in the special revenue fund  
167.12 to the general fund.

167.13 **Nonfederal Share Transfers.** The  
167.14 nonfederal share of activities for which  
167.15 federal administrative reimbursement is  
167.16 appropriated to the commissioner may be  
167.17 transferred to the special revenue fund.

167.18 **TANF Maintenance of Effort.**

167.19 (a) In order to meet the basic maintenance  
167.20 of effort (MOE) requirements of the TANF  
167.21 block grant specified under Code of Federal  
167.22 Regulations, title 45, section 263.1, the  
167.23 commissioner may only report nonfederal  
167.24 money expended for allowable activities  
167.25 listed in the following clauses as TANF/MOE  
167.26 expenditures:

167.27 (1) MFIP cash, diversionary work program,  
167.28 and food assistance benefits under Minnesota  
167.29 Statutes, chapter 256J;

167.30 (2) the child care assistance programs  
167.31 under Minnesota Statutes, sections 119B.03  
167.32 and 119B.05, and county child care  
167.33 administrative costs under Minnesota  
167.34 Statutes, section 119B.15;

168.1 (3) state and county MFIP administrative  
168.2 costs under Minnesota Statutes, chapters  
168.3 256J and 256K;

168.4 (4) state, county, and tribal MFIP  
168.5 employment services under Minnesota  
168.6 Statutes, chapters 256J and 256K;

168.7 (5) expenditures made on behalf of  
168.8 noncitizen MFIP recipients who qualify  
168.9 for the medical assistance without federal  
168.10 financial participation program under  
168.11 Minnesota Statutes, section 256B.06,  
168.12 subdivision 4, paragraphs (d), (e), and (j);  
168.13 ~~and~~

168.14 (6) qualifying working family credit  
168.15 expenditures under Minnesota Statutes,  
168.16 section 290.0671; and

168.17 (7) qualifying Minnesota education credit  
168.18 expenditures under Minnesota Statutes,  
168.19 section 290.0674.

168.20 (b) The commissioner shall ensure that  
168.21 sufficient qualified nonfederal expenditures  
168.22 are made each year to meet the state's  
168.23 TANF/MOE requirements. For the activities  
168.24 listed in paragraph (a), clauses (2) to  
168.25 (6), the commissioner may only report  
168.26 expenditures that are excluded from the  
168.27 definition of assistance under Code of  
168.28 Federal Regulations, title 45, section 260.31.

168.29 (c) For fiscal years beginning with state  
168.30 fiscal year 2003, the commissioner shall  
168.31 ensure that the maintenance of effort used  
168.32 by the commissioner of finance for the  
168.33 February and November forecasts required  
168.34 under Minnesota Statutes, section 16A.103,  
168.35 contains expenditures under paragraph (a),



169.1 clause (1), equal to at least 16 percent of  
169.2 the total required under Code of Federal  
169.3 Regulations, title 45, section 263.1.

169.4 (d) For the federal fiscal years beginning on  
169.5 or after October 1, 2007, the commissioner  
169.6 may not claim an amount of TANF/MOE in  
169.7 excess of the 75 percent standard in Code  
169.8 of Federal Regulations, title 45, section  
169.9 263.1(a)(2), except:

169.10 (1) to the extent necessary to meet the 80  
169.11 percent standard under Code of Federal  
169.12 Regulations, title 45, section 263.1(a)(1),  
169.13 if it is determined by the commissioner  
169.14 that the state will not meet the TANF work  
169.15 participation target rate for the current year;

169.16 (2) to provide any additional amounts  
169.17 under Code of Federal Regulations, title 45,  
169.18 section 264.5, that relate to replacement of  
169.19 TANF funds due to the operation of TANF  
169.20 penalties; and

169.21 (3) to provide any additional amounts that  
169.22 may contribute to avoiding or reducing  
169.23 TANF work participation penalties through  
169.24 the operation of the excess MOE provisions  
169.25 of Code of Federal Regulations, title 45,  
169.26 section 261.43 (a)(2).

169.27 For the purposes of clauses (1) to (3),  
169.28 the commissioner may supplement the  
169.29 MOE claim with working family credit  
169.30 expenditures to the extent such expenditures  
169.31 or other qualified expenditures are otherwise  
169.32 available after considering the expenditures  
169.33 allowed in this section.

169.34 (e) Minnesota Statutes, section 256.011,  
169.35 subdivision 3, which requires that federal

170.1 grants or aids secured or obtained under that  
170.2 subdivision be used to reduce any direct  
170.3 appropriations provided by law, do not apply  
170.4 if the grants or aids are federal TANF funds.

170.5 (f) Notwithstanding any contrary provision  
170.6 in this article, this provision expires June 30,  
170.7 2013.

170.8 **Working Family Credit Expenditures as**  
170.9 **TANF/MOE.** The commissioner may claim  
170.10 as TANF/MOE up to \$6,707,000 per year of  
170.11 working family credit expenditures for fiscal  
170.12 year 2010 through fiscal year 2011.

170.13 **Working Family Credit Expenditures**  
170.14 **to be Claimed for TANF/MOE.** The  
170.15 commissioner may count the following  
170.16 amounts of working family credit expenditure  
170.17 as TANF/MOE:

170.18 (1) fiscal year 2010, ~~\$50,973,000~~  
170.19 \$50,897,000;

170.20 (2) fiscal year 2011, ~~\$53,793,000~~  
170.21 \$54,243,000;

170.22 (3) fiscal year 2012, ~~\$23,516,000~~  
170.23 \$23,345,000; and

170.24 (4) fiscal year 2013, ~~\$16,808,000~~  
170.25 \$16,585,000.

170.26 Notwithstanding any contrary provision in  
170.27 this article, this rider expires June 30, 2013.

170.28 **Food Stamps Employment and Training.**

170.29 (a) The commissioner shall apply for and  
170.30 claim the maximum allowable federal  
170.31 matching funds under United States Code,  
170.32 title 7, section 2025, paragraph (h), for  
170.33 state expenditures made on behalf of family  
170.34 stabilization services participants voluntarily

171.1 engaged in food stamp employment and  
171.2 training activities, where appropriate.

171.3 (b) Notwithstanding Minnesota Statutes,  
171.4 sections 256D.051, subdivisions 1a, 6b,  
171.5 and 6c, and 256J.626, federal food stamps  
171.6 employment and training funds received  
171.7 as reimbursement of MFIP consolidated  
171.8 fund grant expenditures for diversionary  
171.9 work program participants and child  
171.10 care assistance program expenditures for  
171.11 two-parent families must be deposited in the  
171.12 general fund. The amount of funds must be  
171.13 limited to \$3,350,000 in fiscal year 2010  
171.14 and \$4,440,000 in fiscal years 2011 through  
171.15 2013, contingent on approval by the federal  
171.16 Food and Nutrition Service.

171.17 (c) Consistent with the receipt of these federal  
171.18 funds, the commissioner may adjust the  
171.19 level of working family credit expenditures  
171.20 claimed as TANF maintenance of effort.  
171.21 Notwithstanding any contrary provision in  
171.22 this article, this rider expires June 30, 2013.

171.23 **ARRA Food Support Administration.**

171.24 The funds available for food support  
171.25 administration under the American Recovery  
171.26 and Reinvestment Act (ARRA) of 2009  
171.27 are appropriated to the commissioner  
171.28 to pay actual costs of implementing the  
171.29 food support benefit increases, increased  
171.30 eligibility determinations, and outreach. Of  
171.31 these funds, 20 percent shall be allocated  
171.32 to the commissioner and 80 percent shall  
171.33 be allocated to counties. The commissioner  
171.34 shall allocate the county portion based on  
171.35 caseload. Reimbursement shall be based on

172.1 actual costs reported by counties through  
172.2 existing processes. Tribal reimbursement  
172.3 must be made from the state portion based  
172.4 on a caseload factor equivalent to that of a  
172.5 county.

172.6 **ARRA Food Support Benefit Increases.**  
172.7 The funds provided for food support benefit  
172.8 increases under the Supplemental Nutrition  
172.9 Assistance Program provisions of the  
172.10 American Recovery and Reinvestment Act  
172.11 (ARRA) of 2009 must be used for benefit  
172.12 increases beginning July 1, 2009.

172.13 **Emergency Fund for the TANF Program.**  
172.14 TANF Emergency Contingency funds  
172.15 available under the American Recovery  
172.16 and Reinvestment Act of 2009 (Public Law  
172.17 111-5) are appropriated to the commissioner.  
172.18 The commissioner must request TANF  
172.19 Emergency Contingency funds from the  
172.20 Secretary of the Department of Health  
172.21 and Human Services to the extent the  
172.22 commissioner meets or expects to meet the  
172.23 requirements of section 403(c) of the Social  
172.24 Security Act. The commissioner must seek  
172.25 to maximize such grants. The funds received  
172.26 must be used as appropriated. Each county  
172.27 must maintain the county's current level of  
172.28 emergency assistance funding under the  
172.29 MFIP consolidated fund and use the funds  
172.30 under this paragraph to supplement existing  
172.31 emergency assistance funding levels.

172.32 Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by  
172.33 Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

|                                                         |            |            |
|---------------------------------------------------------|------------|------------|
| 172.34 Subd. 3. <b>Revenue and Pass-Through Revenue</b> |            |            |
| 172.35 <b>Expenditures</b>                              | 68,337,000 | 70,505,000 |

173.1 This appropriation is from the federal TANF  
173.2 fund.

173.3 **TANF Transfer to Federal Child Care**  
173.4 **and Development Fund.** The following  
173.5 TANF fund amounts are appropriated to the  
173.6 commissioner for the purposes of MFIP and  
173.7 transition year child care under Minnesota  
173.8 Statutes, section 119B.05:

- 173.9 (1) fiscal year 2010, ~~\$6,531,000~~ \$862,000;
- 173.10 (2) fiscal year 2011, ~~\$10,241,000~~ \$978,000;
- 173.11 (3) fiscal year 2012, ~~\$10,826,000~~ \$0; and
- 173.12 (4) fiscal year 2013, ~~\$4,046,000~~ \$0.

173.13 The commissioner shall authorize the  
173.14 transfer of sufficient TANF funds to the  
173.15 federal child care and development fund to  
173.16 meet this appropriation and shall ensure that  
173.17 all transferred funds are expended according  
173.18 to federal child care and development fund  
173.19 regulations.

173.20 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by  
173.21 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

173.22 Subd. 4. **Children and Economic Assistance**  
173.23 **Grants**

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

173.26 **(a) MFIP/DWP Grants**

|        |                        |             |            |
|--------|------------------------|-------------|------------|
| 173.27 | Appropriations by Fund |             |            |
| 173.28 | General                | 63,205,000  | 89,033,000 |
| 173.29 | Federal TANF           | 100,818,000 | 84,538,000 |

173.30 **(b) Support Services Grants**

|        |                        |             |             |
|--------|------------------------|-------------|-------------|
| 173.31 | Appropriations by Fund |             |             |
| 173.32 | General                | 8,715,000   | 12,498,000  |
| 173.33 | Federal TANF           | 116,557,000 | 107,457,000 |

174.1 **MFIP Consolidated Fund.** The MFIP  
174.2 consolidated fund TANF appropriation is  
174.3 reduced by \$1,854,000 in fiscal year 2010  
174.4 and fiscal year 2011.

174.5 Notwithstanding Minnesota Statutes, section  
174.6 256J.626, subdivision 8, paragraph (b), the  
174.7 commissioner shall reduce proportionately  
174.8 the reimbursement to counties for  
174.9 administrative expenses.

174.10 **Subsidized Employment Funding Through**  
174.11 **ARRA.** The commissioner is authorized to  
174.12 apply for TANF emergency fund grants for  
174.13 subsidized employment activities. Growth  
174.14 in expenditures for subsidized employment  
174.15 within the supported work program and the  
174.16 MFIP consolidated fund over the amount  
174.17 expended in the calendar quarters in the  
174.18 TANF emergency fund base year shall be  
174.19 used to leverage the TANF emergency fund  
174.20 grants for subsidized employment and to  
174.21 fund supported work. The commissioner  
174.22 shall develop procedures to maximize  
174.23 reimbursement of these expenditures over the  
174.24 TANF emergency fund base year quarters,  
174.25 and may contract directly with employers  
174.26 and providers to maximize these TANF  
174.27 emergency fund grants.

174.28 **Supported Work.** Of the TANF  
174.29 appropriation, \$4,700,000 in fiscal year 2010  
174.30 and \$4,700,000 in fiscal year 2011 are to the  
174.31 commissioner for supported work for MFIP  
174.32 recipients and is available until expended.  
174.33 Supported work includes paid transitional  
174.34 work experience and a continuum of  
174.35 employment assistance, including outreach

175.1 and recruitment, program orientation  
175.2 and intake, testing and assessment, job  
175.3 development and marketing, preworksite  
175.4 training, supported worksite experience,  
175.5 job coaching, and postplacement follow-up,  
175.6 in addition to extensive case management  
175.7 and referral services. This is a onetime  
175.8 appropriation.

175.9 **Base Adjustment.** The general fund base  
175.10 is reduced by \$3,783,000 in each of fiscal  
175.11 years 2012 and 2013. The TANF fund base  
175.12 is increased by \$5,004,000 in each of fiscal  
175.13 years 2012 and 2013.

175.14 **Integrated Services Program Funding.**  
175.15 The TANF appropriation for integrated  
175.16 services program funding is \$1,250,000 in  
175.17 fiscal year 2010 and \$0 in fiscal year 2011  
175.18 and the base for fiscal years 2012 and 2013  
175.19 is \$0.

175.20 **TANF Emergency Fund; Nonrecurrent**  
175.21 **Short-Term Benefits.** (1) TANF emergency  
175.22 contingency fund grants received due to  
175.23 increases in expenditures for nonrecurrent  
175.24 short-term benefits must be used to offset the  
175.25 increase in these expenditures for counties  
175.26 under the MFIP consolidated fund, under  
175.27 Minnesota Statutes, section 256J.626,  
175.28 and the diversionary work program. The  
175.29 commissioner shall develop procedures  
175.30 to maximize reimbursement of these  
175.31 expenditures over the TANF emergency fund  
175.32 base year quarters. Growth in expenditures  
175.33 for the diversionary work program over the  
175.34 amount expended in the calendar quarters in

176.1 the TANF emergency fund base year shall be  
176.2 used to leverage these funds.

176.3 (2) To the extent that the commissioner  
176.4 can claim eligible tax credit growth as  
176.5 nonrecurrent short-term benefits, the  
176.6 commissioner shall use those funds to  
176.7 leverage the increased expenditures in clause  
176.8 (1).

176.9 (3) TANF emergency funds for nonrecurrent  
176.10 short-term benefits received in excess of the  
176.11 amounts necessary for clauses (1) and (2)  
176.12 shall be used to reimburse the general fund  
176.13 for the costs of eligible tax credits in fiscal  
176.14 year 2011. The amount of such funds shall  
176.15 not exceed \$28,000,000.

|        |                                              |            |            |
|--------|----------------------------------------------|------------|------------|
| 176.16 | <b>(c) MFIP Child Care Assistance Grants</b> | 61,171,000 | 65,214,000 |
|--------|----------------------------------------------|------------|------------|

176.17 **Acceleration of ARRA Child Care and**  
176.18 **Development Fund Expenditure.** The  
176.19 commissioner must liquidate all child care  
176.20 and development money available under  
176.21 the American Recovery and Reinvestment  
176.22 Act (ARRA) of 2009, Public Law 111-5,  
176.23 by September 30, 2010. In order to expend  
176.24 those funds by September 30, 2010, the  
176.25 commissioner may redesignate and expend  
176.26 the ARRA child care and development funds  
176.27 appropriated in fiscal year 2011 for purposes  
176.28 under this section for related purposes that  
176.29 will allow liquidation by September 30,  
176.30 2010. Child care and development funds  
176.31 otherwise available to the commissioner  
176.32 for those related purposes shall be used to  
176.33 fund the purposes from which the ARRA  
176.34 child care and development funds had been  
176.35 redesignated.



|        |                                                      |            |            |
|--------|------------------------------------------------------|------------|------------|
| 177.1  | <b>School Readiness Service Agreements.</b>          |            |            |
| 177.2  | \$400,000 in fiscal year 2010 and \$400,000          |            |            |
| 177.3  | in fiscal year 2011 are from the federal             |            |            |
| 177.4  | TANF fund to the commissioner of human               |            |            |
| 177.5  | services consistent with federal regulations         |            |            |
| 177.6  | for the purpose of school readiness service          |            |            |
| 177.7  | agreements under Minnesota Statutes,                 |            |            |
| 177.8  | section 119B.231. This is a onetime                  |            |            |
| 177.9  | appropriation. Any unexpended balance the            |            |            |
| 177.10 | first year is available in the second year.          |            |            |
| 177.11 | <b>(d) Basic Sliding Fee Child Care Assistance</b>   |            |            |
| 177.12 | <b>Grants</b>                                        | 40,100,000 | 45,092,000 |
| 177.13 | <b>School Readiness Service Agreements.</b>          |            |            |
| 177.14 | \$257,000 in fiscal year 2010 and \$257,000          |            |            |
| 177.15 | in fiscal year 2011 are from the general             |            |            |
| 177.16 | fund for the purpose of school readiness             |            |            |
| 177.17 | service agreements under Minnesota                   |            |            |
| 177.18 | Statutes, section 119B.231. This is a onetime        |            |            |
| 177.19 | appropriation. Any unexpended balance the            |            |            |
| 177.20 | first year is available in the second year.          |            |            |
| 177.21 | <b>Child Care Development Fund</b>                   |            |            |
| 177.22 | <b>Unexpended Balance.</b> In addition to            |            |            |
| 177.23 | the amount provided in this section, the             |            |            |
| 177.24 | commissioner shall expend \$5,244,000 in             |            |            |
| 177.25 | fiscal year 2010 from the federal child care         |            |            |
| 177.26 | development fund unexpended balance                  |            |            |
| 177.27 | for basic sliding fee child care under               |            |            |
| 177.28 | Minnesota Statutes, section 119B.03. The             |            |            |
| 177.29 | commissioner shall ensure that all child             |            |            |
| 177.30 | care and development funds are expended              |            |            |
| 177.31 | according to the federal child care and              |            |            |
| 177.32 | development fund regulations.                        |            |            |
| 177.33 | <b>Basic Sliding Fee.</b> \$4,000,000 in fiscal year |            |            |
| 177.34 | 2010 and \$4,000,000 in fiscal year 2011 are         |            |            |
| 177.35 | from the federal child care development              |            |            |
| 177.36 | funds received from the American Recovery            |            |            |

178.1 and Reinvestment Act of 2009, Public  
178.2 Law 111-5, to the commissioner of human  
178.3 services consistent with federal regulations  
178.4 for the purpose of basic sliding fee child care  
178.5 assistance under Minnesota Statutes, section  
178.6 119B.03. This is a onetime appropriation.  
178.7 Any unexpended balance the first year is  
178.8 available in the second year.

178.9 **Basic Sliding Fee Allocation for Calendar**  
178.10 **Year 2010.** Notwithstanding Minnesota  
178.11 Statutes, section 119B.03, subdivision 6,  
178.12 in calendar year 2010, basic sliding fee  
178.13 funds shall be distributed according to  
178.14 this provision. Funds shall be allocated  
178.15 first in amounts equal to each county's  
178.16 guaranteed floor, according to Minnesota  
178.17 Statutes, section 119B.03, subdivision 8,  
178.18 with any remaining available funds allocated  
178.19 according to the following formula:

178.20 (a) Up to one-fourth of the funds shall be  
178.21 allocated in proportion to the number of  
178.22 families participating in the transition year  
178.23 child care program as reported during and  
178.24 averaged over the most recent six months  
178.25 completed at the time of the notice of  
178.26 allocation. Funds in excess of the amount  
178.27 necessary to serve all families in this category  
178.28 shall be allocated according to paragraph (d).

178.29 (b) Up to three-fourths of the funds shall  
178.30 be allocated in proportion to the average  
178.31 of each county's most recent six months of  
178.32 reported waiting list as defined in Minnesota  
178.33 Statutes, section 119B.03, subdivision 2, and  
178.34 the reinstatement list of those families whose  
178.35 assistance was terminated with the approval

179.1 of the commissioner under Minnesota Rules,  
179.2 part 3400.0183, subpart 1. Funds in excess  
179.3 of the amount necessary to serve all families  
179.4 in this category shall be allocated according  
179.5 to paragraph (d).

179.6 (c) The amount necessary to serve all families  
179.7 in paragraphs (a) and (b) shall be calculated  
179.8 based on the basic sliding fee average cost of  
179.9 care per family in the county with the highest  
179.10 cost in the most recently completed calendar  
179.11 year.

179.12 (d) Funds in excess of the amount necessary  
179.13 to serve all families in paragraphs (a) and  
179.14 (b) shall be allocated in proportion to each  
179.15 county's total expenditures for the basic  
179.16 sliding fee child care program reported  
179.17 during the most recent fiscal year completed  
179.18 at the time of the notice of allocation. To  
179.19 the extent that funds are available, and  
179.20 notwithstanding Minnesota Statutes, section  
179.21 119B.03, subdivision 8, for the period  
179.22 January 1, 2011, to December 31, 2011, each  
179.23 county's guaranteed floor must be equal to its  
179.24 original calendar year 2010 allocation.

179.25 **Base Adjustment.** The general fund base is  
179.26 decreased by \$257,000 in each of fiscal years  
179.27 2012 and 2013.

|                                                 |           |           |
|-------------------------------------------------|-----------|-----------|
| 179.28 <b>(e) Child Care Development Grants</b> | 1,487,000 | 1,487,000 |
|-------------------------------------------------|-----------|-----------|

179.29 **Family, friends, and neighbor grants.**  
179.30 \$375,000 in fiscal year 2010 and \$375,000  
179.31 in fiscal year 2011 are from the child  
179.32 care development fund required targeted  
179.33 quality funds for quality expansion and  
179.34 infant/toddler from the American Recovery  
179.35 and Reinvestment Act of 2009, Public

180.1 Law 111-5, to the commissioner of human  
180.2 services for family, friends, and neighbor  
180.3 grants under Minnesota Statutes, section  
180.4 119B.232. This appropriation may be used  
180.5 on programs receiving family, friends, and  
180.6 neighbor grant funds as of June 30, 2009,  
180.7 or on new programs or projects. This is a  
180.8 onetime appropriation. Any unexpended  
180.9 balance the first year is available in the  
180.10 second year.

180.11 **Voluntary quality rating system training,**  
180.12 **coaching, consultation, and supports.**  
180.13 \$633,000 in fiscal year 2010 and \$633,000  
180.14 in fiscal year 2011 are from the federal child  
180.15 care development fund required targeted  
180.16 quality funds for quality expansion and  
180.17 infant/toddler from the American Recovery  
180.18 and Reinvestment Act of 2009, Public  
180.19 Law 111-5, to the commissioner of human  
180.20 services consistent with federal regulations  
180.21 for the purpose of providing grants to provide  
180.22 statewide child-care provider training,  
180.23 coaching, consultation, and supports to  
180.24 prepare for the voluntary Minnesota quality  
180.25 rating system rating tool. This is a onetime  
180.26 appropriation. Any unexpended balance the  
180.27 first year is available in the second year.

180.28 **Voluntary quality rating system.** \$184,000  
180.29 in fiscal year 2010 and \$1,200,000 in fiscal  
180.30 year 2011 are from the federal child care  
180.31 development fund required targeted funds for  
180.32 quality expansion and infant/toddler from the  
180.33 American Recovery and Reinvestment Act of  
180.34 2009, Public Law 111-5, to the commissioner  
180.35 of human services consistent with federal  
180.36 regulations for the purpose of implementing

181.1 the voluntary Parent Aware quality star  
181.2 rating system pilot in coordination with the  
181.3 Minnesota Early Learning Foundation. The  
181.4 appropriation for the first year is to complete  
181.5 and promote the voluntary Parent Aware  
181.6 quality rating system pilot program through  
181.7 June 30, 2010, and the appropriation for  
181.8 the second year is to continue the voluntary  
181.9 Minnesota quality rating system pilot  
181.10 through June 30, 2011. This is a onetime  
181.11 appropriation. Any unexpended balance the  
181.12 first year is available in the second year.

|        |                                             |           |           |
|--------|---------------------------------------------|-----------|-----------|
| 181.13 | <b>(f) Child Support Enforcement Grants</b> | 3,705,000 | 3,705,000 |
|--------|---------------------------------------------|-----------|-----------|

181.14 **(g) Children's Services Grants**

|        |                        |            |            |
|--------|------------------------|------------|------------|
| 181.15 | Appropriations by Fund |            |            |
| 181.16 | General                | 48,333,000 | 50,498,000 |
| 181.17 | Federal TANF           | 340,000    | 240,000    |

181.18 **Base Adjustment.** The general fund base is  
181.19 decreased by \$5,371,000 in fiscal year 2012  
181.20 and decreased \$5,371,000 in fiscal year 2013.

181.21 **Privatized Adoption Grants.** Federal  
181.22 reimbursement for privatized adoption grant  
181.23 and foster care recruitment grant expenditures  
181.24 is appropriated to the commissioner for  
181.25 adoption grants and foster care and adoption  
181.26 administrative purposes.

181.27 **Adoption Assistance Incentive Grants.**  
181.28 Federal funds available during fiscal year  
181.29 2010 and fiscal year 2011 for the adoption  
181.30 incentive grants are appropriated to the  
181.31 commissioner for postadoption services  
181.32 including parent support groups.

181.33 **Adoption Assistance and Relative Custody**  
181.34 **Assistance.** The commissioner may transfer  
181.35 unencumbered appropriation balances for

|        |                                                   |            |            |
|--------|---------------------------------------------------|------------|------------|
| 182.1  | adoption assistance and relative custody          |            |            |
| 182.2  | assistance between fiscal years and between       |            |            |
| 182.3  | programs.                                         |            |            |
| 182.4  | <b>(h) Children and Community Services Grants</b> | 67,663,000 | 67,542,000 |
| 182.5  | <b>Targeted Case Management Temporary</b>         |            |            |
| 182.6  | <b>Funding Adjustment.</b> The commissioner       |            |            |
| 182.7  | shall recover from each county and tribe          |            |            |
| 182.8  | receiving a targeted case management              |            |            |
| 182.9  | temporary funding payment in fiscal year          |            |            |
| 182.10 | 2008 an amount equal to that payment. The         |            |            |
| 182.11 | commissioner shall recover one-half of the        |            |            |
| 182.12 | funds by February 1, 2010, and the remainder      |            |            |
| 182.13 | by February 1, 2011. At the commissioner's        |            |            |
| 182.14 | discretion and at the request of a county         |            |            |
| 182.15 | or tribe, the commissioner may revise             |            |            |
| 182.16 | the payment schedule, but full payment            |            |            |
| 182.17 | must not be delayed beyond May 1, 2011.           |            |            |
| 182.18 | The commissioner may use the recovery             |            |            |
| 182.19 | procedure under Minnesota Statutes, section       |            |            |
| 182.20 | 256.017, to recover the funds. Recovered          |            |            |
| 182.21 | funds must be deposited into the general          |            |            |
| 182.22 | fund.                                             |            |            |
| 182.23 | <b>(i) General Assistance Grants</b>              | 48,215,000 | 48,608,000 |
| 182.24 | <b>General Assistance Standard.</b> The           |            |            |
| 182.25 | commissioner shall set the monthly standard       |            |            |
| 182.26 | of assistance for general assistance units        |            |            |
| 182.27 | consisting of an adult recipient who is           |            |            |
| 182.28 | childless and unmarried or living apart           |            |            |
| 182.29 | from parents or a legal guardian at \$203.        |            |            |
| 182.30 | The commissioner may reduce this amount           |            |            |
| 182.31 | according to Laws 1997, chapter 85, article       |            |            |
| 182.32 | 3, section 54.                                    |            |            |
| 182.33 | <b>Emergency General Assistance.</b> The          |            |            |
| 182.34 | amount appropriated for emergency general         |            |            |
| 182.35 | assistance funds is limited to no more            |            |            |

183.1 than \$7,889,812 in fiscal year 2010 and  
183.2 \$7,889,812 in fiscal year 2011. Funds  
183.3 to counties must be allocated by the  
183.4 commissioner using the allocation method  
183.5 specified in Minnesota Statutes, section  
183.6 256D.06.

|       |                                              |            |            |
|-------|----------------------------------------------|------------|------------|
| 183.7 | <b>(j) Minnesota Supplemental Aid Grants</b> | 33,930,000 | 35,191,000 |
|-------|----------------------------------------------|------------|------------|

183.8 **Emergency Minnesota Supplemental**  
183.9 **Aid Funds.** The amount appropriated for  
183.10 emergency Minnesota supplemental aid  
183.11 funds is limited to no more than \$1,100,000  
183.12 in fiscal year 2010 and \$1,100,000 in fiscal  
183.13 year 2011. Funds to counties must be  
183.14 allocated by the commissioner using the  
183.15 allocation method specified in Minnesota  
183.16 Statutes, section 256D.46.

|        |                                             |             |             |
|--------|---------------------------------------------|-------------|-------------|
| 183.17 | <b>(k) Group Residential Housing Grants</b> | 111,778,000 | 114,034,000 |
|--------|---------------------------------------------|-------------|-------------|

183.18 **Group Residential Housing Costs**  
183.19 **Refinanced.** (a) Effective July 1, 2011, the  
183.20 commissioner shall increase the home and  
183.21 community-based service rates and county  
183.22 allocations provided to programs for persons  
183.23 with disabilities established under section  
183.24 1915(c) of the Social Security Act to the  
183.25 extent that these programs will be paying  
183.26 for the costs above the rate established  
183.27 in Minnesota Statutes, section 256I.05,  
183.28 subdivision 1.

183.29 (b) For persons receiving services under  
183.30 Minnesota Statutes, section 245A.02, who  
183.31 reside in licensed adult foster care beds  
183.32 for which a difficulty of care payment  
183.33 was being made under Minnesota Statutes,  
183.34 section 256I.05, subdivision 1c, paragraph  
183.35 (b), counties may request an exception to

|        |                                                               |            |            |
|--------|---------------------------------------------------------------|------------|------------|
| 184.1  | the individual's service authorization not to                 |            |            |
| 184.2  | exceed the difference between the client's                    |            |            |
| 184.3  | monthly service expenditures plus the                         |            |            |
| 184.4  | amount of the difficulty of care payment.                     |            |            |
| 184.5  | <b>(l) Children's Mental Health Grants</b>                    | 16,885,000 | 16,882,000 |
| 184.6  | <b>Funding Usage.</b> Up to 75 percent of a fiscal            |            |            |
| 184.7  | year's appropriation for children's mental                    |            |            |
| 184.8  | health grants may be used to fund allocations                 |            |            |
| 184.9  | in that portion of the fiscal year ending                     |            |            |
| 184.10 | December 31.                                                  |            |            |
| 184.11 | <b>(m) Other Children and Economic Assistance</b>             |            |            |
| 184.12 | <b>Grants</b>                                                 | 16,047,000 | 15,339,000 |
| 184.13 | <b>Fraud Prevention Grants.</b> Of this                       |            |            |
| 184.14 | appropriation, \$228,000 in fiscal year 2010                  |            |            |
| 184.15 | and <del>\$228,000</del> <u>\$379,000</u> in fiscal year 2011 |            |            |
| 184.16 | is to the commissioner for fraud prevention                   |            |            |
| 184.17 | grants to counties.                                           |            |            |
| 184.18 | <b>Homeless and Runaway Youth.</b> \$218,000                  |            |            |
| 184.19 | in fiscal year 2010 is for the Runaway                        |            |            |
| 184.20 | and Homeless Youth Act under Minnesota                        |            |            |
| 184.21 | Statutes, section 256K.45. Funds shall be                     |            |            |
| 184.22 | spent in each area of the continuum of care                   |            |            |
| 184.23 | to ensure that programs are meeting the                       |            |            |
| 184.24 | greatest need. Any unexpended balance in                      |            |            |
| 184.25 | the first year is available in the second year.               |            |            |
| 184.26 | Beginning July 1, 2011, the base is increased                 |            |            |
| 184.27 | by \$119,000 each year.                                       |            |            |
| 184.28 | <b>ARRA Homeless Youth Funds.</b> To the                      |            |            |
| 184.29 | extent permitted under federal law, the                       |            |            |
| 184.30 | commissioner shall designate \$2,500,000                      |            |            |
| 184.31 | of the Homeless Prevention and Rapid                          |            |            |
| 184.32 | Re-Housing Program funds provided under                       |            |            |
| 184.33 | the American Recovery and Reinvestment                        |            |            |
| 184.34 | Act of 2009, Public Law 111-5, for agencies                   |            |            |



185.1 providing homelessness prevention and rapid  
185.2 rehousing services to youth.

185.3 **Supportive Housing Services.** \$1,500,000  
185.4 each year is for supportive services under  
185.5 Minnesota Statutes, section 256K.26. This is  
185.6 a onetime appropriation.

185.7 **Community Action Grants.** Community  
185.8 action grants are reduced one time by  
185.9 \$1,794,000 each year. This reduction is due  
185.10 to the availability of federal funds under the  
185.11 American Recovery and Reinvestment Act.

185.12 **Base Adjustment.** The general fund base  
185.13 is increased by ~~\$773,000~~ \$903,000 in fiscal  
185.14 year 2012 and ~~\$773,000~~ \$413,000 in fiscal  
185.15 year 2013.

185.16 **Federal ARRA Funds for Existing**  
185.17 **Programs.** ~~(a)~~ (1) Federal funds received by  
185.18 the commissioner for the emergency food  
185.19 and shelter program from the American  
185.20 Recovery and Reinvestment Act of 2009,  
185.21 Public Law 111-5, but not previously  
185.22 approved by the legislature are appropriated  
185.23 to the commissioner for the purposes of the  
185.24 grant program.

185.25 ~~(b)~~ (2) Federal funds received by the  
185.26 commissioner for the emergency shelter  
185.27 grant program including the Homelessness  
185.28 Prevention and Rapid Re-Housing  
185.29 Program from the American Recovery and  
185.30 Reinvestment Act of 2009, Public Law  
185.31 111-5, are appropriated to the commissioner  
185.32 for the purposes of the grant programs.

185.33 ~~(c)~~ (3) Federal funds received by the  
185.34 commissioner for the emergency food  
185.35 assistance program from the American

186.1 Recovery and Reinvestment Act of 2009,  
186.2 Public Law 111-5, are appropriated to the  
186.3 commissioner for the purposes of the grant  
186.4 program.

186.5 ~~(d)~~ (4) Federal funds received by the  
186.6 commissioner for senior congregate meals  
186.7 and senior home-delivered meals from the  
186.8 American Recovery and Reinvestment Act  
186.9 of 2009, Public Law 111-5, are appropriated  
186.10 to the commissioner for the Minnesota Board  
186.11 on Aging, for purposes of the grant programs.

186.12 ~~(e)~~ (5) Federal funds received by the  
186.13 commissioner for the community services  
186.14 block grant program from the American  
186.15 Recovery and Reinvestment Act of 2009,  
186.16 Public Law 111-5, are appropriated to the  
186.17 commissioner for the purposes of the grant  
186.18 program.

186.19 **Long-Term Homeless Supportive**  
186.20 **Service Fund Appropriation.** To the  
186.21 extent permitted under federal law, the  
186.22 commissioner shall designate \$3,000,000  
186.23 of the Homelessness Prevention and Rapid  
186.24 Re-Housing Program funds provided under  
186.25 the American Recovery and Reinvestment  
186.26 Act of 2009, Public Law, 111-5, to the  
186.27 long-term homeless service fund under  
186.28 Minnesota Statutes, section 256K.26. This  
186.29 appropriation shall become available by July  
186.30 1, 2009. This paragraph is effective the day  
186.31 following final enactment.

186.32 Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by  
186.33 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

186.34 Subd. 8. **Continuing Care Grants**

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

|       |                                            |            |            |
|-------|--------------------------------------------|------------|------------|
| 187.3 | <b>(a) Aging and Adult Services Grants</b> | 13,499,000 | 15,805,000 |
|-------|--------------------------------------------|------------|------------|

187.4 **Base Adjustment.** The general fund base is  
187.5 increased by \$5,751,000 in fiscal year 2012  
187.6 and \$6,705,000 in fiscal year 2013.

187.7 **Information and Assistance**

187.8 **Reimbursement.** Federal administrative  
187.9 reimbursement obtained from information  
187.10 and assistance services provided by the  
187.11 Senior LinkAge or Disability Linkage lines  
187.12 to people who are identified as eligible for  
187.13 medical assistance shall be appropriated to  
187.14 the commissioner for this activity.

187.15 **Community Service Development Grant**

187.16 **Reduction.** Funding for community service  
187.17 development grants must be reduced by  
187.18 \$260,000 for fiscal year 2010; \$284,000 in  
187.19 fiscal year 2011; \$43,000 in fiscal year 2012;  
187.20 and \$43,000 in fiscal year 2013. Base level  
187.21 funding shall be restored in fiscal year 2014.

187.22 **Community Service Development Grant**

187.23 **Community Initiative.** Funding for  
187.24 community service development grants shall  
187.25 be used to offset the cost of aging support  
187.26 grants. Base level funding shall be restored  
187.27 in fiscal year 2014.

187.28 **Senior Nutrition Use of Federal Funds.**

187.29 For fiscal year 2010, general fund grants  
187.30 for home-delivered meals and congregate  
187.31 dining shall be reduced by \$500,000. The  
187.32 commissioner must replace these general  
187.33 fund reductions with equal amounts from  
187.34 federal funding for senior nutrition from the

|        |                                                   |             |               |
|--------|---------------------------------------------------|-------------|---------------|
| 188.1  | American Recovery and Reinvestment Act            |             |               |
| 188.2  | of 2009.                                          |             |               |
| 188.3  | <b>(b) Alternative Care Grants</b>                | 50,234,000  | 48,576,000    |
| 188.4  | <b>Base Adjustment.</b> The general fund base is  |             |               |
| 188.5  | decreased by \$3,598,000 in fiscal year 2012      |             |               |
| 188.6  | and \$3,470,000 in fiscal year 2013.              |             |               |
| 188.7  | <b>Alternative Care Transfer.</b> Any money       |             |               |
| 188.8  | allocated to the alternative care program that    |             |               |
| 188.9  | is not spent for the purposes indicated does      |             |               |
| 188.10 | not cancel but must be transferred to the         |             |               |
| 188.11 | medical assistance account.                       |             |               |
| 188.12 | <b>(c) Medical Assistance Grants; Long-Term</b>   |             |               |
| 188.13 | <b>Care Facilities.</b>                           | 367,444,000 | 419,749,000   |
| 188.14 | <b>(d) Medical Assistance Long-Term Care</b>      |             |               |
| 188.15 | <b>Waivers and Home Care Grants</b>               | 853,567,000 | 1,039,517,000 |
| 188.16 | <b>Manage Growth in TBI and CADI</b>              |             |               |
| 188.17 | <b>Waivers.</b> During the fiscal years beginning |             |               |
| 188.18 | on July 1, 2009, and July 1, 2010, the            |             |               |
| 188.19 | commissioner shall allocate money for home        |             |               |
| 188.20 | and community-based waiver programs               |             |               |
| 188.21 | under Minnesota Statutes, section 256B.49,        |             |               |
| 188.22 | to ensure a reduction in state spending that is   |             |               |
| 188.23 | equivalent to limiting the caseload growth of     |             |               |
| 188.24 | the TBI waiver to 12.5 allocations per month      |             |               |
| 188.25 | each year of the biennium and the CADI            |             |               |
| 188.26 | waiver to 95 allocations per month each year      |             |               |
| 188.27 | of the biennium. Limits do not apply: (1)         |             |               |
| 188.28 | when there is an approved plan for nursing        |             |               |
| 188.29 | facility bed closures for individuals under       |             |               |
| 188.30 | age 65 who require relocation due to the          |             |               |
| 188.31 | bed closure; (2) to fiscal year 2009 waiver       |             |               |
| 188.32 | allocations delayed due to unallotment; or (3)    |             |               |
| 188.33 | to transfers authorized by the commissioner       |             |               |
| 188.34 | from the personal care assistance program         |             |               |
| 188.35 | of individuals having a home care rating          |             |               |

189.1 of "CS," "MT," or "HL." Priorities for the  
189.2 allocation of funds must be for individuals  
189.3 anticipated to be discharged from institutional  
189.4 settings or who are at imminent risk of a  
189.5 placement in an institutional setting.

189.6 **Manage Growth in ~~DD~~ Developmental**  
189.7 **Disability Waiver.** The commissioner  
189.8 shall manage the growth in the DD waiver  
189.9 by limiting the allocations included in the  
189.10 February 2009 forecast to 15 additional  
189.11 diversion allocations each month for the  
189.12 calendar years that begin on January 1, 2010,  
189.13 and January 1, 2011. Additional allocations  
189.14 must be made available for transfers  
189.15 authorized by the commissioner from the  
189.16 personal care program of individuals having  
189.17 a home care rating of "CS," "MT," or "HL."

189.18 **Adjustment to Lead Agency Waiver**  
189.19 **Allocations.** Prior to the availability of the  
189.20 alternative license defined in Minnesota  
189.21 Statutes, section 245A.11, subdivision 8,  
189.22 the commissioner shall reduce lead agency  
189.23 waiver allocations for the purposes of  
189.24 implementing a moratorium on corporate  
189.25 foster care.

189.26 **Alternatives to Personal Care Assistance**  
189.27 **Services.** Base level funding of \$3,237,000  
189.28 in fiscal year 2012 and \$4,856,000 in  
189.29 fiscal year 2013 is to implement alternative  
189.30 services to personal care assistance services  
189.31 for persons with mental health and other  
189.32 behavioral challenges who can benefit  
189.33 from other services that more appropriately  
189.34 meet their needs and assist them in living  
189.35 independently in the community. These

190.1 services may include, but not be limited to, a  
190.2 1915(i) state plan option.

190.3 **(e) Mental Health Grants**

|       |                        |            |            |
|-------|------------------------|------------|------------|
| 190.4 | Appropriations by Fund |            |            |
| 190.5 | General                | 77,739,000 | 77,739,000 |
| 190.6 | Health Care Access     | 750,000    | 750,000    |
| 190.7 | Lottery Prize          | 1,508,000  | 1,508,000  |

190.8 **Funding Usage.** Up to 75 percent of a fiscal  
190.9 year's appropriation for adult mental health  
190.10 grants may be used to fund allocations in that  
190.11 portion of the fiscal year ending December  
190.12 31.

|        |                                            |           |           |
|--------|--------------------------------------------|-----------|-----------|
| 190.13 | <b>(f) Deaf and Hard-of-Hearing Grants</b> | 1,930,000 | 1,917,000 |
|--------|--------------------------------------------|-----------|-----------|

|        |                                                   |             |             |
|--------|---------------------------------------------------|-------------|-------------|
| 190.14 | <b>(g) Chemical Dependency Entitlement Grants</b> | 111,303,000 | 122,822,000 |
|--------|---------------------------------------------------|-------------|-------------|

190.15 **Payments for Substance Abuse Treatment.**

190.16 For ~~services provided~~placements beginning  
190.17 during fiscal years 2010 and 2011,  
190.18 county-negotiated rates and provider claims  
190.19 to the consolidated chemical dependency  
190.20 fund must not exceed the lesser of: (1) rates  
190.21 charged for these services on January 1,  
190.22 2009; or (2) 160 percent of the average rate  
190.23 on January 1, 2009, for each group of vendors  
190.24 with similar attributes. For services provided  
190.25 during fiscal year 2011, all payment rates  
190.26 are reduced by five percent from the rates in  
190.27 effect on June 1, 2010. For services provided  
190.28 in fiscal years 2012 and 2013, the statewide  
190.29 ~~average rates~~ aggregate payment under the  
190.30 new rate methodology to be developed under  
190.31 Minnesota Statutes, section 254B.12, must  
190.32 not exceed the ~~average rates charged for~~  
190.33 ~~these services on January 1, 2009, plus a~~  
190.34 ~~state share increase of \$3,787,000 for fiscal~~  
190.35 ~~year 2012 and \$5,023,000 for fiscal year~~

191.1 ~~2013~~ projected aggregate payment under  
191.2 the rates in effect for fiscal year 2010 minus  
191.3 1.25 percent. Notwithstanding any provision  
191.4 to the contrary in this article, this provision  
191.5 expires on June 30, 2013.

191.6 **Chemical Dependency Special Revenue**  
191.7 **Account.** For fiscal year 2010, \$750,000  
191.8 must be transferred from the consolidated  
191.9 chemical dependency treatment fund  
191.10 administrative account and deposited into the  
191.11 general fund.

191.12 **County CD Share of MA Costs for**  
191.13 **ARRA Compliance.** Notwithstanding the  
191.14 provisions of Minnesota Statutes, chapter  
191.15 254B, for chemical dependency services  
191.16 provided during the period October 1, 2008,  
191.17 to December 31, 2010, and reimbursed by  
191.18 medical assistance at the enhanced federal  
191.19 matching rate provided under the American  
191.20 Recovery and Reinvestment Act of 2009, the  
191.21 county share is 30 percent of the nonfederal  
191.22 share. This provision is effective the day  
191.23 following final enactment.

|        |                                               |            |            |
|--------|-----------------------------------------------|------------|------------|
| 191.24 | <b>(h) Chemical Dependency Nonentitlement</b> |            |            |
| 191.25 | <b>Grants</b>                                 | 1,729,000  | 1,729,000  |
| 191.26 | <b>(i) Other Continuing Care Grants</b>       | 19,201,000 | 17,528,000 |

191.27 **Base Adjustment.** The general fund base is  
191.28 increased by \$2,639,000 in fiscal year 2012  
191.29 and increased by \$3,854,000 in fiscal year  
191.30 2013.

191.31 **Technology Grants.** \$650,000 in fiscal  
191.32 year 2010 and \$1,000,000 in fiscal year  
191.33 2011 are for technology grants, case  
191.34 consultation, evaluation, and consumer  
191.35 information grants related to developing and

192.1 supporting alternatives to shift-staff foster  
192.2 care residential service models.

### 192.3 Other Continuing Care Grants; HIV

192.4 **Grants.** Money appropriated for the HIV

192.5 drug and insurance grant program in fiscal

192.6 year 2010 may be used in either year of the

192.7 biennium.

192.8 **Quality Assurance Commission.** Effective

192.9 July 1, 2009, state funding for the quality

192.10 assurance commission under Minnesota

192.11 Statutes, section 256B.0951, is canceled.

192.12 Sec. 15. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by

192.13 Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

192.14 Subd. 8. **Board of Nursing Home**

## 192.15 Administrators

1,211,000

1,023,000

192.16 **Administrative Services Unit - Operating**

192.17 **Costs.** Of this appropriation, \$524,000

192.18 in fiscal year 2010 and \$526,000 in

192.19 fiscal year 2011 are for operating costs

192.20 of the administrative services unit. The

192.21 administrative services unit may receive

192.22 and expend reimbursements for services

192.23 performed by other agencies.

192.24 **Administrative Services Unit - Retirement**

192.25 **Costs.** Of this appropriation in fiscal year

192.26 2010, \$201,000 is for onetime retirement

192.27 costs in the health-related boards. This

192.28 funding may be transferred to the health

192.29 boards incurring those costs for their

192.30 payment. These funds are available either

192.31 year of the biennium.

192.32 **Administrative Services Unit - Volunteer**

192.33 **Health Care Provider Program.** Of this

192.34 appropriation, \$79,000 in fiscal year 2010



193.1 and \$89,000 in fiscal year 2011 are to pay  
193.2 for medical professional liability coverage  
193.3 required under Minnesota Statutes, section  
193.4 214.40.

193.5 **Administrative Services Unit - Contested**  
193.6 **Cases and Other Legal Proceedings.** Of  
193.7 this appropriation, \$200,000 in fiscal year  
193.8 2010 and \$200,000 in fiscal year 2011 are  
193.9 for costs of contested case hearings and other  
193.10 unanticipated costs of legal proceedings  
193.11 involving health-related boards funded  
193.12 under this section and for unforeseen  
193.13 expenditures of an urgent nature. Upon  
193.14 certification of a health-related board to the  
193.15 administrative services unit that the costs  
193.16 will be incurred and that there is insufficient  
193.17 money available to pay for the costs out of  
193.18 money currently available to that board, the  
193.19 administrative services unit is authorized  
193.20 to transfer money from this appropriation  
193.21 to the board for payment of those costs  
193.22 with the approval of the commissioner of  
193.23 finance. This appropriation does not cancel.  
193.24 Any unencumbered and unspent balances  
193.25 remain available for these expenditures in  
193.26 subsequent fiscal years. The boards receiving  
193.27 funds under this section shall include these  
193.28 amounts when setting fees to cover their  
193.29 costs.

193.30 Sec. 16. **CANCELLATIONS.**

193.31 The remaining balance from Laws 2008, chapter 358, article 5, section 4, subdivision  
193.32 3, appropriation for Section 125 employer incentives, is canceled.

193.33 Sec. 17. **TRANSFERS.**

194.1        The commissioner of management and budget shall transfer from the general fund to  
194.2 the health care access fund \$38,475,000 in fiscal year 2011, \$14,758,000 in fiscal year  
194.3 2012, and \$35,058,000 in fiscal year 2013.

194.4        **EFFECTIVE DATE.** This section is effective upon federal approval of the  
194.5 amendments to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056,  
194.6 subdivision 4.

194.7        Sec. 18. **EXPIRATION OF UNCODIFIED LANGUAGE.**

194.8        All uncodified language contained in this article expires on June 30, 2011, unless a  
194.9 different expiration date is explicit.

194.10      Sec. 19. **EFFECTIVE DATE.**

194.11      The provisions in this article are effective July 1, 2010, unless a different effective  
194.12 date is explicit.

APPENDIX  
Article locations in H2614-2

|            |                                                |                |
|------------|------------------------------------------------|----------------|
| ARTICLE 1  | DHS LICENSING .....                            | Page.Ln 2.11   |
| ARTICLE 2  | HEALTH CARE .....                              | Page.Ln 12.28  |
| ARTICLE 3  | CONTINUING CARE .....                          | Page.Ln 63.18  |
| ARTICLE 4  | CHILDREN AND FAMILY SERVICES .....             | Page.Ln 75.20  |
| ARTICLE 5  | MISCELLANEOUS .....                            | Page.Ln 83.13  |
| ARTICLE 6  | DEPARTMENT OF HEALTH .....                     | Page.Ln 100.13 |
| ARTICLE 7  | HEALTH CARE REFORM .....                       | Page.Ln 124.11 |
| ARTICLE 8  | PUBLIC HEALTH .....                            | Page.Ln 131.27 |
| ARTICLE 9  | HUMAN SERVICES FORECAST ADJUSTMENTS .....      | Page.Ln 137.1  |
| ARTICLE 10 | HUMAN SERVICES CONTINGENT APPROPRIATIONS ..... | Page.Ln 138.29 |
| ARTICLE 11 | HEALTH AND HUMAN SERVICES APPROPRIATIONS ..... | Page.Ln 144.8  |