A bill for an act

relating to the state budget; balancing proposed general fund spending and anticipated general fund revenue; modifying certain payment schedules to improve cash flow; making reductions in appropriations for E-12 education, higher education, environment and natural resources, energy and commerce, agriculture, economic development, transportation, public safety, state government, human services, and health; modifying calculation of state tax aids and credits; providing for deposit of certain receipts in the special revenue fund rather than the general fund; making changes to health and human services policy provisions including state health care programs, continuing care, children and family services, health care reform, Department of Health, public health, health plans; increasing fees and surcharges; 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 3.9741, subdivision 2; 8.15, subdivision 3; 13.03, subdivision 10; 13.3806, subdivision 13; 16C.23, subdivision 6; 62D.08, by adding a subdivision; 62J.692, subdivision 4; 62Q.19, subdivision 1; 103B.101, subdivision 9; 103I.681, subdivision 11; 116J.551, subdivision 1; 123B.75, subdivisions 5, 9, by adding a subdivision; 126C.48, subdivision 7; 127A.441; 127A.45, subdivisions 2, 3, 13, by adding a subdivision; 127A.46; 144.05, by adding a subdivision; 144.226, subdivision 3; 144.293, subdivision 4; 144.603; 144.605, subdivisions 2, 3, by adding a subdivision; 144.608, subdivision 1; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144D.03, subdivision 2; 144D.04, subdivision 2; 144E.37; 144G.06; 152.126, as amended; 190.32; 214.40, subdivision 7; 246.18, by adding a subdivision; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4; 254B.05, subdivision 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivisions 2, 3, 3a; 256.969, subdivisions 21, 26, by adding a subdivision; 256B.04, subdivision 14a; 256B.055, by adding a subdivision; 256B.056, subdivisions 3, 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.0915, by adding a subdivision; 256B.19, subdivision 1c; 256B.5012, by adding a subdivision; 256B.69, subdivisions 20, as amended, 27, by adding subdivisions; 256B.692, subdivision 1; 256B.76, subdivisions 2, 4; 256D.03, subdivision 3b; 256D.0515; 256I.05, by adding a subdivision; 256J.24, subdivision 6; 256L.07, by adding a subdivision; 256L.11, subdivision 6; 256L.12, subdivisions 5, 9, by adding a subdivision; 256L.15, subdivision 1; 257.69, subdivision 2; 260C.331, subdivision 6; 273.1384, subdivision 6, as

added; 276.112; 289A.60, by adding a subdivision; 299C.48; 299E.02; 446A.086, subdivision 2, as amended; 469.177, subdivision 11; 517.08, subdivision 1c, as amended; 518.165, subdivision 3; 609.3241; 611.20, subdivision 3; Minnesota Statutes 2009 Supplement, sections 123B.54; 137.025, subdivision 1; 157.16, subdivision 3; 252.27, subdivision 2a; 256.969, subdivisions 2b, 3a; 256.975, subdivision 7; 256B.056, subdivision 3c; 256B.0625, subdivision 13h; 256B.0659, subdivision 11; 256B.0911, subdivision 1a; 256B.441, subdivision 55; 256B.69, subdivisions 5a, 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256J.425, subdivision 3; 256J.621; 256L.03, subdivision 5; 270.97; 289A.20, subdivision 4; 327.15, subdivision 3; 517.08, subdivision 1b; Laws 1994, chapter 531, section 1; 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; 84; article 13, sections 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 4, subdivision 4, as amended; 5, subdivision 8, as amended; Laws 2009, chapter 96, article 1, section 24, subdivisions 2, 4, 5, 6, 7; article 2, section 67, subdivisions 2, 3, 4, 7, 9; article 3, section 21, subdivisions 2, 4, 5; article 4, section 12, subdivisions 2, 3, 4, 6; article 5, section 13, subdivisions 4, 6, 7, 9; article 6, section 11, subdivisions 2, 3, 4, 6, 7, 8, 9, 12; article 7, section 3, subdivision 2; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter 200, article 1, sections 12, subdivision 5; 16; 21; article 2, section 2, subdivisions 1, 5, 8; Laws 2010, chapter 215, article 3, section 3, subdivision 6; article 13, section 6; proposing coding for new law in Minnesota Statutes, chapters 62D; 62E; 62Q; 137; 144; 144D; 246; 254B; 256; 256B; 477A; repealing Minnesota Statutes 2008, sections 144.607; 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3, 3a, 5, 6, 7, 8; 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, 10; 18; 19.

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

ARTICLE 1

SUMMARY

Section 1. **GENERAL FUND SUMMARY.**

The amounts shown in this section summarize general fund direct and open appropriations, and transfers into the general fund from other funds, made in articles 2 to 14, after forecast adjustments and after voiding certain allotment reductions.

	2010	**2011**	**Total**
E-12 Education	$ (1,069,361,000)	$ (893,834,000)	$ (1,963,195,000)
Higher Education	(77,000)	(100,077,000)	(100,154,000)
Environment and Natural Resources	(1,571,000)	(1,564,000)	(3,135,000)
Energy	(247,000)	(247,000)	(494,000)
Agriculture	(493,000)	(492,000)	(985,000)
Economic Development	(489,000)	(745,000)	(1,234,000)
Transportation	(1,649,000)	(11,649,000)	(13,298,000)
Public Safety	(79,000)	(79,000)	(158,000)
State Government	(1,694,000)	(15,820,000)	(17,514,000)
Health and Human Services	(74,704,000)	(83,052,000)	(157,756,000)

Tax Aids and Credits	(103,986,000)	(385,495,000)	(489,481,000)
Subtotal of Appropriations	**(1,254,530,000)**	**(1,493,054,000)**	**(2,747,584,000)**
Transfers In	40,418,000	40,000,000	80,418,000
Total	**$ (1,294,948,000)**	**$ (1,533,054,000)**	**$ (2,828,002,000)**

Sec. 2. **ALLOTMENT REDUCTIONS VOID.**

The allotment reductions made by the commissioner of management and budget from July 1, 2009, to the effective date of this section are void.

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

ARTICLE 2

CASH FLOW

Section 1. Minnesota Statutes 2008, section 127A.46, is amended to read:

127A.46 CHANGE IN PAYMENT OF AIDS AND CREDITS.

If the commissioner of management and budget determines that modifications in the payment schedule would reduce the need for state short-term borrowing, the commissioner ~~shall~~ may modify payments to districts according to this section. The modifications must begin no sooner than September 1 of each fiscal year, and must remain in effect until no later than May 30 of that same fiscal year. In calculating the payment to a district pursuant to section 127A.45, subdivision 3, the commissioner may subtract the sum specified in that subdivision, plus an additional amount no greater than the following:

(1) the net cash balance in each of the district's operating funds on June 30 of the preceding fiscal year; minus

(2) the product of ~~$150~~ $700 times the number of resident pupil units in the preceding fiscal year; minus

(3) the amount of payments made by the county treasurer during the preceding fiscal year, pursuant to section 276.11, which is considered revenue for the current school year. However, no additional amount shall be subtracted if the total of the net unappropriated fund balances in the district's four operating funds on June 30 of the preceding fiscal year, is less than the product of ~~$350~~ $700 times the number of resident pupil units in the preceding fiscal year. The net cash balance must include all cash and investments, less certificates of indebtedness outstanding, and orders not paid for want of funds.

A district may appeal the payment schedule established by this section according to the procedures established in section 127A.45, subdivision 4.

Sec. 2. Minnesota Statutes 2009 Supplement, section 137.025, subdivision 1, is amended to read:

Subdivision 1. **Monthly payments.** The commissioner of management and budget shall pay 1/12 of the annual appropriation to the University of Minnesota ~~on~~ by the ~~21st~~ 25th day of each month. If the ~~21st~~ 25th day of the month falls on a Saturday or Sunday, the monthly payment must be made ~~on~~ by the first business day immediately following the ~~21st~~ 25th day of the month.

Sec. 3. Minnesota Statutes 2008, section 276.112, is amended to read:

276.112 STATE PROPERTY TAXES; COUNTY TREASURER.

On ~~or before January 25 each year, for the period ending December 31 of the prior year, and on or before June 28 each year, for the period ending on the most recent settlement day determined in section 276.09, and on or before December 2 each year, for the period ending November 20~~ the estimated payment and settlement dates provided in this chapter for the settlement of taxes levied by school districts, the county treasurer must make full settlement with the county auditor ~~according to sections 276.09, 276.10, and 276.111~~ for all receipts of state property taxes levied under section 275.025, and must transmit those receipts to the commissioner of revenue by electronic means on the dates and according to the provisions applicable to distributions to school districts.

EFFECTIVE DATE. This section is effective for distributions beginning October 1, 2010, and thereafter.

Sec. 4. Minnesota Statutes 2009 Supplement, section 289A.20, subdivision 4, is amended to read:

Subd. 4. **Sales and use tax.** (a) The taxes imposed by chapter 297A are due and payable to the commissioner monthly on or before the 20th day of the month following the month in which the taxable event occurred, or following another reporting period as the commissioner prescribes or as allowed under section 289A.18, subdivision 4, paragraph (f) or (g), except that:

(1) use taxes due on an annual use tax return as provided under section 289A.11, subdivision 1, are payable by April 15 following the close of the calendar year~~.~~; and

(2) except as provided in paragraph (f), for a vendor having a liability of $120,000 or more during a fiscal year ending June 30, 2009, and fiscal years thereafter, the taxes imposed by chapter 297A, except as provided in paragraph (b), are due and payable to the commissioner monthly in the following manner:

(i) On or before the 14th day of the month following the month in which the taxable event occurred, the vendor must remit to the commissioner 90 percent of the estimated liability for the month in which the taxable event occurred.

(ii) On or before the 20th day of the month in which the taxable event occurs, the vendor must remit to the commissioner a prepayment for the month in which the taxable event occurs equal to 67 percent of the liability for the previous month.

(iii) On or before the 20th day of the month following the month in which the taxable event occurred, the vendor must pay any additional amount of tax not previously remitted under either item (i) or (ii) or, if the payment made under item (i) or (ii) was greater than the vendor's liability for the month in which the taxable event occurred, the vendor may take a credit against the next month's liability in a manner prescribed by the commissioner.

(iv) Once the vendor first pays under either item (i) or (ii), the vendor is required to continue to make payments in the same manner, as long as the vendor continues having a liability of $120,000 or more during the most recent fiscal year ending June 30.

(v) Notwithstanding items (i), (ii), and (iv), if a vendor fails to make the required payment in the first month that the vendor is required to make a payment under either item (i) or (ii), then the vendor is deemed to have elected to pay under item (ii) and must make subsequent monthly payments in the manner provided in item (ii).

(vi) For vendors making an accelerated payment under item (ii), for the first month that the vendor is required to make the accelerated payment, on the 20th of that month, the vendor will pay 100 percent of the liability for the previous month and a prepayment for the first month equal to 67 percent of the liability for the previous month.

(b) Notwithstanding paragraph (a), a vendor having a liability of $120,000 or more during a fiscal year ending June 30 must remit the June liability for the next year in the following manner:

(1) Two business days before June 30 of the year, the vendor must remit 90 percent of the estimated June liability to the commissioner.

(2) On or before August 20 of the year, the vendor must pay any additional amount of tax not remitted in June.

(c) A vendor having a liability of:

~~(1) $20,000 or more in the fiscal year ending June 30, 2005; or~~

~~(2)~~ (1) $10,000 or more ~~in the~~, but less than $120,000 during a fiscal year ending June 30, ~~2006~~ 2009, and fiscal years thereafter, must remit by electronic means all liabilities on returns due for periods beginning in the subsequent calendar year ~~by electronic means~~ on or before the 20th day of the month following the month in which the taxable event occurred, or on or before the 20th day of the month following the month in

which the sale is reported under section 289A.18, subdivision 4~~, except for 90 percent of the estimated June liability, which is due two business days before June 30. The remaining amount of the June liability is due on August 20.~~; or

(2) $120,000 or more, during a fiscal year ending June 30, 2009, and fiscal years thereafter, must remit by electronic means all liabilities in the manner provided in paragraph (a), clause (2), on returns due for periods beginning in the subsequent calendar year, except for 90 percent of the estimated June liability, which is due two business days before June 30. The remaining amount of the June liability is due on August 20.

(d) Notwithstanding paragraph (b) or (c), a person prohibited by the person's religious beliefs from paying electronically shall be allowed to remit the payment by mail. The filer must notify the commissioner of revenue of the intent to pay by mail before doing so on a form prescribed by the commissioner. No extra fee may be charged to a person making payment by mail under this paragraph. The payment must be postmarked at least two business days before the due date for making the payment in order to be considered paid on a timely basis.

(e) Whenever the liability is $120,000 or more separately for: (1) the tax imposed under chapter 297A; (2) a fee that is to be reported on the same return as and paid with the chapter 297A taxes; or (3) any other tax that is to be reported on the same return as and paid with the chapter 297A taxes, then the payment of all the liabilities on the return must be accelerated as provided in this subdivision.

(f) At the start of the first calendar quarter at least 90 days after the cash flow account established in section 16A.152, subdivision 1, and the budget reserve account established in section 16A.152, subdivision 1a, reach the amounts listed in section 16A.152, subdivision 2, paragraph (a), the remittance of the accelerated payments required under paragraph (a), clause (2), must be suspended. The commissioner of management and budget shall notify the commissioner of revenue when the accounts have reached the required amounts. Beginning with the suspension of paragraph (a), clause (2), for a vendor with a liability of $120,000 or more during a fiscal year ending June 30, 2009, and fiscal years thereafter, the taxes imposed by chapter 297A are due and payable to the commissioner on the 20th day of the month following the month in which the taxable event occurred. Payments of tax liabilities for taxable events occurring in June under paragraph (b) are not changed.

EFFECTIVE DATE. This section is effective for taxes due and payable after September 1, 2010.

Sec. 5. Minnesota Statutes 2008, section 289A.60, is amended by adding a subdivision to read:

Subd. 31. **Accelerated payment of monthly sales tax liability; penalty for underpayment.** For payments made after September 1, 2010, if a vendor is required by section 289A.20, subdivision 4, paragraph (a), clause (2), item (i) or (ii), to make accelerated payments, then the penalty for underpayment is as follows:

(a) For those vendors that must remit a 90 percent payment by the 14th day of the month following the month in which the taxable event occurred, as an estimation of monthly sales tax liabilities, including the liability of any fee or other tax that is to be reported on the same return as and paid with the chapter 297A taxes, for the month in which the taxable event occurred, the vendor shall pay a penalty equal to ten percent of the amount of liability that was required to be paid by the 14th day of the month, less the amount remitted by the 14th day of the month. The penalty must not be imposed, however, if the amount remitted by the 14th day of the month equals the least of: (1) 90 percent of the liability for the month preceding the month in which the taxable event occurred; (2) 90 percent of the liability for the same month in the previous calendar year as the month in which the taxable event occurred; or (3) 90 percent of the average monthly liability for the previous calendar year.

(b) For those vendors that, on or before the 20th day of the month in which the taxable event occurs, must remit to the commissioner a prepayment of sales tax liabilities for the month in which the taxable event occurs equal to 67 percent of the liabilities for the previous month, including the liability of any fee or other tax that is to be reported on the same return as and paid with the chapter 297A taxes, for the month in which the taxable event occurred, the vendor shall pay a penalty equal to ten percent of the amount of liability that was required to be paid by the 20th of the month, less the amount remitted by the 20th of the month. The penalty must not be imposed, however, if the amount remitted by the 20th of the month equals the lesser of 67 percent of the liability for the month preceding the month in which the taxable event occurred or 67 percent of the liability of the same month in the previous calendar year as the month in which the taxable event occurred.

EFFECTIVE DATE. This section is effective for taxes due and payable after September 1, 2010.

Sec. 6. **PAYMENT OF REFUNDS.**

(a) In paying refunds during fiscal year 2011 of overpayments of corporate franchise tax and of sales tax, including but not limited to capital equipment refunds, the commissioner of revenue shall delay paying a sufficient number of these refunds

until fiscal year 2012 so that $152,000,000 less in refunds is paid in fiscal year 2011 than otherwise would have been paid. This amount is in addition to any amount that the commissioner delays pursuant to administrative actions undertaken in connection with the unallotment announced in June 2009. Refunds delayed by the commissioner under this section are deemed to be due on July 1, 2011, for budget purposes, if the law otherwise would provide an earlier date. Any refunds paid after June 30, 2011, and before the close of fiscal year 2011 are deemed to be paid in fiscal year 2012 for budget purposes.

(b) In carrying out the requirement of paragraph (a), the commissioner shall, to the extent possible, minimize delaying the payment of refunds that would result in payment of additional interest by the state. The commissioner may select refunds for delayed payment under this section or exempt refunds from this section in the manner that the commissioner determines, in the commissioner's sole discretion, has the least adverse effect on tax administration and taxpayer compliance.

ARTICLE 3

E-12 EDUCATION

Section 1. Minnesota Statutes 2008, section 123B.75, is amended by adding a subdivision to read:

Subd. 1a. **Definition.** For the purposes of this section, "school district tax settlement revenue" means the current, delinquent, and manufactured home property tax receipts collected by the county and distributed to the school district.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 2. Minnesota Statutes 2008, section 123B.75, subdivision 5, is amended to read:

Subd. 5. **Levy recognition.** (a) ~~"School district tax settlement revenue" means the current, delinquent, and manufactured home property tax receipts collected by the county and distributed to the school district.~~

~~(b)~~ For fiscal ~~year 2004 and later~~ years 2009 and 2010, in June of each year, the school district must recognize as revenue, in the fund for which the levy was made, the lesser of:

(1) the sum of May, June, and July school district tax settlement revenue received in that calendar year, plus general education aid according to section 126C.13, subdivision 4, received in July and August of that calendar year; or

(2) the sum of:

(i) 31 percent of the referendum levy certified according to section 126C.17, in calendar year 2000; and

(ii) the entire amount of the levy certified in the prior calendar year according to section 124D.86, subdivision 4, for school districts receiving revenue under sections 124D.86, subdivision 3, clauses (1), (2), and (3); 126C.41, subdivisions 1, 2, paragraph (a), and 3, paragraphs (b), (c), and (d); 126C.43, subdivision 2; 126C.457; and 126C.48, subdivision 6; plus

(iii) zero percent of the amount of the levy certified in the prior calendar year for the school district's general and community service funds, plus or minus auditor's adjustments, not including the levy portions that are assumed by the state, that remains after subtracting the referendum levy certified according to section 126C.17 and the amount recognized according to item (ii).

(b) For fiscal year 2011 and later years, in June of each year, the school district must recognize as revenue, in the fund for which the levy was made, the lesser of:

(1) the sum of May, June, and July school district tax settlement revenue received in that calendar year, plus general education aid according to section 126C.13, subdivision 4, received in July and August of that calendar year; or

(2) the sum of:

(i) the greater of 48.6 percent of the referendum levy certified according to section 126C.17 in the prior calendar year, or 31 percent of the referendum levy certified according to section 126C.17 in calendar year 2000; plus

(ii) the entire amount of the levy certified in the prior calendar year according to section 124D.86, subdivision 4, for school districts receiving revenue under sections 124D.86, subdivision 3, clauses (1), (2), and (3); 126C.41, subdivisions 1, 2, paragraph (a), and 3, paragraphs (b), (c), and (d); 126C.43, subdivision 2; 126C.457; and 126C.48, subdivision 6; plus

(iii) 48.6 percent of the amount of the levy certified in the prior calendar year for the school district's general and community service funds, plus or minus auditor's adjustments, not including the levy portions that are assumed by the state, that remains after subtracting the referendum levy certified according to section 126C.17 and the amount recognized according to item (ii).

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 3. Minnesota Statutes 2008, section 123B.75, subdivision 9, is amended to read:

Subd. 9. **Commissioner shall specify fiscal year.** The commissioner shall specify the fiscal year or years to which the revenue from any aid or tax levy is applicable if

Minnesota Statutes do not so specify. The commissioner must report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over education finance by January 15 of each year any adjustments under this subdivision in the previous year.

Sec. 4. Minnesota Statutes 2008, section 126C.48, subdivision 7, is amended to read:

Subd. 7. **Reporting.** For each tax settlement, the county auditor shall report to each school district by fund, the district tax settlement revenue defined in section 123B.75, subdivision ~~5, paragraph (a)~~ 1a, on the form specified in section 276.10. The county auditor shall send to the district a copy of the spread levy report specified in section 275.124.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 5. Minnesota Statutes 2008, section 127A.441, is amended to read:

127A.441 AID REDUCTION; LEVY REVENUE RECOGNITION CHANGE.

Each year, the state aids payable to any school district for that fiscal year that are recognized as revenue in the school district's general and community service funds shall be adjusted by an amount equal to (1) the amount the district recognized as revenue for the prior fiscal year pursuant to section 123B.75, subdivision 5, paragraph (a) or (b), minus (2) the amount the district recognized as revenue for the current fiscal year pursuant to section 123B.75, subdivision 5, paragraph (a) or (b). For purposes of making the aid adjustments under this section, the amount the district recognizes as revenue for either the prior fiscal year or the current fiscal year pursuant to section 123B.75, subdivision 5, paragraph (b), shall not include any amount levied pursuant to section 124D.86, subdivision 4, for school districts receiving revenue under sections 124D.86, subdivision 3, clauses (1), (2), and (3); 126C.41, subdivisions 1, 2, and 3, paragraphs (b), (c), and (d); 126C.43, subdivision 2; 126C.457; and 126C.48, subdivision 6. Payment from the permanent school fund shall not be adjusted pursuant to this section. The school district shall be notified of the amount of the adjustment made to each payment pursuant to this section.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 6. Minnesota Statutes 2008, section 127A.45, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) ~~The term~~ "Other district receipts" means payments by county treasurers pursuant to section 276.10, apportionments from the school endowment fund pursuant to section 127A.33, apportionments by the county auditor pursuant to

section 127A.34, subdivision 2, and payments to school districts by the commissioner of revenue pursuant to chapter 298.

(b) ~~The term~~ "Cumulative amount guaranteed" means the product of

(1) the cumulative disbursement percentage shown in subdivision 3; times

(2) the sum of

(i) the current year aid payment percentage of the estimated aid and credit entitlements paid according to subdivision 13; plus

(ii) 100 percent of the entitlements paid according to subdivisions 11 and 12; plus

(iii) the other district receipts.

(c) ~~The term~~ "Payment date" means the date on which state payments to districts are made by the electronic funds transfer method. If a payment date falls on a Saturday, a Sunday, or a weekday which is a legal holiday, the payment shall be made on the immediately preceding business day. The commissioner may make payments on dates other than those listed in subdivision 3, but only for portions of payments from any preceding payment dates which could not be processed by the electronic funds transfer method due to documented extenuating circumstances.

(d) The current year aid payment percentage equals ~~90~~ 73 in fiscal year 2010, 70 in fiscal year 2011, and 90 in fiscal years 2012 and later.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2009.

Sec. 7. Minnesota Statutes 2008, section 127A.45, subdivision 3, is amended to read:

Subd. 3. **Payment dates and percentages.** (a) ~~For fiscal year 2004 and later,~~ The commissioner shall pay to a district on the dates indicated an amount computed as follows: the cumulative amount guaranteed minus the sum of ~~(a)~~ (1) the district's other district receipts through the current payment, and ~~(b)~~ (2) the aid and credit payments through the immediately preceding payment. For purposes of this computation, the payment dates and the cumulative disbursement percentages are as follows:

	Payment date	Percentage
Payment 1	July 15:	5.5
Payment 2	July 30:	8.0
Payment 3	August 15:	17.5
Payment 4	August 30:	20.0
Payment 5	September 15:	22.5
Payment 6	September 30:	25.0
Payment 7	October 15:	27.0
Payment 8	October 30:	30.0
Payment 9	November 15:	32.5

Payment 10	November 30:	36.5
Payment 11	December 15:	42.0
Payment 12	December 30:	45.0
Payment 13	January 15:	50.0
Payment 14	January 30:	54.0
Payment 15	February 15:	58.0
Payment 16	February 28:	63.0
Payment 17	March 15:	68.0
Payment 18	March 30:	74.0
Payment 19	April 15:	78.0
Payment 20	April 30:	85.0
Payment 21	May 15:	90.0
Payment 22	May 30:	95.0
Payment 23	June 20:	100.0

~~(b) In addition to the amounts paid under paragraph (a), for fiscal year 2004, the commissioner shall pay to a district on the dates indicated an amount computed as follows:~~

~~Payment 3~~	~~August 15: the final adjustment for the prior fiscal year for the state paid property tax credits established in section 273.1392~~
~~Payment 4~~	~~August 30: one-third of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits~~
~~Payment 6~~	~~September 30: one-third of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits~~
~~Payment 8~~	~~October 30: one-third of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits~~

~~(c)~~ (b) In addition to the amounts paid under paragraph (a), ~~for fiscal year 2005 and later,~~ the commissioner shall pay to a district on the dates indicated an amount computed as follows:

Payment 3	August 15: the final adjustment for the prior fiscal year for the state paid property tax credits established in section 273.1392
Payment 4	August 30: 30 percent of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits
Payment 6	September 30: 40 percent of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits
Payment 8	October 30: 30 percent of the final adjustment for the prior fiscal year for all aid entitlements except state paid property tax credits

EFFECTIVE DATE. This section is effective the day following final enactment and applies to fiscal years 2010 and later.

Sec. 8. Minnesota Statutes 2008, section 127A.45, is amended by adding a subdivision to read:

Subd. 7b. **Advance final payment.** (a) Notwithstanding subdivisions 3 and 7, if the current year aid payment percentage, under subdivision 2, is less than 90, then a school district or charter school exceeding its expenditure limitations under section 123B.83 as of June 30 of the prior fiscal year may receive a portion of its final payment for the current fiscal year on June 20, if requested by the district or charter school. The amount paid under this subdivision must not exceed the lesser of:

(1) the difference between 90 percent and the current year payment percentage in subdivision 2, paragraph (d), in the current fiscal year times the sum of the district or charter school's general education aid plus the aid adjustment in section 127A.50 for the current fiscal year; or

(2) the amount by which the district's or charter school's net negative unreserved general fund balance as of June 30 of the prior fiscal year exceeds 2.5 percent of the district or charter school's expenditures for that fiscal year.

(b) The state total advance final payment under this subdivision for any year must not exceed $7,500,000. If the amount request exceeds $7,500,000, the advance final payment for each eligible district must be reduced proportionately.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to fiscal years 2010 and later.

Sec. 9. Minnesota Statutes 2008, section 127A.45, subdivision 13, is amended to read:

Subd. 13. **Aid payment percentage.** Except as provided in subdivisions 11, 12, 12a, and 14, each fiscal year, all education aids and credits in this chapter and chapters 120A, 120B, 121A, 122A, 123A, 123B, 124D, 125A, 125B, 126C, 134, and section 273.1392, shall be paid at the current year aid payment percentage of the estimated entitlement during the fiscal year of the entitlement. ~~For the purposes of this subdivision, a district's estimated entitlement for special education excess cost aid under section 125A.79 for fiscal year 2005 equals 70 percent of the district's entitlement for the second prior fiscal year.~~ For the purposes of this subdivision, a district's estimated entitlement for special education excess cost aid under section 125A.79 for fiscal year 2006 and later equals 74.0 percent of the district's entitlement for the current fiscal year. The final adjustment payment, according to subdivision 9, must be the amount of the actual entitlement, after adjustment for actual data, minus the payments made during the fiscal year of the entitlement.

Sec. 10. Laws 2009, chapter 96, article 1, section 24, subdivision 2, is amended to read:

Subd. 2. **General education aid.** For general education aid under Minnesota Statutes, section 126C.13, subdivision 4:

~~5,195,504,000~~
$ 4,291,422,000 2010

~~5,626,994,000~~
$ 4,776,884,000 2011

The 2010 appropriation includes ~~$555,864,000~~ $553,591,000 for 2009 and ~~$4,639,640,000~~ $3,737,831,000 for 2010.

The 2011 appropriation includes ~~$500,976,000~~ $1,363,306,000 for 2010 and ~~$5,126,018,000~~ $3,413,578,000 for 2011.

Sec. 11. Laws 2009, chapter 96, article 6, section 11, subdivision 6, is amended to read:

Subd. 6. **Educate parents partnership.** For the educate parents partnership under Minnesota Statutes, section 124D.129:

$ ~~50,000~~ 49,000 2010
$ ~~50,000~~ 49,000 2011

Any balance in the first year does not cancel but is available in the second year.

Sec. 12. Laws 2009, chapter 96, article 6, section 11, subdivision 7, is amended to read:

Subd. 7. **Kindergarten entrance assessment initiative and intervention program.** For the kindergarten entrance assessment initiative and intervention program under Minnesota Statutes, section 124D.162:

$ ~~287,000~~ 281,000 2010
$ ~~287,000~~ 281,000 2011

Any balance in the first year does not cancel but is available in the second year.

Sec. 13. Laws 2009, chapter 96, article 7, section 3, subdivision 2, is amended to read:

Subd. 2. **Department.** (a) For the Department of Education:

~~20,943,000~~
$ 20,147,600 2010

~~20,943,000~~
$ 19,811,000 2011

Any balance in the first year does not cancel but is available in the second year.

(b) $260,000 each year is for the Minnesota Children's Museum.

(c) $41,000 each year is for the Minnesota Academy of Science.

(d) ~~$632,000~~ $618,000 each year is for the Board of Teaching. Any balance in the first year does not cancel but is available in the second year.

(e) ~~$171,000~~ $167,000 each year is for the Board of School Administrators. Any balance in the first year does not cancel but is available in the second year.

(f) ~~$40,000 each year~~ $10,000 is for an early hearing loss intervention coordinator under Minnesota Statutes, section 125A.63, subdivision 5. This appropriation is for fiscal year 2010 only. If the department expends federal funds to employ a hearing loss coordinator under Minnesota Statutes, section 125A.63, subdivision 5, then the appropriation under this paragraph is reallocated for purposes of employing a world languages coordinator.

(g) $50,000 each year is for the Duluth Children's Museum.

(h) None of the amounts appropriated under this subdivision may be used for Minnesota's Washington, D.C., office.

(i) The expenditures of federal grants and aids as shown in the biennial budget document and its supplements are approved and appropriated and shall be spent as indicated. The commissioner must provide, to the K-12 Education Finance Division in the house of representatives and the E-12 Budget Division in the senate, details about the distribution of state incentive grants, education technology state grants, teacher incentive funds, and statewide data system funds as outlined in the supplemental federal funds submission dated March 25, 2009.

ARTICLE 4

E-12 EDUCATION FORECAST ADJUSTMENTS

Section 1. Minnesota Statutes 2009 Supplement, section 123B.54, is amended to read:

123B.54 DEBT SERVICE APPROPRIATION.

(a) ~~$9,109,000 in fiscal year 2009, $7,948,000 in fiscal year 2010, $9,275,000 in fiscal year 2011, $9,574,000~~ $17,161,000 in fiscal year 2012, and ~~$8,904,000~~ $19,175,000 in fiscal year 2013 and later are appropriated from the general fund to the commissioner of education for payment of debt service equalization aid under section 123B.53.

(b) The appropriations in paragraph (a) must be reduced by the amount of any money specifically appropriated for the same purpose in any year from any state fund.

Sec. 2. Laws 2009, chapter 96, article 1, section 24, subdivision 4, is amended to read:

Subd. 4. **Abatement revenue.** For abatement aid under Minnesota Statutes, section 127A.49:

	~~1,175,000~~		
$	1,000,000	.....	2010
	~~1,034,000~~		
$	1,132,000	.....	2011

The 2010 appropriation includes $140,000 for 2009 and ~~$1,035,000~~ $860,000 for 2010.

The 2011 appropriation includes ~~$115,000~~ $317,000 for 2010 and ~~$919,000~~ $815,000 for 2011.

Sec. 3. Laws 2009, chapter 96, article 1, section 24, subdivision 5, is amended to read:

Subd. 5. **Consolidation transition.** For districts consolidating under Minnesota Statutes, section 123A.485:

$ ~~854,000~~ 684,000 2010

$ ~~927,000~~ 576,000 2011

The 2010 appropriation includes $0 for 2009 and ~~$854,000~~ $684,000 for 2010.

The 2011 appropriation includes ~~$94,000~~ $252,000 for 2010 and ~~$833,000~~ $324,000 for 2011.

Sec. 4. Laws 2009, chapter 96, article 1, section 24, subdivision 6, is amended to read:

Subd. 6. **Nonpublic pupil education aid.** For nonpublic pupil education aid under Minnesota Statutes, sections 123B.40 to 123B.43 and 123B.87:

$ ~~17,250,000~~ 12,861,000 2010

$ ~~17,889,000~~ 16,157,000 2011

The 2010 appropriation includes ~~$1,647,000~~ $1,067,000 for 2009 and ~~$15,603,000~~ $11,794,000 for 2010.

The 2011 appropriation includes ~~$1,733,000~~ $4,362,000for 2010 and ~~$16,156,000~~ $11,795,000 for 2011.

Sec. 5. Laws 2009, chapter 96, article 1, section 24, subdivision 7, is amended to read:

Subd. 7. **Nonpublic pupil transportation.** For nonpublic pupil transportation aid under Minnesota Statutes, section 123B.92, subdivision 9:

$ ~~22,159,000~~ 17,297,000 2010

$ ~~22,712,000~~ 19,729,000 2011

The 2010 appropriation includes $2,077,000 for 2009 and ~~$20,082,000~~ $15,220,000 for 2010.

The 2011 appropriation includes ~~$2,231,000~~ $5,629,000 for 2010 and ~~$20,481,000~~ $14,100,000 for 2011.

Sec. 6. Laws 2009, chapter 96, article 2, section 67, subdivision 2, is amended to read:

Subd. 2. **Charter school building lease aid.** For building lease aid under Minnesota Statutes, section 124D.11, subdivision 4:

~~40,453,000~~
$ 34,833,000 2010

~~44,775,000~~
$ 44,938,000 2011

The 2010 appropriation includes $3,704,000 for 2009 and ~~$36,749,000~~ $31,129,000 for 2010.

The 2011 appropriation includes ~~$4,083,000~~ $11,513,000 for 2010 and ~~$40,692,000~~ $33,425,000 for 2011.

Sec. 7. Laws 2009, chapter 96, article 2, section 67, subdivision 3, is amended to read:

Subd. 3. **Charter school startup aid.** For charter school startup cost aid under Minnesota Statutes, section 124D.11:

~~1,488,000~~
$ 1,218,000 2010

~~1,064,000~~
$ 743,000 2011

The 2010 appropriation includes $202,000 for 2009 and ~~$1,286,000~~ $1,016,000 for 2010.

The 2011 appropriation includes ~~$142,000~~ $375,000 for 2010 and ~~$922,000~~ $368,000 for 2011.

Sec. 8. Laws 2009, chapter 96, article 2, section 67, subdivision 4, is amended to read:

Subd. 4. **Integration aid.** For integration aid under Minnesota Statutes, section 124D.86, subdivision 5:

~~65,358,000~~
$ 50,812,000 2010

~~65,484,000~~
$ 61,782,000 2011

The 2010 appropriation includes ~~$6,110,000~~ $5,832,000 for 2009 and ~~$59,248,000~~ $44,980,000 for 2010.

The 2011 appropriation includes ~~$6,583,000~~ $16,636,000 for 2010 and ~~$58,901,000~~ $45,146,000 for 2011.

Sec. 9. Laws 2009, chapter 96, article 2, section 67, subdivision 7, is amended to read:

Subd. 7. **Success for the future.** For American Indian success for the future grants under Minnesota Statutes, section 124D.81:

~~2,137,000~~
$ 1,774,000 2010

~~2,137,000~~
$ 2,072,000 2011

The 2010 appropriation includes $213,000 for 2009 and ~~$1,924,000~~ $1,561,000 for 2010.

The 2011 appropriation includes ~~$213,000~~ $576,000 for 2010 and ~~$1,924,000~~ $1,496,000 for 2011.

Sec. 10. Laws 2009, chapter 96, article 2, section 67, subdivision 9, is amended to read:

Subd. 9. **Tribal contract schools.** For tribal contract school aid under Minnesota Statutes, section 124D.83:

~~2,030,000~~
$ 1,702,000 2010

~~2,211,000~~
$ 2,119,000 2011

The 2010 appropriation includes $191,000 for 2009 and ~~$1,839,000~~ $1,511,000 for 2010.

The 2011 appropriation includes ~~$204,000~~ $558,000 for 2010 and ~~$2,007,000~~ $1,561,000 for 2011.

Sec. 11. Laws 2009, chapter 96, article 3, section 21, subdivision 2, is amended to read:

Subd. 2. **Special education; regular.** For special education aid under Minnesota Statutes, section 125A.75:

~~734,071,000~~
$ 609,003,000 2010

~~781,497,000~~
$ 749,248,000 2011

The 2010 appropriation includes $71,947,000 for 2009 and ~~$662,124,000~~ $537,056,000 for 2010.

The 2011 appropriation includes ~~$73,569,000~~ $198,637,000 for 2010 and ~~$707,928,000~~ $550,611,000 for 2011.

Sec. 12. Laws 2009, chapter 96, article 3, section 21, subdivision 4, is amended to read:

Subd. 4. **Travel for home-based services.** For aid for teacher travel for home-based services under Minnesota Statutes, section 125A.75, subdivision 1:

$ ~~258,000~~ 224,000 2010

$ ~~282,000~~ 282,000 2011

The 2010 appropriation includes $24,000 for 2009 and ~~$234,000~~ $200,000 for 2010.

The 2011 appropriation includes ~~$26,000~~ $73,000 for 2010 and ~~$256,000~~ $209,000 for 2011.

Sec. 13. Laws 2009, chapter 96, article 3, section 21, subdivision 5, is amended to read:

Subd. 5. **Special education; excess costs.** For excess cost aid under Minnesota Statutes, section 125A.79, subdivision 7:

~~110,871,000~~

$ 96,926,000 2010

~~110,877,000~~

$ 108,410,000 2011

The 2010 appropriation includes $37,046,000 for 2009 and ~~$73,825,000~~ $59,880,000 for 2010.

The 2011 appropriation includes ~~$37,022,000~~ $50,967,000 for 2010 and ~~$73,855,000~~ $57,443,000 for 2011.

Sec. 14. Laws 2009, chapter 96, article 4, section 12, subdivision 2, is amended to read:

Subd. 2. **Health and safety revenue.** For health and safety aid according to Minnesota Statutes, section 123B.57, subdivision 5:

$ ~~161,000~~ 132,000 2010

$ ~~160,000~~ 135,000 2011

The 2010 appropriation includes $10,000 for 2009 and ~~$151,000~~ $122,000 for 2010.

The 2011 appropriation includes ~~$16,000~~ $44,000 for 2010 and ~~$144,000~~ $91,000 for 2011.

Sec. 15. Laws 2009, chapter 96, article 4, section 12, subdivision 3, is amended to read:

Subd. 3. **Debt service equalization.** For debt service aid according to Minnesota Statutes, section 123B.53, subdivision 6:

~~7,948,000~~

$ 6,608,000 2010

~~9,275,000~~

$ 8,204,000 2011

The 2010 appropriation includes $851,000 for 2009 and ~~$7,097,000~~ $5,757,000 for 2010.

The 2011 appropriation includes ~~$788,000~~ $2,128,000 for 2010 and ~~$8,487,000~~ $6,076,000 for 2011.

Sec. 16. Laws 2009, chapter 96, article 4, section 12, subdivision 4, is amended to read:

Subd. 4. **Alternative facilities bonding aid.** For alternative facilities bonding aid, according to Minnesota Statutes, section 123B.59, subdivision 1:

~~19,287,000~~
$ 16,008,000 2010

~~19,287,000~~
$ 18,708,000 2011

The 2010 appropriation includes $1,928,000 for 2009 and ~~$17,359,000~~ $14,080,000 for 2010.

The 2011 appropriation includes ~~$1,928,000~~ $5,207,000 for 2010 and ~~$17,359,000~~ $13,501,000 for 2011.

Sec. 17. Laws 2009, chapter 96, article 4, section 12, subdivision 6, is amended to read:

Subd. 6. **Deferred maintenance aid.** For deferred maintenance aid, according to Minnesota Statutes, section 123B.591, subdivision 4:

~~2,302,000~~
$ 1,918,000 2010

~~2,073,000~~
$ 2,146,000 2011

The 2010 appropriation includes $260,000 for 2009 and ~~$2,042,000~~ $1,658,000 for 2010.

The 2011 appropriation includes ~~$226,000~~ $613,000 for 2010 and ~~$1,847,000~~ $1,533,000 for 2011.

Sec. 18. Laws 2009, chapter 96, article 5, section 13, subdivision 4, is amended to read:

Subd. 4. **Kindergarten milk.** For kindergarten milk aid under Minnesota Statutes, section 124D.118:

~~1,098,000~~
$ 1,104,000 2010

~~1,120,000~~
$ 1,126,000 2011

Sec. 19. Laws 2009, chapter 96, article 5, section 13, subdivision 6, is amended to read:

Subd. 6. **Basic system support.** For basic system support grants under Minnesota Statutes, section 134.355:

~~13,570,000~~
$ 11,264,000 2010

~~13,570,000~~
$ 13,162,000 2011

The 2010 appropriation includes $1,357,000 for 2009 and ~~$12,213,000~~ $9,907,000 for 2010.

The 2011 appropriation includes ~~$1,357,000~~ $3,663,000 for 2010 and ~~$12,213,000~~ $9,499,000 for 2011.

Sec. 20. Laws 2009, chapter 96, article 5, section 13, subdivision 7, is amended to read:

Subd. 7. **Multicounty, multitype library systems.** For grants under Minnesota Statutes, sections 134.353 and 134.354, to multicounty, multitype library systems:

~~1,300,000~~
$ 1,079,000 2010

~~1,300,000~~
$ 1,261,000 2011

The 2010 appropriation includes $130,000 for 2009 and ~~$1,170,000~~ $949,000 for 2010.

The 2011 appropriation includes ~~$130,000~~ $351,000 for 2010 and ~~$1,170,000~~ $910,000 for 2011.

Sec. 21. Laws 2009, chapter 96, article 5, section 13, subdivision 9, is amended to read:

Subd. 9. **Regional library telecommunications aid.** For regional library telecommunications aid under Minnesota Statutes, section 134.355:

~~2,300,000~~
$ 1,909,000 2010

~~2,300,000~~
$ 2,231,000 2011

The 2010 appropriation includes $230,000 for 2009 and ~~$2,070,000~~ $1,679,000 for 2010.

The 2011 appropriation includes ~~$230,000~~ $621,000 for 2010 and ~~$2,070,000~~ $1,610,000 for 2011.

Sec. 22. Laws 2009, chapter 96, article 6, section 11, subdivision 2, is amended to read:

Subd. 2. **School readiness.** For revenue for school readiness programs under Minnesota Statutes, sections 124D.15 and 124D.16:

~~10,095,000~~
$ 8,379,000 2010
~~10,095,000~~
$ 9,792,000 2011

The 2010 appropriation includes $1,009,000 for 2009 and ~~$9,086,000~~ $7,370,000 for 2010.

The 2011 appropriation includes ~~$1,009,000~~ $2,725,000 for 2010 and ~~$9,086,000~~ $7,067,000 for 2011.

Sec. 23. Laws 2009, chapter 96, article 6, section 11, subdivision 3, is amended to read:

Subd. 3. **Early childhood family education aid.** For early childhood family education aid under Minnesota Statutes, section 124D.135:

~~22,955,000~~
$ 19,005,000 2010
~~22,547,000~~
$ 21,460,000 2011

The 2010 appropriation includes $3,020,000 for 2009 and ~~$19,935,000~~ $15,985,000 for 2010.

The 2011 appropriation includes ~~$2,214,000~~ $5,911,000 for 2010 and ~~$20,333,000~~ $15,549,000 for 2011.

Sec. 24. Laws 2009, chapter 96, article 6, section 11, subdivision 4, is amended to read:

Subd. 4. **Health and developmental screening aid.** For health and developmental screening aid under Minnesota Statutes, sections 121A.17 and 121A.19:

~~3,694,000~~
$ 2,922,000 2010
~~3,800,000~~
$ 3,425,000 2011

The 2010 appropriation includes $367,000 for 2009 and ~~$3,327,000~~ $2,555,000 for 2010.

The 2011 appropriation includes ~~$369,000~~ $945,000 for 2010 and ~~$3,431,000~~ $2,480,000 for 2011.

Sec. 25. Laws 2009, chapter 96, article 6, section 11, subdivision 8, is amended to read:

Subd. 8. **Community education aid.** For community education aid under Minnesota Statutes, section 124D.20:

$ ~~585,000~~ 476,000 2010
$ ~~467,000~~ 473,000 2011

The 2010 appropriation includes $73,000 for 2009 and ~~$512,000~~ $403,000 for 2010.

The 2011 appropriation included ~~$56,000~~ $148,000 for 2010 and ~~$411,000~~ $325,000 for 2011.

Sec. 26. Laws 2009, chapter 96, article 6, section 11, subdivision 9, is amended to read:

Subd. 9. **Adults with disabilities program aid.** For adults with disabilities programs under Minnesota Statutes, section 124D.56:

$ ~~710,000~~ 588,000 2010

$ ~~710,000~~ 688,000 2011

The 2010 appropriation includes ~~$71,000~~ $69,000 for 2009 and ~~$639,000~~ $519,000 for 2010.

The 2011 appropriation includes ~~$71,000~~ $191,000 for 2010 and ~~$639,000~~ $497,000 for 2011.

Sec. 27. Laws 2009, chapter 96, article 6, section 11, subdivision 12, is amended to read:

Subd. 12. **Adult basic education aid.** For adult basic education aid under Minnesota Statutes, section 124D.531:

$ ~~42,975,000~~ 35,671,000 2010

$ ~~44,258,000~~ 42,732,000 2011

The 2010 appropriation includes $4,187,000 for 2009 and ~~$38,788,000~~ $31,484,000 for 2010.

The 2011 appropriation includes ~~$4,309,000~~ $11,644,000 for 2010 and ~~$39,949,000~~ $31,088,000 for 2011.

ARTICLE 5

HIGHER EDUCATION

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (77,000)	$ (100,077,000)	$ (100,154,000)

Sec. 2. **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 95, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **MINNESOTA OFFICE OF HIGHER EDUCATION**	**$ (77,000)**	**$ (77,000)**
This reduction is from the appropriation for agency administration.		
If an extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5, section 5001, to at least June 30, 2011, is enacted by June 15, 2010, $35,000,000 is appropriated from the general fund to the Minnesota Office of Higher Education for the state grant program, to be available for the fiscal year ending June 30, 2011.		
Sec. 4. **BOARD OF TRUSTEES OF THE MINNESOTA STATE COLLEGES AND UNIVERSITIES**	**$ -0-**	**$ (50,000,000)**
$2,079,000 of the reduction in 2011 is from the central offices and shared services unit appropriation. None of these reductions may be charged back or allocated to the campuses.		

$47,921,000 of the reduction in 2011 is from the operations and maintenance appropriation.

For fiscal years 2012 and 2013, the base for operations and maintenance is $580,802,000 each year.

Sec. 5. **BOARD OF REGENTS OF THE UNIVERSITY OF MINNESOTA**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$ (50,000,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.			
Subd. 2. **Operations and Maintenance**		-0-	(44,606,000)
For fiscal years 2012 and 2013, the base for operations and maintenance is $578,370,000 each year.			
Subd. 3. **Special Appropriations**			
(a) **Agriculture and Extension Service**		-0-	(3,858,000)
(b) **Health Sciences**		-0-	(389,000)
$26,000 of the 2011 reduction is from the St. Cloud family practice residency program.			
(c) **Institute of Technology**		-0-	(102,000)
(d) **System Special**		-0-	(454,000)
(e) **University of Minnesota and Mayo Foundation Partnership**		-0-	(591,000)

ARTICLE 6

ENVIRONMENT AND NATURAL RESOURCES

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize changes to direct appropriations, by fund, made in this article.

	2010	2011	Total
General	$ (1,571,000)	$ (1,564,000)	$ (3,135,000)

Sec. 2. **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 37, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from the appropriation listed under them are 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	2011
Sec. 3. **POLLUTION CONTROL AGENCY**		
Subdivision 1. **Total Appropriation**	**$ (110,000)**	**$ (99,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Water**	(98,000)	(38,000)
The $98,000 reduction in fiscal year 2010 is from the agency's activities to develop minimal impact design standards for urban stormwater runoff.		
Subd. 3. **Land**	-0-	(30,000)
The $30,000 reduction in the second year is from the environmental health tracking and biomonitoring activities of the agency.		
Subd. 4. **Environmental Assistance and Cross Media**	-0-	(16,000)

Subd. 5. **Administrative Support**	(12,000)	(15,000)

Sec. 4. **NATURAL RESOURCES**

Subdivision 1. **Total Appropriation**	**$ (1,375,000)**	**$ (1,379,000)**

The appropriation reductions for each purpose are shown in the following subdivisions.

Subd. 2. **Lands and Minerals**	(30,000)	(30,000)
Subd. 3. **Water Resources Management**	(84,000)	(84,000)
Subd. 4. **Forest Management**	(188,000)	(188,000)

$53,000 of the reduction each year is from activities supporting the Forest Resources Council with implementation of the Sustainable Forest Resources Act.

Subd. 5. **Parks and Trails Management**	(420,000)	(422,000)
Subd. 6. **Fish and Wildlife Management**	(265,000)	(265,000)

$265,000 of the reduction each year is from activities for preserving, restoring, and enhancing grassland/wetland complexes on public or private land.

Subd. 7. **Ecological Services**	(46,000)	(47,000)
Subd. 8. **Enforcement**	(230,000)	(230,000)
Subd. 9. **Operations Support**	(112,000)	(113,000)

Sec. 5. **METROPOLITAN COUNCIL**	**$ (86,000)**	**$ (86,000)**

Sec. 6. Laws 2010, chapter 215, article 3, section 3, subdivision 6, is amended to read:

Subd. 6. **Transfers In**

(a) The amounts appropriated from the agency indirect costs account in the special revenue fund are reduced by $328,000 in fiscal year 2010 and $462,000 in fiscal year 2011, and those amounts must be transferred to the general fund by June 30, 2011. The appropriation reductions are onetime.

(b) The commissioner of management and budget shall transfer ~~$8,000,000~~ $48,000,000 in fiscal year 2011 from the closed landfill investment fund in Minnesota Statutes, section 115B.421, to the general fund. The commissioner shall transfer ~~$4,000,000~~ $12,000,000 on July 1~~, 2013, and $4,000,000 on July 1,~~ in each of the years 2014, 2015, 2016, and 2017 from the general fund to the closed landfill investment fund. For ~~the July 1, 2014,~~ each transfer to the closed landfill investment fund, the commissioner shall determine the total amount of interest and other earnings that would have accrued to the fund if the transfers to the general fund under this paragraph had not been made and add this amount to the transfer. The amounts necessary for these transfers are appropriated from the general fund in the fiscal years specified for the transfers.

ARTICLE 7

ENERGY

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (247,000)	$ (247,000)	$ (494,000)

Sec. 2. **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 37, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **DEPARTMENT OF COMMERCE**		
Subdivision 1. **Total Appropriation**	**$ (247,000)**	**$ (247,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Administrative Services**	(97,000)	(97,000)
Subd. 3. **Market Assurance**	(150,000)	(150,000)

ARTICLE 8

AGRICULTURE

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (493,000)	$ (492,000)	$ (985,000)

Sec. 2. **AGRICULTURAL 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 94, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the

general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from the appropriations listed under them are 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **DEPARTMENT OF AGRICULTURE**		
Subdivision 1. **Total Appropriation**	**$ (493,000)**	**$ (492,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Protection Services**	(228,000)	(228,000)
$13,000 in fiscal year 2010 and $13,000 in fiscal year 2011 are reductions from plant pest surveys.		
Subd. 3. **Agricultural Marketing and Development**	(127,000)	(127,000)
$77,000 in fiscal year 2010 and $77,000 in fiscal year 2011 are reductions for integrated pest management activities.		
Subd. 4. **Administration and Financial Assistance**	(138,000)	(137,000)
$69,000 in fiscal year 2010 and $69,000 in fiscal year 2011 are reductions from the dairy and profitability enhancement and dairy business planning grant programs established under Laws 1997, chapter 216, section 7, subdivision 2, and Laws 2001, First Special Session chapter 2, section 9, subdivision 2.		

$1,000 in fiscal year 2010 is a reduction from the appropriation for the administration of the Feeding Minnesota Task Force.

ARTICLE 9

ECONOMIC DEVELOPMENT

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	2011	Total
General	$ (489,000)	$ (745,000)	$ (1,234,000)

Sec. 2. **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 78, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	2011
Sec. 3. **EMPLOYMENT AND ECONOMIC DEVELOPMENT**		
Subdivision 1. **Total Appropriation**	**$ (285,000)**	**$ (285,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Business and Community Development**	(87,000)	(87,000)

$25,000 in 2010 and $25,000 in 2011 are from the appropriation for the Office of Science and Technology.

Subd. 3. **Workforce Development** (115,000) (115,000)

$15,000 in 2010 and $15,000 in 2011 are from the appropriation for the Minnesota job skills partnership program under Minnesota Statutes, sections 116L.01 to 116L.17.

$11,000 in 2010 and $11,000 in 2011 are from the appropriation for administrative expenses to programs that provide employment support services to persons with mental illness under Minnesota Statutes, sections 268A.13 and 268A.14.

$89,000 in 2010 and $89,000 in 2011 are from the appropriation for state services for the blind activities.

Subd. 4. **State-Funded Administration** (83,000) (83,000)

Sec. 4. **HOUSING FINANCE AGENCY** **$ -0- $ (256,000)**

This reduction is from the appropriation to the Housing Finance Agency for the housing rehabilitation program under Minnesota Statutes, section 462A.05, subdivision 14, for rental housing developments.

On or before June 30, 2010, the Housing Finance Agency shall transfer $256,000 from the housing rehabilitation program in the housing development fund to the general fund.

Sec. 5. **DEPARTMENT OF LABOR AND INDUSTRY** **$ (20,000) $ (20,000)**

This reduction is from the general fund appropriation for labor standards/apprenticeship.

Sec. 6. **BUREAU OF MEDIATION SERVICES** **$ (16,000) $ (16,000)**

This reduction is from the general fund appropriation for mediation services.

Sec. 7. **MINNESOTA HISTORICAL SOCIETY**

Subdivision 1. **Total Appropriation** **$ (168,000) $ (168,000)**

The appropriation reductions for each purpose are shown in the following subdivisions.

Subd. 2. **Education and Outreach** (96,000) (96,000)

Subd. 3. **Preservation and Access** (72,000) (72,000)

ARTICLE 10

TRANSPORTATION

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (1,649,000)	$ (11,649,000)	$ (13,298,000)

Sec. 2. **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 36, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from the appropriation listed under them are 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.

	APPROPRIATIONS Available for the Year Ending June 30 2010	2011
Sec. 3. **TRANSPORTATION**		
Subdivision 1. **Total Appropriation**	**$ (24,000)**	**$ (1,474,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Multimodal Systems**		
(a) **Transit**	(9,000)	(1,459,000)
This reduction is to the Transit Improvement Administration appropriation.		
The base appropriation from the general fund for fiscal years 2012 and 2013 is $16,292,000 each year.		
(b) **Freight**	(9,000)	(9,000)
This reduction is to the rail service plan appropriation.		
(c) **Electronic Communication**	(6,000)	(6,000)
This reduction is to the Roosevelt Tower appropriation.		
Sec. 4. **METROPOLITAN COUNCIL**		
Subdivision 1. **Total Appropriation**	**$ (1,625,000)**	**$ (10,175,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Bus Transit**	(1,506,000)	(10,056,000)
This reduction is to the appropriation for bus system operations.		

The base appropriation for fiscal years 2012 and 2013 is $59,796,000 each year.

Subd. 3. **Rail Operations** (119,000) (119,000)

This reduction is to the appropriation for rail systems.

The base appropriation for fiscal years 2012 and 2013 is $5,174,000 each year.

ARTICLE 11

PUBLIC SAFETY

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	2011	Total
General	$ (79,000)	$ (79,000)	$ (158,000)

Sec. 2. **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 83, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	2011
Sec. 3. **HUMAN RIGHTS**	**$ (79,000)**	**$ (79,000)**

ARTICLE 12

STATE GOVERNMENT

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	2011	Total
General	$ (1,694,000)	$ (15,820,000)	$ (17,514,000)

Sec. 2. **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 101, article 1, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	2011
Sec. 3. **GOVERNOR AND LIEUTENANT GOVERNOR**	**$ (81,000)**	**$ (81,000)**

$13,000 of the reduction in each of fiscal years 2010 and 2011 are from the appropriation for necessary expenses in the normal performance of the governor's and lieutenant governor's duties for which no other reimbursement is provided.

Sec. 4. **OFFICE OF ENTERPRISE TECHNOLOGY**	**$ (130,000)**	**$ (130,000)**

$96,000 of the reduction in each of fiscal years 2010 and 2011 are from the

appropriation for information technology security.

Sec. 5. **ADMINISTRATION** **$ (100,000) $ (200,000)**

These reductions are from the Government and Citizen Services Program.

$162,000 of the balance in the central stores fund is transferred to the general fund on or before June 30, 2010. This is a onetime transfer.

The base appropriation from the general fund for the Government and Citizen Services Program for fiscal years 2012 and 2013 is $17,116,000 each year.

Sec. 6. **MANAGEMENT AND BUDGET** **$ (459,000) $ (459,000)**

Health Care Access Fund Loan

(a) By June 30, 2011, the commissioner of management and budget shall transfer up to $40,000,000 from the balance of the health care access fund to the general fund.

(b) By June 30, 2012, the commissioner of management and budget shall transfer the amount transferred in paragraph (a) from the general fund to the health care access fund.

(c) The amounts necessary to complete these transfers are appropriated to the commissioner from each fund.

Sec. 7. **REVENUE** **$ (924,000) $ (950,000)**

These reductions are from the tax system management program.

Sec. 8. **GENERAL REDUCTION.**

Subdivision 1. **Plan submitted; effective date.** By June 15, 2010, the commissioner of management and budget, in consultation with the affected agencies, shall reduce general fund appropriations for fiscal year 2010 or 2011 to the affected agencies listed in this section by a total of $14,000,000. No single appropriation or program may be reduced by more than 1.5 percent. These reductions are onetime.

Subd. 2. **Report.** By July 1, 2010, the commissioner of management and budget shall submit to the chair and ranking minority member of the senate and house of representatives Committees on Finance and Ways and Means a report of the appropriations reduced.

Subd. 3. **Affected agencies.** The agencies whose appropriations must be reduced are the following:

(1) Department of Education, state agency operations;

(2) Minnesota Office of Higher Education, state agency operations;

(3) Department of Human Services, state agency operations;

(4) Department of Health, state agency operations;

(5) Pollution Control Agency, all general fund programs;

(6) Department of Natural Resources, all general fund programs;

(7) Board of Water and Soil Resources, all general fund programs;

(8) Department of Commerce, all general fund programs;

(9) Department of Agriculture, all general fund programs;

(10) Department of Employment and Economic Development, all general fund programs;

(11) Explore Minnesota Tourism, all general fund programs;

(12) Housing Finance Agency, all general fund programs;

(13) Department of Labor and Industry, all general fund programs;

(14) Bureau of Mediation Services, all general fund programs;

(15) Minnesota Historical Society, all general fund programs;

(16) Department of Transportation, all general fund programs, except greater Minnesota transit;

(17) Department of Public Safety, all general fund programs;

(18) Department of Corrections, all general fund programs;

(19) Department of Human Rights, all general fund programs;

(20) Office of Enterprise Technology, all general fund programs;

(21) Department of Administration, all general fund programs;

(22) Department of Management and Budget, state agency operations; and

(23) Department of Revenue, state agency operations;

(24) all other executive branch state agencies, as defined in Minnesota Statutes, section 16A.011, subdivision 12a, all general fund programs.

ARTICLE 13

HEALTH AND HUMAN SERVICES

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	2011	Total
General	$ (74,704,000)	$ (83,052,000)	$ (157,756,000)

Sec. 2. **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. All reductions in this article are onetime, unless otherwise stated.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	2011
Sec. 3. **DEPARTMENT OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (74,177,000)**	**$ (82,527,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Agency Management; Financial Operations**	(3,289,000)	(3,282,000)

Subd. 3. **Children and Economic Assistance Grants**		
(a) **Child Support Enforcement Grants**	(3,400,000)	(1,249,000)
(b) **Children's Services Grants**	(600,000)	-0-
American Indian Child Welfare Projects. Notwithstanding Laws 2009, chapter 79, article 2, section 35, $600,000 of the fiscal year 2009 funds extended in fiscal year 2010 cancel to the general fund.		
(c) **Children and Community Services Grants**	(16,900,000)	(1,500,000)
(d) **General Assistance Grants**	(5,267,000)	(3,190,000)
(e) **Minnesota Supplemental Aid Grants**	(733,000)	-0-
(f) **Group Residential Housing Grants**	(467,000)	(706,000)
Subd. 4. **Basic Health Care Grants**		
(a) **Medical Assistance Basic Health Care Grants - Families and Children**	(5,599,000)	(30,585,000)
(b) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	(2,331,000)	(24,062,000)
Hospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for Minnesota health care program enrollees must be delayed as follows: for fiscal year 2011, June payments must be included in the first payments in fiscal year 2012. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. This payment delay includes, and is not in addition to, the payment delay for inpatient hospital services in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (c).		

Nonhospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for nonhospital acute care services for Minnesota health care program enrollees must be delayed as follows: for fiscal year 2011, June payments must be included in the first payments in fiscal year 2012. This payment delay must not include nursing facilities, intermediate care facilities for persons with developmental disabilities, home and community-based services, prepaid health plans, personal care provider organizations, and home health agencies. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. This payment delay includes, and is not in addition to, the payment delay for nonhospital acute care services in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (c).

(c) **General Assistance Medical Care Grants**	(15,879,000)	-0-
Subd. 5. **Health Care Management; Administration**	(180,000)	(360,000)

Incentive Program and Outreach Grants. The general fund appropriation for the incentive program under Laws 2008, chapter 358, article 5, section 3, subdivision 4, paragraph (b), is canceled. This paragraph is effective retroactively from January 1, 2010.

Subd. 6. **Continuing Care Grants**

(a) **Aging and Adult Services Grants**	(3,600,000)	(3,600,000)

Community Service/Service Development Grants Reduction. Effective retroactively from July 1, 2009, funding for grants made

under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $3,600,000 for each year of the biennium. Grants made during the biennium under Minnesota Statutes, section 256.9754, shall not be used for new construction or building renovation.

Aging Grants Delay. Aging grants must be reduced by $917,000 in fiscal year 2011 and increased by $917,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

(b) **Medical Assistance Long-Term Care Facilities Grants**	(3,827,000)	(2,520,000)

ICF/MR Variable Rates Suspension. Effective retroactively from July 1, 2009, to June 30, 2010, no new variable rates shall be authorized for intermediate care facilities for persons with developmental disabilities under Minnesota Statutes, section 256B.5013, subdivision 1.

ICF/MR Occupancy Rate Adjustment Suspension. Effective retroactively from July 1, 2009, to June 30, 2011, approval of new applications for occupancy rate adjustments for unoccupied short-term beds under Minnesota Statutes, section 256B.5013, subdivision 7, is suspended.

(c) **Medical Assistance Long-Term Care Waivers and Home Care Grants**	(2,318,000)	(4,477,000)

Developmental Disability Waiver Acuity Factor. Effective retroactively from January 1, 2010, the January 1, 2010, one percent growth factor in the developmental disability

waiver allocations under Minnesota Statutes, section 256B.092, subdivisions 4 and 5, that is attributable to changes in acuity, is suspended to June 30, 2011.

(d) **Deaf and Hard-of-Hearing Grants**	-0-	(169,000)

Deaf and Hard-of-Hearing Services Grants Delay. Deaf and hard-of-hearing services grants must be reduced by $169,000 in fiscal year 2011 and increased by $169,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

(e) **Adult Mental Health Grants**	(5,000,000)	-0-
(f) **Chemical Dependency Entitlement Grants**	(3,622,000)	(3,622,000)
(g) **Chemical Dependency Nonentitlement Grants**	(393,000)	(393,000)
(h) **Other Continuing Care Grants**	-0-	(1,414,000)

Other Continuing Care Grants Delay. Other continuing care grants must be reduced by $1,414,000 in fiscal year 2011 and increased by $1,414,000 in fiscal year 2012. These adjustments are onetime and must not be applied to the base. This provision expires June 30, 2012.

Subd. 7. **Continuing Care Management**	(350,000)	-0-

County Maintenance of Effort. The general fund appropriation for the State-County Results Accountability and Service Delivery Reform under Minnesota Statutes, chapter 402A, is canceled. This paragraph is effective retroactively from July 1, 2009.

Subd. 8. **State-Operated Services; Adult Mental Health Services**	(422,000)	(4,588,000)

Sec. 4. **DEPARTMENT OF HEALTH**

Subdivision. 1. **Total Appropriation**	**$ (527,000)**	**$ (525,000)**
The appropriation reductions for each purpose are shown in the following subdivisions.		
Subd. 2. **Community and Family Health Promotion**	(53,000)	(355,000)
Subd. 3. **Policy Quality and Compliance**	(118,000)	(74,000)
Office of Unlicensed Health Care Practice. Of the general fund reduction $74,000 in fiscal year 2011 is from the Office of Unlicensed Complementary and Alternative Health Care Practice.		
Subd. 4. **Health Protection**	(225,000)	(74,000)
Subd. 5. **Administrative Support Services**	(131,000)	(22,000)

Sec. 5. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

Subd. 8. **Continuing Care Grants**

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

(a) Aging and Adult Services Grants	13,499,000	15,805,000
Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.		
Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.		

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

(b) Alternative Care Grants	50,234,000	48,576,000

Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals

having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver Allocations. Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

Alternatives to Personal Care Assistance Services. Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.

(e) Mental Health Grants

	Appropriations by Fund	
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

Payments for Substance Abuse Treatment. For services provided during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed rates charged for these services on January 1, 2009; and rates for fiscal years 2010 and 2011 must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. For services provided in fiscal years 2012 and 2013, statewide average rates under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the average rates charged for these services on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the

county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 6. Laws 2009, chapter 79, article 13, section 4, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 2, subdivision 4, is amended to read:

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	9,871,000	9,780,000
State Government Special Revenue	30,209,000	30,209,000

Base Adjustment. The general fund base is reduced by $50,000 in each of fiscal years 2012 and 2013.

Health Protection Appropriations. (a) $163,000 each year is for the lead abatement grant program.

(b) $100,000 each year is for emergency preparedness and response activities.

(c) $50,000 each year is for tuberculosis prevention and control. This is a onetime appropriation.

~~(d) $55,000 in fiscal year 2010 is for pentachlorophenol.~~

~~(e) $20,000 in fiscal year 2010 is for a PFC Citizens Advisory Group.~~

American Recovery and Reinvestment Act Funds. Federal funds received by the commissioner for immunization operations from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant.

Sec. 7. Minnesota Statutes 2009 Supplement, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $20,000 in total net assets except that this asset limit shall be $6,000 for the period January 1, 2011, through June 30, 2011, plus $200 for each additional legal dependent, and a household of one person must not own more than $10,000 in total net assets, except that this asset limit shall be $3,000 for the period January 1, 2011, through June 30, 2011. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16,

1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; and

(7) assets owned by children are not considered.

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

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

Sec. 8. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 310 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2010, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting.

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

Sec. 9. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55, is amended to read:

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. ~~For the rate year beginning October 1, 2009, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434.~~ For rate years beginning October 1, 2009; October 1, 2010; October 1, 2011; and October 1, 2012, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

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

Sec. 10. 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~~ 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.

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold ~~four~~ 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. If an extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5, section 5001, is enacted before June 15, 2010, the withhold percentage stated in this paragraph shall be 4.0 percent.

(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.

EFFECTIVE DATE. The additional withhold percentage in paragraph (f) is effective retroactively from January 1, 2010.

Sec. 11. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the

period July 1, 2009, through June 30, 2010, payments rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. The additional 1.5 percent reduction in effect for the period from July 1, 2010, through June 30, 2010, does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. This reduction does not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction does not apply to federally qualified health centers, rural health centers, and Indian health services. 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.

EFFECTIVE DATE. The additional rate reductions in this section are effective retroactively from July 1, 2009.

Sec. 12. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) 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

(3) whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.

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.

(b) Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.

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

Sec. 13. 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, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. 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.

EFFECTIVE DATE. The additional rate reductions in this section are effective retroactively from July 1, 2009.

Sec. 14. **REDUCTION OF GROUP RESIDENTIAL HOUSING SUPPLEMENTAL SERVICE RATE.**

Effective retroactively from November 1, 2009, through June 30, 2011, the commissioner of human services shall decrease the group residential housing (GRH) supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a, by five percent for services rendered on or after that date, except that reimbursement rates for a GRH facility reimbursed as a nursing facility shall not be reduced. The reduction in this paragraph is in addition to the reduction under Laws 2009, chapter 79, article 8, section 79, paragraph (b), clause (11).

EFFECTIVE DATE. This section is effective retroactively from November 1, 2009.

Sec. 15. **ARTICLE EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 14

AIDS, CREDITS, REFUNDS

Section 1. Minnesota Statutes 2008, section 273.1384, subdivision 6, as added by Laws 2010, chapter 215, article 13, section 2, is amended to read:

Subd. 6. **Credit reduction.** In 2011 and each year thereafter, the market value credit reimbursement amount for each taxing jurisdiction determined under this section is reduced by the dollar amount of the reduction in market value credit reimbursements for that taxing jurisdiction in 2010 due to ~~unallotment~~ the reductions ~~announced prior to February 28, 2010, under section 16A.152~~ under section 477A.0132. No taxing jurisdiction's market value credit reimbursements are reduced to less than zero under this subdivision. The commissioner of revenue shall pay the annual market value credit reimbursement amounts, after reduction under this subdivision, to the affected taxing jurisdictions as provided in this section.

EFFECTIVE DATE. This section is effective for taxes payable in 2011 and thereafter.

Sec. 2. **[477A.0132] 2009 AND 2010 AID REDUCTIONS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them in this subdivision.

(b) The "2009 revenue base" for a statutory or home rule charter city is the sum of the city's certified property tax levy for taxes payable in 2009, plus the amount of local government aid under section 477A.013, subdivision 9, that the city was certified to receive in 2009, plus the amount of taconite aids under sections 298.28 and 298.282 that the city was certified to receive in 2009, including any amounts required to be placed in a special fund for distribution in a later year.

(c) The "2009 revenue base" for a county is the sum of the county's certified property tax levy for taxes payable in 2009, plus the amount of county program aid under section 477A.0124 that the county was certified to receive in 2009, plus the amount of taconite aids under sections 298.28 and 298.282 that the county was certified to receive in 2009, including any amounts required to be placed in a special fund for distribution in a later year.

(d) The "2009 revenue base" for a town is the sum of the town's certified property tax levy for taxes payable in 2009, plus the amount of aid under section 477A.013 that the town was certified to receive in 2009, plus the amount of taconite aids under sections 298.28 and 298.282 that the town was certified to receive in 2009, including any amounts required to be placed in a special fund for distribution in a later year.

(e) "Population" means the population of the county, city, or town for 2007 based on information available to the commissioner of revenue in July 2009.

(f) "Adjusted net tax capacity" means the amount of net tax capacity for the county, city, or town, computed using equalized market values according to section 477A.011, subdivision 20, for aid payable in 2009.

(g) "Adjusted net tax capacity per capita" means the jurisdiction's adjusted net tax capacity divided by its population.

Subd. 2. **2009 aid reductions.** (a) The commissioner of revenue must compute a 2009 aid reduction amount for each county.

The aid reduction amount is zero for a county with a population of less than 5,000, and is zero for a county containing the Shooting Star Casino property that was removed from the tax rolls in 2009.

For all other counties, the aid reduction amount is equal to 1.188968672 percent of the county's 2009 revenue base.

The reduction amount is limited to the sum of the amount of county program aid under section 477A.0124 that the county was certified to receive in 2009, plus the amount of market value credit reimbursements under section 273.1384 payable to the county in 2009 before the reductions in this section.

The reduction amount is applied first to reduce the amount payable to the county in 2009 as county program aid under section 477A.013 and then, if necessary, to reduce the amount payable to the county in 2009 as market value credit reimbursements under section 273.1384.

No county's aid or reimbursements are reduced to less than zero under this section.

(b) The commissioner of revenue must compute a 2009 aid reduction amount for each city.

The aid reduction amount is zero for any city with a population of less than 1,000 that has an adjusted net tax capacity per capita amount less than the statewide average adjusted net tax capacity amount per capita for all cities. The aid reduction amount is also zero for a city located outside the seven-county metropolitan area, with a 2006 population greater than 3,500, a pre-1940 housing percentage greater than 29 percent, a commercial-industrial

percentage less than nine percent, and a population decline percentage of zero based on the data used to certify the 2009 local government aid distribution under section 477A.013.

For all other cities, the aid reduction amount is equal to 3.3127634 percent of the city's 2009 revenue base.

The reduction amount is limited to the sum of the amount of local government aid under section 477A.013, subdivision 9, that the city was certified to receive in 2009, plus the amount of market value credit reimbursements under section 273.1384 payable to the city in 2009 before the reductions in this section.

The reduction amount for a city is further limited to $22 per capita.

The reduction amount is applied first to reduce the amount payable to the city in 2009 as local government aid under section 477A.013 and then, if necessary, to reduce the amount payable to the city in 2009 as market value credit reimbursements under section 273.1384.

No city's aid or reimbursements are reduced to less than zero under this section.

(c) The commissioner of revenue must compute a 2009 aid reduction amount for each town.

The aid reduction amount is zero for any town with a population of less than 1,000 that has an adjusted net tax capacity per capita amount less than the statewide average adjusted net tax capacity amount per capita for all towns.

For all other towns, the aid reduction amount is equal to 1.735103 percent of the town's 2009 revenue base.

The reduction amount is limited to $5 per capita.

The reduction amount is applied to reduce the amount payable to the town in 2009 as market value credit reimbursements under section 273.1384.

No town's reimbursements are reduced to less than zero under this section.

Subd. 3. **2010 aid reductions.** (a) The commissioner of revenue must compute a 2010 aid reduction amount for each county.

The aid reduction amount is zero for a county with a population of less than 5,000, and is zero for a county containing the Shooting Star Casino property that was removed from the tax rolls in 2009.

For all other counties, the aid reduction amount is equal to 2.41396687 percent of the county's 2009 revenue base.

The reduction amount is limited to the sum of the amount of county program aid under section 477A.0124 that the county was certified to receive in 2009, plus the amount of market value credit reimbursements under section 273.1384 payable to the county in 2009 before the reductions in this section.

The reduction amount is applied first to reduce the amount payable to the county in 2010 as county program aid under section 477A.013 and then, if necessary, to reduce the amount payable to the county in 2010 as market value credit reimbursements under section 273.1384.

No county's aid or reimbursements are reduced to less than zero under this section.

(b) The commissioner of revenue must compute a 2010 aid reduction amount for each city.

The aid reduction amount is zero for any city with a population of less than 1,000 that has an adjusted net tax capacity per capita amount less than the statewide average adjusted net tax capacity amount per capita for all cities.

For all other cities, the aid reduction amount is equal to 7.643803025 percent of the city's 2009 revenue base.

The reduction amount is limited to the sum of the amount of local government aid under section 477A.013, subdivision 9, that the city was certified to receive in 2010, plus the amount of market value credit reimbursements under section 273.1384 payable to the city in 2010 before the reductions in this section.

The reduction amount for a city is further limited to $55 per capita.

The reduction amount is applied first to reduce the amount payable to the city in 2010 as local government aid under section 477A.013 and then, if necessary, to reduce the amount payable to the city in 2010 as market value credit reimbursements under section 273.1384.

No city's aid or reimbursements are reduced to less than zero under this section.

(c) The commissioner of revenue must compute a 2010 aid reduction amount for each town.

The aid reduction amount is zero for any town with a population of less than 1,000 that has an adjusted net tax capacity per capita amount less than the statewide average adjusted net tax capacity amount per capita for all towns.

For all other towns, the aid reduction amount is equal to 3.660798 percent of the town's 2009 revenue base.

The reduction amount is limited to $10 per capita.

The reduction amount is applied to reduce the amount payable to the town in 2010 as market value credit reimbursements under section 273.1384.

No town's reimbursements are reduced to less than zero under this section.

EFFECTIVE DATE. This section is effective the day following final enactment and is retroactive for aids and credit reimbursements payable in 2009.

Sec. 3. Laws 2010, chapter 215, article 13, section 6, is amended to read:

Sec. 6. **477A.0133 ADDITIONAL 2010 AID AND CREDIT REDUCTIONS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them in this subdivision.

(b) The "2010 revenue base" for a county is the sum of the county's certified property tax levy for taxes payable in 2010, plus the amount of county program aid under section 477A.0124 that the county was certified to receive in 2010, plus the amount of taconite aids under sections 298.28 and 298.282 that the county was certified to receive in 2010 including any amounts required to be placed in a special fund for distribution in a later year.

(c) The "2010 revenue base" for a statutory or home rule charter city is the sum of the city's certified property tax levy for taxes payable in 2010, plus the amount of local government aid under section 477A.013, subdivision 9, that the city was certified to receive in 2010, plus the amount of taconite aids under sections 298.28 and 298.282 that the city was certified to receive in 2010 including any amounts required to be placed in a special fund for distribution in a later year.

Subd. 2. **2010 reductions; counties and cities.** The commissioner of revenue must compute additional 2010 aid and credit reimbursement reduction amounts for each county and city under this section, after implementing any reduction of county program aid under section 477A.0124, local government aid under section 477A.013, or market value credit reimbursements under section 273.1384, to reflect the ~~reduction of allotments under section 16A.152~~ reductions under section 477A.0132.

The additional reduction amounts under this section are limited to the sum of the amount of county program aid under section 477A.0124, local government aid under section 477A.013, and market value credit reimbursements under section 273.1384 payable to the county or city in 2010 before the reductions in this section, but after the reductions ~~for unallotments~~ under section 477A.0132.

The reduction amount under this section is applied first to reduce the amount payable to the county or city in 2010 as market value credit reimbursements under section 273.1384, and then if necessary, to reduce the amount payable as either county program aid under section 477A.0124 in the case of a county, or local government aid under section 477A.013 in the case of a city.

No aid or reimbursement amount is reduced to less than zero under this section.

The additional 2010 aid reduction amount for a county is equal to 1.82767 percent of the county's 2010 revenue base. The additional 2010 aid reduction amount for a city is equal to the lesser of (1) 3.4287 percent of the city's 2010 revenue base or (2) $28 multiplied by the city's 2008 population.

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

Sec. 4. **REFUNDS AND CREDITS.**

Subdivision 1. **Political contribution credit.** Notwithstanding the provisions of Minnesota Statutes, section 290.06, subdivision 23, or any other law to the contrary, the political contribution refund does not apply to contributions made after June 30, 2009, and before July 1, 2011.

Subd. 2. **Property tax refund.** For property tax refunds based on rent paid during calendar year 2009 only, but also applying to refunds based on property taxes payable in 2010 that include gross rent paid in 2009, the following rules apply:

(1) "rent constituting property taxes" must be calculated by substituting "15 percent" for "19 percent" under Minnesota Statutes, section 290A.03, subdivision 11; and

(2) "property taxes payable" must be calculated under Minnesota Statutes, section 290A.03, subdivision 13, by substituting "15 percent" for "19 percent" in determining the portion of gross rent paid that is included in property taxes payable.

Subd. 3. **Sustainable forest incentive program.** The maximum sustainable forest incentive program payments under Minnesota Statutes, section 290C.07, per each Social Security number or state or federal business tax identification number must not exceed $100,000. The provisions of this subdivision apply only to payments made during fiscal year 2011.

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

Sec. 5. **LEVY VALIDATION.**

Any special levy under Minnesota Statutes, section 275.70, subdivision 5, clause (22), approved by the commissioner of revenue for taxes payable in 2010, is validated notwithstanding a later judicial decision that may affect the validity of unallotments that were announced in 2009. A local government may not levy under Minnesota Statutes, section 275.70, subdivision 5, clause (22), for taxes payable in 2011 for any retroactive reduction in aid and credit reimbursements for aids and credits payable in 2008 or 2009.

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

ARTICLE 15

SPECIAL REVENUE FUND

Section 1. Minnesota Statutes 2008, section 3.9741, subdivision 2, is amended to read:

Subd. 2. **Postsecondary Education Board.** The legislative auditor may enter into an interagency agreement with the Board of Trustees of the Minnesota State Colleges and Universities to conduct financial audits, in addition to audits conducted under section 3.972, subdivision 2. All payments received for audits requested by the board shall be ~~added to the appropriation for~~ deposited in the special revenue fund and appropriated to the legislative auditor to pay audit expenses.

Sec. 2. Minnesota Statutes 2008, section 8.15, subdivision 3, is amended to read:

Subd. 3. **Agreements.** (a) To facilitate the delivery of legal services, the attorney general may:

(1) enter into agreements with executive branch agencies, political subdivisions, or quasi-state agencies to provide legal services for the benefit of the citizens of Minnesota; and

(2) in addition to funds otherwise appropriated by the legislature, accept and spend funds received under any agreement authorized in clause (1) for the purpose set forth in clause (1), subject to a report of receipts to the chairs of the senate Finance Committee and the house of representatives Ways and Means Committee by October 15 each year.

(b) When entering into an agreement for legal services, the attorney general must notify the committees responsible for funding the Office of the Attorney General. When the attorney general enters into an agreement with a state agency, the attorney general must also notify the committees responsible for funding that agency.

Funds received under this subdivision must be deposited in ~~the general~~ an account in the special revenue fund and are appropriated to the attorney general for the purposes set forth in this subdivision.

Sec. 3. Minnesota Statutes 2008, section 13.03, subdivision 10, is amended to read:

Subd. 10. **Costs for providing copies of data.** Money may be collected by a responsible authority in a state agency for the actual cost to the agency of providing copies or electronic transmittal of government data ~~is appropriated to the agency and added to the appropriations from which the costs were paid~~. When money collected for purposes of this section is of a magnitude sufficient to warrant a separate account in the state treasury, that money must be deposited in a fund other than the general fund and is appropriated to the agency.

Sec. 4. Minnesota Statutes 2008, section 16C.23, subdivision 6, is amended to read:

Subd. 6. **State surplus property.** The commissioner may do any of the following to dispose of state surplus property:

(1) transfer it to or between state agencies;

(2) transfer it to a governmental unit or nonprofit organization in Minnesota; or

(3) sell it and charge a fee to cover expenses incurred by the commissioner in the disposal of the surplus property.

The proceeds of the sale less the fee must be deposited in an account in a fund other than the general fund and are appropriated to the agency for whose account the sale was made, to be used and expended by that agency to purchase similar state property.

Sec. 5. Minnesota Statutes 2008, section 103B.101, subdivision 9, is amended to read:

Subd. 9. **Powers and duties.** In addition to the powers and duties prescribed elsewhere, the board shall:

(1) coordinate the water and soil resources planning activities of counties, soil and water conservation districts, watershed districts, watershed management organizations, and any other local units of government through its various authorities for approval of local plans, administration of state grants, and by other means as may be appropriate;

(2) facilitate communication and coordination among state agencies in cooperation with the Environmental Quality Board, and between state and local units of government, in order to make the expertise and resources of state agencies involved in water and soil resources management available to the local units of government to the greatest extent possible;

(3) coordinate state and local interests with respect to the study in southwestern Minnesota under United States Code, title 16, section 1009;

(4) develop information and education programs designed to increase awareness of local water and soil resources problems and awareness of opportunities for local government involvement in preventing or solving them;

(5) provide a forum for the discussion of local issues and opportunities relating to water and soil resources management;

(6) adopt an annual budget and work program that integrate the various functions and responsibilities assigned to it by law; and

(7) report to the governor and the legislature by October 15 of each even-numbered year with an assessment of board programs and recommendations for any program changes and board membership changes necessary to improve state and local efforts in water and soil resources management.

The board may accept grants, gifts, donations, or contributions in money, services, materials, or otherwise from the United States, a state agency, or other source to achieve an authorized purpose. The board may enter into a contract or agreement necessary or appropriate to accomplish the transfer. The board may receive and expend money to acquire conservation easements, as defined in chapter 84C, on behalf of the state and federal government consistent with the Camp Ripley's Army Compatible Use Buffer Project.

Any money received is hereby deposited in an account in a fund other than the general fund and appropriated and dedicated for the purpose for which it is granted.

Sec. 6. Minnesota Statutes 2008, section 103I.681, subdivision 11, is amended to read:

Subd. 11. **Permit fee schedule.** (a) The commissioner of natural resources shall adopt a permit fee schedule under chapter 14. The schedule may provide minimum fees for various classes of permits, and additional fees, which may be imposed subsequent to the application, based on the cost of receiving, processing, analyzing, and issuing the permit, and the actual inspecting and monitoring of the activities authorized by the permit, including costs of consulting services.

(b) A fee may not be imposed on a state or federal governmental agency applying for a permit.

(c) The fee schedule may provide for the refund of a fee, in whole or in part, under circumstances prescribed by the commissioner of natural resources. Fees received must be deposited in the state treasury and credited to ~~the general~~ an account in the natural resources fund. Permit fees received are appropriated annually from the ~~general~~ natural resources fund to the commissioner of natural resources for the costs of inspecting and monitoring the activities authorized by the permit, including costs of consulting services.

Sec. 7. Minnesota Statutes 2008, section 116J.551, subdivision 1, is amended to read:

Subdivision 1. **Grant account.** A contaminated site cleanup and development grant account is created in the ~~general~~ special revenue fund. Money in the account may be used, as appropriated by law, to make grants as provided in section 116J.554 and to pay for the commissioner's costs in reviewing applications and making grants. Notwithstanding section 16A.28, money appropriated to the account for this program from any source is available until spent.

Sec. 8. Minnesota Statutes 2008, section 190.32, is amended to read:

190.32 FEDERAL REIMBURSEMENT RECEIPTS.

The Department of Military Affairs may deposit federal reimbursement receipts into ~~the general fund~~ an account in the special revenue fund, maintenance of military training facilities. These receipts are for services, supplies, and materials initially purchased by the Camp Ripley maintenance account.

Sec. 9. Minnesota Statutes 2008, section 257.69, subdivision 2, is amended to read:

Subd. 2. **Guardian; legal fees.** (a) The court may order expert witness and guardian ad litem fees and other costs of the trial and pretrial proceedings, including appropriate tests, to be paid by the parties in proportions and at times determined by the court. The court shall require a party to pay part of the fees of court-appointed counsel according to the party's ability to pay, but if counsel has been appointed the appropriate agency shall pay the party's proportion of all other fees and costs. The agency responsible for child support enforcement shall pay the fees and costs for blood or genetic tests in a proceeding in which it is a party, is the real party in interest, or is acting on behalf of the child. However, at the close of a proceeding in which paternity has been established under sections 257.51 to 257.74, the court shall order the adjudicated father to reimburse the public agency, if the court finds he has sufficient resources to pay the costs of the blood or genetic tests. When a party bringing an action is represented by the county attorney, no filing fee shall be paid to the court administrator.

(b) In each fiscal year, the commissioner of management and budget shall deposit guardian ad litem reimbursements in the ~~general~~ special revenue fund and credit them to a separate account with the trial courts. The balance of this account is appropriated to the trial courts and does not cancel but is available until expended. Expenditures by the state court administrator's office from this account must be based on the amount of the guardian ad litem reimbursements received by the state from the courts in each judicial district.

Sec. 10. Minnesota Statutes 2008, section 260C.331, subdivision 6, is amended to read:

Subd. 6. **Guardian ad litem fees.** (a) In proceedings in which the court appoints a guardian ad litem pursuant to section 260C.163, subdivision 5, clause (a), the court may inquire into the ability of the parents to pay for the guardian ad litem's services and, after giving the parents a reasonable opportunity to be heard, may order the parents to pay guardian fees.

(b) In each fiscal year, the commissioner of management and budget shall deposit guardian ad litem reimbursements in the ~~general~~ special revenue fund and credit them to a separate account with the trial courts. The balance of this account is appropriated to the trial courts and does not cancel but is available until expended. Expenditures by the state

court administrator's office from this account must be based on the amount of the guardian ad litem reimbursements received by the state from the courts in each judicial district.

Sec. 11. Minnesota Statutes 2009 Supplement, section 270.97, is amended to read:

270.97 DEPOSIT OF REVENUES.

The commissioner shall deposit all revenues derived from the tax, interest, and penalties received from the county in the contaminated site cleanup and development account in the ~~general~~ special revenue fund and is annually appropriated to the commissioner of the Department of Employment and Economic Development, for the purposes of section 116J.551.

Sec. 12. Minnesota Statutes 2008, section 299C.48, is amended to read:

299C.48 CONNECTION BY AUTHORIZED AGENCY; FEE, APPROPRIATION.

(a) An agency authorized under section 299C.46, subdivision 3, may connect with and participate in the criminal justice data communications network upon approval of the commissioner of public safety; provided, that the agency shall first agree to pay installation charges as may be necessary for connection and monthly operational charges as may be established by the commissioner of public safety. Before participation by a criminal justice agency may be approved, the agency must have executed an agreement with the commissioner providing for security of network facilities and restrictions on access to data supplied to and received through the network.

(b) In addition to any fee otherwise authorized, the commissioner of public safety shall impose a fee for providing secure dial-up or Internet access for criminal justice agencies and noncriminal justice agencies. The following monthly fees apply:

(1) criminal justice agency accessing via Internet, $15;

(2) criminal justice agency accessing via dial-up, $35;

(3) noncriminal justice agency accessing via Internet, $35; and

(4) noncriminal justice agency accessing via dial-up, $35.

(c) The installation and monthly operational charges collected by the commissioner of public safety under paragraphs (a) and (b) must be deposited in an account in the special revenue fund and are annually appropriated to the commissioner to administer sections 299C.46 to 299C.50.

Sec. 13. Minnesota Statutes 2008, section 299E.02, is amended to read:

299E.02 CONTRACT SERVICES; APPROPRIATION.

Fees charged for contracted security services provided by the Capitol Complex Security Division of the Department of Public Safety must be deposited in an account in the special revenue fund and are annually appropriated to the commissioner of public safety to administer and provide these services.

Sec. 14. Minnesota Statutes 2008, section 446A.086, subdivision 2, as amended by Laws 2010, chapter 290, section 14, is amended to read:

Subd. 2. **Application.** (a) This section provides a state guarantee of the payment of principal and interest on debt obligations if:

(1) the obligations are issued for new projects and are not issued for the purposes of refunding previous obligations;

(2) application to the Public Facilities Authority is made before issuance; and

(3) the obligations are covered by an agreement meeting the requirements of subdivision 3.

(b) Applications to be covered by the provisions of this section must be made in a form and contain the information prescribed by the authority. Applications are subject to either a fee of $500 for each bond issue requested by a county or governmental unit or the applicable fees under section 446A.087.

(c) Application fees paid under this section must be deposited in a separate credit enhancement bond guarantee account in the ~~general~~ special revenue fund. Money in the credit enhancement bond guarantee account is appropriated to the authority for purposes of administering this section.

(d) Neither the authority nor the commissioner is required to promulgate administrative rules under this section and the procedures and requirements established by the authority or commissioner under this section are not subject to chapter 14.

Sec. 15. Minnesota Statutes 2008, section 469.177, subdivision 11, is amended to read:

Subd. 11. **Deduction for enforcement costs; appropriation.** (a) The county treasurer shall deduct an amount equal to 0.25 percent of any increment distributed to an authority or municipality. The county treasurer shall pay the amount deducted to the commissioner of management and budget for deposit in ~~the state general~~ an account in the special revenue fund.

(b) The amounts deducted and paid under paragraph (a) are appropriated to the state auditor for the cost of (1) the financial reporting of tax increment financing information

and (2) the cost of examining and auditing of authorities' use of tax increment financing as provided under section 469.1771, subdivision 1. Notwithstanding section 16A.28 or any other law to the contrary, this appropriation does not cancel and remains available until spent.

(c) For taxes payable in 2002 and thereafter, the commissioner of revenue shall increase the percent in paragraph (a) to a percent equal to the product of the percent in paragraph (a) and the amount that the statewide tax increment levy for taxes payable in 2002 would have been without the class rate changes in this act and the elimination of the general education levy in this act divided by the statewide tax increment levy for taxes payable in 2002.

Sec. 16. Minnesota Statutes 2008, section 518.165, subdivision 3, is amended to read:

Subd. 3. **Fees.** (a) A guardian ad litem appointed under either subdivision 1 or 2 may be appointed either as a volunteer or on a fee basis. If a guardian ad litem is appointed on a fee basis, the court shall enter an order for costs, fees, and disbursements in favor of the child's guardian ad litem. The order may be made against either or both parties, except that any part of the costs, fees, or disbursements which the court finds the parties are incapable of paying shall be borne by the state courts. The costs of court-appointed counsel to the guardian ad litem shall be paid by the county in which the proceeding is being held if a party is incapable of paying for them. Until the recommendations of the task force created in Laws 1999, chapter 216, article 7, section 42, are implemented, the costs of court-appointed counsel to a guardian ad litem in the Eighth Judicial District shall be paid by the state courts if a party is incapable of paying for them. In no event may the court order that costs, fees, or disbursements be paid by a party receiving public assistance or legal assistance or by a party whose annual income falls below the poverty line as established under United States Code, title 42, section 9902(2).

(b) In each fiscal year, the commissioner of management and budget shall deposit guardian ad litem reimbursements in the ~~general~~ special revenue fund and credit them to a separate account with the trial courts. The balance of this account is appropriated to the trial courts and does not cancel but is available until expended. Expenditures by the state court administrator's office from this account must be based on the amount of the guardian ad litem reimbursements received by the state from the courts in each judicial district.

Sec. 17. Minnesota Statutes 2008, section 609.3241, is amended to read:

609.3241 PENALTY ASSESSMENT AUTHORIZED.

When a court sentences an adult convicted of violating section 609.322 or 609.324, while acting other than as a prostitute, the court shall impose an assessment of not less than $250 and not more than $500 for a violation of section 609.324, subdivision 2, or a misdemeanor violation of section 609.324, subdivision 3; otherwise the court shall impose an assessment of not less than $500 and not more than $1,000. The mandatory minimum portion of the assessment is to be used for the purposes described in section 626.558, subdivision 2a, and is in addition to the surcharge required by section 357.021, subdivision 6. Any portion of the assessment imposed in excess of the mandatory minimum amount shall be ~~forwarded to the general~~ deposited in an account in the special revenue fund and is appropriated annually to the commissioner of public safety. The commissioner, with the assistance of the General Crime Victims Advisory Council, shall use money received under this section for grants to agencies that provide assistance to individuals who have stopped or wish to stop engaging in prostitution. Grant money may be used to provide these individuals with medical care, child care, temporary housing, and educational expenses.

Sec. 18. Minnesota Statutes 2008, section 611.20, subdivision 3, is amended to read:

Subd. 3. **Reimbursement.** In each fiscal year, the commissioner of management and budget shall deposit the payments in the ~~general~~ special revenue fund and credit them to a separate account with the Board of Public Defense. The amount credited to this account is appropriated to the Board of Public Defense.

The balance of this account does not cancel but is available until expended. Expenditures by the board from this account for each judicial district public defense office must be based on the amount of the payments received by the state from the courts in each judicial district. A district public defender's office that receives money under this subdivision shall use the money to supplement office overhead payments to part-time attorneys providing public defense services in the district. By January 15 of each year, the Board of Public Defense shall report to the chairs and ranking minority members of the senate and house of representatives divisions having jurisdiction over criminal justice funding on the amount appropriated under this subdivision, the number of cases handled by each district public defender's office, the number of cases in which reimbursements were ordered, the average amount of reimbursement ordered, and the average amount of money received by part-time attorneys under this subdivision.

Sec. 19. Laws 1994, chapter 531, section 1, is amended to read:

Section 1. **SALE OF WILDLIFE LANDS.**

Notwithstanding Minnesota Statutes, sections 84.027, subdivision 10; 92.45; 94.09 to 94.165; 97A.135; 103F.535, or any other law, the commissioner of administration may sell lands located in the Gordy Yaeger wildlife management area in Olmsted county. The consideration for the lands described in sections 2 and 3 shall be $950 per acre. The conveyances shall be by ~~quitclaim~~ quitclaim deed in a form approved by the attorney general and shall reserve to the state all minerals and mineral rights. The proceeds received from the sales are to be deposited in an account in the ~~general~~ natural resources fund and are appropriated to the commissioner of natural resources for acquisition of replacement wildlife management area lands. These sales are pursuant to the recommendation of the Gordy Yaeger wildlife management area advisory committee.

ARTICLE 16

HEALTH CARE

Section 1. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

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

Sec. 2. Minnesota Statutes 2008, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective July 1, 2010, the surcharge under paragraph (b) is increased to 2.63 percent.

(d) Effective October 1, 2011, the surcharge under paragraph (c) is reduced to 2.30 percent.

(e) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

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

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

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

(b) Effective October 1, 2010, in addition to the surcharge under paragraph (a), each health maintenance organization shall pay to the commissioner a surcharge equal to 0.52 percent of total premium revenues and each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to 1.12 percent of the total premium revenues of the plan, as reported to the commissioner of health, according to the payment schedule in subdivision 4. Notwithstanding section 256.9656, money collected under this paragraph shall be deposited in the health care access fund established in section 16A.724.

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

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

(2) premiums from Medicare wrap-around subscribers for health benefits which 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 July 1, 2010.

Sec. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009. For the first ~~three~~ 24 months of the rebased period beginning January 1, 2011, rates shall not be rebased ~~at 74.25 percent of the full value of the rebasing percentage change. From April 1, 2011, to March 31, 2012, rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change~~, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent rate setting periods in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. Effective ~~April 1, 2012~~ January 1, 2013, rates shall be rebased at full value. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

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

Sec. 5. 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 order to offset the ratable reductions provided for in this subdivision, the total payment rate for medical assistance fee-for-service admissions occurring on or after July 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by five percent from the current statutory rates. Effective July 1, 2011, the rate increase under this paragraph shall be reduced to 1.96 percent. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

Sec. 6. 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) In order to ensure adequate access for the provision of mental health services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, payment rates for medical assistance admissions occurring on or after July 1, 2010, at a Minnesota private, not-for-profit hospital above the 75th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521 to 523 admissions paid by medical assistance for admissions occurring in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than $10,000,000 each fiscal year, including state and federal shares. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract

with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

Sec. 7. Minnesota Statutes 2008, section 256.969, subdivision 26, is amended to read:

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

(2) 371 cesarean section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity and respiratory distress syndrome, neonate;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn;

(9) 385 neonate, died or transferred to another acute care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunction;

(11) 430 psychoses;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

(c) For medical assistance admissions occurring on or after July 1, 2010, the payment rate under paragraph (a), clause (2), shall be increased to 100 percent from 90 percent. For purposes of this paragraph, medical assistance does not include general

assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

Sec. 8. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Hospital payment adjustment after June 30, 2010.** (a) For medical assistance admissions occurring on or after July 1, 2010, to March 31, 2011, the commissioner shall increase rates at Minnesota private, not-for-profit hospitals as follows:

(1) for a hospital with total admissions reimbursed by government payers equal to or greater than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 437 percent;

(2) for a hospital with total admissions reimbursed by government payers equal to or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 349.6 percent; and

(3) for a hospital with total admissions reimbursed by government payers of less than 40 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 262.2 percent.

(b) For medical assistance admissions occurring on or after April 1, 2011, the commissioner shall increase rates at Minnesota private, not-for-profit hospitals as follows:

(1) for a hospital with total admissions reimbursed by government payers equal to or greater than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 145 percent;

(2) for a hospital with total admissions reimbursed by government payers equal to or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 116 percent; and

(3) for a hospital with total admissions reimbursed by government payers of less than 40 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 87 percent.

(c) For purposes of paragraphs (a) and (b), "government payers" means Medicare, medical assistance, MinnesotaCare, and general assistance medical care.

(d) For medical assistance admissions occurring on or after July 1, 2010, to March 31, 2011, the commissioner shall increase rates for inpatient hospital services at Minnesota hospitals by $850 for each admission. For medical assistance admissions occurring on

or after April 1, 2011, the payment under this paragraph shall be reduced to $320 per admission.

(e) For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

Sec. 9. Minnesota Statutes 2008, section 256B.04, subdivision 14a, is amended to read:

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician's assistant, a nurse practitioner, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than ~~semiannually~~ annually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

Sec. 10. Minnesota Statutes 2008, section 256B.055, is amended by adding a subdivision to read:

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

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

(2) not pregnant;

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

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

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

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

Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; and

(5) effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (c).

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

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

Sec. 12. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

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

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

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

(d) Effective July 1, 2010, to be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size.

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

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

Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to read:

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

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, and January 1, 2011, for services provided through managed care.

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

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

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, and January 1, 2011, for services provided through managed care.

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

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

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, and January 1, 2011, for services provided through managed care.

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

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

Sec. 17. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding long-term care and group homes, if the service is ordered by the provider-directed care coordination team; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the

estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

Sec. 18. 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 January 1, 2011.

Sec. 19. 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. 20. 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 licensed birth center 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) Nursery care services provided by a birth center shall be paid the lower of billed charges or 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available.

(d) 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.

(e) 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 July 1, 2010.

Sec. 21. 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 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. This section is effective January 1, 2011.

Sec. 22. 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. 23. 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) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers.~~

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

Sec. 24. **[256B.0755] HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.**

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed upon total cost of care or risk-gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the delivery system demonstrations; and

(11) encourage participation of privately insured population so as to create sufficient alignment in demonstration systems.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

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

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

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

(d) A health care delivery system demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

(e) The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in a health care delivery system.

(b) Eligible applicants and recipients may enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a county, the applicant or recipient shall be allowed to choose among the delivery systems. The commissioner may assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, and rural clinics to the extent practicable.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall explore the expansion of the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration.

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

Sec. 25. **[256B.0756] HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under Minnesota Statutes, section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network

in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

Sec. 26. 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~~ plan payments 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, 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 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 plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold in this paragraph does not apply to county-based purchasing plans.

~~(g)~~ (h) 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)~~ (i) 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)~~ (j) 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)~~ (k) 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)~~ (l) 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)~~ (m) 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.

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

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

Subd. 5k. **Rate modifications.** For services rendered on or after October 1, 2010, the total payment made to managed care plans and county-based purchasing plans under the medical assistance program shall be increased by 0.88 percent.

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

Sec. 28. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5l. **Actuarial soundness.** (a) Rates paid to managed care plans and county-based purchasing plans shall satisfy requirements for actuarial soundness. In order to comply with this subdivision, the rates must:

(1) be neither inadequate nor excessive;

(2) satisfy federal requirements;

(3) in the case of contracts with incentive arrangements, not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement;

(4) be developed in accordance with generally accepted actuarial principles and practices;

(5) be appropriate for the populations to be covered and the services to be furnished under the contract; and

(6) be certified as meeting the requirements of federal regulations by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(b) Each year within 30 days of the establishment of plan rates, the commissioner shall report to the chairs and ranking minority members of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division to certify how each of these conditions have been met by the new payment rates.

Sec. 29. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by Laws 2010, chapter 200, article 1, section 10, is amended to read:

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

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

Sec. 30. 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. 31. 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. 32. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. This reduction ~~docs~~ and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction ~~docs~~ and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. 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 an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. 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 reduction described in this paragraph.

(e) Effective for services rendered on or after October 1, 2010, payment rates for physician and professional services billed by physicians employed by and clinics owned by a nonprofit health maintenance organization shall be increased by 14 percent. 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 increase described in this paragraph.

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

Sec. 33. 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 reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(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.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

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

Sec. 34. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) 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~~ managed care plans and county-based purchasing plans 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:~~

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(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~~ nonprofit community clinics that:

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

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(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~~ federally qualified health centers, rural health clinics, and public health clinics; ~~and~~

(3) ~~whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area~~ county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with 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; and

(5) a dental clinic 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.

~~In the absence of a critical access dental provider in a service area,~~ (c) 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 July 1, 2010.

Sec. 35. 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. 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. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech language pathology and related services provided on or after July 1, 2010.

(b) 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~~ the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

~~(b)~~ (c) 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. 36. **[256B.767] MEDICARE PAYMENT LIMIT.**

(a) 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, as adjusted for any changes

in Medicare payment rates after July 1, 2010. 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.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

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

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

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

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

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

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

(d) For the period beginning April 1, 2010, to June 30, 2010, general assistance medical care covers the services listed in subdivision 4.

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

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

Subd. 3b. **Cooperation.** ~~(a)~~ General assistance ~~or general assistance medical care~~ applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. ~~General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.~~

~~(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.~~

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

Sec. 39. Minnesota Statutes 2008, section 256D.031, subdivision 5, as added by Laws 2010, chapter 200, article 1, section 12, subdivision 5, is amended to read:

Subd. 5. **Payment rates and contract modification; April 1, 2010, to ~~May 31~~ June 30, 2010.** (a) For the period April 1, 2010, to ~~May 31~~ June 30, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010, except that for the period June 1, 2010, to June 30, 2010, fee-for-service payment rates for services other than prescription drugs shall be set at 27 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to ~~May 31~~ June 30, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

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

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

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and 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 reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing 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. This section is effective July 1, 2010.

Sec. 41. Minnesota Statutes 2008, section 256L.11, subdivision 6, is amended to read:

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) ~~For admissions occurring during the period of July 1, 1997, through June 30, 1998, for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits in excess of the $10,000 annual inpatient~~

~~benefit limit.~~ For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5.

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

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

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

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

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

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

Sec. 43. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

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

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

Sec. 44. 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 and county-based purchasing 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.~~

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing 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).

(d) Effective for services rendered on or after January 1, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the 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 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 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 plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold described in this paragraph does not apply to county-based purchasing plans.

(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 that is reasonably expected to be returned.

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

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

Subd. 9c. **Rate setting; increase effective October 1, 2010.** For services rendered on or after October 1, 2010, the total payment made to managed care plans and county-based purchasing plans under MinnesotaCare for families with children shall be increased by 0.88 percent.

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

Sec. 46. 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, 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, and must be limited to two visits per child. The home visit payment rates must be based on a rate commensurate with a first-time visit rate and follow-up visit rate. 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. 47. 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. 48. Laws 2010, chapter 200, article 1, section 16, is amended by adding an effective date to read:

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

Sec. 49. Laws 2010, chapter 200, article 1, section 21, is amended to read:

Sec. 21. **REPEALER.**

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

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

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

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

(e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision 4; and 256L.17, subdivision 7, are repealed ~~January 1, 2011~~ July 1, 2010.

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

Sec. 50. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ (7,985,000) $ (93,128,000)**

Appropriations by Fund

	2010	2011
General	34,807,000	118,493,000
Health Care Access	(42,792,000)	(211,621,000)

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

Special Revenue Fund Transfers.

(a) The commissioner shall transfer the following amounts from special revenue fund balances to the general fund by June 30 of each respective fiscal year: $410,000 for fiscal year 2010, and $412,000 for fiscal year 2011.

(b) Actual transfers made under paragraph (a) must be separately identified and reported as part of the quarterly reporting of transfers to the chairs of the relevant senate budget division and house of representatives finance division.

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

Sec. 51. Laws 2010, chapter 200, article 2, section 2, subdivision 5, is amended to read:

Subd. 5. **Health Care Management**

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

Health Care Administration. (2,998,000) (5,270,000)

Base Adjustment. The general fund base for health care administration is reduced by

~~$182,000~~ $36,000 in fiscal year 2012 and

~~$182,000~~ $36,000 in fiscal year 2013.

Sec. 52. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

Subd. 8. **Transfers**

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

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

Compulsive Gambling ~~Special Revenue~~ Administration. The lottery prize fund appropriation for compulsive gambling administration is reduced by $6,000 for fiscal year 2010 and $4,000 for fiscal year 2011 ~~must be transferred from the lottery prize fund appropriation for compulsive gambling administration to the general fund by June 30 of each respective fiscal year~~. These are onetime reductions.

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

Sec. 53. **PREPAID HEALTH PLAN RATES.**

In negotiating the prepaid health plan contract rates for services rendered on or after January 1, 2011, the commissioner of human services shall take into consideration and the rates shall reflect the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

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

Sec. 54. **STATE PLAN AMENDMENT; FEDERAL APPROVAL.**

The commissioner of human services shall submit a Medicaid state plan amendment to receive federal fund participation for adults without children whose income is equal to or less than 75 percent of federal poverty guidelines in accordance with the Patient Protection and Affordable Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The effective date of the state plan amendment shall be June 1, 2010.

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

Sec. 55. **UPPER PAYMENT LIMIT REPORT.**

Each January 15, beginning in 2011, the commissioner of human services shall report the following information to the chairs of the house of representatives and senate finance committees and divisions with responsibility for human services appropriations:

(1) the estimated room within the Medicare hospital upper payment limit for the federal year beginning on October 1 of the year the report is made;

(2) the amount of a rate increase under Minnesota Statutes, section 256.969, subdivision 3a, paragraph (i), that would increase medical assistance hospital spending to the upper payment limit; and

(3) the amount of a surcharge increase under Minnesota Statutes, section 256.9657, subdivision 2, needed to generate the state share of the potential rate increase under clause (2).

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

Sec. 56. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall edit Minnesota Statutes and Minnesota Rules to remove references to the general assistance medical care program and references to Minnesota Statutes, section 256D.03, subdivision 3, or Minnesota Statutes, chapter 256D, as it pertains to general assistance medical care and make other changes as may be necessary to remove references to the general assistance medical care program. The revisor may consult with the Department of Human Services when making editing decisions on the removal of these references.

Sec. 57. **REPEALER.**

(a) Minnesota Statutes 2008, section 256D.03, subdivisions 3, 3a, 5, 6, 7, and 8, are repealed July 1, 2010.

(b) Laws 2010, chapter 200, article 1, sections 12, subdivisions 1, 2, 3, and 5; 18; and 19, are repealed July 1, 2010.

(c) Laws 2010, chapter 200, article 1, section 12, subdivisions 4, 6, 7, 8, 9, and 10, are repealed the day following final enactment.

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

ARTICLE 17

CONTINUING CARE

Section 1. Minnesota Statutes 2008, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; ~~and~~

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

Sec. 2. Minnesota Statutes 2008, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 3. **[144D.08] UNIFORM CONSUMER INFORMATION GUIDE.**

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06.

Sec. 4. **[144D.09] TERMINATION OF LEASE.**

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and phone number along with a statement of how to request problem-solving assistance.

Sec. 5. Minnesota Statutes 2008, section 144G.06, is amended to read:

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in section 144G.01, that includes information about services offered by that provider, which services may be covered by Medicare, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 6. 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;

(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 percent of adjusted gross income;

(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.

(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, 2013, the parental contribution shall be computed by applying the following contribution schedule 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 525 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 eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 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 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 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.

Sec. 7. **[256.4825] REPORT REGARDING PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES.**

The Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of each year, beginning in 2012, to the chairs and ranking minority members of the legislative

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

Sec. 8. Minnesota Statutes 2008, section 256.9657, subdivision 3a, is amended to read:

Subd. 3a. **ICF/MR license surcharge.** (a) Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

(b) Effective July 1, 2010, the surcharge under paragraph (a) is increased to $4,037 per licensed bed.

Sec. 9. Minnesota Statutes 2009 Supplement, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with

limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

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

The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs; and

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability.

Sec. 10. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 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 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. This section is effective January 1, 2011.

Sec. 11. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to ~~310~~ 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting.

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

Sec. 12. Minnesota Statutes 2008, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3i. **Rate reduction for customized living and 24-hour customized living services.** (a) Effective July 1, 2010, the commissioner shall reduce service component rates and service rate limits for customized living services and 24-hour customized living services, from the rates in effect on June 30, 2010, by five percent.

(b) To implement the rate reductions in this subdivision, capitation rates paid by the commissioner to managed care organizations under section 256B.69 shall reflect a ten percent reduction for the specified services for the period January 1, 2011, to June 30, 2011, and a five percent reduction for those services on and after July 1, 2011.

Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55, is amended to read:

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. ~~For the rate year beginning October 1, 2009, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434. For rate years beginning October 1, 2010; October 1, 2011; and October 1, 2012,~~ For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

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

Sec. 14. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **Rate increase effective June 1, 2010.** For rate periods beginning on or after June 1, 2010, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $8.74 per day. The increase shall not be subject to any annual percentage increase.

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

Sec. 15. 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, waivered 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 January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. 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~~ to reopen 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 implementation.

(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. 16. 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. 17. Laws 2009, chapter 79, article 8, section 84, is amended to read:

Sec. 84. **HOUSING OPTIONS.**

The commissioner of human services, in consultation with the commissioner of administration and the Minnesota Housing Finance Agency, and representatives of counties, residents' advocacy groups, consumers of housing services, and provider agencies shall explore ways to maximize the availability and affordability of housing choices available to persons with disabilities or who need care assistance due to other health challenges. A goal shall also be to minimize state physical plant costs in order to serve more persons with appropriate program and care support. Consideration shall be given to:

(1) improved access to rent subsidies;

(2) use of cooperatives, land trusts, and other limited equity ownership models;

(3) whether a public equity housing fund should be established that would maintain the state's interest, to the extent paid from state funds, including group residential housing and Minnesota supplemental aid shelter-needy funds in provider-owned housing, so that when sold, the state would recover its share for a public equity fund to be used for future public needs under this chapter;

(4) the desirability of the state acquiring an ownership interest or promoting the use of publicly owned housing;

(5) promoting more choices in the market for accessible housing that meets the needs of persons with physical challenges; ~~and~~

(6) what consumer ownership models, if any, are appropriate; and

(7) a review of the definition of home and community services and appropriate settings where these services may be provided, including the number of people who

may reside under one roof, through the home and community-based waivers for seniors and individuals with disabilities.

The commissioner shall provide a written report on the findings of the evaluation of housing options to the chairs and ranking minority members of the house of representatives and senate standing committees with jurisdiction over health and human services policy and funding by December 15, 2010. This report shall replace the November 1, 2010, annual report by the commissioner required in Minnesota Statutes, sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.

Sec. 18. **COMMISSIONER TO SEEK FEDERAL MATCH.**

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

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

Sec. 19. **ICF/MR RATE INCREASE.**

The daily rate at an intermediate care facility for the developmentally disabled located in Clearwater County and classified as a Class A facility with 15 beds shall be increased from $112.73 to $138.23 for the rate period July 1, 2010, to June 30, 2011.

ARTICLE 18

CHILDREN AND FAMILY SERVICES

Section 1. 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~~

~~(2) they have financial resources, excluding vehicles, of less than $7,000~~ is equal to or less than 165 percent of the federal poverty guidelines for the same family size.

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

Sec. 2. 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, for the rate period July 1, 2010, to June 30, 2011, 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. 3. Minnesota Statutes 2008, section 256J.24, subdivision 6, is amended to read:

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

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

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

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

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

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

(5) the child is the mother's first child subsequent to a pregnancy that did not result in a live birth; or

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is amended to read:

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

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

(2) a person who:

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

(ii) has an IQ below 80 who has been assessed by a vocational specialist or a county agency to be employable, but the condition severely limits the person's ability to obtain or maintain suitable employment. The determination of IQ level must be made by a qualified professional. In the case of a non-English-speaking person: (A) the determination must

be made by a qualified professional with experience conducting culturally appropriate assessments, whenever possible; (B) the county may accept reports that identify an IQ range as opposed to a specific score; (C) these reports must include a statement of confidence in the results;

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2009 Supplement, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION CASH BENEFITS.

(a) ~~Effective October 1, 2009,~~ Upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program with earnings, a participant who is employed may be eligible for work participation cash benefits of ~~$50~~ $25 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

(b) To be eligible for work participation cash benefits, the participant shall not receive MFIP or diversionary work program assistance during the month and the participant or participants must meet the following work requirements:

(1) if the participant is a single caregiver and has a child under six years of age, the participant must be employed at least 87 hours per month;

(2) if the participant is a single caregiver and does not have a child under six years of age, the participant must be employed at least 130 hours per month; or

(3) if the household is a two-parent family, at least one of the parents must be employed an average of at least 130 hours per month.

Whenever a participant exits the diversionary work program or is terminated from MFIP and meets the other criteria in this section, work participation cash benefits are available for up to 24 consecutive months.

(c) Expenditures on the program are maintenance of effort state funds under a separate state program for participants under paragraph (b), clauses (1) and (2). Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort funds. Months in which a participant receives work participation cash benefits under this section do not count toward the participant's MFIP 60-month time limit.

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

ARTICLE 19

MISCELLANEOUS

Section 1. **[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 covered under a health plan for persons who are concurrently covered by both the health plan 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 such services as required by section 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions of the health 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. 2. **[137.32] MINNESOTA COUPLES ON THE BRINK PROJECT.**

Subdivision 1. **Establishment.** Within the limits of available appropriations, the Board of Regents of the University of Minnesota is requested to develop and implement a Minnesota couples on the brink project, as provided for in this section. The regents may administer the project with federal grants, state appropriations, and in-kind services received for this purpose.

Subd. 2. **Purpose.** The purpose of the project is to develop, evaluate, and disseminate best practices for promoting successful reconciliation between married persons who are considering or have commenced a marriage dissolution proceeding and who choose to pursue reconciliation.

Subd. 3. **Implementation.** The regents shall:

(1) enter into contracts or manage a grant process for implementation of the project; and

(2) develop and implement an evaluation component for the project.

Sec. 3. Minnesota Statutes 2008, section 152.126, as amended by Laws 2009, chapter 79, article 11, sections 9, 10, and 11, is amended to read:

152.126 ~~SCHEDULE II AND III~~ CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM.

Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 5, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or interfere with the legitimate prescribing of controlled substances for pain. No prescriber shall be subject to disciplinary action by a health-related licensing board for prescribing a controlled substance according to the provisions of section 152.125.

Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish by January 1, 2010, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, operation, and maintenance of the electronic reporting system.

Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The board shall convene an advisory committee. The committee must include at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a professional nursing association;

(7) a professional dental association;

(8) a consumer privacy or security advocate; and

(9) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

~~(c) The Board of Pharmacy, after consultation with the advisory committee, shall present recommendations and draft legislation on the issues addressed by the advisory committee under paragraph (b), to the legislature by December 15, 2007.~~

Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the following data to the board or its designated vendor, subject to the notice required under paragraph (d):

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) prescription number;

(6) name of the patient for whom the prescription was written;

(7) address of the patient for whom the prescription was written;

(8) date of birth of the patient for whom the prescription was written;

(9) date the prescription was written;

(10) date the prescription was filled;

(11) name and strength of the controlled substance;

(12) quantity of controlled substance prescribed;

(13) quantity of controlled substance dispensed; and

(14) number of days supply.

(b) The dispenser must submit the required information by a procedure and in a format established by the board. The board may allow dispensers to omit data listed in this subdivision or may require the submission of data not listed in this subdivision provided the omission or submission is necessary for the purpose of complying with the electronic reporting or data transmission standards of the American Society for Automation in Pharmacy, the National Council on Prescription Drug Programs, or other relevant national standard-setting body.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

(1) individuals residing in licensed skilled nursing or intermediate care facilities;

(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;

(3) individuals receiving medication intravenously;

(4) individuals receiving hospice and other palliative or end-of-life care; and

(5) individuals receiving services from a home care provider regulated under chapter 144A.

(d) A dispenser must not submit data under this subdivision unless a conspicuous notice of the reporting requirements of this section is given to the patient for whom the prescription was written.

Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. The database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or substantiate a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from ~~the date~~ the last day of the month during which the data was received.

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is prescribing or considering prescribing any controlled substance and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any

controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(4) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, operation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities;

(7) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant; and

(8) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

For purposes of clause (3), access by an individual includes persons in the definition of an individual under section 13.02.

(c) Any permissible user identified in paragraph (b), who directly accesses the data electronically, shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(d) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(e) The board shall not release the name of a prescriber without the written consent of the prescriber or a valid search warrant or court order. The board shall provide a mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.

(f) The board shall maintain a log of all persons who access the data and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting system to determine if the system is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the system to the legislature by ~~January~~ July 15, 2011.

Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit charitable foundations, the federal government, and other sources to fund the enhancement and ongoing operations of the prescription electronic reporting system established under

this section. Any funds received shall be appropriated to the board for this purpose. The board may not expend funds to enhance the program in a way that conflicts with this section without seeking approval from the legislature.

(b) The administrative services unit for the health-related licensing boards shall apportion between the Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of Optometry, and the Board of Pharmacy an amount to be paid through fees by each respective board. The amount apportioned to each board shall equal each board's share of the annual appropriation to the Board of Pharmacy from the state government special revenue fund for operating the prescription electronic reporting system under this section. Each board's apportioned share shall be based on the number of prescribers or dispensers that each board identified in this paragraph licenses as a percentage of the total number of prescribers and dispensers licensed collectively by these boards. Each respective board may adjust the fees that the boards are required to collect to compensate for the amount apportioned to each board by the administrative services unit.

Sec. 4. **[246.125] CHEMICAL AND MENTAL HEALTH SERVICES TRANSFORMATION ADVISORY TASK FORCE.**

Subdivision 1. **Establishment.** The Chemical and Mental Health Services Transformation Advisory Task Force is established to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency.

Subd. 2. **Duties.** The Chemical and Mental Health Services Transformation Advisory Task Force shall make recommendations to the commissioner and the legislature no later than December 15, 2010, on the following:

(1) transformation needed to improve service delivery and provide a continuum of care, such as transition of current facilities, closure of current facilities, or the development of new models of care, including the redesign of the Anoka-Metro Regional Treatment Center;

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

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

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

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

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

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

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

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

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

(4) one representative appointed by AFSCME Council 5;

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

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

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

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

(9) one representative appointed by NAMI-MN;

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

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

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

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

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

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

(16) one representative appointed by the Consumer Survivor Network;

(17) one representative appointed by the Association of Residential Resources in Minnesota;

(18) one representative appointed by the Minnesota Council of Child Caring Agencies;

(19) one representative appointed by the Association of Minnesota Counties; and

(20) one representative appointed by the Minnesota Pharmacists Association.

The commissioner may appoint additional members to reflect stakeholders who are not represented above.

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

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

Subd. 6. **Member requirement.** The commissioner shall provide per diem and travel expenses pursuant to section 256.01, subdivision 6, for task force members who are consumers or family members and whose participation on the task force is not as a paid representative of any agency, organization, or association. Notwithstanding section 15.059, other task force members are not eligible for per diem or travel reimbursement.

Sec. 5. **[246.128] NOTIFICATION TO LEGISLATURE REQUIRED.**

The commissioner shall notify the chairs and ranking minority members of the relevant legislative committees regarding the redesign, closure, or relocation of state-operated services programs. The notification must include the advice of the Chemical and Mental Health Services Transformation Advisory Task Force under section 246.125.

Sec. 6. **[246.129] LEGISLATIVE APPROVAL REQUIRED.**

If the closure of a state-operated facility is proposed, and the department and respective bargaining units fail to arrive at a mutually agreed upon solution to transfer affected state employees to other state jobs, the closure of the facility requires legislative approval. This does not apply to state-operated enterprise services.

Sec. 7. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision to read:

Subd. 8. **State-operated services account.** The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

Sec. 8. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

Subd. 2. **American Indian.** For purposes of services provided under section 254B.09, subdivision ~~7~~ 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~~ 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. 9. 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:~~

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

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

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

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

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

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

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

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

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

~~(j) The remaining funds shall be allocated proportional to the county adjusted population~~ in the special revenue account must be used according to the requirements in this chapter.

Sec. 10. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

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

Sec. 11. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section. ~~If all funds allocated according to section 254B.02 are exhausted by a county and the county has met or exceeded the base level of expenditures under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the costs paid by the state under this section. The commissioner may refuse to pay state funds for services to persons not eligible under section 254B.04, subdivision 1, if the county financially responsible for the persons has exhausted its allocation.~~

Sec. 12. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

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

Sec. 13. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal financial participation collections to ~~the reserve fund under section 254B.02, subdivision 3~~ a special revenue account. The commissioner shall ~~retain 85~~ allocate 83.86 percent of patient payments and third-party payments to the special revenue account and ~~allocate the collections to the treatment allocation for the county that is financially responsible for the person. Fifteen~~ 16.14 percent ~~of patient and third-party payments must be paid~~ to the county financially responsible for the patient. ~~Collections for patient payment and~~

~~third-party payment for services provided under section 254B.09 shall be allocated to the allocation of the tribal unit which placed the person. Collections of federal financial participation for services provided under section 254B.09 shall be allocated to the tribal reserve account under section 254B.09, subdivision 5.~~

Sec. 14. 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. 15. **[254B.13] PILOT PROJECTS; CHEMICAL HEALTH CARE.**

Subdivision 1. **Authorization for pilot projects.** The commissioner 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 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 shall evaluate pilot projects under this section and report the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over chemical health issues by January 15, 2013. Evaluation of the pilot projects must be based on outcome evaluation criteria negotiated with the pilot 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 (d), shall be transferred to the consolidated chemical dependency treatment 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 nontreatment pilot 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) For purposes of this section, "nontreatment pilot services" include navigator services, peer support, family engagement and support, housing support, rent subsidies, supported employment, and independent living skills.

(c) State expenditures for chemical dependency services and nontreatment pilot services provided by or through the pilot projects must not be greater than the chemical dependency treatment fund expected share of forecasted expenditures 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.

(d) To the extent that state fiscal year expenditures within a pilot project are less than the expected share of forecasted expenditures in the absence of the pilot projects, the commissioner shall deposit the unexpended funds in a separate account within the consolidated chemical dependency treatment fund, and make these funds available for expenditure by the pilot projects the following year. To the extent that treatment and nontreatment pilot services expenditures within the pilot project exceed the amount expected in the absence of the pilot projects, the pilot project county or counties are responsible for the portion of nontreatment pilot services expenditures in excess of the otherwise expected share of forecasted expenditures.

(e) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the pilot project, except that any chemical dependency treatment funded under this section must continue to be provided by a licensed treatment provider.

(f) The commissioner shall not approve or enter into any agreement related to pilot projects authorized under this section that 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 with timely and pertinent information as negotiated in agreements governing operation of the pilot projects.

Sec. 16. Minnesota Statutes 2009 Supplement, section 517.08, subdivision 1b, is amended to read:

Subd. 1b. **Term of license; fee; premarital education.** (a) The local registrar shall examine upon oath the parties applying for a license relative to the legality of the contemplated marriage. If one party is unable to appear in person, the party appearing may complete the absent applicant's information. The local registrar shall provide a copy of the marriage application to the party who is unable to appear, who must verify the accuracy of the party's information in a notarized statement. The marriage license must not be released until the verification statement has been received by the local registrar. If at the expiration of a five-day period, on being satisfied that there is no legal impediment to it, including the restriction contained in section 259.13, the local registrar shall issue the license, containing the full names of the parties before and after marriage, and county and state of residence, with the county seal attached, and make a record of the date of issuance. The license shall be valid for a period of six months. Except as provided in paragraph (c), the local registrar shall collect from the applicant a fee of ~~$110~~ $115 for administering the oath, issuing, recording, and filing all papers required, and preparing and transmitting to the state registrar of vital statistics the reports of marriage required by this section. If the license should not be used within the period of six months due to illness or other extenuating circumstances, it may be surrendered to the local registrar for cancellation, and in that case a new license shall issue upon request of the parties of the original license without fee. A local registrar who knowingly issues or signs a marriage license in any manner other than as provided in this section shall pay to the parties aggrieved an amount not to exceed $1,000.

(b) In case of emergency or extraordinary circumstances, a judge of the district court of the county in which the application is made may authorize the license to be issued at any time before expiration of the five-day period required under paragraph (a). A waiver of the five-day waiting period must be in the following form:

STATE OF MINNESOTA, COUNTY OF ..... (insert county name)

APPLICATION FOR WAIVER OF MARRIAGE LICENSE WAITING PERIOD:

..... (legal names of the applicants)

Represent and state as follows:

That on ..... (date of application) the applicants applied to the local registrar of the above-named county for a license to marry.

That it is necessary that the license be issued before the expiration of five days from the date of the application by reason of the following: (insert reason for requesting waiver of waiting period)

.....

.....

.....

WHEREAS, the applicants request that the judge waive the required five-day waiting period and the local registrar be authorized and directed to issue the marriage license immediately.

Date: .....

.....

.....

(Signatures of applicants)

Acknowledged before me on this ..... day of ..... .

.....

NOTARY PUBLIC

COURT ORDER AND AUTHORIZATION:

STATE OF MINNESOTA, COUNTY OF ..... (insert county name)

After reviewing the above application, I am satisfied that an emergency or extraordinary circumstance exists that justifies the issuance of the marriage license before the expiration of five days from the date of the application. IT IS HEREBY ORDERED that the local registrar is authorized and directed to issue the license forthwith.

.....

..... (judge of district court)

..... (date).

(c) The marriage license fee for parties who have completed at least 12 hours of premarital education is $40. In order to qualify for the reduced license fee, the parties must submit at the time of applying for the marriage license a signed, dated, and notarized statement from the person who provided the premarital education on their letterhead confirming that it was received. The premarital education must be provided by a licensed or ordained minister or the minister's designee, a person authorized to solemnize marriages under section 517.18, or a person authorized to practice marriage and family therapy under section 148B.33. The education must include the use of a premarital inventory and the teaching of communication and conflict management skills.

(d) The statement from the person who provided the premarital education under paragraph (b) must be in the following form:

"I, ... (name of educator), confirm that ..... (names of both parties) received at least 12 hours of premarital education that included the use of a premarital inventory and the teaching of communication and conflict management skills. I am a licensed or ordained minister, a person authorized to solemnize marriages under Minnesota Statutes, section 517.18, or a person licensed to practice marriage and family therapy under Minnesota Statutes, section 148B.33."

The names of the parties in the educator's statement must be identical to the legal names of the parties as they appear in the marriage license application. Notwithstanding section 138.17, the educator's statement must be retained for seven years, after which time it may be destroyed.

(e) If section 259.13 applies to the request for a marriage license, the local registrar shall grant the marriage license without the requested name change. Alternatively, the local registrar may delay the granting of the marriage license until the party with the conviction:

(1) certifies under oath that 30 days have passed since service of the notice for a name change upon the prosecuting authority and, if applicable, the attorney general and no objection has been filed under section 259.13; or

(2) provides a certified copy of the court order granting it. The parties seeking the marriage license shall have the right to choose to have the license granted without the name change or to delay its granting pending further action on the name change request.

Sec. 17. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws 2010, chapter 200, article 1, section 17, is amended to read:

Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected pursuant to subdivision 1b, paragraph (a), $25 must be retained by the county. The local registrar must pay ~~$85~~ $90 to the commissioner of management and budget to be deposited as follows:

(1) $55 in the general fund;

(2) $3 in the state government special revenue fund to be appropriated to the commissioner of public safety for parenting time centers under section 119A.37;

(3) $2 in the special revenue fund to be appropriated to the commissioner of health for developing and implementing the MN ENABL program under section 145.9255; ~~and~~

(4) $25 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96; and

(5) $5 in the special revenue fund, which is appropriated to the Board of Regents of the University of Minnesota for the Minnesota couples on the brink project under section 137.32.

(b) Of the $40 fee under subdivision 1b, paragraph (b), $25 must be retained by the county. The local registrar must pay $15 to the commissioner of management and budget to be deposited as follows:

(1) $5 as provided in paragraph (a), clauses (2) and (3); and

(2) $10 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96.

Sec. 18. 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 Chemical and Mental Health Services Transformation Advisory Task Force shall ~~develop~~ recommend an array of community-based services in the metro area 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~~ established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers, and community partnerships, and must be staffed by state employees. The planning for this transition must be completed by October 1, ~~2009~~ 2010, with ~~an initial~~ a report detailing the transition plan, services that will be provided, including incorporating peer specialists where appropriate, the location of the services, and the number of patients that will be served, to the committee chairs of health and human services by November 30, ~~2009, 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~~ 2010. The individuals ~~working in~~ employed by 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. Savings generated as a result of transitioning patients from the Anoka-Metro Regional Treatment Center to community-based services may be used to fund supportive housing staffed by state employees.

Sec. 19. **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 note office in the human services department and (2) transferring the responsibility for preparing human services fiscal notes to the legislature. The report must include detailed information regarding the financial costs, staff resources, training, access to information, and data protection issues relative to the preparation of human services fiscal notes. The report shall describe methods and procedures used by other states to insure independence and accuracy of fiscal estimates on legislative proposals for changes in human services.

Sec. 20. **PRESCRIPTION DRUG WASTE REDUCTION.**

The Minnesota Board of Pharmacy, in cooperation with the commissioners of human services, pollution control, health, veterans affairs, and corrections, shall study prescription drug waste reduction techniques and technologies applicable to long-term care facilities, veterans nursing homes, and correctional facilities. In conducting the study, the commissioners shall consult with the Minnesota Pharmacists Association, the University of Minnesota College of Pharmacy, University of Minnesota's Minnesota Technical Assistance Project, consumers, long-term care providers, and other interested parties. The board shall evaluate the extent to which new prescription drug waste reduction techniques and technologies can reduce the amount of prescription drugs that enter the waste stream and reduce state prescription drug costs. The techniques and technologies studied must include, but are not limited to, daily, weekly, and automated dose dispensing. The study must provide an estimate of the cost of adopting these and other techniques and technologies, and an estimate of waste reduction and state prescription drug savings that would result from adoption. The study must also evaluate methods of encouraging the adoption of effective drug waste reduction techniques and technologies. The board shall present recommendations on the adoption of new prescription drug waste reduction techniques and technologies to the legislature by December 15, 2011.

Sec. 21. **VETERINARY PRACTICE AND CONTROLLED SUBSTANCE ABUSE STUDY.**

The Board of Pharmacy, in consultation with the Prescription Electronic Reporting Advisory Committee and the Board of Veterinary Medical Practice, shall study the issue of the diversion of controlled substances from veterinary practice and report to the chairs

and ranking minority members of the senate health and human services policy and finance division and the house of representatives health care and human services policy and finance division by December 15, 2011, on recommendations to include veterinarians in the prescription electronic reporting system in Minnesota Statutes, section 152.126.

Sec. 22. **DATA COLLECTION ON HEALTH DISPARITIES.**

Subdivision 1. **Inventory.** The commissioners of health and human services shall conduct an inventory on the health-related data collected by each respective department including, but not limited to, health care programs and activities, vital statistics, disease surveillance registries and screenings, and health outcome measurements.

The inventory must review the categories of data that are collected, describe the methods of collecting, organizing, and reporting data relating to race, ethnicity, country of origin, primary language, tribal enrollment status, and socioeconomic status, and specify whether the data being collected in these categories is currently required.

Subd. 2. **Review.** (a) Upon completion of the inventory in subdivision 1, the commissioners of health and human services shall consult with representatives of culturally based community groups, community health boards, tribal governments, hospitals, and health plan companies to review the compiled inventory and make recommendations on:

(1) whether the data currently being collected is sufficient to identify and describe health disparities for particular communities or if the collection of additional types and categories of data is necessary in order to better identify health disparities and to facilitate efforts to reduce these disparities;

(2) if additional types and categories of data collection is determined necessary, what additional types and categories should be collected and in what areas;

(3) whether there is a need to aggregate data to make data in the categories identified in subdivision 1 more accessible to community groups, researchers, and to the legislature; and

(4) other ways to improve data collection efforts in order to ensure the collection of high-quality, reliable data in clauses (1) to (3) that will ensure accurate research and the ability to create measurable program outcomes in order to facilitate public policy decisions regarding the elimination of health disparities.

(b) In making recommendations, the work group shall consider national and state standardized data classification systems, as well as federal or state requirements for collection of certain data based on predetermined classification systems that may impact some data collection efforts.

Subd. 3. **Report.** By January 15, 2011, the commissioners of health and human services shall submit to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services the inventory compiled in subdivision 1 and the recommendations developed in subdivision 2.

Sec. 23. **REPEALER.**

(a) Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09, subdivisions 4, 5, and 7, are repealed.

(b) Laws 2009, chapter 79, article 7, section 26, subdivision 3, is repealed.

Sec. 24. **EFFECTIVE DATE.**

Sections 8 to 14 and 22 are effective for claims paid on or after July 1, 2010.

ARTICLE 20

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2008, section 13.3806, subdivision 13, is amended to read:

Subd. 13. **Traumatic injury.** Data on individuals with a brain or spinal injury or who sustain major trauma that are collected by the commissioner of health are classified under ~~section~~ sections 144.6071 and 144.665.

Sec. 2. Minnesota Statutes 2008, section 62D.08, is amended by adding a subdivision to read:

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 3. **[62D.31] ADVISORY GROUP ON ADMINISTRATIVE EXPENSES.**

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

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

(1) the commissioner of health or the commissioner's designee;

(2) the commissioner of human services or the commissioner's designee;

(3) the commissioner of commerce or the commissioner's designee; and

(4) representatives of health maintenance organizations and county-based purchasers appointed by the commissioner of health.

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

Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses must report its recommendations, including any proposed legislation necessary to implement the recommendations, to the commissioner of health and to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health policy and finance by February 15, 2012.

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

Sec. 4. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently 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. 5. Minnesota Statutes 2008, section 144.05, is amended by adding a subdivision to read:

Subd. 5. **Firearms data.** Notwithstanding any law to the contrary, the commissioner of health is prohibited from collecting data on individuals regarding lawful firearm ownership in the state or data related to an individual's right to carry a weapon under section 624.714.

Sec. 6. 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 management and budget for deposit in the general fund. 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. 7. 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. 8. Minnesota Statutes 2008, section 144.603, is amended to read:

144.603 STATEWIDE TRAUMA SYSTEM CRITERIA.

Subdivision 1. **Criteria established.** The commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall address emergency medical service trauma triage and transportation guidelines as approved under section

144E.101, subdivision 14, designation of hospitals as trauma hospitals, interhospital transfers, a trauma registry, and a trauma system governance structure.

Subd. 2. **Basis; verification.** The commissioner shall base the establishment, implementation, and modifications to the criteria under subdivision 1 on the department-published Minnesota comprehensive statewide trauma system plan. The commissioner shall seek the advice of the Trauma Advisory Council in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma ~~Resources Network~~ Center Association of America, and other widely recognized trauma experts. The commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

Subd. 3. **Rule exemption and report to legislature.** In developing and adopting the criteria under this section, the commissioner of health is exempt from chapter 14, including section 14.386. ~~By September 1, 2009, the commissioner must report to the legislature on implementation of the voluntary trauma system, including recommendations on the need for including the trauma system criteria in rule.~~

Sec. 9. Minnesota Statutes 2008, section 144.605, subdivision 2, is amended to read:

Subd. 2. **Designation; reverification.** The commissioner shall designate ~~four~~ six levels of trauma hospitals. A hospital that voluntarily meets the criteria for a particular level of trauma hospital shall apply to the commissioner for designation and, upon the commissioner's verifying the hospital meets the criteria, be designated a trauma hospital at the appropriate level for a three-year period. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary system must apply for and successfully complete a reverification process, be awaiting the site visit for the reverification, or be awaiting the results of the site visit. The commissioner may extend a hospital's existing designation for up to 18 months on a provisional basis if the hospital has applied for reverification in a timely manner but has not yet completed the reverification process within the expiration of the three-year designation and the extension is in the best interest of trauma system patient safety. To be granted a provisional extension, the hospital must be:

(1) scheduled and awaiting the site visit for reverification;

(2) awaiting the results of the site visit; or

(3) responding to and correcting identified deficiencies identified in the site visit.

Sec. 10. Minnesota Statutes 2008, section 144.605, subdivision 3, is amended to read:

Subd. 3. **ACS verification.** The commissioner shall grant the appropriate level I, II, or III trauma hospital or level I or II pediatric trauma hospital designation to a hospital that successfully completes and passes the American College of Surgeons (ACS) verification standards at the hospital's cost, submits verification documentation to the Trauma Advisory Council, and formally notifies the Trauma Advisory Council of ACS verification.

Sec. 11. Minnesota Statutes 2008, section 144.605, is amended by adding a subdivision to read:

Subd. 9. **Designation process protection.** Data on patients in information and reports related to the designation and redesignation of trauma hospitals pursuant to subdivisions 3 to 5 are private data on individuals, as defined in section 13.02, subdivision 12.

Sec. 12. **[144.6071] TRAUMA REGISTRY.**

Subdivision 1. **Registry.** The commissioner of health shall establish and maintain a central registry of persons who sustain major trauma as defined in section 144.602, subdivision 3. The registry shall collect information to facilitate the development of clinical and system quality improvement, injury prevention, treatment, and rehabilitation programs.

Subd. 2. **Registry participation required.** A trauma hospital must participate in the statewide trauma registry. The consent of the injured person is not required.

Subd. 3. **Registry information.** Trauma hospitals must electronically submit the following information to the registry:

(1) demographic information of the injured person;

(2) information about the date, location, and cause of the injury;

(3) information about the condition of the injured person;

(4) information about the treatment, comorbidities, and diagnosis of the injured person;

(5) information about the outcome and disposition of the injured person; and

(6) other trauma-related information required by the commissioner, if necessary to facilitate the development of clinical and system quality improvement, treatment, and rehabilitation programs.

Subd. 4. **Rules.** The commissioner may adopt rules to collect other information required to facilitate the development of clinical and system quality improvement, injury prevention, treatment, and rehabilitation programs. The commissioner may adopt rules at any time to implement this section and is not subject to the requirements of section 14.125.

Subd. 5. **Reporting without liability.** Any person or facility furnishing information required in this section shall not be subject to any action for damages or other relief, provided that the person or facility is acting in good faith.

Subd. 6. **Data classification.** Data on individuals collected by the commissioner of health under this section are private data on individuals, as defined in section 13.02, subdivision 12. Data not on individuals are nonpublic data as defined in section 13.02, subdivision 9. The commissioner shall provide summary registry data to public and private entities to conduct studies using data collected by the registry. The commissioner may charge a fee under section 13.03, subdivision 3, for all out-of-pocket expenses associated with the provision of data or data analysis.

Subd. 7. **Report requirements.** The commissioner shall use the registry to annually publish a report that includes comparative demographic and risk-adjusted epidemiological data on designated trauma hospitals. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have 21 days to review the data for accuracy.

Sec. 13. Minnesota Statutes 2008, section 144.608, subdivision 1, is amended to read:

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American ~~College of Surgeons~~ Board of Surgery or the American Osteopathic Board of Surgery who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American ~~College of Surgeons~~ Board of Surgery or the American Osteopathic Board of Surgery whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American ~~College~~ Board of Emergency ~~Physicians~~ Medicine or the American Osteopathic Board of Emergency Medicine whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) ~~an emergency room nurse manager~~ a trauma program manager or coordinator who practices in a level III or IV trauma hospital;

(7) a ~~family practice~~ physician certified by the American Board of Family Medicine or the American Osteopathic Board of Family Practice whose practice includes emergency ~~room~~ department care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (h), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (j), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(9) a pediatrician certified by the American ~~Academy~~ Board of Pediatrics or the American Osteopathic Board of Pediatrics whose practice includes emergency ~~room~~ department care in a level I, II, III, or IV trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery or the American Osteopathic Board of Orthopedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b); and

(15) the commissioner of public safety or the commissioner's designee.

~~(c) Council members whose appointment is dependent on practice in a level III or IV trauma hospital may be appointed to an initial term based upon their statements that the hospital intends to become a level III or IV facility by July 1, 2009.~~

Sec. 14. **[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. 15. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board

and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

Sec. 16. Minnesota Statutes 2008, section 144.9504, is amended by adding a subdivision to read:

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

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

Sec. 17. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

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

Sec. 18. Minnesota Statutes 2008, section 144E.37, is amended to read:

144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.

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

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

Sec. 19. **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. 20. **VENDOR ACCREDITATION SIMPLIFICATION.**

The Minnesota Hospital Association must coordinate with the Minnesota Credentialing Collaborative to make recommendations by January 1, 2012, on the development of standard accreditation methods for vendor services provided within hospitals and clinics. The recommendations must be consistent with requirements of hospital credentialing organizations and applicable federal requirements.

Sec. 21. **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. 22. **TRANSFER.**

The powers and duties of the Emergency Medical Services Regulatory Board with respect to the comprehensive advanced life-support educational program under Minnesota Statutes, section 144E.37, are transferred to the commissioner of health under Minnesota Statutes, section 15.039.

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

Sec. 23. **REVISOR'S INSTRUCTION.**

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

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

Sec. 24. **REPEALER.**

Minnesota Statutes 2008, section 144.607, is repealed.

ARTICLE 21

PUBLIC HEALTH

Section 1. Minnesota Statutes 2008, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) Following the distribution described under paragraph (b), the commissioner shall annually distribute the available medical education funds to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid

general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) $5,350,000 of the available medical education funds shall be distributed as follows:

(1) $1,475,000 to the University of Minnesota Medical Center-Fairview;

(2) $2,075,000 to the University of Minnesota School of Dentistry; and

(3) $1,800,000 to the Academic Health Center. $150,000 of the funds distributed to the Academic Health Center under this paragraph shall be used for a program to assist internationally trained physicians who are legal residents and who commit to serving underserved Minnesota communities in a health professional shortage area to successfully compete for family medicine residency programs at the University of Minnesota.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving

notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(f) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 2. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is amended to read:

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, youth camps, hotels, motels, lodging establishments, public pools, and resorts licensed under this chapter. Food and beverage service establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable fee under paragraph (d), clause (6) or (7). The license fee for new operators previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

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

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

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

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

(i) prepackaged food that receives heat treatment and is served in the package;

(ii) frozen pizza that is heated and served;

(iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

(iv) soft drinks, coffee, or nonalcoholic beverages; or

(v) cleaning for eating, drinking, or cooking utensils, when the only food served is prepared off site.

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

(i) possesses food service equipment that consists of no more than a deep fat fryer, a grill, two hot holding containers, and one or more microwave ovens;

(ii) serves dipped ice cream or soft serve frozen desserts;

(iii) serves breakfast in an owner-occupied bed and breakfast establishment;

(iv) is a boarding establishment; or

(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron seating capacity of not more than 50.

(3) Medium establishment, $310. "Medium establishment" means a fee category that meets one or more of the following:

(i) possesses food service equipment that includes a range, oven, steam table, salad bar, or salad preparation area;

(ii) possesses food service equipment that includes more than one deep fat fryer, one grill, or two hot holding containers; or

(iii) is an establishment where food is prepared at one location and served at one or more separate locations.

Establishments meeting criteria in clause (2), item (v), are not included in this fee category.

(4) Large establishment, $540. "Large establishment" means either:

(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium establishment, (B) seats more than 175 people, and (C) offers the full menu selection an average of five or more days a week during the weeks of operation; or

(ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium establishment, and (B) prepares and serves 500 or more meals per day.

(5) Other food and beverage service, including food carts, mobile food units, seasonal temporary food stands, and seasonal permanent food stands, $60.

(6) Beer or wine table service, $60. "Beer or wine table service" means a fee category where the only alcoholic beverage service is beer or wine, served to customers seated at tables.

(7) Alcoholic beverage service, other than beer or wine table service, $165.

"Alcohol beverage service, other than beer or wine table service" means a fee category where alcoholic mixed drinks are served or where beer or wine are served from a bar.

(8) Lodging per sleeping accommodation unit, $10, including hotels, motels, lodging establishments, and resorts, up to a maximum of $1,000. "Lodging per sleeping accommodation unit" means a fee category including the number of guest rooms, cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the number of beds in a dormitory.

(9) First public pool, $325; each additional public pool, $175. "Public pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

(10) First spa, $175; each additional spa, $100. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, $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
	medium establishment	$350
	large food establishment	$400
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
Alcohol	beer or wine table service	$150
	alcohol service from bar	$250
Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300
	100 rooms or more	$450
	less than five cabins	$250
	five to less than ten cabins	$350
	ten cabins or more	$400

(g) Special event food stands are not required to submit construction or remodeling plans for review.

(h) Youth camps shall pay an annual single fee for food and lodging as follows:

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

(i) A youth camp which pays fees under paragraph (d) is not required to pay fees under paragraph (h).

Sec. 3. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is amended to read:

Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The following fees are required for manufactured home parks and recreational camping areas licensed under this chapter. Recreational camping areas and manufactured home parks shall pay the highest applicable base fee under paragraph ~~(c)~~ (b). The license fee for new operators of a manufactured home park or recreational camping area previously licensed under this chapter for the same calendar year is one-half of the appropriate annual license fee, plus any penalty that may be required. The license fee for operators opening on or after October 1 is one-half of the appropriate annual license fee, plus any penalty that may be required.

(b) All manufactured home parks and recreational camping areas shall pay the following annual base fee:

(1) a manufactured home park, $150; and

(2) a recreational camping area with:

(i) 24 or less sites, $50;

(ii) 25 to 99 sites, $212; and

(iii) 100 or more sites, $300.

In addition to the base fee, manufactured home parks and recreational camping areas shall pay $4 for each licensed site. This paragraph does not apply to special event recreational camping areas ~~or to~~. Operators of a manufactured home park or a recreational camping area also licensed under section 157.16 for the same location shall pay only one base fee, whichever is the highest of the base fees found in this section or section 157.16.

(c) In addition to the fee in paragraph (b), each manufactured home park or recreational camping area shall pay an additional annual fee for each fee category specified in this paragraph:

(1) Manufactured home parks and recreational camping areas with public swimming pools and spas shall pay the appropriate fees specified in section 157.16.

(2) Individual private sewer or water, $60. "Individual private water" means a fee category with a water supply other than a community public water supply as defined in Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface sewage treatment system which uses subsurface treatment and disposal.

(d) The following fees must accompany a plan review application for initial construction of a manufactured home park or recreational camping area:

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to 99 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

(e) The following fees must accompany a plan review application when an existing manufactured home park or recreational camping area is expanded:

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 to 99 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 4. **FOOD SUPPORT FOR CHILDREN WITH SEVERE ALLERGIES.**

The commissioner of human services must seek a federal waiver from the federal Department of Agriculture, Food and Nutrition Service, for the supplemental nutrition assistance program, to increase the income eligibility requirements to 375 percent of the federal poverty guidelines, in order to cover nutritional food products required to treat or manage severe food allergies, including allergies to wheat and gluten, for infants and children who have been diagnosed with life-threatening severe food allergies.

ARTICLE 22

HEALTH CARE REFORM

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

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

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

(c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, including any federal regulations adopted under it.

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

Subd. 2. **Timing of this section.** This section applies beginning the date the temporary federal qualified high-risk health pool created under the federal law begins to provide coverage in this state.

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

Subd. 4. **Coordination with state health care programs.** The commissioner of commerce and the Minnesota Comprehensive Health Association shall ensure that

applicants for coverage through the federal qualified high-risk pool, or through the Minnesota Comprehensive Health Association, are referred to the medical assistance or MinnesotaCare programs if they are determined to be potentially eligible for coverage through those programs. The commissioner of human services shall ensure that applicants for coverage under medical assistance or MinnesotaCare who are determined not to be eligible for those programs are provided information about coverage through the federal qualified high-risk pool and the Minnesota Comprehensive Health Association.

Subd. 5. **Federal funding.** Minnesota shall coordinate its efforts with the United States Department of Health and Human Services (HHS) to obtain the federal funds to implement in Minnesota the federal qualified high-risk pool.

Sec. 2. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

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

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

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

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition; or

(3) one serious and persistent mental health condition.

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

(1) comprehensive care management;

(2) care coordination and health promotion;

(3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(4) patient and family support, including authorized representatives;

(5) referral to community and social support services, if relevant; and

(6) use of health information technology to link services, as feasible and appropriate.

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

Subd. 4. **Health teams.** The commissioner shall establish health teams to support the patient-centered health home and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants or contracts as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health teams and provide capitated payments to primary care providers. For purposes of this section, "health teams" means community-based, interdisciplinary, inter-professional teams of health care providers that support primary care practices. These providers may include medical specialists, nurses, advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers, doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician 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. 3. **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, including a demonstration project for the specific population of childless adults under 75 percent of federal poverty guidelines that were to be served by the general assistance medical care program;

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

(c) The commissioner of health shall apply for federal grants available under the federal Patient Protection and Affordable Care Act, Public Law 111-148, for purposes of funding wellness and prevention, and health improvement programs. To the extent possible under federal law, the commissioner of health must utilize the state health improvement program, established under Minnesota Statutes, section 145.986, to implement grant programs related to wellness and prevention, and health improvement, for which the state receives funding under the federal Patient Protection and Affordable Care Act, Public Law 111-148.

Sec. 4. **HEALTH CARE REFORM TASK FORCE.**

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

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

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

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

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

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

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

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

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

Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and present to the legislature and the governor a preliminary report and recommendations on state implementation of federal health care reform legislation. The report must include recommendations for state law and program changes necessary to comply with the federal 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. 5. **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 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.

ARTICLE 23

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

		2010		**2011**		**Total**
General	$	(109,876,000)	$	(28,344,000)	$	(138,220,000)
Health Care Access	$	99,654,000	$	276,500,000	$	376,154,000
Federal TANF	$	(9,830,000)	$	15,133,000	$	5,303,000
Total	**$**	**(20,052,000)**	**$**	**263,289,000**	**$**	**243,237,000**

Sec. 2. **DEPARTMENT OF HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 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, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from appropriations listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions for the fiscal year ending June 30, 2010, are effective the day following final enactment unless a different effective date is explicit.

		APPROPRIATIONS Available for the Year Ending June 30	
		2010	2011
Sec. 3. **DEPARTMENT OF HUMAN SERVICES**			
Subdivision 1. **Total Appropriation**	$	(20,052,000)	$ 263,289,000

Appropriations by Fund

	2010	2011
General	(109,876,000)	(28,344,000)
Health Care Access	99,654,000	276,500,000
Federal TANF	(9,830,000)	15,133,000

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

Subd. 2. **Revenue and Pass-through**

Appropriations by Fund

Federal TANF	390,000	(251,000)

Subd. 3. **Children and Economic Assistance Grants**

Appropriations by Fund

General	4,489,000	(4,140,000)
Federal TANF	(10,220,000)	15,384,000

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

(a) **MFIP Grants**

General	7,916,000	(14,481,000)
Federal TANF	(10,220,000)	15,384,000

(b) **MFIP Child Care Assistance Grants**	(7,832,000)	2,579,000
(c) **General Assistance Grants**	875,000	1,339,000
(d) **Minnesota Supplemental Aid Grants**	2,454,000	3,843,000
(e) **Group Residential Housing Grants**	1,076,000	2,580,000

Subd. 4. **Basic Health Care Grants**

	Appropriations by Fund		
General	(62,770,000)	29,192,000	
Health Care Access	99,654,000	276,500,000	

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

(a) **MinnesotaCare Grants**

Health Care Access	99,654,000	276,500,000	

(b) **Medical Assistance Basic Health Care - Families and Children**	1,165,000	24,146,000
(c) **Medical Assistance Basic Health Care - Elderly and Disabled**	(63,935,000)	5,046,000
Subd. 5. **Continuing Care Grants**	(51,595,000)	(53,396,000)

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

(a) **Medical Assistance Long-Term Care Facilities**	(3,774,000)	(8,275,000)
(b) **Medical Assistance Long-Term Care Waivers**	(27,710,000)	(22,452,000)
(c) **Chemical Dependency Entitlement Grants**	(20,111,000)	(22,669,000)

Sec. 4. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 24

HUMAN SERVICES CONTINGENT APPROPRIATIONS

Section 1. **SUMMARY OF HUMAN SERVICES APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this bill.

	2010	**2011**	**Total**
General	$ -0-	$ 13,383,000	$ 13,383,000
Health Care Access	-0-	686,000	686,000
Total	**$ -0-**	**$ 14,069,000**	**$ 14,069,000**

Sec. 2. **HEALTH AND HUMAN SERVICES CONTINGENT APPROPRIATIONS.**

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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ -0-**	**$ 14,069,000**
Appropriations by Fund		
	2010	2011
General	-0-	13,383,000
Health Care Access	-0-	686,000
The appropriations for each purpose are shown in the following subdivisions.		
Subd. 2. **Basic Health Care Grants**		
(a) **MinnesotaCare Grants**	-0-	686,000
This appropriation is from the health care access fund.		
(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	6,297,000
(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	3,697,000
Subd. 3. **Continuing Care Grants**		
(a) **Medical Assistance - Long-Term Care Facilities Grants**	-0-	2,486,000
(b) **Medical Assistance Grants - Long-Term Care Waivers and Home Care Grants**	-0-	547,000
(c) **Chemical Dependency Entitlement Grants**	-0-	356,000

EFFECTIVE DATE. This section is effective upon enactment of an extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5, section 5001, to at least June 30, 2011.

Sec. 4. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

EFFECTIVE DATE. This section is effective retroactive from March 23, 2010.

Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations on cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated screening to determine the need for a institutional level of care under section 256B.0911, ~~subdivision 4, paragraph (a)~~ subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), based on assessment and support plan development with appropriate referrals;

(8) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(9) assistance to transition people back to community settings after facility admission.

(b) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(c) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

Sec. 6. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately ~~$3,400,000, plus any available federal matching funds,~~ $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

Sec. 7. 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.

Sec. 8. Laws 2005, First Special Session chapter 4, article 8, section 66, as amended by Laws 2009, chapter 173, article 3, section 24, the effective date, is amended to read:

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2009, ~~and~~ upon federal approval and on the date when it is no longer subject to the 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. Paragraph (e) is effective September 1, 2006.

Sec. 9. Laws 2009, chapter 79, article 5, section 17, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective January 1, 2011, or upon federal approval~~, whichever is later~~ and on the date when it is no longer subject to the 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.

Sec. 10. Laws 2009, chapter 79, article 5, section 18, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January 1, 2011~~ upon federal approval and on the date when it is no longer subject to the maintenance of effort requirements of section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Laws 2009, chapter 79, article 5, section 22, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for periods of ineligibility 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.

Sec. 12. Laws 2009, chapter 79, article 8, section 4, the effective date, is amended to read:

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

Sec. 13. 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 25

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations by fund made in this article.

		2010	**2011**	**Total**
General	$	(6,784,000)	$ 210,746,000	$ 203,962,000

State Government Special Revenue	113,000	624,000	737,000
Health Care Access	998,000	(1,276,000)	(278,000)
Federal TANF	8,000,000	20,000,000	28,000,000
Special Revenue	-0-	93,000	93,000
Total	**$ 2,327,000**	**$ 230,187,000**	**$ 232,514,000**

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, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from appropriations listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions for the fiscal year ending June 30, 2010, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**4,409,000**	**$ 226,513,000**

Appropriations by Fund

	2010	2011
General	(4,589,000)	209,026,000
Health Care Access	998,000	(2,513,000)
Federal TANF	8,000,000	20,000,000

The appropriation modifications for each purpose are shown in the following subdivisions.

TANF Financing and Maintenance of Effort. The commissioner, with the approval of the commissioner of management and

budget, and after notification of the chairs of the relevant senate budget division and house of representatives finance division, may adjust the amount of TANF transfers between the MFIP transition year child care assistance program and MFIP grant programs within the fiscal year and within the current biennium and the biennium ending June 30, 2013, to ensure that state and federal match and maintenance of effort requirements are met. These transfers and amounts shall be reported to the chairs of the senate and house of representatives Finance Committees, the senate Health and Human Services Budget Division, and the house of representatives Health Care and Human Services Finance Division and Early Childhood Finance and Policy Division by December 1 of each fiscal year. Notwithstanding any contrary provision in this article, this paragraph expires June 30, 2013.

SNAP Enhanced Administrative Funding. The funds available for administration of the Supplemental Nutrition Assistance Program under the Department of Defense Appropriations Act of 2010, Public Law 111-118, are appropriated to the commissioner to pay the actual costs of providing for increased eligibility determinations, caseload-related costs, timely application processing, and quality control. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on recent caseload.

Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion, based on a caseload factor equivalent to that of a county.

TANF Summer Food Programs - TANF Emergency Fund Non-Recurrent Short-Term Benefits. In addition to the TANF emergency fund (TEF) non-recurrent short-term benefits provided in this subdivision, the commissioner may supplement funds available under Minnesota Statutes, section 256E.34 to provide for summer food programs to the extent such funds are available and eligible to leverage TANF emergency funds non-recurrent benefits. The commissioner may contract directly with providers or third-party funders to maximize these TANF emergency fund grants. Up to $800,000 of TEF non-recurrent short-term benefit earnings may be used in this program. This paragraph is effective the day following final enactment.

TANF Transfer to Federal Child Care and Development Fund. Of the TANF appropriation in fiscal year 2011, $12,500,000 is to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05. The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Special Revenue Fund Transfers. (a) The commissioner shall transfer the following amounts from special revenue fund balances to the general fund by June 30 of each respective fiscal year: $613,000 in fiscal year 2010, and $493,000 in fiscal year 2011. This provision is effective the day following final enactment.

(b) The actual transfers made under paragraph (a) must be separately identified and reported as part of the quarterly reporting of transfers to the chairs of the relevant senate budget division and house of representatives finance division.

Subd. 2. **Agency Management**

(a) **Financial Operations**	-0-	103,000
Base Adjustment. The general fund base is decreased by $10,000 in fiscal year 2012 and $10,000 in fiscal year 2013.		
(b) **Legal and Regulatory Operations**	-0-	114,000
Base Adjustment. The general fund base is decreased by $18,000 in fiscal year 2012 and $18,000 in fiscal year 2013.		
(c) **Management Operations**	-0-	(114,000)
Base Adjustment. The general fund base is increased by $18,000 in fiscal year 2012 and $18,000 in fiscal year 2013.		
(d) **Information Technology Operations**	-0-	(2,500,000)
Base Adjustment. The general fund base is decreased by $1,666,000 in fiscal year 2012 and $1,666,000 in fiscal year 2013.		
Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	8,000,000	20,000,000

These appropriations are from the federal TANF fund.

TANF Funding for the Working Family Tax Credit. In addition to the amounts specified in Minnesota Statutes, section 290.0671, subdivision 6, $15,500,000 of TANF funds in fiscal year 2010 are appropriated to the commissioner to reimburse the general fund for the cost of the working family tax credit for eligible families. With respect to the amounts appropriated for fiscal year 2010, the commissioner shall reimburse the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall carry over and expend in fiscal year 2011 $7,500,000 of the TANF funds transferred in fiscal year 2010 that reflect the child care and development fund unexpended balance for the basic sliding fee child care assistance program under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all funds are expended according to the federal child care and development fund regulations relating to the TANF transfers.

Base Adjustment. The general fund base is increased by $7,500,000 in fiscal year 2012 and $7,500,000 in fiscal year 2013.

Subd. 4. **Economic Support Grants**

(a) **Support Services Grants**	-0-	-0-

Base Adjustment. The federal TANF fund base is decreased by $5,004,000 in fiscal year 2012 and $5,004,000 in fiscal year 2013.

(b) **MFIP/DWP Grants**	-0-	(1,583,000)
(c) **Basic Sliding Fee Child Care Assistance Grants**	-0-	(7,500,000)
(d) **Children's Services Grants**	(900,000)	-0-

Adoption Assistance. Of the appropriation reduction in fiscal year 2010, $900,000 is from the adoption assistance program. This reduction is onetime.

(e) **Child and Community Services Grants**	-0-	(16,750,000)

Base adjustment. The general fund is increased by $13,509,000 in fiscal year 2012 and $13,509,000 in fiscal year 2013.

(f) **Group Residential Housing Grants**	-0-	84,000

Reduction of Supplemental Service Rate. Effective July 1, 2011, to June 30, 2013, the commissioner shall decrease the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a, by five percent for services rendered on or after that date, except that reimbursement rates for a group residential housing facility reimbursed as a nursing facility shall not be reduced. The reduction in this paragraph is in addition to the reduction under Laws 2009, chapter 79, article 8, section 79, paragraph (b), clause (11).

Base Adjustment. The general fund base is decreased by $784,000 in fiscal year 2012 and $784,000 in fiscal year 2013.

(g) **Children's Mental Health Grants**	(200,000)	(200,000)

(h) **Other Children's and Economic Assistance Grants**	400,000	213,000

Minnesota Food Assistance Program. Of the 2011 appropriation, $150,000 is for the Minnesota Food Assistance Program. This appropriation is onetime.

Of this appropriation, $400,000 in fiscal year 2010 and $63,000 in fiscal year 2011 is for food shelf programs under Minnesota Statutes, section 256E.34. This appropriation is available until spent.

Base Adjustment. The general fund base is decreased by $20,000 in fiscal year 2012 and decreased by $510,000 in fiscal year 2013.

Subd. 5. **Children and Economic Assistance Management**

(a) **Children and Economic Assistance Administration**	-0-	-0-

Base Adjustment. The federal TANF fund base is decreased by $700,000 in fiscal year 2012 and $700,000 in fiscal year 2013.

(b) **Children and Economic Assistance Operations**	-0-	195,000

Base Adjustment. The general fund base is decreased by $12,000 in fiscal year 2012 and $12,000 in fiscal year 2013.

Subd. 6. **Health Care Grants**

(a) **MinnesotaCare Grants**	998,000	4,269,000

This appropriation is from the health care access fund.

Health Care Access Fund Transfer to General Fund. The commissioner of management and budget shall transfer $998,000 in fiscal year 2010 and

$194,404,000 in fiscal year 2011 from the health care access fund to the general fund. This paragraph is effective the day following final enactment.

The amount of this transfer is $178,682,000 in fiscal year 2012 and $286,150,000 in fiscal year 2013.

MinnesotaCare Ratable Reduction. Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by 15 percent. Effective for services provided from July 1, 2010, to June 30, 2011, this reduction shall apply to all services. Effective for services provided from July 1, 2011, to December 31, 2013, this reduction shall apply to all services except inpatient hospital services. Notwithstanding any contrary provision of this article, this paragraph shall expire on December 31, 2013.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	314,662,000

Critical Access Dental. Of the general fund appropriation, $731,000 in fiscal year 2011 is to the commissioner for critical access dental provider reimbursement payments under Minnesota Statutes, section 256B.76 subdivision 4. This is a onetime appropriation.

Nonadministrative Rate Reduction. For services rendered on or after July 1, 2010, to December 31, 2013, the commissioner shall reduce contract rates paid to managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, by three percent of the contract rate attributable to nonadministrative services in effect on June 30, 2010. Notwithstanding any contrary provision in this article, this rider expires on December 31, 2013.

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	(6,309,000)

MnDHO Transition. Of the general fund appropriation for fiscal year 2011, $250,000 is to the commissioner to be made available to county agencies to assist in the transition of the approximately 1,290 current MnDHO members to the fee-for-service Medicaid program or another managed care option by January 1, 2011.

County agencies shall work with the commissioner, health plans, and MnDHO members and their legal representatives to develop and implement transition plans that include:

(1) identification of service needs of MnDHO members based on the current assessment or through the completion of a new assessment;

(2) identification of services currently provided to MnDHO members and which of those services will continue to be reimbursable through fee-for-service

or another managed care option under the Medicaid state plan or a home and community-based waiver program;

(3) identification of service providers who do not have a contract with the county or who are currently reimbursed at a different rate than the county contracted rate; and

(4) development of an individual service plan that is within allowable waiver funding limits.

(d) **General Assistance Medical Care Grants**	-0-	(75,389,000)
(e) **Other Health Care Grants**	-0-	(7,000,000)

Cobra Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel and are available to the commissioner for fiscal year 2011 COBRA grant expenditures. Up to $111,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner for costs related to administration of the COBRA grants.

Subd. 7. **Health Care Management**

(a) **Health Care Administration**	-0-	442,000

Fiscal Note Report. Of this appropriation, $50,000 in fiscal year 2011 is for a transfer to the commissioner of Minnesota Management and Budget for the completion of the human services fiscal note report in article 5.

PACE Implementation Funding. For fiscal year 2011, $145,000 is appropriated from the general fund to the commissioner of

human services to complete the actuarial and administrative work necessary to begin the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $130,000 in fiscal year 2012 and $0 in fiscal year 2013.

Minnesota Senior Health Options Reimbursement. Effective July 1, 2011, federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity. Notwithstanding any contrary provision, this provision expires June 30, 2013.

Utilization Review. Effective July 1, 2011, federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to, and is appropriated to, the commissioner for these activities. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance. Notwithstanding any contrary provision of this article, this paragraph expires June 30, 2013.

Certified Public Expenditures. (1) The entities named in Minnesota Statutes, section 256B.199, paragraph (b), clause (1), shall comply with the requirements of that statute by promptly reporting on a quarterly basis certified public expenditures that may qualify for federal matching funds. Reporting under this paragraph shall be voluntary from July 1,

2010, to December 31, 2010. 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, reporting under this paragraph shall also be voluntary from January 1, 2011, to June 30, 2011.

(2) To the extent that certified public expenditures reported in compliance with paragraph (1) earn federal matching payments that exceed $8,079,000 in fiscal year 2012 and $18,316,000 in fiscal year 2013, the excess amount shall be deposited in the health care access fund. For each fiscal year after fiscal year 2013, the commissioner shall forecast in November the amount of federal payments anticipated to match certified public expenditures reported in compliance with paragraph (a). Any federal match earned in a fiscal year in excess of the amount forecasted in November shall be deposited to the health care access fund.

(3) Notwithstanding any contrary provision of this article, this rider shall not expire.

Poverty Guidelines. Notwithstanding Minnesota Statutes, sections 256B.56, subdivision 1c; 256D.03, subdivision 3; or 256L.04, subdivision 7b, the poverty guidelines for medical assistance, general assistance medical care, and MinnesotaCare from July 1, 2010, through June 30, 2011, shall not be lower than the poverty guidelines issued by the Secretary of Health and Human Services on January 23, 2009. This section shall have no effect on the revision of poverty

guidelines for the Minnesota health care programs that would be in effect starting on July 1, 2011. This paragraph is effective the day following final enactment.

Base Adjustment. The general fund base is decreased by $227,000 in fiscal year 2012 and $357,000 in fiscal year 2013.

(b) **Health Care Operations**

Appropriations by Fund		
General	-0-	186,000
Health Care Access	-0-	218,000

The general fund appropriation is a onetime appropriation in fiscal year 2011.

Base Adjustment. The health care access fund base for health care operations is decreased by $812,000 in fiscal year 2012 and $944,000 in fiscal year 2013.

Subd. 8. **Continuing Care Grants**

(a) **Aging and Adult Services Grants**	-0-	(1,113,000)

Base Adjustment. The general fund base for aging and adult services grants is increased by $974,000 in fiscal year 2012 and $1,113,000 in fiscal year 2013.

Community Service Development Reduction. The appropriation in Laws 2009, chapter 79, article 13, section 3, subdivision 8, paragraph (a), for community service development grants, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, paragraph (a), is reduced by $154,000 in fiscal year 2011. The appropriation base is reduced by $139,000 for fiscal year 2012 and $0 for fiscal year 2013. Notwithstanding any law or rule to

the contrary, this provision expires June 30, 2012.

(b) **Medical Assistance Long-Term Care Facilities Grants** -0- 3,864,000

ICF/MR Occupancy Rate Adjustment Suspension. Effective for fiscal years 2012 and 2013, approval of new applications for occupancy rate adjustments for unoccupied short-term beds under Minnesota Statutes, section 256B.5013, subdivision 7, is suspended.

Kandiyohi County; ICF/MR Payment Rate. $36,000 is appropriated from the general fund in fiscal year 2011 and $4,000 in fiscal year 2012 to increase payment rates for an ICF/MR licensed for six beds and located in Kandiyohi County to serve persons with high behavioral needs. The payment rate increase shall be effective for services provided from July 1, 2010, through June 30, 2011. These appropriations are onetime.

(c) **Medical Assistance Long-Term Care Waivers and Home Care Grants** -0- (4,035,000)

Manage Growth in Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waivers. During the fiscal year beginning July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the traumatic brain injury waiver to six allocations per month and the community alternatives for disabled individuals waiver to 60 allocations per month. The limits do not

apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in the Developmental Disability (DD) Waiver. The commissioner shall manage the growth in the developmental disability waiver by limiting the allocations included in the November 2010 forecast to six additional diversion allocations each month for the calendar year that begins on January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. This provision is effective through December 31, 2011.

(d) **Adult Mental Health Grants**	(3,500,000)	(300,000)

Compulsive Gambling Special Revenue Account. $149,000 for fiscal year 2010 and $27,000 for fiscal year 2011 from the compulsive gambling special revenue account established under Minnesota Statutes, section 245.982, shall be transferred and deposited into the general fund by

June 30 of each respective fiscal year. This paragraph is effective the day following final enactment.

Compulsive Gambling Lottery Prize Fund. The lottery prize fund appropriation for compulsive gambling is reduced by $80,000 in fiscal year 2010 and $79,000 in fiscal year 2011. This is a onetime reduction.

Culturally Specific Treatment. The appropriation for culturally specific treatment is reduced by $300,000 in fiscal year 2011. This is a onetime reduction.

(1) Of the fiscal year 2010 general fund appropriation for grants to counties for housing with support services for adults with serious and persistent mental illness, $3,300,000 is canceled and returned to the general fund.

(2) Of the fiscal year 2010 general fund appropriation for additional crisis intervention team training for law enforcement, $200,000 is canceled and returned to the general fund.

Base Adjustment. The general fund base is increased by $300,000 in fiscal year 2012 and $300,000 in fiscal year 2013.

(e) **Chemical Dependency Entitlement Grants**	-0-	(2,433,000)
(f) **Chemical Dependency Nonentitlement Grants**	(389,000)	-0-

Base adjustment. The general fund base is reduced by $393,000 in fiscal year 2012 and fiscal year 2013.

Chemical Health. Of the fiscal year 2010 general fund appropriation to Mother's First

and the Native American Program, $389,000 is canceled and returned to the general fund.

(g) **Other Continuing Care Grants** -0- 350,000

This is a onetime appropriation in fiscal year 2011.

Region 10 Quality Assurance Commission. $100,000 is appropriated from the general fund in fiscal year 2011 to the commissioner of human services for the purposes of the Region 10 Quality Assurance Commission under Minnesota Statutes, section 256B.0951. This appropriation is onetime.

Subd. 9. **Continuing Care Management** -0- 296,000

PACE Implementation Funding. For fiscal year 2011, $111,000 is appropriated from the general fund to the commissioner of human services to complete the actuarial and administrative work necessary to begin the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $101,000 in fiscal year 2012 and $0 in fiscal year 2013. For fiscal year 2013 and beyond, the commissioner must work with stakeholders to develop financing mechanisms to complete the actuarial and administrative costs of PACE. The commissioner shall inform the chairs and ranking minority members of the legislative committee with jurisdiction over health care funding by January 15, 2011, on progress to develop financing mechanisms.

Base Adjustment. The general fund base for continuing care management is increased by

$7,000 in fiscal year 2012 and decreased by $94,000 in fiscal year 2013.

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

Operating Budget Reductions. No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

Prohibition on Transferring Funds. The commissioner shall not transfer mental health grants to state-operated services without specific legislative approval. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

(a) **Adult Mental Health Services**	-0-	6,888,000

Base Adjustment. The general fund base is decreased by $12,286,000 in fiscal year 2012 and $12,394,000 in fiscal year 2013.

Appropriation Requirements. (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The

commissioner shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health hospitals in Wadena and Willmar to facilities that provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The

services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this

clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of $6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by $6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established

under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

(b) **Minnesota Sex Offender Services** -0- (145,000)

Sex Offender Services. Base level funding for Minnesota sex offender services is reduced by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

Interagency Agreements. The commissioner of human services may enter into interagency agreements with the commissioner of corrections to continue sex offender treatment and chemical dependency treatment on a cost-sharing basis, in which each department pays 50 percent of the costs of these services.

Base Adjustment. The general fund base is increased by $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ (2,392,000) $ 2,310,000**

Appropriations by Fund	2010	2011
General	(2,392,000)	2,064,000
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	237,000

Subd. 2. **Community and Family Health** (221,000) 953,000

Base Level Adjustment. The general fund base is decreased by $1,388,000 in fiscal years 2012 and 2013.

Positive Alternatives. Of the general fund appropriation, $1,000,000 in fiscal year 2011 is to the commissioner for positive alternatives grants under Minnesota Statutes, section 145.4235. This is a onetime appropriation.

Subd. 3. **Policy, Quality, and Compliance**

Appropriations by Fund		
	2010	2011
General	(1,797,000)	497,000
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	237,000

Health Care Reform. Funds appropriated in Laws 2008, chapter 358, article 5, section 4, subdivision 3, for health reform activities to implement Laws 2008, chapter 358, article 4, are available until expended. Notwithstanding any contrary provision in this article, this provision shall not expire.

Health Care Reform Task Force. $198,000 from the general fund is for expenses related to the Health Care Reform Task Force established under article 7. This is a onetime appropriation.

Rural Hospital Capital Improvement Grants. Of the general fund reductions in fiscal year 2010, $1,755,000 is for the rural hospital capital improvement grant program.

Section 125 Plans. The remaining balance from the Laws 2008, chapter 358, article 5,

section 4, subdivision 3, appropriation for Section 125 Plan Employer Incentives is canceled.

Birth Centers. Of the appropriation in fiscal year 2011 from the state government special revenue fund, $9,000 is to the commissioner to license birth centers. Base level funding for this activity shall be $7,000 in fiscal year 2012 and $7,000 in fiscal year 2013.

Comprehensive Advanced Life Support Program. Of the general fund appropriation, $377,000 in fiscal year 2011 is to the commissioner for the comprehensive advanced life support educational program. For fiscal year 2012, base level funding for this program shall be $377,000.

Advisory Group on Administrative Expenses. Of the health care access fund appropriation for fiscal year 2011, $39,000 is to the commissioner for the advisory group established under Minnesota Statutes, section 62D.31. This is a onetime appropriation.

Base Level Adjustment. The general fund base is decreased by $253,000 in fiscal year 2012 and $253,000 in fiscal year 2013. The state government special revenue fund base is decreased by $2,000 in fiscal year 2012 and $2,000 in fiscal year 2013.

Office of Unlicensed Health Care Practice. Of the general fund appropriation, $74,000 in fiscal year 2011 is for the Office of Unlicensed Complementary and Alternative Health Care Practice. This is a onetime appropriation.

Subd. 4. **Health Protection**		(374,000)	714,000

Lead Base Grant Program. Of the general fund reduction, $25,000 in fiscal year 2010 and fiscal year 2011 is for the elimination of state funding for the temporary lead-safe housing base grant program.

Birth Defects Information System. Of the general fund appropriation for fiscal year 2011, $919,000 is for the Minnesota Birth Defects Information System established under Minnesota Statutes, section 144.2215.

Base Adjustment. The general fund base is increased by $440,000 in fiscal year 2012 and $984,000 in fiscal year 2013.

Subd. 5. **Administrative Support Services** -0- (100,000)

The general fund base is decreased by $22,000 in fiscal year 2012 and $22,000 in fiscal year 2013.

Sec. 5. **DEPARTMENT OF VETERANS AFFAIRS** **$ (50,000)** **$ -0-**

Cancellation of Prior Appropriation. By June 30, 2010, the commissioner of management and budget shall cancel the $50,000 appropriation for fiscal year 2008 to the board in Laws 2007, chapter 147, article 19, section 5, in the paragraph titled "Pay for Performance."

Sec. 6. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 113,000** **$ 615,000**

The appropriations in this section are from the state government special revenue fund.

In fiscal year 2010, $591,000 shall be transferred from the state government special revenue fund to the general fund. In fiscal

year 2011, $3,052,000 shall be transferred from the state government special revenue fund to the general fund. These transfers are in addition to those made in Laws 2009, chapter 79, article 13, section 5, as amended by Laws 2009, chapter 173, article 2, section 3.

The transfers in this section are onetime in the fiscal year 2010-2011 biennium.

The appropriations for each purpose are shown in the following subdivisions.

Subd. 2. **Board of Marriage and Family Therapy**	47,000	22,000

Operating Costs and Rulemaking. Of this appropriation, $22,000 in fiscal year 2010 and $22,000 in fiscal year 2011 are for operating costs. This is an ongoing appropriation. Of this appropriation, $25,000 in fiscal year 2010 is for rulemaking. This is a onetime appropriation.

Subd. 3. **Board of Nursing Home Administrators**	51,000	61,000
Subd. 4. **Board of Pharmacy**	-0-	517,000

Prescription Electronic Reporting. Of the state government special revenue fund appropriation, $517,000 in fiscal year 2011 is to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126. Base level funding for this activity in fiscal year 2012 shall be $356,000.

Subd. 5. **Board of Podiatry**	15,000	15,000

Purpose. This appropriation is to pay health insurance coverage costs and to cover the cost of expert witnesses in disciplinary cases.

Sec. 7. **EMERGENCY MEDICAL SERVICES BOARD** **$ 247,000** **$ (382,000)**

Sec. 8. **UNIVERSITY OF MINNESOTA** **$ -0-** **$ 93,000**

This appropriation is from the special revenue fund for the couples on the brink program.

Sec. 9. **DEPARTMENT OF CORRECTIONS** **$ -0-** **$ -0-**

Sex Offender Services. From the general fund appropriations to the commissioner of corrections, the commissioner shall transfer $418,000 in fiscal year 2012 and $419,000 in fiscal year 2013 to the commissioner of human services to provide clinical treatment to incarcerated offenders. This transfer shall become part of the base for the Department of Corrections.

Sec. 10. **DEPARTMENT OF COMMERCE** **$ -0-** **$ 38,000**

Health Plan Filings. Of this appropriation:

(1) $19,000 is for the review and approval of new health plan filings due to Minnesota Statutes, section 62Q.545. This is a onetime appropriation in fiscal year 2011; and

(2) $19,000 is for regulation of Minnesota Statutes, section 62A.3075. This is a onetime appropriation.

Sec. 11. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds appropriated for this program, the administrative services unit must purchase medical

professional liability insurance, if available, for a health care provider who is registered in accordance with subdivision 4 and who is not otherwise covered by a medical professional liability insurance policy or self-insured plan either personally or through another facility or employer. The administrative services unit is authorized to prorate payments or otherwise limit the number of participants in the program if the costs of the insurance for eligible providers exceed the funds appropriated for the program.

(b) Coverage purchased under this subdivision must be limited to the provision of health care services performed by the provider for which the provider does not receive direct monetary compensation.

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

Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ 5,225,451,000 $ 6,002,864,000**

Appropriations by Fund

	2010	2011
General	4,375,689,000	5,209,765,000
State Government Special Revenue	565,000	565,000
Health Care Access	450,662,000	527,411,000
Federal TANF	286,770,000	263,458,000
Lottery Prize	1,665,000	1,665,000
Federal Fund	110,000,000	0

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services

considers necessary, except that any transfers to one project that exceed $1,000,000 or multiple transfers to one project that exceed $1,000,000 in total require the express approval of the legislature. The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations. Any computer project with a total cost exceeding $1,000,000, including, but not limited to, a replacement for the proposed HealthMatch system, shall not be commenced without the express approval of the legislature.

HealthMatch Systems Project. In fiscal year 2010, $3,054,000 shall be transferred from the HealthMatch account in the state systems account in the special revenue fund to the general fund.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal

money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

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

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

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

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

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

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671~~.~~; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities

listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

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

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

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through

the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures to the extent such expenditures or other qualified expenditures are otherwise available after considering the expenditures allowed in this section.

(e) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(f) Notwithstanding any contrary provision in this article, this provision expires June 30, 2013.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures for fiscal year 2010 through fiscal year 2011.

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

(1) fiscal year 2010, ~~$50,973,000~~ $50,897,000;

(2) fiscal year 2011, ~~$53,793,000~~ $54,243,000;

(3) fiscal year 2012, ~~$23,516,000~~ $23,345,000; and

(4) fiscal year 2013, ~~$16,808,000~~ $16,585,000.

Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

Food Stamps Employment and Training.

(a) The commissioner shall apply for and claim the maximum allowable federal matching funds under United States Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family stabilization services participants voluntarily engaged in food stamp employment and training activities, where appropriate.

(b) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures for two-parent families must be deposited in the general fund. The amount of funds must be limited to $3,350,000 in fiscal year 2010 and $4,440,000 in fiscal years 2011 through 2013, contingent on approval by the federal Food and Nutrition Service.

(c) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

ARRA Food Support Administration.

The funds available for food support administration under the American Recovery and Reinvestment Act (ARRA) of 2009 are appropriated to the commissioner to pay actual costs of implementing the food support benefit increases, increased eligibility determinations, and outreach. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion based on a caseload factor equivalent to that of a county.

ARRA Food Support Benefit Increases.

The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Emergency Fund for the TANF Program.

TANF Emergency Contingency funds available under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) are appropriated to the commissioner. The commissioner must request TANF Emergency Contingency funds from the Secretary of the Department of Health and Human Services to the extent the commissioner meets or expects to meet the requirements of section 403(c) of the Social

Security Act. The commissioner must seek to maximize such grants. The funds received must be used as appropriated. Each county must maintain the county's current level of emergency assistance funding under the MFIP consolidated fund and use the funds under this paragraph to supplement existing emergency assistance funding levels.

Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	68,337,000	70,505,000

This appropriation is from the federal TANF fund.

TANF Transfer to Federal Child Care and Development Fund. The following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2010, ~~$6,531,000~~ $862,000;

(2) fiscal year 2011, ~~$10,241,000~~ $978,000;

(3) fiscal year 2012, ~~$10,826,000~~ $0; and

(4) fiscal year 2013, ~~$4,046,000~~ $0.

The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

Subd. 4. **Children and Economic Assistance Grants**

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

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	63,205,000	89,033,000
Federal TANF	100,818,000	84,538,000

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	12,498,000
Federal TANF	116,557,000	107,457,000

MFIP Consolidated Fund. The MFIP consolidated fund TANF appropriation is reduced by $1,854,000 in fiscal year 2010 and fiscal year 2011.

Notwithstanding Minnesota Statutes, section 256J.626, subdivision 8, paragraph (b), the commissioner shall reduce proportionately the reimbursement to counties for administrative expenses.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the

TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants, including provisions of TANF summer youth program wage subsidies for MFIP youth and caregivers. MFIP youth are individuals up to age 25 who are part of an eligible household as defined under rules governing TANF maintenance of effort with incomes less than 200 percent of federal poverty guidelines. Expenditures may only be used for subsidized wages and benefits and eligible training and supervision expenditures. The commissioner shall contract with the Minnesota Department of Employment and Economic Development for the summer youth program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund year quarters. No more than $6,000,000 shall be reimbursed. This provision is effective upon enactment.

Supported Work. Of the TANF appropriation, $4,700,000 in fiscal year 2010 and $4,700,000 in fiscal year 2011 are to the commissioner for supported work for MFIP recipients and is available until expended. Supported work includes paid transitional work experience and a continuum of employment assistance, including outreach and recruitment, program orientation and intake, testing and assessment, job development and marketing, preworksite training, supported worksite experience, job coaching, and postplacement follow-up,

in addition to extensive case management and referral services. This is a onetime appropriation.

Base Adjustment. The general fund base is reduced by $3,783,000 in each of fiscal years 2012 and 2013. ~~The TANF fund base is increased by $5,004,000 in each of fiscal years 2012 and 2013.~~

Integrated Services Program Funding. The TANF appropriation for integrated services program funding is $1,250,000 in fiscal year 2010 and $0 in fiscal year 2011 and the base for fiscal years 2012 and 2013 is $0.

TANF Emergency Fund; Nonrecurrent Short-Term Benefits. (a) TANF emergency contingency fund grants received due to increases in expenditures for nonrecurrent short-term benefits must be used to offset the increase in these expenditures for counties under the MFIP consolidated fund, under Minnesota Statutes, section 256J.626, and the diversionary work program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters. Growth in expenditures for the diversionary work program over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage these funds.

(b) To the extent that the commissioner can claim eligible tax credit growth as nonrecurrent short-term benefits, the commissioner shall use those funds to

leverage the increased expenditures in paragraph (a).

(c) TANF emergency funds for nonrecurrent short-term benefits received in excess of the amounts necessary for paragraphs (a) and (b) shall be used to reimburse the general fund for the costs of eligible tax credits in fiscal year 2011. The amount of such funds shall not exceed $15,500,000 in fiscal year 2010.

(d) This rider is effective the day following final enactment.

(c) MFIP Child Care Assistance Grants	61,171,000	65,214,000

Acceleration of ARRA Child Care and Development Fund Expenditure. The commissioner must liquidate all child care and development money available under the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5, by September 30, 2010. In order to expend those funds by September 30, 2010, the commissioner may redesignate and expend the ARRA child care and development funds appropriated in fiscal year 2011 for purposes under this section for related purposes that will allow liquidation by September 30, 2010. Child care and development funds otherwise available to the commissioner for those related purposes shall be used to fund the purposes from which the ARRA child care and development funds had been redesignated.

School Readiness Service Agreements. $400,000 in fiscal year 2010 and $400,000 in fiscal year 2011 are from the federal TANF fund to the commissioner of human

services consistent with federal regulations for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(d) Basic Sliding Fee Child Care Assistance Grants	40,100,000	45,092,000

School Readiness Service Agreements. $257,000 in fiscal year 2010 and $257,000 in fiscal year 2011 are from the general fund for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,244,000 in fiscal year 2010 from the federal child care development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

Basic Sliding Fee. $4,000,000 in fiscal year 2010 and $4,000,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of basic sliding fee child care

assistance under Minnesota Statutes, section 119B.03. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Basic Sliding Fee Allocation for Calendar Year 2010. Notwithstanding Minnesota Statutes, section 119B.03, subdivision 6, in calendar year 2010, basic sliding fee funds shall be distributed according to this provision. Funds shall be allocated first in amounts equal to each county's guaranteed floor, according to Minnesota Statutes, section 119B.03, subdivision 8, with any remaining available funds allocated according to the following formula:

(a) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(b) Up to three-fourths of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in Minnesota Statutes, section 119B.03, subdivision 2, and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families

in this category shall be allocated according to paragraph (d).

(c) The amount necessary to serve all families in paragraphs (a) and (b) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

(d) Funds in excess of the amount necessary to serve all families in paragraphs (a) and (b) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation. To the extent that funds are available, and notwithstanding Minnesota Statutes, section 119B.03, subdivision 8, for the period January 1, 2011, to December 31, 2011, each county's guaranteed floor must be equal to its original calendar year 2010 allocation.

Base Adjustment. The general fund base is decreased by $257,000 in each of fiscal years 2012 and 2013.

(e) Child Care Development Grants	1,487,000	1,487,000

Family, friends, and neighbor grants. $375,000 in fiscal year 2010 and $375,000 in fiscal year 2011 are from the child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services for family, friends, and neighbor grants under Minnesota Statutes, section

119B.232. This appropriation may be used on programs receiving family, friends, and neighbor grant funds as of June 30, 2009, or on new programs or projects. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system training, coaching, consultation, and supports. $633,000 in fiscal year 2010 and $633,000 in fiscal year 2011 are from the federal child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of providing grants to provide statewide child-care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system rating tool. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system. $184,000 in fiscal year 2010 and $1,200,000 in fiscal year 2011 are from the federal child care development fund required targeted funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of implementing the voluntary Parent Aware quality star rating system pilot in coordination with the Minnesota Early Learning Foundation. The

appropriation for the first year is to complete and promote the voluntary Parent Aware quality rating system pilot program through June 30, 2010, and the appropriation for the second year is to continue the voluntary Minnesota quality rating system pilot through June 30, 2011. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(f) Child Support Enforcement Grants 3,705,000 3,705,000

(g) Children's Services Grants

Appropriations by Fund		
General	48,333,000	50,498,000
Federal TANF	340,000	240,000

Base Adjustment. The general fund base is decreased by $5,371,000 in fiscal year 2012 and decreased $5,371,000 in fiscal year 2013.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for postadoption services including parent support groups.

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

(h) Children and Community Services Grants	67,663,000	67,542,000

Targeted Case Management Temporary Funding Adjustment. The commissioner shall recover from each county and tribe receiving a targeted case management temporary funding payment in fiscal year 2008 an amount equal to that payment. The commissioner shall recover one-half of the funds by February 1, 2010, and the remainder by February 1, 2011. At the commissioner's discretion and at the request of a county or tribe, the commissioner may revise the payment schedule, but full payment must not be delayed beyond May 1, 2011. The commissioner may use the recovery procedure under Minnesota Statutes, section 256.017, to recover the funds. Recovered funds must be deposited into the general fund.

(i) General Assistance Grants	48,215,000	48,608,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in fiscal year 2010 and $7,889,812 in fiscal year 2011. Funds to counties must be allocated by the

commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants 33,930,000 35,191,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $1,100,000 in fiscal year 2010 and $1,100,000 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(k) Group Residential Housing Grants 111,778,000 114,034,000

Group Residential Housing Costs Refinanced. (a) Effective July 1, 2011, the commissioner shall increase the home and community-based service rates and county allocations provided to programs for persons with disabilities established under section 1915(c) of the Social Security Act to the extent that these programs will be paying for the costs above the rate established in Minnesota Statutes, section 256I.05, subdivision 1.

(b) For persons receiving services under Minnesota Statutes, section 245A.02, who reside in licensed adult foster care beds for which a difficulty of care payment was being made under Minnesota Statutes, section 256I.05, subdivision 1c, paragraph (b), counties may request an exception to the individual's service authorization not to exceed the difference between the client's

monthly service expenditures plus the amount of the difficulty of care payment.

(l) Children's Mental Health Grants 16,885,000 16,882,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(m) Other Children and Economic Assistance Grants 16,047,000 15,339,000

Fraud Prevention Grants. Of this appropriation, $228,000 in fiscal year 2010 and ~~$228,000~~ $379,000 in fiscal year 2011 is to the commissioner for fraud prevention grants to counties.

Homeless and Runaway Youth. $218,000 in fiscal year 2010 is for the Runaway and Homeless Youth Act under Minnesota Statutes, section 256K.45. Funds shall be spent in each area of the continuum of care to ensure that programs are meeting the greatest need. Any unexpended balance in the first year is available in the second year. Beginning July 1, 2011, the base is increased by $119,000 each year.

ARRA Homeless Youth Funds. To the extent permitted under federal law, the commissioner shall designate $2,500,000 of the Homeless Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, for agencies providing homelessness prevention and rapid rehousing services to youth.

Supportive Housing Services. $1,500,000 each year is for supportive services under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

Community Action Grants. Community action grants are reduced one time by $1,794,000 each year. This reduction is due to the availability of federal funds under the American Recovery and Reinvestment Act.

Base Adjustment. The general fund base is increased by ~~$773,000~~ $903,000 in fiscal year 2012 and ~~$773,000~~ $413,000 in fiscal year 2013.

Federal ARRA Funds for Existing Programs. (a) Federal funds received by the commissioner for the emergency food and shelter program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, but not previously approved by the legislature are appropriated to the commissioner for the purposes of the grant program.

(b) Federal funds received by the commissioner for the emergency shelter grant program including the Homelessness Prevention and Rapid Re-Housing Program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

(c) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the

commissioner for the purposes of the grant program.

(d) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

(e) Federal funds received by the commissioner for the community services block grant program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

Long-Term Homeless Supportive Service Fund Appropriation. To the extent permitted under federal law, the commissioner shall designate $3,000,000 of the Homelessness Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law, 111-5, to the long-term homeless service fund under Minnesota Statutes, section 256K.26. This appropriation shall become available by July 1, 2009. This paragraph is effective the day following final enactment.

Sec. 15. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

Subd. 8. **Continuing Care Grants**

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

(a) Aging and Adult Services Grants		13,499,000	15,805,000

Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.

Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

(b) Alternative Care Grants		50,234,000	48,576,000
Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.			
Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.			
(c) Medical Assistance Grants; Long-Term Care Facilities.		367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants		853,567,000	1,039,517,000
Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals			

anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver Allocations. Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

Alternatives to Personal Care Assistance Services. Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.

(e) Mental Health Grants

	Appropriations by Fund	
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

Payments for Substance Abuse Treatment.

For ~~services provided~~ placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

(1) rates charged for these services on January 1, 2009; or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, ~~statewide average rates~~ the statewide aggregate payment under

the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the ~~average rates charged for these services on January 1, 2009~~ projected aggregate payment under the rates in effect for fiscal year 2011 excluding the rate reduction for rates that were below the average on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 16. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing Home Administrators**	1,211,000	1,023,000

Administrative Services Unit - Operating Costs. Of this appropriation, $524,000 in fiscal year 2010 and $526,000 in fiscal year 2011 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year

2010, $201,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, ~~$79,000~~ $130,000 in fiscal year 2010 and ~~$89,000~~ $150,000 in fiscal year 2011 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2010 and $200,000 in fiscal year 2011 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section and for unforeseen expenditures of an urgent nature. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years. The boards receiving funds under this section shall include these

amounts when setting fees to cover their costs.

Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2011, unless a different expiration date is explicit.

Sec. 18. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2010, unless a different effective date is explicit.

APPENDIX
Article locations in H3834-1

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144.607 TRAUMA REGISTRY.

Subdivision 1. **Registry participation required.** A trauma hospital must participate in the statewide trauma registry.

Subd. 2. **Trauma reporting.** A trauma hospital must report major trauma injuries as part of the reporting for the traumatic brain injury and spinal cord injury registry required in sections 144.661 to 144.665.

Subd. 3. **Application of other law.** Sections 144.661 to 144.665 apply to a major trauma reported to the statewide trauma registry, with the exception of sections 144.662, clause (2), and 144.664, subdivision 3.

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subd. 2. **County adjustment; maximum allocation.** The commissioner shall determine the state money used by each county in fiscal year 1986, using all state data sources. If available records do not provide specific chemical dependency expenditures for every county, the commissioner shall determine the amount of state money using estimates based on available data. In state fiscal year 1988, a county must not be allocated more than 150 percent of the state money spent by or on behalf of the county in fiscal year 1986 for chemical dependency treatment services eligible for payment under section 254B.05 but not including expenditures made for persons eligible for placement under section 254B.09, subdivision 6. The allocation maximums must be increased by 25 percent each year. After fiscal year 1992, there must be no allocation maximum. The commissioner shall reallocate the excess over the maximum to counties allocated less than the fiscal year 1986 state money, using the following process:

(a) The allocation is divided by 1986 state expenditures to determine percentage of prior expenditure, and counties are ranked by percentage of prior expenditure less expenditures for persons eligible for placement under section 254B.09, subdivision 6.

(b) The allocation of the lowest ranked county is raised to the same percentage of prior expenditure as the second lowest ranked county. The allocation of these two counties is then raised to the percentage of prior expenditures of the third lowest ranked county.

(c) The operations under paragraph (b) are repeated with each county by ranking until the money in excess of the allocation maximum has been allocated.

Subd. 3. **Reserve account.** The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, at the end of each biennium, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Subd. 4. **Allocation spending limits.** Money allocated according to subdivision 1 and section 254B.09, subdivision 4, is available for payments for up to two years. The commissioner shall deduct payments from the most recent year allocation in which money is available. Allocations under this section that are not used within two years must be reallocated to the reserve account for payments under subdivision 3. Allocations under section 254B.09, subdivision 4,

that are not used within two years must be reallocated for payments under section 254B.09, subdivision 5.

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subd. 4. **Tribal allocation.** Eighty-five percent of the American Indian chemical dependency tribal account must be allocated to the federally recognized American Indian tribal governing bodies that have entered into an agreement under subdivision 2 as follows: $10,000 must be allocated to each governing body and the remainder must be allocated in direct proportion to the population of the reservation according to the most recently available estimates from the federal Bureau of Indian Affairs. When a tribal governing body has not entered into an agreement with the commissioner under subdivision 2, the county may use funds allocated to the reservation to pay for chemical dependency services for a current resident of the county and of the reservation.

Subd. 5. **Tribal reserve account.** The commissioner shall reserve 15 percent of the American Indian chemical dependency tribal account. The reserve must be allocated to those tribal units that have used all money allocated under subdivision 4 according to agreements made under subdivision 2 and to counties submitting invoices for American Indians under subdivision 1 when all money allocated under subdivision 4 has been used. An American Indian tribal governing body or a county submitting invoices under subdivision 1 may receive not more than 30 percent of the reserve account in a year. The commissioner may refuse to make reserve payments for persons not eligible under section 254B.04, subdivision 1, if the tribal governing body responsible for treatment placement has exhausted its allocation. Money must be allocated as invoices are received.

Subd. 7. **Nonreservation Indian account.** The nonreservation American Indian chemical dependency allocation must be held in reserve by the commissioner in an account for treatment of Indians not residing on lands of a reservation receiving money under subdivision 4. This money must be used to pay for services certified by county invoice to have been provided to an American Indian eligible recipient. Money allocated under this subdivision may be used for payments on behalf of American Indian county residents only if, in addition to other placement standards, the county certifies that the placement was appropriate to the cultural orientation of the client. Any funds for treatment of nonreservation Indians remaining at the end of a fiscal year shall be reallocated under section 254B.02.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

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

(2) who is a resident of Minnesota; and

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

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

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

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

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

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

(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

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

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

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

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

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

(6) are eligible under paragraph (k);

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

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

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

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

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

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

person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

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

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

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

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

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

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

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 5. **Certain county agencies to pay state for county share.** The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related

travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities

under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Laws 2009, chapter 79, article 7, section 26, subdivision 3

Sec. 26. STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT PROJECT.

Subd. 3. **Report.** The Department of Human Services shall evaluate the efficacy and feasibility of the pilot projects and report the results of that evaluation to the legislative committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot projects may occur only if the department's report finds the pilot projects effective.

Laws 2010, chapter 200, article 1, section 12 Subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,

Sec. 12. [256D.031] GENERAL ASSISTANCE MEDICAL CARE.

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

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

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of $1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

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

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

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

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

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human

Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare-certified rehabilitation agencies;

(4) prescription drugs;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations;

(7) hearing aids;

(8) prosthetic devices, if not covered by veterans benefits;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services;

(15) mental health services covered under chapter 256B;

(16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for

inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(18) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(19) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) $25 for nonemergency visits to a hospital-based emergency room; and

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the $7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 5. **Payment rates and contract modification; April 1, 2010, to May 31, 2010.** (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

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

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than $1,500,000, or (B) equal to or greater than 1.3 percent of net

patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

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

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

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

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

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

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

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

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

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

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

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

deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

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

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

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

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

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

Subd. 8. **Temporary uncompensated care pool.** (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to November 30, 2010.

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

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

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

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

Subd. 9. **Prescription drug pool.** (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

Subd. 10. **Assistance for veterans.** Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers,

and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

Laws 2010, chapter 200, article 1, section 18

Sec. 18. **DRUG REBATE PROGRAM.**

The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph (cc), and 256D.03.

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

Laws 2010, chapter 200, article 1, section 19

Sec. 19. **TRANSITIONAL MINNESOTACARE PHASEOUT.**

For any applicant or recipient who meets the requirements of Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), before April 1, 2010, and who is not exempt under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (f), the commissioner of human services shall continue the process of enrolling the recipient in MinnesotaCare as required under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), and, upon the completion of enrollment, the recipient shall receive services under MinnesotaCare in accordance with Minnesota Statutes, section 256L.03. County agencies shall continue to perform all duties necessary to administer the MinnesotaCare program ongoing for individuals enrolled in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), including the redetermination of MinnesotaCare eligibility at renewal.

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