CONFERENCE COMMITTEE REPORT ON H. F. No. 2614

A bill for an act

relating to state government; licensing; state health care programs; continuing care; children and family services; health reform; Department of Health; public health; health plans; assessing administrative penalties; modifying foreign operating corporation taxes; requiring reports; making supplemental and contingent appropriations and reductions for the Departments of Health and Human Services and other health-related boards and councils; amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision; 62J.07, subdivision 2, by adding a subdivision; 62J.38; 62J.692, subdivision 4; 62Q.19, subdivision 1; 62Q.76, subdivision 1; 62U.05; 119B.025, subdivision 1; 119B.09, subdivision 4; 119B.11, subdivision 1; 144.05, by adding a subdivision; 144.226, subdivision 3; 144.291, subdivision 2; 144.293, subdivision 4, by adding a subdivision; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144E.37; 214.40, subdivision 7; 245C.27, subdivision 2; 245C.28, subdivision 3; 246B.04, subdivision 2; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivision 3; 256B.04, subdivision 14; 256B.055, by adding a subdivision; 256B.056, 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.0754, by adding a subdivision; 256B.0915, subdivision 3b; 256B.19, subdivision 1c; 256B.441, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 20, as amended, 27, by adding subdivisions; 256B.692, subdivision 1; 256B.75; 256B.76, subdivisions 2, 4, by adding a subdivision; 256D.03, subdivision 3b; 256D.0515; 256D.425, subdivision 2; 256I.05, by adding a subdivision; 256J.20, subdivision 3; 256J.24, subdivision 10; 256J.37, subdivision 3a; 256J.39, by adding subdivisions; 256L.02, subdivision 3; 256L.03, subdivision 3, by adding a subdivision; 256L.04, subdivision 7; 256L.05, by adding a subdivision; 256L.07, subdivision 1, by adding a subdivision; 256L.12, subdivisions 5, 6, 9; 256L.15, subdivision 1; 290.01, subdivision 5, by adding a subdivision; 290.17, subdivision 4; 326B.43, subdivision 2; 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 157.16, subdivision 3; 245A.11, subdivision 7b; 245C.27, subdivision 1; 246B.06, subdivision 6; 252.025, subdivision 7; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969, subdivision 3a; 256B.056, subdivision 3c; 256B.0625, subdivisions 9, 13e; 256B.0653, subdivision 5; 256B.0911, subdivision 1a; 256B.0915, subdivision 3a; 256B.69, subdivisions 5a, 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256D.44, subdivision 5; 256J.425, subdivision 3; 256L.03, subdivision 5; 256L.11, subdivision 1; 289A.08, subdivision 3; 290.01, subdivisions 19c, 19d; 327.15, subdivision 3; Laws 2005, First Special Session

chapter 4, article 8, section 66, as amended; Laws 2009, chapter 79, article 3, section 18; article 5, sections 17; 18; 22; 75, subdivision 1; 78, subdivision 5; article 8, sections 2; 51; 81; article 13, sections 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5, subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter 200, article 1, sections 12, subdivisions 5, 6, 7, 8; 13, subdivision 1b; 16; 21; article 2, section 2, subdivisions 1, 8; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 62E; 62J; 62Q; 144; 245; 254B; 256; 256B; proposing coding for new law as Minnesota Statutes, chapter 62V; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8; 290.01, subdivision 6b; 290.0921, subdivision 7; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; Laws 2009, chapter 79, article 7, section 26, subdivision 3; Laws 2010, chapter 200, article 1, sections 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 18; 19.

May 12, 2010

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

The Honorable James P. Metzen
President of the Senate

We, the undersigned conferees for H. F. No. 2614 report that we have agreed upon the items in dispute and recommend as follows:

That the House recede from its amendment and that H. F. No. 2614 be further amended as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

HEALTH CARE

Section 1. 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. 2. 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 0.85 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 1.45 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. 3. 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. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment

of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

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

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

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

(i) In 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. 5. Minnesota Statutes 2008, section 256.969, subdivision 21, is amended to read:

Subd. 21. **Mental health or chemical dependency admissions; rates.** (a) Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

(b) 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. 6. 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. 7. 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. 8. 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. 9. 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. 10. 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 June 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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. 16. 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. 17. 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. 18. 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. 19. 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 July 1, 2010.

Sec. 20. 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. 21. 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. 22. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5, is amended to read:

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

(b) Home care therapies must be:

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

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

(3) assessed by an appropriate therapist; and

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

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

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

Sec. 23. **[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 ACO 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, 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. 24. **[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. 25. 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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the 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. 26. 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 1.28 percent.

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

Sec. 27. 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. 28. 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. 29. 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. 30. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. This reduction ~~does~~ 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 ~~does~~ 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 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 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 25 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. 31. Minnesota Statutes 2008, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a 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. 32. 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. 33. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, prior to third-party liability and spenddown calculation. This reduction applies to physical therapy services, occupational

therapy services, and speech language pathology and related services provided on or after July 1, 2010. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech language pathology and related services as basic care services. Effective October 1, 2010, payments made to managed care and county-based purchasing plans shall reflect the July 1, 2010, payment adjustments in this paragraph. Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

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

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

Sec. 35. 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 May 31, 2010, general assistance medical care covers the services listed in subdivision 4.

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

Sec. 36. 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. 37. 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. 38. 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. 39. 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. 40. 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. 41. 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. 42. 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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the 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. 43. 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 1.28 percent.

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

Sec. 44. 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. 45. 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. 46. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to read:

EFFECTIVE DATE. This section, except for subdivision 4, is effective for services rendered on or after April 1, 2010. Subdivision 4 of this section is effective June 1, 2010.

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

Sec. 47. 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. 48. 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~~ June 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. 49. 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. 50. 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. 51. 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. 52. **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. 53. **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. 54. **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. 55. **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. 56. **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; 18; and 19, are repealed July 1, 2010.

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

ARTICLE 2

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.03, is amended by adding a subdivision to read:

Subd. 3. **Certificate of transitional consultation.** (a) A housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line that transition to housing with services consultation under section 256B.0911, subdivision 3c, has been completed. Prospective residents may be allowed to move in on an emergency basis prior to receiving a certificate, however, the certification must occur within 30 calendar days of admission. The housing with services establishment shall maintain copies of contracts and certificates for audit for a period of three years. The Senior LinkAge Line shall issue a certification within 24 hours of a contact by a prospective resident.

(b) This subdivision applies to housing with services establishments that are required to register under section 144D.02 and:

(1) include any service in the base rate as described in the contract established under section 144D.04; or

(2) require residents to purchase services as a condition of tenancy.

Sec. 3. 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. 4. **[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. 5. **[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. 6. 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. 7. 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. 8. **[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. 9. 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. 10. 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. 11. 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) <u>but for excess earnings or assets,</u> 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. 12. 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. 13. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments ~~offering or providing assisted living under chapter 144G~~ shall inform all prospective residents of the ~~availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident~~ requirement to contact the Senior LinkAge Line for long-term care options counseling and transitional consultation. The Senior LinkAge Line shall provide a certificate to the prospective resident and also send a copy of the certificate to the housing with services establishment that the prospective resident chooses, verifying that consultation has been provided to the prospective resident or the prospective resident's legal representative. The housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line. Prospective residents refusing to contact the Senior LinkAge Line are required to sign a waiver form supplied by the provider. The housing with services establishment shall maintain copies of contracts, waiver forms, and certificates for audit for a period of three years. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least

restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units~~, and the Area Agencies on Aging~~ under section 144D.03, subdivision 3, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; ~~and~~

(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals who are at highest risk of nursing facility placement or as needed for determining eligibility~~.~~;

(4) a prospective resident does not include a person moving from the community, a hospital, or an institutional setting to housing with services during nonworking hours when:

(i) the move is based on a recent precipitating event that precludes the person from living safely in the community or institution, such as sustaining injury, unanticipated discharge from hospital or nursing facility, inability of caregivers to provide needed care, lack of access to needed care or services, or declining health status; and

(ii) the Senior LinkAge Line is contacted within ten working days following the move to the registered housing with services, or as soon as is reasonable considering the prospective resident's condition; and

(5) the Senior LinkAge Line may provide the long-term care options counseling and transitional consultation service.

Sec. 14. 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. 15. 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. 16. 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. 17. 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 December 31, 2010, 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. 18. 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. 19. 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. 20. **CASE MANAGEMENT REFORM.**

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

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

(2) standardize and simplify processes, standards, and timelines for case management within the Department of Human Services, Disability Services Division, including eligibility determinations, resource allocation, management of dollars, provision for assignment of one case manager at a time per person, waiting lists, quality assurance, host county concurrence requirements, county of financial responsibility provisions, and waiver compliance; and

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

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

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

Sec. 21. **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. 22. **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 3

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. **REPEALER.**

Minnesota Statutes 2009 Supplement, section 256J.621, is repealed.

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

ARTICLE 4

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 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.

88.1 .....

88.2 ..... (judge of district court)

88.3 ..... (date).

88.4 (c) The marriage license fee for parties who have completed at least 12 hours of
88.5 premarital education is $40. In order to qualify for the reduced license fee, the parties
88.6 must submit at the time of applying for the marriage license a signed, dated, and notarized
88.7 statement from the person who provided the premarital education on their letterhead
88.8 confirming that it was received. The premarital education must be provided by a licensed
88.9 or ordained minister or the minister's designee, a person authorized to solemnize marriages
88.10 under section 517.18, or a person authorized to practice marriage and family therapy under
88.11 section 148B.33. The education must include the use of a premarital inventory and the
88.12 teaching of communication and conflict management skills.

88.13 (d) The statement from the person who provided the premarital education under
88.14 paragraph (b) must be in the following form:

88.15 "I, ... (name of educator), confirm that ..... (names of
88.16 both parties) received at least 12 hours of premarital education that included the use of a
88.17 premarital inventory and the teaching of communication and conflict management skills.
88.18 I am a licensed or ordained minister, a person authorized to solemnize marriages under
88.19 Minnesota Statutes, section 517.18, or a person licensed to practice marriage and family
88.20 therapy under Minnesota Statutes, section 148B.33."

88.21 The names of the parties in the educator's statement must be identical to the legal
88.22 names of the parties as they appear in the marriage license application. Notwithstanding
88.23 section 138.17, the educator's statement must be retained for seven years, after which
88.24 time it may be destroyed.

88.25 (e) If section 259.13 applies to the request for a marriage license, the local registrar
88.26 shall grant the marriage license without the requested name change. Alternatively, the local
88.27 registrar may delay the granting of the marriage license until the party with the conviction:

88.28 (1) certifies under oath that 30 days have passed since service of the notice for a
88.29 name change upon the prosecuting authority and, if applicable, the attorney general and no
88.30 objection has been filed under section 259.13; or

88.31 (2) provides a certified copy of the court order granting it. The parties seeking the
88.32 marriage license shall have the right to choose to have the license granted without the
88.33 name change or to delay its granting pending further action on the name change request.

88.34 Sec. 17. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws
88.35 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. **REPEALER.**

Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09, subdivisions 4, 5, and 7, are repealed.

Sec. 23. **EFFECTIVE DATE.**

Sections 8 to 14 and 22 are effective for claims paid on or after July 1, 2010.

ARTICLE 5

DEPARTMENT OF HEALTH

Section 1. 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. 2. **[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. 3. 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. 4. 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. 5. 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. 6. 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. 7. **[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. 8. 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. 9. 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. 10. 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. 11. 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. 12. **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. 13. **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. 14. **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. 15. **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. 16. **REVISOR'S INSTRUCTION.**

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

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

ARTICLE 6

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 7

HEALTH CARE REFORM

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

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

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

(c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, including any federal regulations adopted under it.

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

Subd. 2. **Timing of this section.** This section applies beginning 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 8

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 9

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.**

(a) The sums shown in the columns marked "Appropriations" are added to the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agency and for the purposes specified in this bill. The appropriations are from the general fund, or another named fund, and are available for the fiscal years

indicated for each purpose. The figures "2010" and "2011" used in this bill mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively.

(b) Upon enactment of the extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the president's budget for federal fiscal year 2011 or contained in House Resolution 2847, the federal "Jobs for Main Street Act, 2010," or contained in House Resolution 4213, "American Workers, State, and Business Relief Act of 2010," or subsequent federal legislation, the appropriations identified in section 3 shall be made for fiscal year 2011.

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ -0-**	**$ 14,069,000**
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

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 10

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)	$ 215,726,000	$ 208,942,000

State Government Special Revenue	113,000	624,000	737,000
Health Care Access	998,000	11,579,000	12,577,000
Federal TANF	8,000,000	20,000,000	28,000,000
Special Revenue	-0-	93,000	93,000
Total	**$ 2,327,000**	**$ 248,021,000**	**$ 250,348,000**

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**	**$**	**4,409,000**	**$ 246,347,000**

Appropriations by Fund

	2010	2011
General	(4,589,000)	215,006,000
Health Care Access	998,000	11,342,000
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 $3,292,000 in fiscal year 2012 and $3,292,000 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.

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-	(1,520,000)

(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	18,124,000

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 $199,337,000 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 $297,135,000 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 ten 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- 318,106,000

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-	(3,659,000)

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-	700,000,000

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-	(1,091,000)

Base Adjustment. The general fund base for aging and adult services grants is increased by $1,139,000 in fiscal year 2012 and $1,280,000 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- 4,143,000

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- (4,631,000)

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.

(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-		414,000

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 $97,000 in fiscal year 2012 and decreased by $12,000 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.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **(2,392,000)** **$** **(1,310,000)**

Appropriations by Fund

	2010	2011
General	(2,392,000)	(1,064,000)
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	237,000

Subd. 2. **Community and Family Health** (221,000) (47,000)

Base Level Adjustment. The general fund base is decreased by $388,000 in fiscal years 2012 and 2013.

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.

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.

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."

Delete the title and insert:

"A bill for an act

relating to state government; 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 62D.08, by adding a subdivision; 62J.692, subdivision 4; 62Q.19, subdivision 1; 144.05, by adding a subdivision; 144.226, subdivision 3; 144.293, subdivision 4; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144D.03, subdivision 2, by adding a subdivision; 144D.04, subdivision 2; 144E.37; 144G.06; 152.126, as amended; 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; 256.9657, subdivisions 2, 3, 3a; 256.969, subdivisions 21, 26, by adding a subdivision; 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 a subdivision; 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; 517.08, subdivision 1c, as amended; Minnesota Statutes 2009 Supplement, sections 157.16, subdivision 3; 252.27, subdivision 2a; 256.969, subdivisions 2b, 3a; 256.975, subdivision 7; 256B.0625, subdivision 13h; 256B.0653, subdivision 5; 256B.0659, subdivision 11; 256B.0911, subdivisions 1a, 3c; 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; 256L.03, subdivision 5; 327.15, subdivision 3; 517.08, subdivision 1b; 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; 5, subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter 200, article 1, sections 12; 16; 21; article 2, section 2, subdivisions 1, 5, 8; proposing coding for new law in Minnesota Statutes, chapters 62D; 62E; 62Q; 137; 144; 144D; 246; 254B; 256; 256B; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3, 3a, 5, 6, 7, 8; Minnesota Statutes 2009 Supplement, section 256J.621; Laws 2010, chapter 200, article 1, sections 12; 18; 19."

We request the adoption of this report and repassage of the bill.

House Conferees:

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Thomas Huntley	Karen Clark
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Paul Thissen	Larry Hosch
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Jim Abeler	

Senate Conferees:

.....	.....
Linda Berglin	Yvonne Prettner Solon
.....	.....
Kathy Sheran	Tony Lourey
.....	
Steve Dille	