A bill for an act

relating to state government; making changes to continuing care; agency management; state-operated services; children and family services; health care programs; Department of Health provisions; appropriating money; amending Minnesota Statutes 2006, sections 144.1222, subdivision 1a, by adding subdivisions; 157.16, as amended; 256.741, subdivisions 2, 2a, 3; 256.969, subdivisions 2b, 20; 256B.0571, subdivisions 8, 9; 256B.0621, subdivisions 2, 6, 10; 256B.0625, subdivisions 3c, 13e; 256B.0924, subdivisions 4, 6; 256B.19, subdivision 1d; 256B.431, subdivision 23; 256B.434, by adding a subdivision; 256B.441, by adding a subdivision; 256B.69, subdivisions 5a, 6; 256D.44, subdivisions 2, 5; 256L.12, subdivision 9; 518A.50; 518A.53, subdivision 5; Minnesota Statutes 2007 Supplement, sections 16A.724, subdivision 2; 256.01, subdivision 2; 256.741, subdivision 1; 256B.0625, subdivision 20; 256B.0631, subdivisions 1, 3; 256B.199; 256J.621; 256L.04, subdivisions 1, 7; 256L.07, subdivision 1; Laws 2006, chapter 282, article 20, section 37, as amended; Laws 2007, chapter 147, article 2, section 21; article 19, sections 3, subdivisions 1, 4, 6; 4, subdivisions 2, 4; proposing coding for new law in Minnesota Statutes, chapters 246B; 256B; repealing Minnesota Statutes 2006, sections 62J.58; 256.741, subdivision 15; 256B.441, subdivision 25; Minnesota Statutes 2007 Supplement, sections 256.962, subdivision 5; 256.969, subdivision 27; 256B.057, subdivision 2c; 256B.441, subdivisions 1, 14a, 30, 31, 48, 49, 50, 51, 52, 53, 54, 55, 56, 58; 256L.07, subdivision 7.

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

ARTICLE 1
CONTINUING CARE

Section 1. Minnesota Statutes 2006, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under sections 256B.0651 to 256B.0656: skilled nursing visits, home health aide

visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with developmental disabilities;

(4) "relocation targeted case management" includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the lesser of:

(i) the last 180 consecutive days of an eligible recipient's institutional stay; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 2. Minnesota Statutes 2006, section 256B.0621, subdivision 6, is amended to read:

Subd. 6. **Eligible services.** (a) Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case management services and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery and engaging in advocacy as needed to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) assisting individuals in order to access needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner ~~in the 180-day period~~ before the recipient's discharge.

(b) Relocation targeted county case management includes services under paragraph (a), clauses (1), (2), and (4). Relocation service coordination includes services under paragraph (a), clauses (3) and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

Sec. 3. Minnesota Statutes 2006, section 256B.0621, subdivision 10, is amended to read:

Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case management under this subdivision. Case managers may bill according to the following criteria:

(1) for relocation targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts, in the lesser of:

(i) 180 days preceding an eligible recipient's discharge from an institution; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service;

(2) for home care targeted case management, case managers may bill for direct case management activities, including face-to-face and telephone contacts; and

(3) billings for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with

serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted

vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

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

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Sec. 5. **[256B.0658] HOUSING ACCESS GRANTS.**

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals eligible for publicly funded home and community-based services, including state plan home care, to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assess to assure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section 8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

Sec. 6. Minnesota Statutes 2006, section 256B.0924, subdivision 4, is amended to read:

Subd. 4. **Targeted case management service activities.** (a) For persons with developmental disabilities, targeted case management services must meet the provisions of section 256B.092.

(b) For persons not eligible as a person with a developmental disability, targeted case management service activities include:

(1) an assessment of the person's need for targeted case management services;

(2) the development of a written personal service plan;

(3) a regular review and revision of the written personal service plan with the recipient and the recipient's legal representative, and others as identified by the recipient, to ensure access to necessary services and supports identified in the plan;

(4) effective communication with the recipient and the recipient's legal representative and others identified by the recipient;

(5) coordination of referrals for needed services with qualified providers;

(6) coordination and monitoring of the overall service delivery to ensure the quality and effectiveness of services;

(7) assistance to the recipient and the recipient's legal representative to help make an informed choice of services;

(8) advocating on behalf of the recipient when service barriers are encountered or referring the recipient and the recipient's legal representative to an independent advocate;

(9) monitoring and evaluating services identified in the personal service plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(10) conducting face-to-face monitoring with the recipient at least twice a year;

(11) completing and maintaining necessary documentation that supports and verifies the activities in this section;

(12) coordinating with the medical assistance facility discharge planner ~~in the 180-day period~~ prior to the recipient's discharge into the community; and

(13) a personal service plan developed and reviewed at least annually with the recipient and the recipient's legal representative. The personal service plan must be revised when there is a change in the recipient's status. The personal service plan must identify:

(i) the desired personal short and long-term outcomes;

(ii) the recipient's preferences for services and supports, including development of a person-centered plan if requested; and

(iii) formal and informal services and supports based on areas of assessment, such as: social, health, mental health, residence, family, educational and vocational, safety, legal, self-determination, financial, and chemical health as determined by the recipient and the recipient's legal representative and the recipient's support network.

Sec. 7. Minnesota Statutes 2006, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect

as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

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

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

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

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

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

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

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of finance. For the purposes of targeted case management services provided by county staff

under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility ~~and may not exceed more than six months in a calendar year~~; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 8. Minnesota Statutes 2006, section 256B.19, subdivision 1d, is amended to read:

Subd. 1d. **Portion of nonfederal share to be paid by certain counties.** (a) In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

(b) Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(c) Beginning in 2002, in addition to any transfer under paragraph (b), each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $10,784. The provisions of paragraph (b) apply to transfers under this paragraph.

~~(d) Beginning in 2003, in addition to any transfer under paragraphs (b) and (c), each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any~~

~~nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by $2,230. The provisions of paragraph (b) apply to transfers under this paragraph.~~

~~(c)~~ (d) The commissioner may reduce the intergovernmental transfers under ~~paragraphs~~ paragraph (c) ~~and (d)~~ based on the commissioner's determination of the payment rate in section 256B.431, subdivision 23, paragraphs (c)~~,~~ and (d)~~, and (c)~~. Any adjustments must be made on a per-bed basis and must result in an amount equivalent to the total amount resulting from the rate adjustment in section 256B.431, subdivision 23, paragraphs (c)~~,~~ and (d)~~, and (c)~~.

Sec. 9. Minnesota Statutes 2006, section 256B.431, subdivision 23, is amended to read:

Subd. 23. **County nursing home payment adjustments.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, on that date, was county-owned and operated, with the county named as licensee by the commissioner of health, and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility on that date.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

(c) Beginning in 2002, in addition to any payment under paragraph (a), the commissioner shall pay to a nursing facility described in paragraph (a) an adjustment in an amount equal to $29.55 per calendar day multiplied by the number of beds licensed in the facility on that date. The provisions of paragraphs (a) and (b) apply to payments under this paragraph.

~~(d) Beginning in 2003, in addition to any payment under paragraphs (a) and (c), the commissioner shall pay to a nursing facility described in paragraph (a) an adjustment in an amount equal to $6.11 per calendar day multiplied by the number of beds licensed in the facility on that date. The provisions of paragraphs (a) and (b) apply to payments under this paragraph.~~

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

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

Sec. 10. Minnesota Statutes 2006, section 256B.434, is amended by adding a subdivision to read:

Subd. 21. **Nursing facility rate increases beginning October 1, 2009.** For the rate year beginning October 1, 2009, the commissioner shall make available to each nursing facility reimbursed under this section operating payment rate adjustments equal to 1.5 percent of the operating payment rates in effect on September 30, 2009. The September 30, 2009, operating rate does not include rate adjustments given under subdivision 4, paragraph (d).

Sec. 11. Minnesota Statutes 2006, section 256B.441, is amended by adding a subdivision to read:

Subd. 46b. **Calculation of quality add-on for the rate year beginning October 1, 2009.** (a) The payment rate for the rate year beginning October 1, 2009, for the quality add-on, is a variable amount based on each facility's quality score. For the rate year, the maximum quality add-on is 1.2 percent of the operating payment rate in effect on September 30, 2009. The commissioner shall determine the quality add-on for each facility according to paragraphs (b) to (d).

(b) For each facility, the commissioner shall determine the operating payment rate in effect on September 30, 2009. The September 30, 2009, operating rate does not include rate adjustments given under section 256B.434, subdivision 4, paragraph (d).

(c) For each facility, the commissioner shall determine a ratio of the quality score of the facility determined in subdivision 44 by subtracting 40 from the quality score, and dividing the result by 60. If this value is less than zero, the commissioner shall use the value zero.

(d) For each facility, the quality add-on is the value determined in paragraph (b), multiplied by the value determined in paragraph (c), and then multiplied by 1.2 percent.

Sec. 12. Minnesota Statutes 2006, section 256B.69, subdivision 6, is amended to read:

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

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to

enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

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

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

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

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

Sec. 13. Minnesota Statutes 2006, section 256D.44, subdivision 2, is amended to read:

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

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

Sec. 14. Minnesota Statutes 2006, section 256D.44, subdivision 5, is amended to read:

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

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by

a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f) (1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of ~~January~~ July of ~~the previous~~ each year will be added to the standards of assistance established in subdivisions 1 to 4 for ~~individuals~~ adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622~~, and who are shelter needy~~; (ii) self-directed supports option eligible as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under subdivision 5, paragraph (f), is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

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

Sec. 15. Laws 2006, chapter 282, article 20, section 37, as amended by Laws 2007, chapter 147, article 7, section 69, is amended to read:

Sec. 37. **REPAYMENT DELAY.**

~~(a)~~ A county that overspent its allowed amounts in calendar year 2004 or 2005 under the waivered services program for persons with developmental disabilities shall ~~not be required to~~ pay back the amount of overspending by January 2, 2009. ~~This section applies to Fillmore, Steele, and St. Louis Counties.~~

~~(b) Carver County is not required to pay back the amount of overspending under the waivered services program for persons with developmental disabilities for calendar years 2004 and 2005 until June 30, 2009.~~

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

Sec. 16. **REPEALER.**

Minnesota Statutes 2006, section 256B.441, subdivision 25, is repealed.

Minnesota Statutes 2007 Supplement, section 256B.441, subdivisions 1, 14a, 30, 31, 48, 49, 50, 51, 52, 53, 54, 55, 56, and 58, are repealed.

ARTICLE 2
AGENCY MANAGEMENT

Section 1. Minnesota Statutes 2007 Supplement, section 256.01, subdivision 2, is amended to read:

Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2, the commissioner of human services shall carry out the specific duties in paragraphs (a) through (cc):

(a) Administer and supervise all forms of public assistance provided for by state law and other welfare activities or services as are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

(1) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing human services;

(2) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of human services, enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services and promote excellence of administration and program operation;

(3) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(4) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(5) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 256.017;

(6) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using appropriated funds; and

(7) enter into contractual agreements with federally recognized Indian tribes with a reservation in Minnesota to the extent necessary for the tribe to operate a federally

approved family assistance program or any other program under the supervision of the commissioner. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

(b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs.

(c) Administer and supervise all child welfare activities; promote the enforcement of laws protecting disabled, dependent, neglected and delinquent children, and children born to mothers who were not married to the children's fathers at the times of the conception nor at the births of the children; license and supervise child-caring and child-placing agencies and institutions; supervise the care of children in boarding and foster homes or in private institutions; and generally perform all functions relating to the field of child welfare now vested in the State Board of Control.

(d) Administer and supervise all noninstitutional service to disabled persons, including those who are visually impaired, hearing impaired, or physically impaired or otherwise disabled. The commissioner may provide and contract for the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals when it is not feasible to provide the service in state hospitals.

(e) Assist and actively cooperate with other departments, agencies and institutions, local, state, and federal, by performing services in conformity with the purposes of Laws 1939, chapter 431.

(f) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

(g) Establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as developmentally

disabled. For children under the guardianship of the commissioner or a tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(i) Act as coordinating referral and informational center on requests for service for newly arrived immigrants coming to Minnesota.

(j) The specific enumeration of powers and duties as hereinabove set forth shall in no way be construed to be a limitation upon the general transfer of powers herein contained.

(k) Establish county, regional, or statewide schedules of maximum fees and charges which may be paid by county agencies for medical, dental, surgical, hospital, nursing and nursing home care and medicine and medical supplies under all programs of medical care provided by the state and for congregate living care under the income maintenance programs.

(l) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

(1) the secretary of health and human services of the United States has agreed, for the same project, to waive state plan requirements relative to statewide uniformity; and

(2) a comprehensive plan, including estimated project costs, shall be approved by the Legislative Advisory Commission and filed with the commissioner of administration.

(m) According to federal requirements, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(n) Allocate federal fiscal disallowances or sanctions which are based on quality control error rates for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in clause (1), an amount equal to the portion of the total disallowance which resulted from the noncompliance, and may distribute the balance of the disallowance according to clause (1).

(o) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be

transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(p) Have the authority to make direct payments to facilities providing shelter to women and their children according to section 256D.05, subdivision 3. Upon the written request of a shelter facility that has been denied payments under section 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make a determination within 30 days of the request for review regarding issuance of direct payments to the shelter facility. Failure to act within 30 days shall be considered a determination not to issue direct payments.

(q) Have the authority to establish and enforce the following county reporting requirements:

(1) the commissioner shall establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for human services programs. When establishing financial and statistical reporting requirements, the commissioner shall evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced;

(2) the county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner;

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner shall withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

(4) a county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner shall notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county board plans to correct the problem. The corrective action plan must be submitted

to the commissioner within 45 days after the date the county board received notice of noncompliance;

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period;

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

(7) counties subject to withholding of funds under clause (3) or forfeiture or repayment of funds under clause (5) shall not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(r) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample ~~for the foster care program under title IV-E of the Social Security Act, United States Code, title 42,~~ in direct proportion to each county's ~~title IV-E foster care maintenance~~ claim for that period.

(s) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department.

(t) Require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the department.

(u) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United

States Code, title 42, section 1396r-8. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

(v) Have the authority to administer the federal drug rebate program for drugs purchased under the medical assistance program as allowed by section 1927 of title XIX of the Social Security Act and according to the terms and conditions of section 1927. Rebates shall be collected for all drugs that have been dispensed or administered in an outpatient setting and that are from manufacturers who have signed a rebate agreement with the United States Department of Health and Human Services.

(w) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

(x) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication

systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

(y) Receive any federal matching money that is made available through the medical assistance program for the consumer satisfaction survey. Any federal money received for the survey is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received for the consumer satisfaction survey in either year of the biennium.

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

(aa) Develop recommended standards for foster care homes that address the components of specialized therapeutic services to be provided by foster care homes with those services.

(bb) Authorize the method of payment to or from the department as part of the human services programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the human services programs administered by the department.

(cc) Have the authority to administer a drug rebate program for drugs purchased for persons eligible for general assistance medical care under section 256D.03, subdivision 3. For manufacturers that agree to participate in the general assistance medical care rebate program, the commissioner shall enter into a rebate agreement for covered drugs as defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide payment within the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act. The rebate program shall utilize

the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act.

Effective January 1, 2006, drug coverage under general assistance medical care shall be limited to those 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 such agreements. Prescription drug coverage under general assistance medical care shall conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

The rebate revenues collected under the drug rebate program are deposited in the general fund.

ARTICLE 3
STATE-OPERATED SERVICES

Section 1. **[246B.06] ESTABLISHMENT OF MINNESOTA STATE INDUSTRIES.**

Subdivision 1. **Establishment; purpose.** (a) The commissioner of human services may establish, equip, maintain, and operate the Minnesota State Industries at any Minnesota sex offender program facility under this chapter. The commissioner may establish industrial and commercial activities for sex offender treatment patients as the commissioner deems necessary and suitable to the profitable employment, educational training, and development of proper work habits of patients consistent with the requirements in section 246B.05. The industrial and commercial activities authorized by this section are designated Minnesota State Industries and must be for the primary purpose of sustaining and ensuring Minnesota State Industries' self-sufficiency, providing educational training, meaningful employment, and the teaching of proper work habits to the patients of the Minnesota sex offender program under this chapter, and not solely as competitive business ventures.

(b) The net profits from Minnesota State Industries must be used for the benefit of the patients as it relates to building education and self-sufficiency skills. Prior to the establishment of any industrial and commercial activity, the commissioner of human services may consult with stakeholders including representatives of business, industry, organized labor, the commissioner of education, the state Apprenticeship Council, the commissioner of labor and industry, the commissioner of employment and economic development, the commissioner of administration, and other stakeholders the

commissioner deems qualified. The purpose of the stakeholder consultation is to determine the quantity and nature of the goods, wares, merchandise, and services to be made or provided, and the types of processes to be used in their manufacture, processing, repair, and production consistent with the greatest opportunity for the reform and educational training of the patients, and with the best interests of the state, business, industry, and labor.

(c) The commissioner of human services shall, at all times in the conduct of any industrial or commercial activity authorized by this section, utilize patient labor to the greatest extent feasible, provided that the commissioner may employ all administrative, supervisory, and other skilled workers necessary to the proper instruction of the patients and the profitable and efficient operation of the industrial and commercial activities authorized by this section.

(d) The commissioner of human services may authorize the director of any Minnesota sex offender treatment facility under the commissioner's control to accept work projects from outside sources for processing, fabrication, or repair, provided that preference is given to the performance of work projects for state departments and agencies.

Subd. 2. **Revolving fund.** As described in section 246B.05, subdivision 2, there is established a Minnesota State Industries revolving fund under the control of the commissioner of human services. The revolving fund must be used for Minnesota State Industries authorized under this section, including, but not limited to, the purchase of equipment and raw materials, the payment of salaries and wages, and other necessary expenses as determined by the commissioner of human services. The purchase of services, materials, and commodities used in and held for resale are not subject to the competitive bidding procedures of section 16C.06, but are subject to all other provisions of chapters 16B and 16C. When practical, purchases must be made from small targeted group businesses designated under section 16C.16. Additionally, the expenses of patient educational training and self-sufficiency skills may be financed from the revolving fund in an amount to be determined by the commissioner or designee. The proceeds and income from all Minnesota State Industries conducted at the Minnesota sex offender treatment facilities must be deposited in the revolving fund subject to disbursement under subdivision 3. The commissioner of human services may request that money in the fund be invested pursuant to section 11A.25. Proceeds from the investment not currently needed must be accounted for separately and credited to the revolving fund.

Subd. 3. **Disbursement from fund.** The Minnesota State Industries revolving fund must be deposited in the state treasury and paid out only on proper vouchers as authorized and approved by the commissioner of human services, and in the same manner and under the same restrictions as are now provided by law for the disbursement of funds

by the commissioner. An amount deposited in the state treasury equal to six months of net operating cash as determined by the prior 12 months of revenue and cash flow statements must be restricted for use only by Minnesota State Industries as described under subdivision 2. For purposes of this subdivision, "net operating cash" means net income, minus sales, plus cost of goods sold. Cost of goods sold include all direct costs of industry products attributable to the goods' production.

Subd. 4. **Revolving fund; borrowing.** The commissioner of human services is authorized to borrow sums of money as the commissioner deems necessary to meet current demands on the Minnesota State Industries revolving fund. The sums borrowed must not exceed, in any calendar year, six months of net operating cash as determined by the previous 12 months of the industries' revenue and cash flow statements. If the commissioner of human services determines that borrowing of funds is necessary, the commissioner of human services shall certify this need to the commissioner of finance. Funds may be borrowed from general fund appropriations to the Minnesota sex offender program with the authorization of the commissioner of finance. Upon authorization of the commissioner of finance, the transfer must be made and credited to the Minnesota State Industries revolving fund. The sum transferred to the Minnesota State Industries revolving fund must be repaid by the commissioner of human services from the revolving fund to the fund from which it was transferred in a time period specified by the commissioner of finance, but by no later than the end of the biennium, as defined in section 16A.011, in which the loan is made. When any transfer is made to the Minnesota State Industries revolving fund, the commissioner of finance shall notify the commissioner of human services of the amount transferred to the fund and the date the transfer is to be repaid.

Subd. 5. **Federal grant fund transfers.** Grants received by the commissioner of human services from the federal government for any vocational training program or for administration by the commissioner of human services must (1) be credited to a federal grant fund and then (2) be transferred from the federal grant fund to the credit of the commissioner of human services in the appropriate account upon certification by the commissioner of human services that the amounts requested to be transferred have been earned or are required for the purposes of this section. Funds received by the federal grant fund need not be budgeted as such, provided transfers from the fund are budgeted for allotment purposes in the appropriate appropriation.

Subd. 6. **Wages.** Notwithstanding section 177.24 or any other law to the contrary, wages paid to patients working within this program are at the discretion of the commissioner of human services.

ARTICLE 4
CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2007 Supplement, section 256.741, subdivision 1, is amended to read:

Subdivision 1. ~~**Public assistance**~~ **Definitions.** (a) The term "direct support" as used in this chapter and chapters 257, 518, 518A, and 518C refers to an assigned support payment from an obligor which is paid directly to a recipient of ~~TANF or MFIP~~ public assistance.

(b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A, and 518C, includes any form of assistance provided under the AFDC program formerly codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter 256, MFIP under chapter 256J, work first program formerly codified under chapter 256K; child care assistance provided through the child care fund under chapter 119B; any form of medical assistance under chapter 256B; MinnesotaCare under chapter 256L; and foster care as provided under title IV-E of the Social Security Act.

(c) The term "child support agency" as used in this section refers to the public authority responsible for child support enforcement.

(d) The term "public assistance agency" as used in this section refers to a public authority providing public assistance to an individual.

(e) The terms "child support" and "arrears" as used in this section have the meanings provided in section 518A.26.

(f) The term "maintenance" as used in this section has the meaning provided in section 518.003.

Sec. 2. Minnesota Statutes 2006, section 256.741, subdivision 2, is amended to read:

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under any of the following programs: the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program formerly codified under chapter 256K is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for the Minnesota family investment program unless the caregiver assigns all rights to child support and ~~spousal~~ maintenance benefits according to this section.

(1) ~~An~~ The assignment ~~made according to this section~~ is effective as to~~:~~

~~(i)~~ any current child support and current ~~spousal~~ maintenance~~; and~~.

~~(ii) any accrued child support and spousal maintenance arrears.~~

~~(2) An assignment made after September 30, 1997, is effective as to:~~

~~(i) any current child support and current spousal maintenance;~~

~~(ii) any accrued child support and spousal maintenance arrears collected before October 1, 2000, or the date the individual terminates assistance, whichever is later; and~~

~~(iii) any accrued child support and spousal maintenance arrears collected under federal tax intercept.~~

(2) Any child support or maintenance arrears that accrue while an individual is receiving public assistance in the form of assistance under any of the programs listed in this paragraph are permanently assigned to the state.

(3) The assignment of current child support and current maintenance ends on the date the individual ceases to receive or is no longer eligible to receive public assistance under any of the programs listed in this paragraph.

(b) An individual receiving public assistance in the form of medical assistance, including MinnesotaCare, is considered to have assigned to the state at the time of application all rights to medical support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom medical assistance is provided.

(1) An assignment made after September 30, 1997, is effective as to any medical support accruing after the date of medical assistance or MinnesotaCare eligibility.

(2) Any medical support arrears that accrue while an individual is receiving public assistance in the form of medical assistance, including MinnesotaCare, are permanently assigned to the state.

(3) The assignment of current medical support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of medical assistance or MinnesotaCare.

(c) An individual receiving public assistance in the form of child care assistance under the child care fund pursuant to chapter 119B is considered to have assigned to the state at the time of application all rights to child care support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom child care assistance is provided.

~~An~~ (1) The assignment ~~made according to this paragraph~~ is effective as to~~:~~

~~(1)~~ any current child care support ~~and any child care support arrears assigned and accruing after July 1, 1997, that are collected before October 1, 2000; and~~.

(2) ~~any accrued child care support arrears collected under federal tax intercept.~~ Any child support arrears that accrue while an individual is receiving public assistance in the form of child care assistance under the child care fund in chapter 119B are permanently assigned to the state.

(3) The assignment of current child care support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of child care assistance under the child care fund under chapter 119B.

Sec. 3. Minnesota Statutes 2006, section 256.741, subdivision 2a, is amended to read:

Subd. 2a. **~~Families first~~ Distribution of child support ~~arrearages~~.** (a) The state shall distribute current child support and maintenance received by the state to an individual who assigns the right to that support under subdivision 2, paragraph (a).

(b) When the public authority collects child support arrearages on behalf of an individual who is receiving public assistance ~~provided under MFIP or MFIP-R under this chapter, MFIP under chapter 256J, or work first under chapter 256K, and the public authority has the option of applying the collection to arrears permanently assigned to the state or to arrears temporarily assigned to the state~~, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

(c) When the public authority collects child support arrearages on behalf of an individual who is not receiving public assistance, the public authority shall first apply the collection to satisfy those arrears that are not permanently assigned to the state.

(d) When the public authority collects child support arrearages certified under the federal tax offset, the public authority shall first apply the collection to satisfy those arrears that are permanently assigned to the state.

Sec. 4. Minnesota Statutes 2006, section 256.741, subdivision 3, is amended to read:

Subd. 3. **Existing assignments.** Assignments based on the receipt of public assistance in existence prior to July 1, 1997, are permanently assigned to the state. Arrears that accrued prior to the receipt of assistance that were assigned to the state between July 1, 1997, and October 1, 2009, will no longer be assigned as of October 1, 2009.

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

Sec. 5. Minnesota Statutes 2007 Supplement, section 256J.621, is amended to read:

256J.621 WORK PARTICIPATION ~~BONUS~~ FOOD BENEFITS.

(a) Effective March 1, 2010, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program (MFIP) ~~cash assistance~~ with earnings, a participant who is employed may be eligible for ~~transitional assistance~~ work participation food benefits of $75 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

(b) To be eligible for ~~a transitional assistance payment~~ work participation food benefits, the participant shall not receive MFIP ~~cash assistance~~ or diversionary work program assistance during the month and the participant or participants must meet the following work requirements:

(1) if the participant is a single caregiver and has a child under six years of age, the participant must be employed at least 87 hours per month;

(2) if the participant is a single caregiver and does not have a child under six years of age, the participant must be employed at least 130 hours per month; or

(3) if the household is a two-parent family, at least one of the parents must be employed an average of at least 130 hours per month.

Whenever a participant exits the diversionary work program or is terminated from MFIP ~~cash assistance~~ and meets the other criteria in this section, ~~transitional assistance is~~ work participation food benefits are available for up to 24 consecutive months.

(c) Expenditures on the program are maintenance of effort state funds for participants under paragraph (b), clauses (1) and (2). Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort funds. Months in which a participant receives ~~transitional assistance~~ work participation food benefits under this section do not count toward the participant's MFIP 60-month time limit.

Sec. 6. Minnesota Statutes 2006, section 518A.50, is amended to read:

518A.50 PAYMENT TO PUBLIC AGENCY.

(a) This section applies to all proceedings involving a support order, including, but not limited to, a support order establishing an order for past support or reimbursement of public assistance.

(b) The court shall direct that all payments ordered for maintenance or support be made to the public authority responsible for child support enforcement so long as the obligee is receiving or has applied for public assistance, or has applied for child support or maintenance collection services. Public authorities responsible for child support enforcement may act on behalf of other public authorities responsible for child support enforcement, including the authority to represent the legal interests of or execute documents on behalf of the other public authority in connection with the establishment,

enforcement, and collection of child support, maintenance, or medical support, and collection on judgments.

(c) Payments made to the public authority ~~other than payments under section 518A.53~~ must be credited as of the date the payment is received by the central collections unit~~.~~, except that payments made under section 518A.53 may be considered to have been paid as of the date the obligor received the remainder of the income.

(d) Monthly amounts received by the public agency responsible for child support enforcement from the obligor that are greater than the monthly amount of public assistance granted to the obligee must be remitted to the obligee.

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

Sec. 7. Minnesota Statutes 2006, section 518A.53, subdivision 5, is amended to read:

Subd. 5. **Payor of funds responsibilities.** (a) An order for or notice of withholding is binding on a payor of funds upon receipt. Withholding must begin no later than the first pay period that occurs after 14 days following the date of receipt of the order for or notice of withholding. In the case of a financial institution, preauthorized transfers must occur in accordance with a court-ordered payment schedule.

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

(c) A payor of funds shall not discharge, or refuse to hire, or otherwise discipline an employee as a result of wage or salary withholding authorized by this section. A payor of funds shall be liable to the obligee for any amounts required to be withheld. A payor of funds that fails to withhold or transfer funds in accordance with this section is also liable to the obligee for interest on the funds at the rate applicable to judgments under section 549.09, computed from the date the funds were required to be withheld or transferred. A payor of funds is liable for reasonable attorney fees of the obligee or public authority incurred in enforcing the liability under this paragraph. A payor of funds that has failed to comply with the requirements of this section is subject to contempt sanctions under

section 518A.73. If the payor of funds is an employer or independent contractor and violates this subdivision, a court may award the obligor twice the wages lost as a result of this violation. If a court finds a payor of funds violated this subdivision, the court shall impose a civil fine of not less than $500. The liabilities in this paragraph apply to intentional noncompliance with this section.

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

(1) if the total of the amounts designated in the orders for or notices of withholding as current support exceeds the amount available for income withholding, the payor of funds shall allocate to each order or notice an amount for current support equal to the amount designated in that order or notice as current support, divided by the total of the amounts designated in the orders or notices as current support, multiplied by the amount of the income available for income withholding; and

(2) if the total of the amounts designated in the orders for or notices of withholding as current support does not exceed the amount available for income withholding, the payor of funds shall pay the amounts designated as current support, and shall allocate to each order or notice an amount for past due support, equal to the amount designated in that order or notice as past due support, divided by the total of the amounts designated in the orders or notices as past due support, multiplied by the amount of income remaining available for income withholding after the payment of current support.

(e) When an order for or notice of withholding is in effect and the obligor's employment is terminated, the obligor and the payor of funds shall notify the public authority of the termination within ten days of the termination date. The termination notice shall include the obligor's home address and the name and address of the obligor's new payor of funds, if known.

(f) A payor of funds may deduct one dollar from the obligor's remaining salary for each payment made pursuant to an order for or notice of withholding under this section to cover the expenses of withholding.

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

Sec. 8. Laws 2007, chapter 147, article 2, section 21, the effective date, is amended to read:

EFFECTIVE DATE. Subdivision 1 is effective February 1, 2008, and subdivision 2 is effective ~~May 1, 2008~~ March 1, 2009.

Sec. 9. Laws 2007, chapter 147, article 19, section 3, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ 5,294,627,000 $ 5,695,458,000**

Appropriations by Fund

	2008	2009
General	4,614,727,000	4,940,293,000
State Government Special Revenue	549,000	565,000
Health Care Access	426,628,000	492,759,000
Federal TANF	250,537,000	260,051,000
Lottery Prize Fund	2,185,000	1,790,000

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

Receipts for Systems Projects. Appropriations and federal receipts for information system 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. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Pay for Performance. (a) Of the general fund appropriation, $272,000 each year is available to the commissioner of

human services only under the following circumstances:

(1) $272,000 shall be made available by the commissioner of finance on January 1, 2009, only after notification by the commissioner of human services to the commissioner of finance and to the chairs of the relevant house of representatives and senate finance and policy committees that the average number of days from the receipt of a MinnesotaCare application at the state processing unit until the initial eligibility determination of the application was 30 days or less during the period October 1, 2007, to September 30, 2008. Applications transferred from counties to the state processing unit are excluded from this calculation; and

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

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

Purchasing Alliance Fund Transfer.

On September 1, 2007, any remaining

balance in the purchasing alliance stop-loss fund account established under Minnesota Statutes, section 256.956, shall transfer 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 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.

(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) The commissioner shall ensure that the MOE 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) 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, does not apply if the grants or aids are federal TANF funds.

(e) Beginning 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 in Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state would not meet the TANF work participation rate for the current year;

(2) 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) any additional amounts that may contribute to avoiding 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 or other qualified expenditures to the extent the expenditures are otherwise available after considering the expenditures allowed in this section.

(f) If allowable by the federal Office of Family Assistance, the commissioner may claim excess MOE with respect to federal fiscal years 2006 and 2007 to the extent that working family credit expenditures or other qualified expenditures are otherwise available to supplement the state's MOE claim for those years after considering the expenditures allowed in this section.

~~(c)~~ (g) Notwithstanding any contrary provision in this article, this rider expires June 30, 2011.

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

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

(1) fiscal year 2008, ~~$11,097,000~~ $63,796,000;

(2) fiscal year 2009, ~~$25,401,000~~ $43,219,000;

(3) fiscal year 2010, ~~$20,398,000~~ $24,127,000; and

(4) fiscal year 2011, ~~$19,841,000~~ $21,492,000.

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

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

Sec. 10. Laws 2007, chapter 147, article 19, section 3, 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	62,069,000	62,405,000
Federal TANF	75,904,000	80,841,000

(b) **Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	113,429,000	115,902,000

TANF Prior Appropriation Cancellation. Notwithstanding Laws 2001, First Special Session chapter 9, article 17, section 2, subdivision 11, paragraph (b), any unexpended TANF funds appropriated to the commissioner to contract with the Board of Trustees of Minnesota State Colleges and Universities, to provide tuition waivers to employees of health care and human service providers that are members of qualifying consortia operating under Minnesota Statutes, sections 116L.10 to 116L.15, must cancel at the end of fiscal year 2007.

MFIP Pilot Program. Of the TANF appropriation, $100,000 in fiscal year 2008 and $750,000 in fiscal year 2009 are for a grant to the Stearns-Benton Employment and Training Council for the Workforce U pilot program. Base level funding for this program shall be $750,000 in 2010 and $0 in 2011.

Supported Work. (1) Of the TANF appropriation, $5,468,000 in fiscal year 2008 and $7,291,000 in fiscal year 2009 are for supported work for MFIP participants, to be allocated to counties and tribes based on the criteria under clauses (2) and (3). Paid transitional work experience and other supported employment under this rider provides 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. * (The preceding text "and $7,291,000 in fiscal year 2009" was indicated as vetoed by the governor.)

(2) A county or tribe is eligible to receive an allocation under this rider if:

(i) the county or tribe is not meeting the federal work participation rate;

(ii) the county or tribe has participants who are required to perform work activities under Minnesota Statutes, chapter 256J, but are not meeting hourly work requirements; and

(iii) the county or tribe has assessed participants who have completed six weeks of job search or are required to perform work activities and are not meeting the hourly requirements, and the county or tribe has determined that the participant would benefit from working in a supported work environment.

(3) A county or tribe may also be eligible for funds in order to contract for supplemental hours of paid work at the participant's child's place of education, child care location, or the child's physical or mental health treatment facility or office. This grant to counties and tribes is specifically for MFIP participants who need to work up to five hours more per week in order to meet the hourly work requirement, and the participant's employer cannot or will not offer more hours to the participant.

Work Study. Of the TANF appropriation, $750,000 each year are to the commissioner to contract with the Minnesota Office of Higher Education for the biennium beginning July 1, 2007, for work study grants under Minnesota Statutes, section 136A.233, specifically for low-income individuals who receive assistance under Minnesota Statutes, chapter 256J, and for grants to opportunities industrialization centers. * (The preceding text beginning "Work Study. Of the TANF appropriation," was indicated as vetoed by the governor.)

Integrated Service Projects. $2,500,000 in fiscal year 2008 and $2,500,000 in fiscal year 2009 are appropriated from the TANF fund to the commissioner to continue to fund the existing integrated services projects for MFIP families, and if funding allows, additional similar projects.

Base Adjustment. The TANF base for fiscal year 2010 is $115,902,000 and for fiscal year 2011 is $115,152,000.

(c) **MFIP Child Care Assistance Grants**

General	74,654,000	71,951,000

(d) **Basic Sliding Fee Child Care Assistance Grants**

General	42,995,000	45,008,000

Base Adjustment. The general fund base is $44,881,000 for fiscal year 2010 and $44,852,000 for fiscal year 2011.

At-Home Infant Care Program. No funding shall be allocated to or spent on the at-home infant care program under Minnesota Statutes, section 119B.035.

(e) **Child Care Development Grants**

General	4,390,000	6,390,000

Prekindergarten Exploratory Projects. Of the general fund appropriation, $2,000,000 the first year and $4,000,000 the second year are for grants to the city of St. Paul, Hennepin County, and Blue Earth County to establish scholarship demonstration projects to be conducted in partnership with the Minnesota Early Learning Foundation to promote children's school readiness. This appropriation is available until June 30, 2009.

Child Care Services Grants. Of this appropriation, $500,000 each year are for the purpose of providing child care services grants under Minnesota Statutes, section 119B.21, subdivision 5. This appropriation is for the 2008-2009 biennium only, and does not increase the base funding.

Early Childhood Professional Development System. Of this appropriation,

$500,000 each year are for purposes of the early childhood professional development system, which increases the quality and continuum of professional development opportunities for child care practitioners. This appropriation is for the 2008-2009 biennium only, and does not increase the base funding.

Base Adjustment. The general fund base is $1,515,000 for each of fiscal years 2010 and 2011.

(f) **Child Support Enforcement Grants**

General	11,038,000	3,705,000

Child Support Enforcement. $7,333,000 for fiscal year 2008 is to make grants to counties for child support enforcement programs to make up for the loss under the 2005 federal Deficit Reduction Act of federal matching funds for federal incentive funds passed on to the counties by the state.

This appropriation is available until June 30, 2009.

(g) **Children's Services Grants**

	Appropriations by Fund	
General	63,647,000	71,147,000
Health Care Access	250,000	-0-
TANF	240,000	340,000

Grants for Programs Serving Young Parents. Of the TANF fund appropriation, $140,000 each year is for a grant to a program or programs that provide comprehensive services through a private, nonprofit agency to young parents in Hennepin County who have dropped out of school and are receiving

public assistance. The program administrator shall report annually to the commissioner on skills development, education, job training, and job placement outcomes for program participants.

County Allocations for Rate Increases. County Children and Community Services Act allocations shall be increased by $197,000 effective October 1, 2007, and $696,000 effective October 1, 2008, to help counties pay for the rate adjustments to day training and habilitation providers for participants paid by county social service funds. Notwithstanding the provisions of Minnesota Statutes, section 256M.40, the allocation to a county shall be based on the county's proportion of social services spending for day training and habilitation services as determined in the most recent social services expenditure and grant reconciliation report.

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 2008 and fiscal year 2009 for the adoption incentive grants are appropriated to the commissioner for these purposes.

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.

Children's Mental Health Grants. Of the general fund appropriation, $5,913,000 in fiscal year 2008 and $6,825,000 in fiscal year 2009 are for children's mental health grants. The purpose of these grants is to increase and maintain the state's children's mental health service capacity, especially for school-based mental health services. The commissioner shall require grantees to utilize all available third party reimbursement sources as a condition of using state grant funds. At least 15 percent of these funds shall be used to encourage efficiencies through early intervention services. At least another 15 percent shall be used to provide respite care services for children with severe emotional disturbance at risk of out-of-home placement.

Mental Health Crisis Services. Of the general fund appropriation, $2,528,000 in fiscal year 2008 and $2,850,000 in fiscal year 2009 are for statewide funding of children's mental health crisis services. Providers must utilize all available funding streams.

Children's Mental Health Evidence-Based and Best Practices. Of the general fund appropriation, $375,000 in fiscal year 2008 and $750,000 in fiscal year 2009 are for children's mental health evidence-based and best practices including, but not limited to: Adolescent Integrated Dual Diagnosis Treatment services; school-based mental health services; co-location of mental

health and physical health care, and; the use of technological resources to better inform diagnosis and development of treatment plan development by mental health professionals. The commissioner shall require grantees to utilize all available third-party reimbursement sources as a condition of using state grant funds.

Culturally Specific Mental Health Treatment Grants. Of the general fund appropriation, $75,000 in fiscal year 2008 and $300,000 in fiscal year 2009 are for children's mental health grants to support increased availability of mental health services for persons from cultural and ethnic minorities within the state. The commissioner shall use at least 20 percent of these funds to help members of cultural and ethnic minority communities to become qualified mental health professionals and practitioners. The commissioner shall assist grantees to meet third-party credentialing requirements and require them to utilize all available third-party reimbursement sources as a condition of using state grant funds.

Mental Health Services for Children with Special Treatment Needs. Of the general fund appropriation, $50,000 in fiscal year 2008 and $200,000 in fiscal year 2009 are for children's mental health grants to support increased availability of mental health services for children with special treatment needs. These shall include, but not be limited to: victims of trauma, including children subjected to abuse or neglect, veterans and their families, and refugee populations;

persons with complex treatment needs, such as eating disorders; and those with low incidence disorders.

MFIP and Children's Mental Health Pilot Project. Of the TANF appropriation, $100,000 in fiscal year 2008 and $200,000 in fiscal year 2009 are to fund the MFIP and children's mental health pilot project. Of these amounts, up to $100,000 may be expended on evaluation of this pilot.

Prenatal Alcohol or Drug Use. Of the general fund appropriation, $75,000 each year is to award grants beginning July 1, 2007, to programs that provide services under Minnesota Statutes, section 254A.171, in Pine, Kanabec, and Carlton Counties. This appropriation shall become part of the base appropriation.

Base Adjustment. The general fund base is $62,572,000 in fiscal year 2010 and $62,575,000 in fiscal year 2011.

(h) **Children and Community Services Grants**

General	101,369,000	69,208,000

Base Adjustment. The general fund base is $69,274,000 in each of fiscal years 2010 and 2011.

Targeted Case Management Temporary Funding. (a) Of the general fund appropriation, $32,667,000 in fiscal year 2008 is transferred to the targeted case management contingency reserve account in the general fund to be allocated to counties and tribes affected by reductions in targeted case management federal Medicaid revenue

as a result of the provisions in the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Contingent upon (1) publication by the federal Centers for Medicare and Medicaid Services of final regulations implementing the targeted case management provisions of the federal Deficit Reduction Act of 2005, Public Law 109-171, or (2) the issuance of a finding by the Centers for Medicare and Medicaid Services of federal Medicaid overpayments for targeted case management expenditures, up to $32,667,000 is appropriated to the commissioner of human services. Prior to distribution of funds, the commissioner shall estimate and certify the amount by which the federal regulations or federal disallowance will reduce targeted case management Medicaid revenue over the 2008-2009 biennium.

(c) Within 60 days of a contingency described in paragraph (b), the commissioner shall distribute the grants proportionate to each affected county or tribe's targeted case management federal earnings for calendar year 2005, not to exceed the lower of (1) the amount of the estimated reduction in federal revenue or (2) $32,667,000.

(d) These funds are available in either year of the biennium. Counties and tribes shall use these funds to pay for social service-related costs, but the funds are not subject to provisions of the Children and Community Services Act grant under Minnesota Statutes, chapter 256M.

(e) This appropriation shall be available to pay counties and tribes for expenses incurred on or after July 1, 2007. The appropriation shall be available until expended.

(i) **General Assistance Grants**

General	37,876,000	38,253,000

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 2008 and $7,889,812 in fiscal year 2009. 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**

General	30,505,000	30,812,000

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 2008 and $1,100,000 in fiscal year 2009. 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**

General	91,069,000	98,671,000

People Incorporated. Of the general fund appropriation, $460,000 each year is to augment community support and mental health services provided to individuals residing in facilities under Minnesota Statutes, section 256I.05, subdivision 1m.

(l) **Other Children and Economic Assistance Grants**

General	20,183,000	16,333,000
Federal TANF	1,500,000	1,500,000

Base Adjustment. The general fund base shall be $16,033,000 in fiscal year 2010 and $15,533,000 in fiscal year 2011. The TANF base shall be $1,500,000 in fiscal year 2010 and $1,181,000 in fiscal year 2011.

Homeless and Runaway Youth. Of the general fund appropriation, $500,000 each year are 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. This is a onetime appropriation.

Long-Term Homelessness. Of the general fund appropriation, ~~$1,500,000 each year are~~ $2,000,000 in fiscal year 2008 is for implementation of programs to address long-term homelessness and is available in either year of the biennium. This is a onetime appropriation.

Minnesota Community Action Grants. (a) Of the general fund appropriation, $250,000 each year is for the purposes of Minnesota community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. This is a onetime appropriation.

(b) Of the TANF appropriation, $1,500,000 each year is for community action agencies for auto repairs, auto loans, and auto purchase grants to individuals who are eligible to receive benefits under Minnesota Statutes, chapter 256J, or who have lost eligibility for benefits under Minnesota Statutes, chapter 256J, due to earnings in the prior 12 months. Base level funding for this activity shall be $1,500,000 in fiscal year 2010 and $1,181,000 in fiscal year 2011. * (The preceding text beginning "(b) Of the TANF appropriation," was indicated as vetoed by the governor.)

(c) Money appropriated under paragraphs (a) and (b) that is not spent in the first year does not cancel but is available for the second year.

Sec. 11. **REPEALER.**

Minnesota Statutes 2006, section 256.741, subdivision 15, is repealed.

ARTICLE 5
HEALTH CARE

Section 1. Minnesota Statutes 2006, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner

shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, ~~and~~ January 1, 2005, and for the first year of the rebased period beginning January 1, 2009. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 2. Minnesota Statutes 2006, section 256.969, subdivision 20, is amended to read:

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if: (i) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March

1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if: (i) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987; (ii) the hospital had 100 or fewer licensed beds on March 1, 1988; (iii) the hospital is located in Minnesota; and (iv) the hospital is not located in a city of the first class as defined in section 410.01. For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

(e) For admissions occurring on or after July 1, 2008, fee-for-service inpatient payments must increase eight percent for a hospital with a medical assistance inpatient utilization rate of 17.95 percent of total patient days as of the base year in effect on July 1, 2005, and nine percent for a hospital with a medical assistance inpatient utilization rate of 59.60 percent of total patient days as of the base year in effect on July 1, 2005. Payments made to managed care plans must not be increased to reflect this increase. For purposes of this paragraph, medical assistance does not include general assistance medical care.

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

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

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

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

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

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

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

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

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

(c) The individual shall identify the designated assets and the full fair market value of those assets and designate them as assets to be protected at the time of ~~initial~~ application for medical assistance payment of long-term care services. The full fair market value of real property or interests in real property shall be based on the most recent full assessed value for property tax purposes for the real property, unless the individual provides a complete professional appraisal by a licensed appraiser to establish the full fair market value. The extent of a life estate in real property shall be determined using the life estate table in the health care program's manual. Ownership of any asset in joint tenancy shall be treated as ownership as tenants in common for purposes of its designation as a disregarded asset. The unprotected value of any protected asset is subject to estate recovery according to subdivisions 13 and 15.

(d) The right to designate assets to be protected is personal to the individual and ends when the individual dies, except as otherwise provided in subdivisions 13 and 15. It does not include the increase in the value of the protected asset and the income, dividends, or profits from the asset. It may be exercised by the individual or by anyone with the legal authority to do so on the individual's behalf. It shall not be sold, assigned, transferred, or given away.

(e) ~~If the dollar amount of the benefits utilized under a partnership policy is greater than the full fair market value of all assets protected at the time of the application for medical assistance long-term care services,~~ As the individual continues to utilize benefits under a partnership policy after eligibility for medical assistance payment of long-term care services begins, the individual may designate, for additional protection, an increase in the value of protected assets and additional assets that become available during the individual's lifetime ~~for protection under this section~~ up to the amount of additional benefits utilized. The individual must make the designation in writing to the county agency no later than the last date on which the individual must report a change in circumstances to the county agency, as provided for under the medical assistance program. ~~Any excess used for this purpose shall not be available to the individual's estate to protect assets in the estate from recovery under section 256B.15 or 524.3-1202, or otherwise.~~ The amount used for this purpose must reduce the unused amount of asset protection available to protect assets in the individual's estate from recovery under section 256B.15 or 524.3-1202, or otherwise.

(f) This section applies only to estate recovery under United States Code, title 42, section 1396p, subsections (a) and (b), and does not apply to recovery authorized by other provisions of federal law, including, but not limited to, recovery from trusts under United States Code, title 42, section 1396p, subsection (d)(4)(A) and (C), or to recovery from annuities, or similar legal instruments, subject to section 6012, subsections (a) and (b), of the Deficit Reduction Act of 2005, Public Law 109-171.

(g) An individual's protected assets owned by the individual's spouse who applies for payment of medical assistance long-term care services shall not be protected assets or disregarded for purposes of eligibility of the individual's spouse solely because they were protected assets of the individual.

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

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

Sec. 5. Minnesota Statutes 2006, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services Policy Committee.** The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes. Individuals receiving fee-for-service medical assistance, general assistance medical care, and MinnesotaCare may be directed to obtain these services designated by the Health Services Policy Committee at these centers.

Sec. 6. Minnesota Statutes 2006, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2008, the actual acquisition cost of a drug shall be estimated by the

commissioner, at average wholesale price minus ~~12~~ 14 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

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

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

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms

of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 7. Minnesota Statutes 2007 Supplement, 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 for nonemergency visits to a hospital-based emergency room; and

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

(3) For individuals 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.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256B.0631, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 9. **[256B.194] FEDERAL PAYMENTS.**

Subdivision 1. **Payments at actual cost.** Notwithstanding any other statute or rule to the contrary, for providers that are units of government, the commissioner may limit medical assistance and MinnesotaCare payments to a provider's actual cost of providing services, according to the Centers for Medicare and Medicaid Services (CMS) final rule referenced in this subdivision. The commissioner may also require medical assistance and MinnesotaCare providers to provide any information necessary to determine Medicaid-related costs, and require the cooperation of providers in any audit or review necessary to ensure payments are limited to cost. This section does not apply to providers who are exempt from the provisions of the CMS final rule. This subdivision becomes effective when the CMS final rule, published May 29, 2007, at Federal Register, Vol. 72, No. 100, governing payments to providers that are units of government goes into effect at the end of the moratorium imposed by Congress.

Subd. 2. **Loss of federal financial participation.** For all transfers, certified expenditures, and medical assistance payments listed in this subdivision, if the commissioner determines that federal financial participation is no longer available for the

medical assistance payments listed, then related obligations for the nonfederal share of payments and the medical assistance payments must terminate. The commissioner shall notify all affected parties of the loss of federal financial participation, and the resulting payments and obligations that are terminated. If the commissioner determines that federal financial participation is no longer available for any medical assistance payments or contributions to the nonfederal share of medical assistance payments that have already been made, the commissioner may collect the medical assistance payments from providers and return contributions of the nonfederal share to its source. The transfers, certified expenditures, and medical assistance payments subject to this section are those specified in section 62J.692, subdivision 7, paragraphs (b) and (c); 256B.19, subdivisions 1c and 1d; 256B.195; 256B.431, subdivision 23; and 256B.69, subdivision 5c, paragraph (a), clauses (2) to (4); Laws 2002, chapter 220, article 17, section 2, subdivision 3; and Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 1.

Sec. 10. Minnesota Statutes 2007 Supplement, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County~~,~~ and Hennepin County Medical Center~~, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center~~ shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner ~~for the payments under section 256.969, subdivision 27~~ to offset medical assistance expenditures; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in this paragraph ~~(a)~~ of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2007.

Sec. 11. Minnesota Statutes 2006, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

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

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

Sec. 12. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.

~~(e) Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.~~

Sec. 13. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines. ~~Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 215 percent of the federal poverty guidelines.~~

Sec. 14. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is amended to read:

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

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines ~~or 215 percent of the federal poverty guidelines on or after July 1, 2009,~~ are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month

notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.

Sec. 15. Minnesota Statutes 2006, section 256L.12, subdivision 9, is amended to read:

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

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

(c) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(d) For services rendered on or after January 1, 2009, the commissioner shall withhold an additional two percent of managed care plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

Sec. 16. Laws 2007, chapter 147, article 19, section 3, subdivision 6, is amended to read:

Subd. 6. **Basic Health Care Grants**

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

(a) **MinnesotaCare Grants**

Health Care Access	389,760,000	458,401,000

HealthMatch Delay. Of this appropriation, $2,560,000 the first year and $21,735,000 the second year are for the MinnesotaCare program costs related to a seven-month delay in implementation of the HealthMatch program.

Health Match Enrollment Shift. In fiscal year 2009, $6,178,000 shall be transferred from the health care access fund to the general fund to pay for the Health Match program-related enrollment shift. In the event no systematic enrollment shift of MinnesotaCare families and children to medical assistance occurs prior to June 30, 2009, except as required under Minnesota Statutes, section 256L.04, subdivision 8, this transfer shall not occur.

(b) **MA Basic Health Care - Families and Children**

	Appropriations by Fund	
General	739,957,000	838,874,000
Health Care Access	1,672,000	-0-

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

General	995,560,000	1,101,390,000

Treatment Foster Care Services Delay. (a) Notwithstanding Minnesota Statutes, section

256B.0625, subdivision 47, effective July 1, 2009, and subject to federal approval, medical assistance covers treatment foster care services according to Minnesota Statutes, section 256B.0946.

(b) Of the general fund savings that result from the delayed effective date in paragraph (a):

(1) The commissioner shall present to the legislature, by February 1, 2008, a report and recommendations on establishing a health insurance exchange that would provide individuals with greater access, choice, portability, and affordability of health insurance products. The report must evaluate, identify options, and present recommendations, on:

(i) whether a health insurance exchange would provide individuals with greater access, choice, portability, and affordability of health care products;

(ii) the duties and powers of the exchange;

(iii) the use of the exchange to receive and process employee premiums on a pretax basis through section 125 plans;

(iv) eligibility criteria that enrollees and health plan companies must meet to participate in the exchange;

(v) the types of health plans to be offered through the exchange, and the extent to which these plans should be available for purchase only through the exchange;

(vi) loss ratio requirements for health plans offered through the exchange;

(vii) the extent to which the operation of the exchange will lower the cost of health care insurance coverage;

(viii) estimates of administrative costs of operating the exchange, and methods for funding these administrative costs; and

(iv) other topics relevant to the design and operation of the exchange if its establishment is recommended.

(2) $375,000 each year are for the family, friend, and neighbor grant program in article 1, section 94. Any balance in the first year does not cancel but is available in the second year. This appropriation is for the 2008-2009 biennium only, and does not increase the base funding.

(3) $300,000 each year from the general fund and $150,000 each year from the TANF fund are to the commissioner for the purposes of a program in Ramsey County that provides early intervention efforts designed to discourage pregnant women from using alcohol and illegal drugs. The appropriation shall not become part of base level funding and is available until spent.

(4) $750,000 the first year is for transitional housing programs under Minnesota Statutes, section 256E.33. Up to ten percent of this appropriation may be used for housing and services which extend beyond 24 months. $600,000 the first year is for emergency services grants under Laws 1997, chapter 162, article 3, section 7.

(5) $50,000 each year is for a grant to HOME Line for the tenant hotline services program.

This is a onetime appropriation. * (The preceding text beginning "(5) $50,000 each year is for" was indicated as vetoed by the governor.)

(6) $60,000 in fiscal year 2008 is to the commissioner to contract with a Minnesota-based, nonprofit quality improvement organization that collaborates with providers and consumers in health improvement activities, for the purpose of conducting an independent analysis of the reimbursement methodologies for home health services provided to enrollees in the Minnesota senior health options and Minnesota disability health options programs. The analysis of reimbursement methodologies shall include, at a minimum, a review of:

(i) any limitations on flexibility in services or technology for the home health provider;

(ii) the Medicare program reimbursement methodologies, including possible alternatives, and Medicare benefits;

(iii) potential access issues raised by current reimbursement methodologies; and

(iv) incentives, including episodic care reimbursement methodologies, to promote best practices and achieve identified clinical outcomes.

The analysis and any supporting recommendations shall be presented to the commissioner by December 1, 2007, and to the chairs of the appropriate legislative committees by December 15, 2007. In no event shall the study disclose any specific

reimbursement amount or methodologies attributable to an individual health carrier.

In conducting its analysis, the organization described in paragraph (a) shall consult with the commissioner, the Minnesota Home Care Association, managed care organizations, and other interested home health entities and advocates, and shall convene the parties to discuss pertinent issues.

(7) $50,000 the first year is to conduct a feasibility study of and to predesign a Native American juvenile treatment center on or near the White Earth Reservation. The facility must house and treat Native American juveniles and provide culturally specific programming to juveniles placed in the treatment center. The commissioner may contract with parties who have experience in the design and construction of juvenile treatment centers to assist in the feasibility study and predesign. On or before January 15, 2008, the commissioner shall present the results of the feasibility study and the predesign of the facility to the chairs of house of representatives and senate committees having jurisdiction over human services finance, public safety finance, and capital investment.

(8) $200,000 in fiscal year 2008 and $200,000 in fiscal year 2009 are to develop a statewide quality assurance and improvement system under Minnesota Statutes, section 256B.096, for persons receiving disability services. Any unspent portion of the appropriation for the first year shall not cancel but shall

be available for the second year. These are onetime appropriations.

(9) $200,000 is to the commissioner to be available until June 30, 2009, to make a grant to Advocating Change Together for the purposes of the Remembering With Dignity project. As part of the Remembering With Dignity project, the grant recipient shall:

(i) conduct necessary research on persons buried in state cemeteries who were residents of state hospitals or regional treatment centers and buried in numbered or unmarked graves;

(ii) purchase and install headstones that are properly inscribed with their names on the graves of those persons; and

(iii) collaborate with community groups and state and local government agencies to build community involvement and public awareness, ensure public access to the graves, and ensure appropriate perpetual maintenance of state cemeteries.

(10) $500,000 each year are to fund the Regional Children's Mental Health Initiative pilot project. This is a onetime appropriation. This paragraph does not apply to a radiation therapy facility that is being built attached to a community hospital in Wright County and meets the following conditions prior to August 1, 2007: the capital expenditure report required under Minnesota Statutes, section 62J.17, has been filed with the commissioner of health; a timely construction schedule is developed, stipulating dates for beginning, achieving

various stages, and completing construction; and all zoning and building permits applied for.

Provider-Directed Care Coordination. In addition to medical assistance reimbursement under Minnesota Statutes, sections 256B.0625 and 256B.76, clinics participating in provider-directed care coordination under Minnesota Statutes, section 256B.0625, also receive a monthly payment per client when the clinic serves an eligible client. The payments across the program must average $50 per month per client.

(d) **General Assistance Medical Care Grants**

General	238,822,000	251,412,000

(e) **Other Health Care Grants**

General	421,000	921,000
Health Care Access	850,000	900,000

Community-Based Health Care Demonstration Project. Of the general fund appropriation, $212,000 ~~each year~~ is to be transferred to the commissioner of health for the demonstration project grant described in Minnesota Statutes, section 62Q.80, subdivision 1a. ~~This appropriation shall remain part of base level funding until June 30, 2012. Notwithstanding any contrary provision in this article, this rider expires July 1, 2012.~~

Care Coordination Pilot Projects. Of the health care access fund appropriation, $881,000 in fiscal year 2009 is for the health care pilot projects for children and adults with complex health care needs. Base level

funding for this program is $878,000 in 2010 and $0 in 2011.

Patient Incentive Programs. Of the general fund appropriation, $500,000 in fiscal year 2009 is for patient incentive programs.

Base Adjustment. The health care access fund base is $900,000 in fiscal year 2010 and $150,000 in fiscal year 2011.

Oral Health Care Innovations Grants. (a) Of the health care access fund appropriation, $400,000 for the fiscal year beginning July 1, 2007, is to award competitive oral health care innovations grants to organizations described in Minnesota Statutes, section 256B.76, paragraph (b), clause (4), or coalitions of such organizations, providing access to oral health services for low-income and uninsured persons. The commissioner shall award one grant for a project to develop a nonprofit dental clinic serving public program recipients and uninsured persons in Beltrami County; one grant for the maintenance of nonprofit dental clinics providing oral health care services to children ages birth to 18 in St. Louis County; and one grant for the bright smiles program to increase access to oral health care for low-income and immigrant children, ages birth to five years, and their families in underserved areas in Minneapolis.

(b) This grant shall not become part of base level funding.

State Health Policies Grant. Of the health care access fund appropriation, $300,000 in fiscal year 2008 is to provide a grant to a research center associated with a safety net

hospital and county-affiliated health system to develop the capabilities necessary for evaluating the effects of changes in state health policies on low-income and uninsured individuals, including the impact on state health care program costs, health outcomes, cost-shifting to different units and levels of government, and utilization patterns including use of emergency room care and hospitalization rates. The center shall report on the use of this money by December 1, 2008, to the chairs of the senate and house of representatives committees with relevant jurisdiction. * (The preceding text beginning "State Health Policies Grant." was indicated as vetoed by the governor.)

Sec. 17. **REPEALER.**

(a) Minnesota Statutes 2007 Supplement, section 256.969, subdivision 27, is repealed retroactively from July 1, 2007.

(b) Minnesota Statutes 2007 Supplement, sections 256.962, subdivision 5; 256B.057, subdivision 2c; and 256L.07, subdivision 7, are repealed.

ARTICLE 6
DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2006, section 144.1222, subdivision 1a, is amended to read:

Subd. 1a. **Fees.** All plans and specifications for public swimming pool and spa construction, installation, or alteration or requests for a variance that are submitted to the commissioner according to Minnesota Rules, part 4717.3975, shall be accompanied by the appropriate fees. All public pool construction plans submitted for review after January 1, 2009, must be certified by a professional engineer registered in the state of Minnesota. If the commissioner determines, upon review of the plans, that inadequate fees were paid, the necessary additional fees shall be paid before plan approval. For purposes of determining fees, a project is defined as a proposal to construct or install a public pool, spa, special purpose pool, or wading pool and all associated water treatment equipment

and drains, gutters, decks, water recreation features, spray pads, and those design and safety features that are within five feet of any pool or spa. The commissioner shall charge the following fees for plan review and inspection of public pools and spas and for requests for variance from the public pool and spa rules:

(1) each ~~spa~~ pool, ~~$500~~ $800;

(2) ~~projects valued at $250,000 or less, a minimum of $800 per pool plus:~~ each spa pool, $500;

~~(i)~~ (3) ~~for~~ each slide, ~~an additional~~ $400; ~~and~~

~~(ii) for each spa pool, an additional $500;~~

~~(3)~~ (4) projects valued at $250,000 or more, the greater of the sum of the fees in clauses (1), (2), and (3) or 0.5 percent of the documented estimated project cost to a maximum fee of $10,000;

~~(4)~~ (5) alterations to an existing pool without changing the size or configuration of the pool, $400;

~~(5)~~ (6) removal or replacement of pool disinfection equipment only, $75; and

~~(6)~~ (7) request for variance from the public pool and spa rules, $500.

Sec. 2. Minnesota Statutes 2006, section 144.1222, is amended by adding a subdivision to read:

Subd. 1b. **Unblockable drain.** "Unblockable drain" means a drain of any size and shape that a human body cannot sufficiently block to create a suction entrapment hazard.

Sec. 3. Minnesota Statutes 2006, section 144.1222, is amended by adding a subdivision to read:

Subd. 1c. **Public pool construction.** All public pools constructed after December 19, 2008, must contain a combination of two or more main drains, or drain covers meeting ASME/ANSI standards, connected in parallel, per suction pump.

Sec. 4. Minnesota Statutes 2006, section 144.1222, is amended by adding a subdivision to read:

Subd. 1d. **Public pools; required equipment.** (a) Beginning December 19, 2008, all pools with the deepest water being less than four feet deep must meet the requirements in this subdivision:

(1) Each public pool and spa must be equipped with anti-entrapment devices or systems that comply with ASME/ANSI performance standard A112.19.8, or any successor standard.

(2) Each public pool and spa with a single main drain, other than an unblockable drain, must be equipped, at a minimum, with one or more of the devices listed in items (i) to (vi) or with systems designed to prevent entrapment by pool or spa drains that meet the requirements of paragraph (b):

(i) a safety vacuum release system that ceases operation of the pump, reverses the circulation flow, or otherwise provides a vacuum release at a suction outlet when a blockage is detected, that has been tested by an independent third party and found to conform to ASME/ANSI standard A112.19.17 or ASTM standard F2387;

(ii) a suction-limiting vent system with a tamper-resistant atmospheric opening;

(iii) a gravity drainage system that utilizes a collector tank;

(iv) an automatic pump shut-off system;

(v) a device or system that disables the drain; and

(vi) any other system determined by the commissioner to be equally effective as, or better than, the systems listed in this paragraph at preventing or eliminating the risk of injury or death associated with pool drainage systems.

(b) Any devise or system described in paragraph (a) must meet the requirements of any ASME/ANSI or ASTM performance standard if there is a standard for a device or system, or any applicable consumer product safety standard.

(c) All other existing pools must comply with this subdivision no later than December 19, 2009.

Sec. 5. Minnesota Statutes 2006, section 157.16, as amended by Laws 2007, chapter 147, article 9, section 34, is amended to read:

157.16 LICENSES REQUIRED; FEES.

Subdivision 1. **License required annually.** A license is required annually for every person, firm, or corporation engaged in the business of conducting a food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort. Any person wishing to operate a place of business licensed in this section shall first make application, pay the required fee specified in this section, and receive approval for operation, including plan review approval. Seasonal and temporary food stands and special event food stands are not required to submit plans. Nonprofit organizations operating a special event food stand with multiple locations at an annual one-day event shall be issued only one license. Application shall be made on forms provided by the commissioner and shall require the applicant to state the full name and address of the owner of the building, structure, or enclosure, the lessee and manager of the food and beverage service establishment, hotel, motel, lodging establishment, public pool, or resort;

the name under which the business is to be conducted; and any other information as may be required by the commissioner to complete the application for license.

Subd. 2. **License renewal.** Initial and renewal licenses for all food and beverage service establishments, hotels, motels, lodging establishments, public pools, and resorts shall be issued for the calendar year for which application is made and shall expire on December 31 of such year. Any person who operates a place of business after the expiration date of a license or without having submitted an application and paid the fee shall be deemed to have violated the provisions of this chapter and shall be subject to enforcement action, as provided in the Health Enforcement Consolidation Act, sections 144.989 to 144.993. In addition, a penalty of $50 shall be added to the total of the license fee for any food and beverage service establishment operating without a license as a mobile food unit, a seasonal temporary or seasonal permanent food stand, or a special event food stand, and a penalty of $100 shall be added to the total of the license fee for all restaurants, food carts, hotels, motels, lodging establishments, public pools, and resorts operating without a license for a period of up to 30 days. A late fee of $300 shall be added to the license fee for establishments operating more than 30 days without a license.

Subd. 2a. **Food manager certification.** An applicant for certification or certification renewal as a food manager must submit to the commissioner a $28 nonrefundable certification fee payable to the Department of Health.

Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food and beverage service establishments, 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 $40 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, $50. "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, $100. "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, $260. "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, $460. "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, $50.

(6) Beer or wine table service, $50. "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, $135.

"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, $8, including hotels, motels, lodging establishments, and resorts, up to a maximum of $800. "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 swimming pool, $180; each additional public swimming pool, $100. "Public swimming pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 8.

(10) First spa, $110; each additional spa, $50. "Spa pool" means a fee category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(11) Private sewer or water, $50. "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, $130. "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, $300. "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 of $350 for review of the construction plans must accompany the initial license application for restaurants, hotels, motels, lodging establishments, or resorts with five or more sleeping units.

(f) When existing food and beverage service establishments, hotels, motels, lodging establishments, or resorts are extensively remodeled, a fee of $250 must be submitted with the remodeling plans. A fee of $250 must be submitted for new construction or remodeling for a restaurant with a limited food menu selection, a seasonal permanent food stand, a mobile food unit, or a food cart, or for a hotel, motel, resort, or lodging establishment addition of less than five sleeping units.

(g) Seasonal temporary food stands and special event food stands are not required to submit construction or remodeling plans for review.

Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a licensed boarding establishment, food and beverage service establishment, seasonal temporary or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel, motel, or lodging establishment in Minnesota must submit to the commissioner a $35 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed by the Department of Health is required at the same time the licensure fee is due. For establishments licensed by local governments, the fee is due by July 1 of each year.

Subd. 4. **Posting requirements.** Every food and beverage service establishment, hotel, motel, lodging establishment, <u>public pool,</u> or resort must have the license posted in a conspicuous place at the establishment.

Sec. 6. Laws 2007, chapter 147, article 19, section 4, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Promotion**

	Appropriations by Fund	
General	44,271,000	43,836,000
State Government Special Revenue	870,000	875,000
Health Care Access	4,050,000	4,086,000
Federal TANF	8,735,000	8,735,000

TANF Appropriations. (a) $3,579,000 of the TANF funds is appropriated in each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882,

subdivision 7, clauses (6) and (7). Funding shall be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(b) $4,000,000 in the first year and $4,000,000 in the second year are appropriated to the commissioner of health for the family home visiting grant program according to Minnesota Statutes, section 145A.17. Funding shall be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. The commissioner may use five percent of the funds appropriated in each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and may use ten percent of the funds appropriated each fiscal year to provide training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Loan Forgiveness. $400,000 in fiscal year 2010 and $400,000 in fiscal year 2011 from the state government special revenue fund are to the commissioner for the loan forgiveness program under Minnesota Statutes, section 144.1501. This appropriation shall not become part of base level funding for the biennium beginning July 1, 2011. Notwithstanding any contrary

provision in this article, this rider expires December 31, 2011.

MN ENABL. Base level funding for the MN ENABL program, under Minnesota Statutes, section 145.9255, is reduced by $220,000 each year of the biennium beginning July 1, 2007.

Fetal Alcohol Spectrum Disorder.

$500,000 ~~each year~~ in fiscal year 2008 from the general fund is added to the base for fetal alcohol spectrum disorder.

(1) On July 1 of each fiscal year, the portion of the general fund appropriation to the commissioner of health for fetal alcohol spectrum disorder administration and grants shall be transferred to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorder as follows:

(i) on July 1, 2007, $1,690,000; and

(ii) on July 1, 2008, ~~$1,690,000~~ $1,190,000.

(2) The money shall be used for prevention and intervention services and programs, including, but not limited to, community grants, professional education, public awareness, and diagnosis. The organization may retain $60,000 of the transferred money for administrative costs. The organization shall report to the commissioner annually by January 15 on the services and programs funded by the appropriation.

(3) Notwithstanding any contrary provision in this article, this rider shall not expire.

Family Planning Grants. Of the TANF appropriation, $1,156,000 each year is for family planning grants under Minnesota Statutes, section 145.925.

Suicide prevention programs. Of the general fund appropriation, $335,000 in fiscal year 2008 and $145,000 in fiscal year 2009 are to fund the suicide prevention program.

Hearing Aid and Instrument Loan Bank. Of the general fund appropriation, $70,000 each year is to the commissioner for the purpose of providing a grant to cover administrative costs for a statewide hearing aid and instrument loan bank to families with children newly diagnosed with hearing loss from birth to the age of ten.

Medical Home Learning Collaborative. Of the health care access fund appropriation, $500,000 in fiscal year 2008 and $500,000 in fiscal year 2009 are to expand the medical home learning collaborative initiative in collaboration with the commissioner of human services. Services provided under this funding must support a medical home model for children with special health care needs. The collaborative shall report back to the legislature on use of the funds by January 15, 2010. This appropriation shall not become part of the base funding for the 2010-2011 biennium.

Base Adjustment. The health care access fund base is $3,586,000 in each of fiscal years 2010 and 2011.

Sec. 7. Laws 2007, chapter 147, article 19, section 4, subdivision 4, is amended to read:

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	15,315,000	10,526,000
State Government Special Revenue	27,475,000	28,327,000

Pandemic Influenza Preparedness. Of the general fund appropriation, (1) $115,000 in fiscal year 2008 is for department activities of epidemiology, laboratory services, exercises, and planning, and (2) $3,970,000 is to purchase antiviral medications and prepare and manage a stockpile of health care supplies.

Lead Abatement. Of the general fund appropriation, $388,000 in ~~each~~ fiscal year 2008 is for the lead abatement program in Minnesota Statutes, section 144.9512.

Water Treatment. Of the general fund appropriation, $40,000 in fiscal year 2008 is to augment any appropriation from the remediation fund to conduct an evaluation of point of use water treatment units at removing perfluorooctanoic acid, perfluorooctane sulfonate, and perfluorobutanoic acid from known concentrations of these compounds in drinking water. The evaluation shall be completed by December 31, 2007, and the commissioner may contract for services to complete the evaluation. This is a onetime appropriation.

HIV Information. Of the general fund appropriation, $80,000 each year is to fund a community-based nonprofit organization with demonstrated capacity to operate a statewide HIV information and referral

service using telephone, Internet, and other appropriate technologies. This appropriation shall become part of base level funding for the biennium beginning July 1, 2009. * (The preceding text beginning "HIV Information. Of the general fund" was indicated as vetoed by the governor.)

Base Adjustment. The general fund base is ~~$10,526,000~~ $10,138,000 in each of the fiscal years 2010 and 2011.

Sec. 8. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the public pool definition in Minnesota Rules, part 4717.0250, subpart 8, with the following language: "public pool" means any pool that is open to the public generally, whether for a fee or free of charge; open exclusively to members of an organization and their guests; residents of a multiunit apartment building, apartment complex, residential real estate development, or other multifamily residential area; or patrons of a hotel or lodging or other public accommodation facility; or operated by a person in a park, school, licensed child care facility, group home, motel, camp, resort, club, condominium, manufactured home park, or political subdivision with the exception of swimming pools at family day care homes licensed under Minnesota Statutes, section 245A.14, subdivision 11, paragraph (a).

Sec. 9. **REPEALER.**

Minnesota Statutes 2006, section 62J.58, is repealed.

ARTICLE 7
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.

	2008	**2009**	**Total**
General	$ (87,755,000)	$ (186,164,000)	$ (273,919,000)
State Government Special Revenue	0	633,000	633,000
Health Care Access	0	35,551,000	35,551,000

Federal TANF	52,700,000	38,818,000	91,518,000
Total	**$ (35,055,000)**	**$ (111,162,000)**	**$ (146,217,000)**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2007, chapter 147, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2008" and "2009" used in this article mean that the addition or subtraction from appropriations listed under them are available for the fiscal year ending June 30, 2008, or June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Supplemental appropriations and reductions for the fiscal year ending June 30, 2008, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2008	**2009**

Sec. 3. **HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (35,055,000)** **$ (109,482,000)**

Appropriations by Fund

	2008	2009
General	(87,755,000)	(183,851,000)
Health Care Access	0	35,551,000
Federal TANF	52,700,000	38,818,000

Subd. 2. **Agency Management**

Financial Operations	0	(5,867,000)

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

Base Adjustment. The general fund base is increased $23,000 in fiscal year 2010 and $26,000 in fiscal year 2011.

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**

Federal TANF	25,000,000	27,039,000

Additional TANF Transfer to Social Services Block Grant. In addition to transfers allowed under prior law, $21,000,000 in fiscal year 2009 is appropriated to the commissioner for the purposes of providing services for families with children whose incomes are at or below 200 percent of the federal poverty guidelines. The commissioner shall authorize a sufficient transfer of funds from the state's federal TANF block grant to the state's federal social services block grant to meet this appropriation. The funds must be distributed to counties for the children and community services grant according to the formula for state appropriations in Minnesota Statutes, chapter 256M.

Additional TANF Transfer to Child Care and Development Fund. In addition to transfers allowed under prior law, $25,000,000 in fiscal year 2008 and $6,039,000 in fiscal year 2009 are appropriated to the commissioner for the purposes of MFIP transition year child care under Minnesota Statutes, section 119B.05. The commissioner shall authorize 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 the federal child care and development fund regulations.

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	(27,700,000)	(11,779,000)
Federal TANF	27,700,000	11,779,000

(b) MFIP Child Care Assistance Grants (25,000,000) (6,039,000)

(c) Children's Services Grants (311,000) (1,742,000)

Base Adjustment. The general fund base is increased $1,726,000 in fiscal year 2010 and $1,742,000 in fiscal year 2011 due to the onetime increase in adoption assistance grants and the onetime decreases in relative custody assistance grants, and the delayed rate increase and county shift for children's mental health grants.

Funding Usage. Up to 75 percent of the fiscal year 2010 appropriation for children's mental health screening grants may be used to fund calendar year 2009 allocations for these programs, with the resulting calendar year funding pattern continuing into the future.

(d) Children and Community Services Grants 0 (21,330,000)

Base Adjustment. The general fund base is increased $21,264,000 in fiscal year 2010 and $21,330,000 in fiscal year 2011 to reinvest a onetime reduction to community social service grants and the delay of the cost-of-living adjustment for community social service grants.

(e) Minnesota Supplemental Aid Grants 0 201,000

(f) Group Residential Housing Grants 0 (433,000)

Subd. 5. **Basic Health Care Grants**

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

(a) MinnesotaCare Grants

Health Care Access	0	(9,618,000)

(b) MA Basic Health Care Grants - Families and Children

	(17,985,000)	(33,277,000)

Hospital Payment Delay. Notwithstanding Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 6, payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for medical assistance enrollees are delayed as follows: (1) for fiscal year 2008, the last payments for the month of June must be included in the first payments in fiscal year 2009; and (2) for fiscal year 2009, the last payments in the month of June must be included in the first payment of fiscal year 2010. The provisions of Minnesota Statutes, section 16A.124, shall not apply to these delayed payments.

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

	(14,028,000)	(6,608,000)

Minnesota Disabilities Options Service Limits. Enrollment of new members into the Minnesota disability health options program under Minnesota Statutes, section 256B.69, subdivision 23, must be limited to provision of state plan basic care services as defined under Minnesota Statutes, section 256B.69, subdivision 28, after July 1, 2008, except that nursing home services will remain capitated at 180 days. Notwithstanding any contrary section in this article, this provision expires June 30, 2011.

(d) General Assistance Medical Care Grants

	Appropriations by Fund	
General	0	(50,743,000)
Health Care Access	0	46,835,000

GAMC Transition. Notwithstanding Minnesota Statutes, section 295.581, payments for general assistance medical care under Minnesota Statutes, section 256D.03, subdivision 3, paragraph (c), for adults transitioning to MinnesotaCare must be paid for out of the health care access fund. Notwithstanding any contrary provision in this article, this provision does not expire.

(e) Other Health Care Grants 0 (212,000)

MinnesotaCare Outreach Grants Special Revenue Account. The balance in the MinnesotaCare outreach grants special revenue account at the close of fiscal year 2008 must be transferred to the general fund.

Subd. 6. **Health Care Management**

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

(a) Health Care Administration

	Appropriations by Fund	
General	(200,000)	(1,223,000)
Health Care Access	0	(1,096,000)

Base Adjustment. The general fund base is increased $164,000 in fiscal year 2010 and $335,000 in fiscal year 2011. The health care access fund base is increased $125,000 in fiscal years 2010 and 2011.

(b) Health Care Operations

Health Care Access 0 (570,000)

Base Adjustment. The general fund base is decreased $1,151,000 in fiscal year 2010 and $1,068,000 in fiscal year 2011.

Subd. 7. **Continuing Care Grants**

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

(a) Aging and Adult Services Grants	0	(241,000)

Base Adjustment. The general fund base is increased $193,000 in fiscal year 2010 and $241,000 in fiscal year 2011 due to the delayed rate adjustment for aging and adult services grants.

(b) Alternative Care Grants	0	(661,000)

Base Adjustment. The general fund base is increased $511,000 in fiscal year 2010 and $661,000 in fiscal year 2011 due to the delayed rate adjustment for alternative care grants.

(c) MA Long-Term Care Facilities Grants	(2,306,000)	(8,366,000)

Long-Term Care Provider Rate Adjustment Delay. Notwithstanding Laws 2007, chapter 147, article 7, sections 59 and 71, the long-term care provider rate adjustment for July 1, 2008, is delayed until July 1, 2009.

(d) MA Long-Term Care Waivers and Home Care Grants	0	(23,679,000)

Manage Growth in TBI and CADI Waiver. During the fiscal years beginning on July 1, 2008, July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based programs covered 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 (TBI) waiver to 200 diversions in each year of the biennium and the community alternatives for disabled individuals (CADI) waiver to 1,500 diversions each year of the biennium. 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. Notwithstanding any contrary section in this article, this provision expires June 30, 2011.

(e) Mental Health Grants	0	(5,450,000)

Base Adjustment. The general fund base is increased $5,270,000 in fiscal year 2010 and $5,450,000 in fiscal year 2011 due to the delayed rate adjustment and county payment shift for adult mental health grants.

(f) Deaf and Hard-of-Hearing Grants	0	(20,000)

Base Adjustment. The general fund base is increased $16,000 in fiscal year 2010 and $20,000 in fiscal year 2011 due to the delayed rate increase for deaf and hard-of-hearing grants.

(g) Chemical Dependency Entitlement Grants	0	(3,390,000)

Payments for Substance Abuse Treatment. For services provided in fiscal year 2009, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed rates charged for services in excess of those in effect on May 31, 2008. If statutes authorize a cost-of-living adjustment during fiscal year

2009, then notwithstanding any law to the contrary, fiscal year 2009 rates may not exceed those in effect on May 31, 2008, plus any authorized cost-of-living adjustments.

Chemical Dependency Treatment Fund Special Revenue Account.

The lesser of the balance of the consolidated chemical dependency treatment fund at the close of fiscal year 2008 or $2,500,000 must be transferred and deposited into the general fund.

(h) Chemical Dependency Nonentitlement Grants	0	2,150,000

Base Level Adjustment. The general fund base for chemical dependency nonentitlement treatment grants shall be increased by $150,000 for fiscal years 2010 and 2011 for increased grants for methamphetamine treatment.

American Indian Youth Program. Of the health care access fund appropriation, $2,000,000 in fiscal year 2009 is for grants to be awarded competitively to American Indian tribes to purchase or develop one or more culturally specific treatment programs designed to serve youth from native cultures. This appropriation is onetime and available until spent.

(i) Other Continuing Care Grants	0	(4,832,000)

Base Level Adjustment. The general fund base is increased $7,633,000 in fiscal year 2010 and $5,332,000 in fiscal year 2011, due to the onetime reduction of HIV grants in fiscal year 2009, an increase each year for housing grants under Minnesota Statutes,

section 256B.0658, and the adjustment for the county grant payment shift for developmental disability semi-independent services grants and developmental disability family support grants.

Housing Access Grants. Of the general fund appropriation, $250,000 is appropriated in fiscal year 2009 for housing access grants under Minnesota Statutes, section 256B.0658.

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

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

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

Mental Health Services	(225,000)	(300,000)

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$ 0**	**$ (1,723,000)**

	Appropriations by Fund		
	2008	2009	
General	0	(2,356,000)	
State Government Special Revenue	0	633,000	
Subd. 2. **Community and Family Health**			0 (825,000)
Subd. 3. **Health Protection**			
	Appropriations by Fund		
General	0	(388,000)	
State Government Special Revenue	0	633,000	

Base Adjustment. The state government special revenue fund base is increased $89,000 in fiscal years 2010 and 2011.

Subd. 4. **Administrative Support Services** 0 (1,100,000)

Base Adjustment. The general fund base is increased $46,000 in fiscal years 2010 and 2011.

Sec. 5. **HEALTH RELATED BOARDS**

Subdivision 1. **Total Appropriation**		**2008**		**2009**
State Government Special Revenue	**$**	**416,000**	**$**	**200,000**
Subd. 2. **Board of Nursing Home Administrators**				
State Government Special Revenue		100,000		200,000

Administrative Services Unit. The amounts appropriated are for the administrative services unit to pay for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under Laws 2007, chapter 147, article 19, section 6. Upon certification of a health-related board to the administrative services unit that such costs will be incurred and that there are insufficient

funds available to pay for such costs out of funds currently available to that board, the administrative services unit is authorized to transfer funds from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation shall not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Subd. 3. **Board of Chiropractic Examiners**

State Government Special Revenue	150,000	0

Subd. 4. **Board of Dentistry**

State Government Special Revenue	100,000	0

Subd. 5. **Board of Veterinary Medicine**

State Government Special Revenue	54,000	0

Subd. 6. **Board of Marriage and Family Therapy**

State Government Special Revenue	12,000	0

Sec. 6. Minnesota Statutes 2007 Supplement, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of finance shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

(c) The commissioner of finance shall transfer $250,000,000 from the health care access fund to the general fund on June 30, 2009. This is in addition to the transfer in paragraph (a).

APPENDIX
Article locations in 08-4639

62J.58 IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I industry participants and all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version/release 3051) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim information.

Subd. 2a. **Claim status information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets under section 62J.56, subdivision 3, all category I and II industry participants, excluding pharmacists, may accept or submit the ANSI ASC X12 276/277 health care claim status transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim status information.

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version/release 3051) for the electronic transfer of enrollment and health benefit information.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health benefit eligibility information.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

256.741 CHILD SUPPORT AND MAINTENANCE.

Subd. 15. **Child support distribution.** The state shall distribute current child support and maintenance received by the state to an individual who assigns the right to that support under subdivision 2, paragraph (a).

256.962 MINNESOTA HEALTH CARE PROGRAMS OUTREACH.

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization a $20 application assistance bonus. The organization may provide an applicant a gift certificate or other incentive upon enrollment.

256.969 PAYMENT RATES.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base

year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199 and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 2c. **Extended coverage for children.** A child receiving medical assistance under subdivision 2, who becomes ineligible due to excess income, is eligible for two additional months of medical assistance. Eligibility under this section is effective following any coverage available under section 256B.0625.

A child eligible for extended coverage under this section is deemed automatically eligible for MinnesotaCare until renewal. MinnesotaCare coverage begins in accordance with section 256L.05, subdivision 3.

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subdivision 1. **Rebasing of nursing facility operating cost payment rates.** (a) The commissioner shall rebase nursing facility operating cost payment rates to align payments to facilities with the cost of providing care. The rebased operating cost payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The new operating cost payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015.

(c) Operating cost payment rates shall be rebased on October 1, 2016, and every two years after that date.

(d) Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2006, a statistical and cost report shall be filed by each nursing facility by January 15. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 25. **Normalized direct care costs per day.** "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Subd. 30. **Peer groups.** Facilities shall be classified into three groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) group three: facilities in all other counties.

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section 256B.436 or 256B.437, or single bed room incentives under section 256B.431, subdivision 42.

Subd. 48. **Calculation of operating per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.

Subd. 49. **Determination of total care-related per diem.** The total care-related per diem for each facility shall be the sum of the direct care per diem and the other care-related per diem.

Subd. 50. **Determination of total care-related limit.** (a) The limit on the total care-related per diem shall be determined for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

(b) Beginning with rates determined for October 1, 2016, the total care-related limit shall be a variable amount based on each facility's quality score, as determined under section 256B.441, subdivision 44, in accordance with clauses (1) to (4):

(1) for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage;

(2) if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group;

(3) if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and

(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).

Subd. 51. **Determination of other operating limit.** The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under sections 256B.436 and 256B.437, subdivision 6. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Subd. 54. **Determination of total payment rates.** In rate years when rates are rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level using the weights in subdivision 14.

Subd. 55. **Phase-in of rebased operating cost payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2012, the operating cost payment rate calculated under this section shall be phased in by blending the operating cost rate with the operating cost payment rate determined under section 256B.434. For the rate year beginning October 1, 2008, the operating cost payment rate for each facility shall be 13 percent of the operating cost payment

rate from this section, and 87 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2009, the operating cost payment rate for each facility shall be 14 percent of the operating cost payment rate from this section, and 86 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2010, the operating cost payment rate for each facility shall be 14 percent of the operating cost payment rate from this section, and 86 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2011, the operating cost payment rate for each facility shall be 31 percent of the operating cost payment rate from this section, and 69 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2012, the operating cost payment rate for each facility shall be 48 percent of the operating cost payment rate from this section, and 52 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2013, the operating cost payment rate for each facility shall be 65 percent of the operating cost payment rate from this section, and 35 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating cost payment rate for each facility shall be 82 percent of the operating cost payment rate from this section, and 18 percent of the operating cost payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating cost payment rate for each facility shall be the operating cost payment rate determined under this section. The blending of operating cost payment rates under this section shall be performed separately for each RUG's class.

(b) A portion of the funds received under this subdivision that are in excess of operating cost 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).

Subd. 56. **Hold harmless.** For the rate years beginning October 1, 2008, to October 1, 2016, no nursing facility shall receive an operating cost payment rate less than its operating cost payment rate under section 256B.434. The comparison of operating cost payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subd. 7. **Exception for certain children.** Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.