

A bill for an act

1.1 relating to government finance; appropriating and transferring money and
1.2 supplementing or reducing appropriations for the Departments of Health, Human
1.3 Services, Veterans Affairs, Corrections, and Commerce, health-related boards,
1.4 the Emergency Medical Services Board, and the University of Minnesota;
1.5 establishing, regulating, or modifying health care services programs, continuing
1.6 care services, children and family services, and Department of Health provisions;
1.7 amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision;
1.8 62J.692, subdivision 4; 144.226, subdivision 3; 144D.03, subdivision 2, by
1.9 adding a subdivision; 144D.04, subdivision 2; 144E.37; 144G.06; 152.126, as
1.10 amended; 214.40, subdivision 7; 245C.27, subdivision 2; 245C.28, subdivision 3;
1.11 246.18, by adding a subdivision; 254B.01, subdivision 2; 254B.02, subdivisions
1.12 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision
1.13 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.9657, subdivisions
1.14 1, 2, 3, 3a; 256.969, subdivisions 21, 26, by adding a subdivision; 256B.04,
1.15 subdivision 14a; 256B.055, by adding a subdivision; 256B.056, subdivisions 3,
1.16 4; 256B.0625, subdivision 22, by adding a subdivision; 256B.0631, subdivisions
1.17 1, 3; 256B.0644, as amended; 256B.0753, by adding a subdivision; 256B.0915,
1.18 by adding a subdivision; 256B.441, subdivision 53; 256B.49, by adding a
1.19 subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivision 27,
1.20 by adding a subdivision; 256B.692, subdivision 1; 256B.76, subdivisions 2,
1.21 4; 256D.0515; 256J.24, subdivision 6; 256L.12, subdivisions 5, 9, by adding
1.22 a subdivision; 517.08, subdivision 1c, as amended; 626.556, subdivision
1.23 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections
1.24 150A.06, subdivision 1d; 150A.106, subdivision 1; 157.16, subdivision 3;
1.25 245C.27, subdivision 1; 256.045, subdivision 3; 256.969, subdivisions 2b, 3a;
1.26 256.975, subdivision 7; 256B.0625, subdivision 13h; 256B.0659, subdivision 11;
1.27 256B.0911, subdivision 3c; 256B.441, subdivision 55; 256B.69, subdivisions
1.28 5a, 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended;
1.29 256J.425, subdivision 3; 256L.03, subdivision 5; 327.15, subdivision 3; 517.08,
1.30 subdivision 1b; Laws 2009, chapter 79, article 3, section 18; article 5, sections
1.31 75, subdivision 1; 78, subdivision 5; article 13, sections 3, subdivisions 1, as
1.32 amended, 4, as amended, 6, 8, as amended; 5, subdivision 8, as amended; Laws
1.33 2010, chapter 200, article 1, sections 12, subdivision 7; 16; 21; article 2, section
1.34 2, subdivisions 1, 5, 8; proposing coding for new law in Minnesota Statutes,
1.35 chapters 62D; 62Q; 137; 144D; 256B; repealing Minnesota Statutes 2008,
1.36 sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03,
1.37 subdivisions 3, 3a, 5, 6, 7, 8; Laws 2010, chapter 200, article 1, sections 12;
1.38 18; 19.
1.39

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

2.2 **ARTICLE 1**

2.3 **HEALTH CARE**

2.4 Section 1. Minnesota Statutes 2008, section 256.9657, subdivision 2, is amended to
2.5 read:

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

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

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

2.15 (d) Effective October 1, 2011, the surcharge under paragraph (c) is reduced to
2.16 2.30 percent.

2.17 (e) Notwithstanding the Medicare cost finding and allowable cost principles, the
2.18 hospital surcharge is not an allowable cost for purposes of rate setting under sections
2.19 256.9685 to 256.9695.

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

2.21 Sec. 2. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:

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

2.30 (b) Effective October 1, 2010, in addition to the surcharge under paragraph (a), each
2.31 health maintenance organization shall pay to the commissioner a surcharge equal to 0.85
2.32 percent of total premium revenues and each county-based purchasing plan authorized
2.33 under section 256B.692 shall pay to the commissioner a surcharge equal to 1.45 percent

3.1 of the total premium revenues of the plan, as reported to the commissioner of health,
3.2 according to the payment schedule in subdivision 4. Notwithstanding section 256.9656,
3.3 money collected under this paragraph shall be deposited in the health care access fund
3.4 established in section 16A.724.

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

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

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

3.13 (3) Medicare revenue, as a result of an arrangement between a health maintenance
3.14 organization or a community integrated service network and the Centers for Medicare
3.15 and Medicaid Services of the federal Department of Health and Human Services, for
3.16 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
3.17 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
3.18 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
3.19 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

3.33 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
3.34 corporation's surcharge shall be based on the revenues earned in the second previous
3.35 calendar year by all of the entities or corporations subject to the merger, consolidation,
3.36 or acquisition regardless of whether one of the entities or corporations does not retain a

4.1 certificate of authority under chapter 62D or a license under chapter 62N until the total
4.2 premium revenues of the surviving corporation include the total premium revenues of all
4.3 the merged entities as reported to the commissioner of health.

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

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

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

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

4.19 Sec. 3. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 2b, is
4.20 amended to read:

4.21 Subd. 2b. **Operating payment rates.** In determining operating payment rates for
4.22 admissions occurring on or after the rate year beginning January 1, 1991, and every two
4.23 years after, or more frequently as determined by the commissioner, the commissioner
4.24 shall obtain operating data from an updated base year and establish operating payment
4.25 rates per admission for each hospital based on the cost-finding methods and allowable
4.26 costs of the Medicare program in effect during the base year. Rates under the general
4.27 assistance medical care, medical assistance, and MinnesotaCare programs shall not be
4.28 rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months
4.29 of the rebased period beginning January 1, 2009. For the first ~~three~~ 24 months of the
4.30 rebased period beginning January 1, 2011, rates shall not be rebased ~~at 74.25 percent of~~
4.31 ~~the full value of the rebasing percentage change. From April 1, 2011, to March 31, 2012,~~
4.32 ~~rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change.~~
4.33 Effective ~~April 1, 2012~~ January 1, 2013, rates shall be rebased at full value. The base year
4.34 operating payment rate per admission is standardized by the case mix index and adjusted
4.35 by the hospital cost index, relative values, and disproportionate population adjustment.

S.F. No. 2337, 1st Engrossment - 86th Legislative Session (2009-2010) [s2337-1]

5.1 The cost and charge data used to establish operating rates shall only reflect inpatient
5.2 services covered by medical assistance and shall not include property cost information
5.3 and costs recognized in outlier payments.

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

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

5.7 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
5.8 assistance program must not be submitted until the recipient is discharged. However,
5.9 the commissioner shall establish monthly interim payments for inpatient hospitals that
5.10 have individual patient lengths of stay over 30 days regardless of diagnostic category.
5.11 Except as provided in section 256.9693, medical assistance reimbursement for treatment
5.12 of mental illness shall be reimbursed based on diagnostic classifications. Individual
5.13 hospital payments established under this section and sections 256.9685, 256.9686, and
5.14 256.9695, in addition to third party and recipient liability, for discharges occurring during
5.15 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
5.16 inpatient services paid for the same period of time to the hospital. This payment limitation
5.17 shall be calculated separately for medical assistance and general assistance medical
5.18 care services. The limitation on general assistance medical care shall be effective for
5.19 admissions occurring on or after July 1, 1991. Services that have rates established under
5.20 subdivision 11 or 12, must be limited separately from other services. After consulting with
5.21 the affected hospitals, the commissioner may consider related hospitals one entity and
5.22 may merge the payment rates while maintaining separate provider numbers. The operating
5.23 and property base rates per admission or per day shall be derived from the best Medicare
5.24 and claims data available when rates are established. The commissioner shall determine
5.25 the best Medicare and claims data, taking into consideration variables of recency of the
5.26 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
5.27 The commissioner shall notify hospitals of payment rates by December 1 of the year
5.28 preceding the rate year. The rate setting data must reflect the admissions data used to
5.29 establish relative values. Base year changes from 1981 to the base year established for the
5.30 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
5.31 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
5.32 1. The commissioner may adjust base year cost, relative value, and case mix index data
5.33 to exclude the costs of services that have been discontinued by the October 1 of the year
5.34 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
5.35 that encompass portions of two or more rate years shall have payments established based

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

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

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

6.13 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
6.14 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
6.15 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
6.16 from the current statutory rates. Mental health services within diagnosis related groups
6.17 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
6.18 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
6.19 assistance does not include general assistance medical care. Payments made to managed
6.20 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
6.21 this reduction.

6.22 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
6.23 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
6.24 to hospitals for inpatient services before third-party liability and spenddown, is reduced
6.25 3.46 percent from the current statutory rates. Mental health services with diagnosis related
6.26 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
6.27 paragraph. Payments made to managed care plans shall be reduced for services provided
6.28 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

6.29 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
6.30 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
6.31 to hospitals for inpatient services before third-party liability and spenddown, is reduced
6.32 1.9 percent from the current statutory rates. Mental health services with diagnosis related
6.33 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
6.34 paragraph. Payments made to managed care plans shall be reduced for services provided
6.35 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

S.F. No. 2337, 1st Engrossment - 86th Legislative Session (2009-2010) [s2337-1]

7.1 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
7.2 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
7.3 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
7.4 from the current statutory rates. Mental health services with diagnosis related groups
7.5 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
7.6 Payments made to managed care plans shall be reduced for services provided on or after
7.7 July 1, 2010, to reflect this reduction.

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

7.14 (i) In order to offset the ratable reductions provided for in this subdivision, the total
7.15 payment rate for medical assistance fee-for-service admissions occurring on or after July
7.16 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before
7.17 third-party liability and spenddown, shall be increased by five percent from the current
7.18 statutory rates. Effective July 1, 2011, the rate increase under this paragraph shall be
7.19 reduced to 0.63 percent. For purposes of this paragraph, medical assistance does not
7.20 include general assistance medical care. The commissioner shall not adjust rates paid to a
7.21 prepaid health plan under contract with the commissioner to reflect payments provided
7.22 in this paragraph. The commissioner may utilize a settlement process to adjust rates in
7.23 excess of the Medicare upper limits on payments.

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

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

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

8.1 and covered by medical assistance shall not be billable to any other governmental entity.
8.2 Medical necessity shall be determined under criteria established to meet the requirements
8.3 of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

8.4 (b) In order to ensure adequate access for the provision of mental health services
8.5 and to encourage broader delivery of these services outside the nonstate governmental
8.6 hospital setting, payment rates for medical assistance admissions occurring on or after
8.7 July 1, 2010, at a Minnesota private, not-for-profit hospital above the 75th percentile of all
8.8 Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521
8.9 to 523 admissions paid by medical assistance for admissions occurring in calendar year
8.10 2007, shall be increased for these diagnosis-related groups at a percentage calculated to
8.11 cost not more than \$10,000,000 each fiscal year, including state and federal shares. For
8.12 purposes of this paragraph, medical assistance does not include general assistance medical
8.13 care. The commissioner shall not adjust rates paid to a prepaid health plan under contract
8.14 with the commissioner to reflect payments provided in this paragraph. The commissioner
8.15 may utilize a settlement process to adjust rates in excess of the Medicare upper limits
8.16 on payments.

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

8.18 Sec. 6. Minnesota Statutes 2008, section 256.969, subdivision 26, is amended to read:

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

8.23 (1) the hospital's current payment rate for the diagnostic category to which the
8.24 diagnosis-related group belongs, exclusive of disproportionate population adjustments
8.25 received under subdivision 9 and hospital payment adjustments received under subdivision
8.26 23; or

8.27 (2) 90 percent of the average payment rate for that diagnostic category for hospitals
8.28 located within the seven-county metropolitan area, exclusive of disproportionate
8.29 population adjustments received under subdivision 9 and hospital payment adjustments
8.30 received under subdivisions 20 and 23.

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

- 8.33 (1) 370 cesarean section with complicating diagnosis;
8.34 (2) 371 cesarean section without complicating diagnosis;
8.35 (3) 372 vaginal delivery with complicating diagnosis;

- 9.1 (4) 373 vaginal delivery without complicating diagnosis;
- 9.2 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
- 9.3 (6) 388 full-term neonates with other problems;
- 9.4 (7) 390 prematurity without major problems;
- 9.5 (8) 391 normal newborn;
- 9.6 (9) 385 neonate, died or transferred to another acute care facility;
- 9.7 (10) 425 acute adjustment reaction and psychosocial dysfunction;
- 9.8 (11) 430 psychoses;
- 9.9 (12) 431 childhood mental disorders; and
- 9.10 (13) 164-167 appendectomy.

9.11 (c) For medical assistance admissions occurring on or after July 1, 2010, the
9.12 payment rate under paragraph (a), clause (2), shall be increased to 100 percent from 90
9.13 percent. For purposes of this paragraph, medical assistance does not include general
9.14 assistance medical care. The commissioner shall not adjust rates paid to a prepaid
9.15 health plan under contract with the commissioner to reflect payments provided in this
9.16 paragraph. The commissioner may utilize a settlement process to adjust rates in excess of
9.17 the Medicare upper limits on payments.

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

9.19 Sec. 7. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
9.20 to read:

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

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

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

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

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

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

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

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

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

10.12 (d) For medical assistance admissions occurring on or after July 1, 2010, to March
10.13 31, 2011, the commissioner shall increase rates for inpatient hospital services at Minnesota
10.14 hospitals by \$850 for each admission. For medical assistance admissions occurring on
10.15 or after April 1, 2011, the payment under this paragraph shall be reduced to \$320 per
10.16 admission.

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

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

10.23 Sec. 8. Minnesota Statutes 2008, section 256B.04, subdivision 14a, is amended to read:

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

11.1 to maintain that level of need until otherwise determined by a person authorized to
11.2 perform a level of need determination, or for six months, whichever is sooner.

11.3 Sec. 9. Minnesota Statutes 2008, section 256B.055, is amended by adding a
11.4 subdivision to read:

11.5 Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a
11.6 person who:

11.7 (1) is over the age of 21 and under the age of 65;

11.8 (2) resides in a household with no children;

11.9 (3) is not pregnant; and

11.10 (4) is not eligible under any other subdivision of this section.

11.11 (b) Beginning October 1, 2010, persons who are eligible for medical assistance
11.12 under this subdivision are not eligible for long-term care services.

11.13 (c) Paragraph (b) does not apply to persons who meet the descriptions under section
11.14 1937(a)(2), subparagraph (B), of the Social Security Act. For purposes of this paragraph,
11.15 "medically frail" shall be defined as requiring assistance and being determined dependent
11.16 in at least two activities of daily living as defined in section 256B.0659, subdivision 1,
11.17 paragraph (b).

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

11.19 Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

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

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

12.13 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
12.14 15.

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

12.16 Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

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

12.22 (b) To be eligible for medical assistance, families and children may have an income
12.23 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
12.24 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
12.25 1996, shall be increased by three percent.

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

12.28 (d) Effective June 1, 2010, to be eligible for medical assistance under section
12.29 256B.055, subdivision 15, a person may have an income up to 75 percent of federal
12.30 poverty guidelines for the family size.

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

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

13.2 Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13h,
13.3 is amended to read:

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

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

13.15 (2) formulating a medication treatment plan;

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

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

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

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

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

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

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

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

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

13.33 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
13.34 completed a structured and comprehensive education program approved by the Board of
13.35 Pharmacy and the American Council of Pharmaceutical Education for the provision and

14.1 documentation of pharmaceutical care management services that has both clinical and
14.2 didactic elements;

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

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

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

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

14.23 (e) The commissioner shall establish a pilot project for an intensive medication
14.24 therapy management program for patients identified by the commissioner with multiple
14.25 chronic conditions and a high number of medications who are at high risk of preventable
14.26 hospitalizations, emergency room use, medication complications, and suboptimal
14.27 treatment outcomes due to medication-related problems. For purposes of the pilot
14.28 project, medication therapy management services may be provided in a patient's home
14.29 or community setting, in addition to other authorized settings. The commissioner may
14.30 waive existing payment policies and establish special payment rates for the pilot project.
14.31 The pilot project must be designed to produce a net savings to the state compared to the
14.32 estimated costs that would otherwise be incurred for similar patients without the program.
14.33 The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

15.1 Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to
15.2 read:

15.3 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under
15.4 Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient
15.5 age 21 or under who elects to receive hospice services does not waive coverage for
15.6 services that are related to the treatment of the condition for which a diagnosis of terminal
15.7 illness has been made.

15.8 **EFFECTIVE DATE.** This section is effective retroactive to March 23, 2010.

15.9 Sec. 14. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
15.10 subdivision to read:

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

15.14 (b) Facility services provided by a birth center shall be paid at the lower of billed
15.15 charges or 70 percent of the statewide average for a facility payment rate made to a
15.16 hospital for an uncomplicated vaginal birth as determined using the most recent calendar
15.17 year for which complete claims data is available. If a recipient is transported from a birth
15.18 center to a hospital prior to the delivery, the payment for facility services to the birth center
15.19 shall be the lower of billed charges or 15 percent of the average facility payment made to a
15.20 hospital for the services provided for an uncomplicated vaginal delivery as determined
15.21 using the most recent calendar year for which complete claims data is available.

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

15.26 (d) Professional services provided by traditional midwives licensed under chapter
15.27 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a
15.28 physician performing the same services. If a recipient is transported from a birth center to
15.29 a hospital prior to the delivery, a licensed traditional midwife who does not perform the
15.30 delivery may not bill for any delivery services. Services are not covered if provided by an
15.31 unlicensed traditional midwife.

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

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

16.2 Sec. 15. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
16.3 read:

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

16.7 (1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an
16.8 episode of service which is required because of a recipient's symptoms, diagnosis, or
16.9 established illness, and which is delivered in an ambulatory setting by a physician or
16.10 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
16.11 audiologist, optician, or optometrist;

16.12 (2) \$3 for eyeglasses;

16.13 (3) \$6 for nonemergency visits to a hospital-based emergency room; and

16.14 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
16.15 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
16.16 shall apply to antipsychotic drugs when used for the treatment of mental illness.

16.17 (b) Except as provided in subdivision 2, the medical assistance benefit plan shall
16.18 include the following co-payments for all recipients, effective for services provided on or
16.19 after January 1, 2009, and before January 1, 2011:

16.20 (1) \$6 for nonemergency visits to a hospital-based emergency room;

16.21 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
16.22 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
16.23 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

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

16.29 (c) Except as provided in subdivision 2, the medical assistance benefit plan shall
16.30 include the following co-payments for all recipients, effective for services provided on
16.31 or after January 1, 2011:

16.32 (1) \$3.50 for nonemergency visits to a hospital-based emergency room;

16.33 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
16.34 subject to a \$7 per month maximum for prescription drug co-payments. No co-payments
16.35 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

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

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

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

17.9 Sec. 16. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to
17.10 read:

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

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

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

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

17.20 (c) Medical assistance reimbursement to fee-for-service providers and payments to
17.21 managed care plans and county-based purchasing plans shall not be increased ~~as a result~~
17.22 ~~of the removal of the co-payments effective January 1, 2009;~~

17.23 (1) as a result of the removal of the co-payments effective January 1, 2009; or

17.24 (2) as a result of the reduction of the co-payments effective January 1, 2011.

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

17.26 Sec. 17. Minnesota Statutes 2008, section 256B.0753, is amended by adding a
17.27 subdivision to read:

17.28 Subd. 4. **Consistency with federal reform efforts.** The commissioner may modify
17.29 provisions of the care coordination payment system in order to be consistent with Public
17.30 Law 111-14, section 2703.

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

18.1 Sec. 18. [256B.0755] HEALTH CARE DELIVERY SYSTEMS
18.2 DEMONSTRATION PROJECT.

18.3 Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize
18.4 a demonstration project to test alternative and innovative health care delivery systems,
18.5 including accountable care organizations that provides services to a specified patient
18.6 population for an agreed upon total cost of care payment. The commissioner shall develop
18.7 a request for proposals for participation in the demonstration project in consultation with
18.8 hospitals, primary care providers, health plans, and other key stakeholders.

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

18.10 (1) establish uniform statewide methods of forecasting total cost of care to be used
18.11 by the commissioner for the health care delivery system projects;

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

18.15 (3) allow maximum flexibility to encourage innovation and variation so that a
18.16 variety of provider collaborations are able to become health care delivery systems if
18.17 they are willing and able to be held accountable for the total cost of care and quality and
18.18 performance standards established by the commissioner;

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

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

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

18.26 (7) encourage and authorize projects established by community hospitals, clinics,
18.27 and other providers in rural communities.

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

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

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

18.33 (3) in cooperation with counties, coordinate the delivery of health care services with
18.34 existing social services programs;

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

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

19.4 (d) A health care delivery system may be formed by a county, an integrated delivery
19.5 system or network, a physician-hospital organization, an academic center, a county-based
19.6 purchasing plan, a managed care plan, or other entity. A health care delivery system
19.7 may contract with a managed care plan or a county-based purchasing plan to provide
19.8 administrative services, including the administration of a payment system using the
19.9 payment methods established by the commissioner for health care delivery systems.

19.10 Subd. 2. **Enrollment.** (a) Initially, individuals eligible for medical assistance
19.11 under section 256B.055, subdivision 15, shall be eligible for enrollment in a health care
19.12 delivery system.

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

19.19 Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility
19.20 for the quality of care and the cost of care provided to its enrollees.

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

19.24 Subd. 4. **Payment system.** (a) In developing a payment system for health care
19.25 delivery systems, the commissioner shall establish a total cost of care benchmark to be
19.26 paid for services provided to the recipients enrolled in a health care delivery system. The
19.27 commissioner shall establish a payment arrangement with the health care delivery system
19.28 to provide these services during the specified time period at a cost that is equal to or
19.29 less than 97 percent of the forecasted total cost of care for the enrollee population using
19.30 predetermined payments for the recipients enrolled in the health care delivery system
19.31 rather than fee-for-service methods that pay for units of service. The actual amount to be
19.32 paid may be negotiated, but may not exceed 97 percent of the forecasted cost.

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

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

20.3 Subd. 5. **Hennepin and Ramsey Counties Pilot Program.** (a) The commissioner,
20.4 upon federal approval of a new waiver request or amendment of an existing demonstration,
20.5 may establish a pilot program in Hennepin County or Ramsey County, or both, to test
20.6 alternative and innovative integrated health care delivery networks.

20.7 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
20.8 medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin
20.9 County or Ramsey County.

20.10 (c) Individuals enrolled in the pilot shall be enrolled in an integrated health care
20.11 delivery network in their county of residence. The integrated health care delivery network
20.12 in Hennepin County shall be a network, such as an accountable care organization or
20.13 a community-based collaborative care network, created by or including the Hennepin
20.14 County Medical Center. The integrated health care delivery network in Ramsey County
20.15 shall be a network, such as an accountable care organization or community-based
20.16 collaborative care network, created by or including Regions Hospital.

20.17 (d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for
20.18 Hennepin County and 3,500 enrollees for Ramsey County.

20.19 (e) In developing a payment system for the pilot programs, the commissioner shall
20.20 establish a total cost of care for the recipients enrolled in the pilot programs that equals
20.21 the cost of care that would otherwise be spent for these enrollees in the prepaid medical
20.22 assistance program.

20.23 (f) Counties may transfer funds necessary to support the nonfederal share of
20.24 payments for integrated health care delivery networks in their county. Such transfers per
20.25 county shall not exceed 15 percent of the expected expenses for county enrollees.

20.26 (g) The commissioner shall apply to the federal government for, or as appropriate,
20.27 cooperate with counties, providers, or other entities that are applying for any applicable
20.28 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
20.29 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
20.30 111-152, that would further the purposes of or assist in the creation of an integrated health
20.31 care delivery network for the purposes of this subdivision, including, but not limited to, a
20.32 global payment demonstration or the community-based collaborative care network grants.

20.33 Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers
20.34 or other federal approval required to implement this section. The commissioner shall
20.35 also apply for any applicable grant or demonstration under the Patient Protection and
20.36 Affordable Health Care Act, Public Law 111-148, or the Health Care and Education

21.1 Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or
21.2 assist in the establishment of accountable care organizations.

21.3 Subd. 7. **Expansion.** The commissioner shall explore the expansion of the
21.4 demonstration project to include additional medical assistance and MinnesotaCare
21.5 enrollees, and shall seek participation of Medicare in demonstration projects.

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

21.7 Sec. 19. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a,
21.8 is amended to read:

21.9 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
21.10 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
21.11 basis beginning January 1, 1996. Managed care contracts which were in effect on June
21.12 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
21.13 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
21.14 commissioner may issue separate contracts with requirements specific to services to
21.15 medical assistance recipients age 65 and older.

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

21.21 (c) Effective for services rendered on or after January 1, 2003, the commissioner
21.22 shall withhold five percent of managed care plan payments under this section and
21.23 county-based purchasing ~~plan's payment rate~~ plan payments under section 256B.692 for
21.24 the prepaid medical assistance and general assistance medical care programs pending
21.25 completion of performance targets. Each performance target must be quantifiable,
21.26 objective, measurable, and reasonably attainable, except in the case of a performance target
21.27 based on a federal or state law or rule. Criteria for assessment of each performance target
21.28 must be outlined in writing prior to the contract effective date. The managed care plan
21.29 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
21.30 attainment of the performance target is accurate. The commissioner shall periodically
21.31 change the administrative measures used as performance targets in order to improve plan
21.32 performance across a broader range of administrative services. The performance targets
21.33 must include measurement of plan efforts to contain spending on health care services and
21.34 administrative activities. The commissioner may adopt plan-specific performance targets
21.35 that take into account factors affecting only one plan, including characteristics of the

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22.1 plan's enrollee population. The withheld funds must be returned no sooner than July of the
22.2 following year if performance targets in the contract are achieved. The commissioner may
22.3 exclude special demonstration projects under subdivision 23.

22.4 (d) Effective for services rendered on or after January 1, 2009, through December 31,
22.5 2009, the commissioner shall withhold three percent of managed care plan payments under
22.6 this section and county-based purchasing plan payments under section 256B.692 for the
22.7 prepaid medical assistance and general assistance medical care programs. The withheld
22.8 funds must be returned no sooner than July 1 and no later than July 31 of the following
22.9 year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

22.19 (f) Effective for services rendered on or after January 1, 2010, through December
22.20 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments
22.21 under this section and county-based purchasing plan payments under section 256B.692
22.22 for the prepaid medical assistance program. The withheld funds must be returned no
22.23 sooner than July 1 and no later than July 31 of the following year. The commissioner may
22.24 exclude special demonstration projects under subdivision 23.

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

22.30 The withheld funds must be returned no sooner than July 1 and no later than July
22.31 31 of the following calendar year if the managed care plan or county-based purchasing
22.32 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
22.33 rate was achieved.

22.34 The withhold described in this paragraph shall continue for each consecutive
22.35 contract period until the plan's emergency room utilization rate for state health care

23.1 program enrollees is reduced by 25 percent of the plan's emergency room utilization rate
23.2 for state health care program enrollees for calendar year 2009.

23.3 ~~(g)~~ (h) Effective for services rendered on or after January 1, 2011, through December
23.4 31, 2011, the commissioner shall withhold four percent of managed care plan payments
23.5 under this section and county-based purchasing plan payments under section 256B.692
23.6 for the prepaid medical assistance program. The withheld funds must be returned no
23.7 sooner than July 1 and no later than July 31 of the following year. The commissioner may
23.8 exclude special demonstration projects under subdivision 23.

23.9 ~~(h)~~ (i) Effective for services rendered on or after January 1, 2012, through December
23.10 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
23.11 under this section and county-based purchasing plan payments under section 256B.692
23.12 for the prepaid medical assistance program. The withheld funds must be returned no
23.13 sooner than July 1 and no later than July 31 of the following year. The commissioner may
23.14 exclude special demonstration projects under subdivision 23.

23.15 ~~(i)~~ (j) Effective for services rendered on or after January 1, 2013, through December
23.16 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
23.17 under this section and county-based purchasing plan payments under section 256B.692
23.18 for the prepaid medical assistance program. The withheld funds must be returned no
23.19 sooner than July 1 and no later than July 31 of the following year. The commissioner may
23.20 exclude special demonstration projects under subdivision 23.

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

23.27 ~~(k)~~ (l) A managed care plan or a county-based purchasing plan under section
23.28 256B.692 may include as admitted assets under section 62D.044 any amount withheld
23.29 under this section that is reasonably expected to be returned.

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

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

23.34 Sec. 20. Minnesota Statutes 2008, section 256B.69, is amended by adding a
23.35 subdivision to read:

24.1 Subd. 5k. **Rate modifications.** For services rendered on or after October 1, 2010,
24.2 the total payment made to managed care plans and county-based purchasing plans under
24.3 the medical assistance program shall be increased by 1.28 percent. This increase shall be
24.4 paid from the health care access fund established in section 16A.724.

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

24.6 Sec. 21. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is
24.7 amended to read:

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

24.11 (1) payment for level one Centers for Medicare and Medicaid Services' common
24.12 procedural coding system codes titled "office and other outpatient services," "preventive
24.13 medicine new and established patient," "delivery, antepartum, and postpartum care,"
24.14 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
24.15 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
24.16 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
24.17 30, 1992. If the rate on any procedure code within these categories is different than the
24.18 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
24.19 then the larger rate shall be paid;

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

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

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

24.31 (c) Effective for services rendered on or after July 1, 2009, payment rates for
24.32 physician and professional services shall be reduced by five percent over the rates
24.33 in effect on June 30, 2009. Effective for services rendered on or after July 1, 2011,
24.34 payment rates for physician and professional services shall be reduced an additional
24.35 1.5 percent for the medical assistance and general assistance medical care programs.

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25.1 ~~This reduction does~~ These reductions do not apply to office or other outpatient visits,
25.2 preventive medicine visits ~~and~~, or family planning visits billed by physicians, advanced
25.3 practice nurses, or physician assistants in a family planning agency or in one of the
25.4 following primary care practices: general practice, general internal medicine, general
25.5 pediatrics, general geriatrics, and family medicine. ~~This reduction does~~ These reductions
25.6 do not apply to federally qualified health centers, rural health centers, and Indian health
25.7 services. Effective ~~October 1, 2009~~ July 1, 2011, payments made to managed care plans
25.8 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
25.9 reflect the additional payment reduction described in this paragraph.

25.10 (d) Effective for services rendered on or after October 1, 2010, payment rates for
25.11 physician and professional services billed by physicians employed by and clinics owned
25.12 by a nonprofit health maintenance organization shall be increased by 25 percent. Effective
25.13 October 1, 2010, payments made to managed care plans and county-based purchasing
25.14 plans under sections 256B.69, 256B.692, and 256L.12, shall reflect the payment increase
25.15 described in this paragraph.

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

25.17 Sec. 22. Minnesota Statutes 2008, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

25.26 (c) Effective for services rendered on or after January 1, 2000, payment rates for
25.27 dental services shall be increased by three percent over the rates in effect on December
25.28 31, 1999.

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

25.32 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
25.33 2000, for managed care.

25.34 (f) Effective for dental services rendered on or after October 1, 2010, by a
25.35 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based

26.1 on the Medicare principles of reimbursement. This payment shall be effective for services
26.2 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
26.3 county-based purchasing plans.

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

26.9 (h) If the cost-based payment system for state-operated dental clinics described in
26.10 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
26.11 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
26.12 receive the critical access dental reimbursement rate as described under subdivision 4,
26.13 paragraph (a).

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

26.15 Sec. 23. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

26.16 Subd. 4. **Critical access dental providers.** (a) Effective for dental services
26.17 rendered on or after January 1, 2002, the commissioner shall increase reimbursements
26.18 to dentists and dental clinics deemed by the commissioner to be critical access dental
26.19 providers. For dental services rendered on or after July 1, 2007, the commissioner shall
26.20 increase reimbursement by 30 percent above the reimbursement rate that would otherwise
26.21 be paid to the critical access dental provider. The commissioner shall pay the ~~health plan~~
26.22 ~~companies~~ managed care plans and county-based purchasing plans in amounts sufficient
26.23 to reflect increased reimbursements to critical access dental providers as approved by the
26.24 commissioner. ~~In determining which dentists and dental clinics shall be deemed critical~~
26.25 ~~access dental providers, the commissioner shall review:~~

26.26 (b) The commissioner shall designate the following dentists and dental clinics as
26.27 critical access dental providers:

26.28 ~~(1) the utilization rate in the service area in which the dentist or dental clinic operates~~
26.29 ~~for dental services to patients covered by medical assistance, general assistance medical~~
26.30 ~~care, or MinnesotaCare as their primary source of coverage~~ nonprofit community clinics
26.31 that:

26.32 (i) have nonprofit status in accordance with chapter 317A;

26.33 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
26.34 501(c)(3);

27.1 (iii) are established to provide oral health services to patients who are low income,
27.2 uninsured, have special needs, and are underserved;

27.3 (iv) have professional staff familiar with the cultural background of the clinic's
27.4 patients;

27.5 (v) charge for services on a sliding fee scale designed to provide assistance to
27.6 low-income patients based on current poverty income guidelines and family size;

27.7 (vi) do not restrict access or services because of a patient's financial limitations
27.8 or public assistance status; and

27.9 (vii) have free care available as needed;

27.10 ~~(2) the level of services provided by the dentist or dental clinic to patients covered~~
27.11 ~~by medical assistance, general assistance medical care, or MinnesotaCare as their primary~~
27.12 ~~source of coverage~~ federally qualified health centers, rural health clinics, and public
27.13 health clinics; and

27.14 ~~(3) whether the level of services provided by the dentist or dental clinic is critical~~
27.15 ~~to maintaining adequate levels of patient access within the service area~~ county owned
27.16 and operated hospital-based dental clinics;

27.17 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
27.18 accordance with chapter 317A with more than 10,000 patient encounters per year with
27.19 patients who are uninsured or covered by medical assistance, general assistance medical
27.20 care, or MinnesotaCare; and

27.21 (5) a dental clinic associated with an oral health or dental education program
27.22 operated by the University of Minnesota or an institution within the Minnesota State
27.23 Colleges and Universities system.

27.24 ~~In the absence of a critical access dental provider in a service area, (c) The~~
27.25 commissioner may designate a dentist or dental clinic as a critical access dental provider
27.26 if the dentist or dental clinic is willing to provide care to patients covered by medical
27.27 assistance, general assistance medical care, or MinnesotaCare at a level which significantly
27.28 increases access to dental care in the service area.

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

27.30 Sec. 24. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

27.31 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

27.32 (a) Effective for services provided on or after July 1, 2009, total payments for
27.33 basic care services, shall be reduced by three percent, prior to third-party liability
27.34 and spenddown calculation. Effective for services provided on or after July 1, 2011,

28.1 payment rates shall be reduced an additional 1.5 percent for the medical assistance and
28.2 general assistance medical care programs. Payments made to managed care plans and
28.3 county-based purchasing plans shall be reduced for services provided on or after ~~October~~
28.4 ~~1, 2009~~ July 1, 2011, to reflect this additional reduction.

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

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

28.10 Sec. 25. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is
28.11 amended to read:

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

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

28.17 (2) \$3 per prescription for adult enrollees;

28.18 (3) \$25 for eyeglasses for adult enrollees;

28.19 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
28.20 episode of service which is required because of a recipient's symptoms, diagnosis, or
28.21 established illness, and which is delivered in an ambulatory setting by a physician or
28.22 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
28.23 audiologist, optician, or optometrist; and

28.24 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
28.25 provided through December 31, 2010, and \$3.50 effective January 1, 2011.

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

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

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

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

28.34 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
28.35 or changes from one prepaid health plan to another during a calendar year, any charges

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29.1 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket
29.2 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
29.3 prior to enrollment, or prior to the change in health plans, shall be disregarded.

29.4 (g) MinnesotaCare payments to managed care plans or county-based purchasing
29.5 plans shall not be increased as a result of the reduction of the co-payments in paragraph
29.6 (a), clause (5), effective January 1, 2011.

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

29.8 Sec. 26. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

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

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

30.1 ~~care plan or a county-based purchasing plan under section 256B.692 may include as~~
30.2 ~~admitted assets under section 62D.044 any amount withheld under this paragraph that is~~
30.3 ~~reasonably expected to be returned.~~

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

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

30.14 The withheld funds must be returned no sooner than July 1 and no later than July
30.15 31 of the following calendar year if the managed care plan or county-based purchasing
30.16 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
30.17 rate was achieved.

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

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

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

30.26 Sec. 27. Minnesota Statutes 2008, section 256L.12, is amended by adding a subdivision
30.27 to read:

30.28 Subd. 9c. **Rate setting; increase effective October 1, 2010.** For services
30.29 rendered on or after October 1, 2010, the total payment made to managed care plans and
30.30 county-based purchasing plans under MinnesotaCare for families with children shall be
30.31 increased by 1.28 percent.

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

30.33 Sec. 28. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:

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

31.19 Sec. 29. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

31.20 Subd. 5. **Expiration.** This section, with the exception of subdivision 4, expires
31.21 ~~December 31, 2010~~ May 31, 2011. Subdivision 4 expires November 30, 2011.

31.22 Sec. 30. Laws 2009, chapter 79, article 13, section 3, subdivision 6, is amended to read:

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

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

31.26	(a) MinnesotaCare Grants	391,915,000	485,448,000
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31.27 This appropriation is from the health care
31.28 access fund.

31.29	(b) MA Basic Health Care Grants - Families		
31.30	and Children	751,988,000	973,088,000

31.31 **Medical Education Research Costs**

31.32 **(MERC).** Of these funds, the commissioner
31.33 of human services shall transfer \$38,000,000

32.1 in fiscal year 2010 to the medical education
32.2 research fund. These funds must restore the
32.3 fiscal year 2009 unallotment of the transfers
32.4 under Minnesota Statutes, section 256B.69,
32.5 subdivision 5c, paragraph (a), for the July 1,
32.6 2008, through June 30, 2009, period.

32.7 **Newborn Screening Fee.** Of the general
32.8 fund appropriation, \$34,000 in fiscal year
32.9 2011 is to the commissioner for the hospital
32.10 reimbursement increase described under
32.11 Minnesota Statutes, section 256.969,
32.12 subdivision 28.

32.13 **Local Share Payment Modification**

32.14 **Required for ARRA Compliance.**

32.15 Effective from July 1, 2009, to December
32.16 31, 2010, Hennepin County's monthly
32.17 contribution to the nonfederal share of
32.18 medical assistance costs must be reduced
32.19 to the percentage required on September
32.20 1, 2008, to meet federal requirements for
32.21 enhanced federal match under the American
32.22 Reinvestment and Recovery Act (ARRA)
32.23 of 2009. Notwithstanding the requirements
32.24 of Minnesota Statutes, section 256B.19,
32.25 subdivision 1c, paragraph (d), for the period
32.26 beginning July 1, 2009, to December 31,
32.27 2010, Hennepin County's monthly payment
32.28 under that provision is reduced to \$434,688.

32.29 **Capitation Payments.** Effective from
32.30 July 1, 2009, to December 31, 2010,
32.31 notwithstanding the provisions of Minnesota
32.32 Statutes 2008, section 256B.19, subdivision
32.33 1c, paragraph (c), the commissioner shall
32.34 increase capitation payments made to the
32.35 Metropolitan Health Plan under Minnesota

33.1 Statutes 2008, section 256B.69, by
33.2 \$6,800,000 to recognize higher than average
33.3 medical education costs. The increased
33.4 amount includes federal matching funds.

33.5 **Use of Savings.** Any savings derived
33.6 from implementation of the prohibition in
33.7 Minnesota Statutes, section 256B.032, on the
33.8 enrollment of low-quality, high-cost health
33.9 care providers as vendors of state health care
33.10 program services shall be used to offset on a
33.11 pro rata basis the reimbursement reductions
33.12 for basic care services in Minnesota Statutes,
33.13 section 256B.766.

33.14	(c) MA Basic Health Care Grants - Elderly and		
33.15	Disabled	970,183,000	1,142,310,000

33.16 **Minnesota Disability Health Options.**
33.17 Notwithstanding Minnesota Statutes, section
33.18 256B.69, subdivision 5a, paragraph (b), for
33.19 the period beginning July 1, 2009, to June
33.20 30, 2011, the monthly enrollment of persons
33.21 receiving home and community-based
33.22 waived services under Minnesota
33.23 Disability Health Options shall not exceed
33.24 1,000. If the budget neutrality provision
33.25 in Minnesota Statutes, section 256B.69,
33.26 subdivision 23, paragraph (f), is reached
33.27 prior to June 30, 2013, the commissioner may
33.28 waive this monthly enrollment requirement.

33.29 **Hospital Fee-for-Service Payment Delay.**
33.30 Payments from the Medicaid Management
33.31 Information System that would otherwise
33.32 have been made for inpatient hospital
33.33 services for Minnesota health care program
33.34 enrollees must be delayed as follows: for
33.35 fiscal year 2011, payments in the month of
33.36 June equal to \$15,937,000 must be included

34.1 in the first payment of fiscal year 2012 and
34.2 for fiscal year 2013, payments in the month
34.3 of June equal to \$6,666,000 must be included
34.4 in the first payment of fiscal year 2014. The
34.5 provisions of Minnesota Statutes, section
34.6 16A.124, do not apply to these delayed
34.7 payments. Notwithstanding any contrary
34.8 provision in this article, this paragraph
34.9 expires December 31, 2014.

34.10 **Nonhospital Fee-for-Service Payment**

34.11 **Delay.** Payments from the Medicaid
34.12 Management Information System that would
34.13 otherwise have been made for nonhospital
34.14 acute care services for Minnesota health
34.15 care program enrollees must be delayed as
34.16 follows: payments in the month of June equal
34.17 to \$23,438,000 for fiscal year 2011 must be
34.18 included in the first payment for fiscal year
34.19 2012, and payments in the month of June
34.20 equal to \$27,156,000 for fiscal year 2013
34.21 must be included in the first payment for
34.22 fiscal year 2014. This payment delay must
34.23 not include nursing facilities, intermediate
34.24 care facilities for persons with developmental
34.25 disabilities, home and community-based
34.26 services, prepaid health plans, personal care
34.27 provider organizations, and home health
34.28 agencies. The provisions of Minnesota
34.29 Statutes, section 16A.124, do not apply to
34.30 these delayed payments. Notwithstanding
34.31 any contrary provision in this article, this
34.32 paragraph expires December 31, 2014.

34.33 **(d) General Assistance Medical Care Grants** 345,223,000 381,081,000

34.34 * (The preceding text "381,081,000" was indicated as vetoed by the governor. It
34.35 was reconsidered and not approved by the legislature, May 17, 2009.)

35.1 **(e) Other Health Care Grants**

35.2	Appropriations by Fund		
35.3	General	295,000	295,000
35.4			7,080,000
35.5	Health Care Access	23,533,000	<u>5,252,000</u>

35.6 **Base Adjustment.** The health care access
35.7 fund base is reduced to \$190,000 in each of
35.8 fiscal years 2012 and 2013.

35.9 Sec. 31. **PREPAID HEALTH PLAN RATES.**

35.10 In negotiating the prepaid health plan contract rates for services rendered on or
35.11 after January 1, 2011, the commissioner of human services shall take into consideration
35.12 and the rates shall reflect the anticipated savings in the medical assistance program due
35.13 to extending medical assistance coverage to services provided in licensed birth centers,
35.14 the anticipated use of these services within the medical assistance population, and the
35.15 reduced medical assistance costs associated with the use of birth centers for normal,
35.16 low-risk deliveries.

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

35.18 Sec. 32. **SPECIAL TRANSPORTATION SERVICES.**

35.19 The commissioner of human services shall ensure that effective October 1, 2010, to
35.20 avoid conflicts of interest, all contracts for level of need assessments under Minnesota
35.21 Statutes, section 256B.04, subdivision 14a, require that the contractor have no financial
35.22 interest in the provision of medical transportation services other than performing level of
35.23 need assessments.

35.24 Sec. 33. **STATE PLAN AMENDMENT; FEDERAL APPROVAL.**

35.25 (a) The commissioner of human services shall submit a Medicaid state plan
35.26 amendment to receive federal fund participation for adults without children whose income
35.27 is equal to or less than 75 percent of federal poverty guidelines in accordance with the
35.28 Patient Protection and Affordable Care Act, Public Law 111-148, or the Health Care and
35.29 Education Reconciliation Act of 2010, Public Law 111-152. The effective date of the
35.30 state plan amendment shall be June 1, 2010.

36.1 (b) The commissioner of human services shall submit an amendment to the
36.2 MinnesotaCare health care reform waiver to include in the waiver single adults and
36.3 households without children.

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

36.5 Sec. 34. **UPPER PAYMENT LIMIT REPORT.**

36.6 Each January 15, beginning in 2011, the commissioner of human services shall
36.7 report the following information to the chairs of the house of representatives and senate
36.8 finance committees and divisions with responsibility for human services appropriations:

36.9 (1) the estimated room within the Medicare hospital upper payment limit for the
36.10 federal year beginning on October 1 of the year the report is made;

36.11 (2) the amount of a rate increase under Minnesota Statutes, section 256.969,
36.12 subdivision 3a, paragraph (i), that would increase medical assistance hospital spending
36.13 to the upper payment limit; and

36.14 (3) the amount of a surcharge increase under Minnesota Statutes, section 256.9657,
36.15 subdivision 2, needed to generate the state share of the potential rate increase under
36.16 clause (2).

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

36.18 Sec. 35. **REVISOR'S INSTRUCTION.**

36.19 The revisor of statutes shall edit Minnesota Statutes and Minnesota Rules to remove
36.20 references to the general assistance medical care program and references to Minnesota
36.21 Statutes, section 256D.03, subdivision 3, or Minnesota Statutes, chapter 256D, as it
36.22 pertains to general assistance medical care and make other changes as may be necessary
36.23 to remove references to the general assistance medical care program. The revisor may
36.24 consult with the Department of Human Services when making editing decisions on the
36.25 removal of these references.

36.26 Sec. 36. **REPEALER.**

36.27 (a) Minnesota Statutes 2008, section 256D.03, subdivisions 3, 3a, 5, 6, 7, and 8,
36.28 are repealed June 1, 2010.

36.29 (b) Laws 2010, chapter 200, article 1, sections 12; 18; and 19, are repealed June
36.30 1, 2010.

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

ARTICLE 2

CONTINUING CARE

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Section 1. Minnesota Statutes 2008, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; ~~and~~

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

38.1 Sec. 2. Minnesota Statutes 2008, section 144D.03, is amended by adding a subdivision
38.2 to read:

38.3 Subd. 3. **Certificate of transitional consultation.** A housing with services
38.4 establishment shall not execute a contract or allow a prospective resident to move in until
38.5 the establishment has received certification from the Senior LinkAge Line that transition
38.6 to housing with services consultation under section 256B.0911, subdivision 3c, has been
38.7 completed. The housing with services establishment shall maintain copies of contracts
38.8 and certificates for audit for a period of three years.

38.9 Sec. 3. Minnesota Statutes 2008, section 144D.04, subdivision 2, is amended to read:

38.10 Subd. 2. **Contents of contract.** A housing with services contract, which need not be
38.11 entitled as such to comply with this section, shall include at least the following elements
38.12 in itself or through supporting documents or attachments:

38.13 (1) the name, street address, and mailing address of the establishment;

38.14 (2) the name and mailing address of the owner or owners of the establishment and, if
38.15 the owner or owners is not a natural person, identification of the type of business entity
38.16 of the owner or owners;

38.17 (3) the name and mailing address of the managing agent, through management
38.18 agreement or lease agreement, of the establishment, if different from the owner or owners;

38.19 (4) the name and address of at least one natural person who is authorized to accept
38.20 service of process on behalf of the owner or owners and managing agent;

38.21 (5) a statement describing the registration and licensure status of the establishment
38.22 and any provider providing health-related or supportive services under an arrangement
38.23 with the establishment;

38.24 (6) the term of the contract;

38.25 (7) a description of the services to be provided to the resident in the base rate to be
38.26 paid by resident, including a delineation of the portion of the base rate that constitutes rent
38.27 and a delineation of charges for each service included in the base rate;

38.28 (8) a description of any additional services, including home care services, available
38.29 for an additional fee from the establishment directly or through arrangements with the
38.30 establishment, and a schedule of fees charged for these services;

38.31 (9) a description of the process through which the contract may be modified,
38.32 amended, or terminated;

38.33 (10) a description of the establishment's complaint resolution process available
38.34 to residents including the toll-free complaint line for the Office of Ombudsman for
38.35 Long-Term Care;

- 39.1 (11) the resident's designated representative, if any;
- 39.2 (12) the establishment's referral procedures if the contract is terminated;
- 39.3 (13) requirements of residency used by the establishment to determine who may
39.4 reside or continue to reside in the housing with services establishment;
- 39.5 (14) billing and payment procedures and requirements;
- 39.6 (15) a statement regarding the ability of residents to receive services from service
39.7 providers with whom the establishment does not have an arrangement;
- 39.8 (16) a statement regarding the availability of public funds for payment for residence
39.9 or services in the establishment; and
- 39.10 (17) a statement regarding the availability of and contact information for
39.11 long-term care consultation services under section 256B.0911 in the county in which the
39.12 establishment is located.

39.13 **Sec. 4. [144D.08] UNIFORM CONSUMER INFORMATION GUIDE.**

39.14 All housing with services establishments shall make available to all prospective
39.15 and current residents information consistent with the uniform format and the required
39.16 components adopted by the commissioner under section 144G.06.

39.17 **Sec. 5. [144D.09] TERMINATION OF LEASE.**

39.18 The housing with services establishment shall include with notice of termination
39.19 of lease information about how to contact the ombudsman for long-term care, including
39.20 the address and phone number along with a statement of how to request problem-solving
39.21 assistance.

39.22 Sec. 6. Minnesota Statutes 2008, section 144G.06, is amended to read:

39.23 **144G.06 UNIFORM CONSUMER INFORMATION GUIDE.**

39.24 (a) The commissioner of health shall establish an advisory committee consisting
39.25 of representatives of consumers, providers, county and state officials, and other
39.26 groups the commissioner considers appropriate. The advisory committee shall present
39.27 recommendations to the commissioner on:

- 39.28 (1) a format for a guide to be used by individual providers of assisted living, as
39.29 defined in section 144G.01, that includes information about services offered by that
39.30 provider, which services may be covered by Medicare, service costs, and other relevant
39.31 provider-specific information, as well as a statement of philosophy and values associated
39.32 with assisted living, presented in uniform categories that facilitate comparison with guides
39.33 issued by other providers; and

40.1 (2) requirements for informing assisted living clients, as defined in section 144G.01,
40.2 of their applicable legal rights.

40.3 (b) The commissioner, after reviewing the recommendations of the advisory
40.4 committee, shall adopt a uniform format for the guide to be used by individual providers,
40.5 and the required components of materials to be used by providers to inform assisted
40.6 living clients of their legal rights, and shall make the uniform format and the required
40.7 components available to assisted living providers.

40.8 Sec. 7. Minnesota Statutes 2008, section 256.9657, subdivision 1, is amended to read:

40.9 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993,
40.10 each non-state-operated nursing home licensed under chapter 144A shall pay to the
40.11 commissioner an annual surcharge according to the schedule in subdivision 4. The
40.12 surcharge shall be calculated as \$620 per licensed bed. If the number of licensed beds
40.13 is ~~reduced~~ changed, the surcharge shall be based on the number of remaining licensed
40.14 beds the second month following the receipt of timely notice by the commissioner of
40.15 human services that the number of beds have been delicensed has been changed. The
40.16 nursing home must notify the commissioner of health in writing when the number of beds
40.17 ~~are delicensed~~ is changed. The commissioner of health must notify the commissioner
40.18 of human services within ten working days after receiving written notification. If the
40.19 notification is received by the commissioner of human services by the ~~15th~~ third of the
40.20 month, the invoice for the second following month must be ~~reduced~~ changed to recognize
40.21 the ~~delicensing~~ change in the number of beds. ~~Beds on layaway status continue to be~~
40.22 ~~subject to the surcharge~~. The commissioner of human services must acknowledge a
40.23 medical care surcharge appeal within 30 days of receipt of the written appeal from the
40.24 provider.

40.25 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to \$625.

40.26 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased
40.27 to \$990.

40.28 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased
40.29 to \$2,815.

40.30 (e) Effective July 15, 2010, the surcharge under paragraph (d) shall be increased
40.31 to \$3,400.

40.32 (f) The commissioner may reduce, and may subsequently restore, the surcharge under
40.33 paragraph ~~(d)~~ (e) based on the commissioner's determination of a permissible surcharge.

40.34 ~~(f)~~ (g) ~~Between April 1, 2002, and August 15, 2004~~ July 1, 2010, and June 30,
40.35 2011, a facility governed by this subdivision may elect to assume full participation in

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41.1 the medical assistance program by agreeing to comply with all of the requirements of
41.2 the medical assistance program, including the rate equalization law in section 256B.48,
41.3 subdivision 1, paragraph (a), and all other requirements established in law or rule, and
41.4 to begin intake of new medical assistance recipients. Rates will be determined under
41.5 Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431,
41.6 subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed
41.7 in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and
41.8 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any
41.9 other applicable legislation enacted prior to the finalization of rates, facilities assuming
41.10 full participation in medical assistance under this paragraph are not eligible for any rate
41.11 adjustments until the July 1 following their settle-up period.

41.12 Sec. 8. Minnesota Statutes 2008, section 256.9657, subdivision 3a, is amended to read:

41.13 Subd. 3a. **ICF/MR license surcharge.** (a) Effective July 1, 2003, each
41.14 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
41.15 to the commissioner an annual surcharge according to the schedule in subdivision 4,
41.16 paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of
41.17 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
41.18 beds the second month following the receipt of timely notice by the commissioner of
41.19 human services that beds have been delicensed. The facility must notify the commissioner
41.20 of health in writing when beds are delicensed. The commissioner of health must notify
41.21 the commissioner of human services within ten working days after receiving written
41.22 notification. If the notification is received by the commissioner of human services by
41.23 the 15th of the month, the invoice for the second following month must be reduced to
41.24 recognize the delicensing of beds. The commissioner may reduce, and may subsequently
41.25 restore, the surcharge under this subdivision based on the commissioner's determination of
41.26 a permissible surcharge.

41.27 (b) Effective July 1, 2010, the surcharge under paragraph (a) is increased to \$4,037
41.28 per licensed bed.

41.29 Sec. 9. Minnesota Statutes 2009 Supplement, section 256.975, subdivision 7, is
41.30 amended to read:

41.31 Subd. 7. **Consumer information and assistance and long-term care options**
41.32 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
41.33 statewide service to aid older Minnesotans and their families in making informed choices
41.34 about long-term care options and health care benefits. Language services to persons with

42.1 limited English language skills may be made available. The service, known as Senior
42.2 LinkAge Line, must be available during business hours through a statewide toll-free
42.3 number and must also be available through the Internet.

42.4 (b) The service must provide long-term care options counseling by assisting older
42.5 adults, caregivers, and providers in accessing information and options counseling about
42.6 choices in long-term care services that are purchased through private providers or available
42.7 through public options. The service must:

42.8 (1) develop a comprehensive database that includes detailed listings in both
42.9 consumer- and provider-oriented formats;

42.10 (2) make the database accessible on the Internet and through other telecommunication
42.11 and media-related tools;

42.12 (3) link callers to interactive long-term care screening tools and make these tools
42.13 available through the Internet by integrating the tools with the database;

42.14 (4) develop community education materials with a focus on planning for long-term
42.15 care and evaluating independent living, housing, and service options;

42.16 (5) conduct an outreach campaign to assist older adults and their caregivers in
42.17 finding information on the Internet and through other means of communication;

42.18 (6) implement a messaging system for overflow callers and respond to these callers
42.19 by the next business day;

42.20 (7) link callers with county human services and other providers to receive more
42.21 in-depth assistance and consultation related to long-term care options;

42.22 (8) link callers with quality profiles for nursing facilities and other providers
42.23 developed by the commissioner of health;

42.24 (9) incorporate information about the availability of housing options, as well as
42.25 registered housing with services and consumer rights within the MinnesotaHelp.info
42.26 network long-term care database to facilitate consumer comparison of services and costs
42.27 among housing with services establishments and with other in-home services and to
42.28 support financial self-sufficiency as long as possible. Housing with services establishments
42.29 and their arranged home care providers shall provide information ~~to the commissioner of~~
42.30 ~~human services that is consistent with information required by the commissioner of health~~
42.31 ~~under section 144G.06, the Uniform Consumer Information Guide~~ that will facilitate price
42.32 comparisons, including delineation of charges for rent and for services available. The
42.33 commissioners of health and human services shall align the data elements required by
42.34 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
42.35 consumers standardized information and ease of comparison of long-term care options.

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43.1 The commissioner of human services shall provide the data to the Minnesota Board on
43.2 Aging for inclusion in the MinnesotaHelp.info network long-term care database;

43.3 (10) provide long-term care options counseling. Long-term care options counselors
43.4 shall:

43.5 (i) for individuals not eligible for case management under a public program or public
43.6 funding source, provide interactive decision support under which consumers, family
43.7 members, or other helpers are supported in their deliberations to determine appropriate
43.8 long-term care choices in the context of the consumer's needs, preferences, values, and
43.9 individual circumstances, including implementing a community support plan;

43.10 (ii) provide Web-based educational information and collateral written materials to
43.11 familiarize consumers, family members, or other helpers with the long-term care basics,
43.12 issues to be considered, and the range of options available in the community;

43.13 (iii) provide long-term care futures planning, which means providing assistance to
43.14 individuals who anticipate having long-term care needs to develop a plan for the more
43.15 distant future; and

43.16 (iv) provide expertise in benefits and financing options for long-term care, including
43.17 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
43.18 private pay options, and ways to access low or no-cost services or benefits through
43.19 volunteer-based or charitable programs; and

43.20 (11) using risk management and support planning protocols, provide long-term care
43.21 options counseling to current residents of nursing homes deemed appropriate for discharge
43.22 by the commissioner. In order to meet this requirement, the commissioner shall provide
43.23 designated Senior LinkAge Line contact centers with a list of nursing home residents
43.24 appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall
43.25 provide these residents, if they indicate a preference to receive long-term care options
43.26 counseling, with initial assessment, review of risk factors, independent living support
43.27 consultation, or referral to:

43.28 (i) long-term care consultation services under section 256B.0911;

43.29 (ii) designated care coordinators of contracted entities under section 256B.035 for
43.30 persons who are enrolled in a managed care plan; or

43.31 (iii) the long-term care consultation team for those who are appropriate for relocation
43.32 service coordination due to high-risk factors or psychological or physical disability.

43.33 Sec. 10. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11,
43.34 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45.1 (10) be limited to providing and being paid for up to ~~310~~ 275 hours per month of
45.2 personal care assistance services regardless of the number of recipients being served or the
45.3 number of personal care assistance provider agencies enrolled with.

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

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

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

45.11 Sec. 11. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 3c,
45.12 is amended to read:

45.13 Subd. 3c. **Transition to housing with services.** (a) Housing with services
45.14 establishments ~~offering or providing assisted living under chapter 144G~~ shall inform
45.15 all prospective residents of the ~~availability of and contact information for transitional~~
45.16 ~~consultation services under this subdivision prior to executing a lease or contract with the~~
45.17 ~~prospective resident~~ requirement to contact the Senior LinkAge Line for long-term care
45.18 options counseling and transitional consultation. The Senior LinkAge Line shall provide
45.19 a certificate to the prospective resident and also send a copy of the certificate to the
45.20 housing with services establishment that the prospective resident chooses, verifying that
45.21 consultation has been provided. The housing with services establishment shall not execute
45.22 a contract or allow a prospective resident to move in until the establishment has received
45.23 certification from the Senior LinkAge Line. The housing with services establishment shall
45.24 maintain copies of contracts and certificates for audit for a period of three years. The
45.25 purpose of transitional long-term care consultation is to support persons with current
45.26 or anticipated long-term care needs in making informed choices among options that
45.27 include the most cost-effective and least restrictive settings, and to delay spenddown to
45.28 eligibility for publicly funded programs by connecting people to alternative services in
45.29 their homes before transition to housing with services. Regardless of the consultation,
45.30 prospective residents maintain the right to choose housing with services or assisted living
45.31 if that option is their preference.

45.32 (b) Transitional consultation services are provided as determined by the
45.33 commissioner of human services in partnership with county long-term care consultation
45.34 ~~units, and the Area Agencies on Aging~~ under section 144D.03, subdivision 3, and
45.35 are a combination of telephone-based and in-person assistance provided under models

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46.1 developed by the commissioner. The consultation shall be performed in a manner that
46.2 provides objective and complete information. Transitional consultation must be provided
46.3 within five working days of the request of the prospective resident as follows:

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

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

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

46.17 (4) a prospective resident does not include a person moving from the community
46.18 to housing with services during nonworking hours when:

46.19 (i) the move is based on a recent precipitating event that precludes the person from
46.20 living safely in the community, such as sustaining an injury or the caregiver's inability to
46.21 provide needed care; and

46.22 (ii) the Senior LinkAge Line is contacted on the first working day following the
46.23 nonworking day move to the registered housing with services.

46.24 Sec. 12. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
46.25 subdivision to read:

46.26 **Subd. 3i. Rate reduction for customized living and 24-hour customized living**
46.27 **services.** (a) Effective July 1, 2010, the commissioner shall reduce service component
46.28 rates and service rate limits for customized living services and 24-hour customized living
46.29 services, from the rates in effect on June 30, 2010, by five percent.

46.30 (b) To implement the rate reductions in this subdivision, capitation rates paid by the
46.31 commissioner to managed care organizations under section 256B.69 shall reflect a ten
46.32 percent reduction for the specified services for the period January 1, 2011, to June 30,
46.33 2011, and a five percent reduction for those services on and after July 1, 2011.

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47.1 Sec. 13. Minnesota Statutes 2008, section 256B.441, subdivision 53, is amended to
47.2 read:

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

47.5 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
47.6 shall be equal to ~~\$8.86~~ \$10.86. For a facility licensed as both a nursing home and a
47.7 boarding care home, the portion related to section 256.9657 shall be equal to ~~\$8.86~~ \$10.86
47.8 multiplied by the result of its number of nursing home beds divided by its total number of
47.9 licensed beds.

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

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

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

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

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

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

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

47.30 (i) The single bed room incentives shall be as determined under section 256B.431,
47.31 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
47.32 no longer be included in the payment rate for external fixed costs beginning October 1,
47.33 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
47.34 longer be included in the payment rate for external fixed costs beginning on October 1 of
47.35 the first year not less than two years after their effective date.

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

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

48.4 Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55,
48.5 is amended to read:

48.6 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
48.7 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
48.8 under this section shall be phased in by blending the operating rate with the operating
48.9 payment rate determined under section 256B.434. For purposes of this subdivision, the
48.10 rate to be used that is determined under section 256B.434 shall not include the portion of
48.11 the operating payment rate related to performance-based incentive payments under section
48.12 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the
48.13 operating payment rate for each facility shall be 13 percent of the operating payment rate
48.14 from this section, and 87 percent of the operating payment rate from section 256B.434.
48.15 ~~For the rate year beginning October 1, 2009, the operating payment rate for each facility~~
48.16 ~~shall be 14 percent of the operating payment rate from this section, and 86 percent of~~
48.17 ~~the operating payment rate from section 256B.434. For rate years beginning October 1,~~
48.18 ~~2010; October 1, 2011; and October 1, 2012,~~ For the rate period from October 1, 2009, to
48.19 September 30, 2013, no rate adjustments shall be implemented under this section, but shall
48.20 be determined under section 256B.434. For the rate year beginning October 1, 2013, the
48.21 operating payment rate for each facility shall be 65 percent of the operating payment rate
48.22 from this section, and 35 percent of the operating payment rate from section 256B.434.
48.23 For the rate year beginning October 1, 2014, the operating payment rate for each facility
48.24 shall be 82 percent of the operating payment rate from this section, and 18 percent of the
48.25 operating payment rate from section 256B.434. For the rate year beginning October 1,
48.26 2015, the operating payment rate for each facility shall be the operating payment rate
48.27 determined under this section. The blending of operating payment rates under this section
48.28 shall be performed separately for each RUG's class.

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

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

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

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

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

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

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

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

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

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

49.32 **EFFECTIVE DATE.** This section is effective retroactive to October 1, 2009.

49.33 Sec. 15. Minnesota Statutes 2008, section 256B.49, is amended by adding a
49.34 subdivision to read:

50.1 Subd. 23. **Living arrangements.** The commissioner shall not place a limit,
50.2 without express legislative approval, on the number of adult recipients of home and
50.3 community-based waived services receiving assisted living plus services or customized
50.4 living services who may reside in one building, regardless of adult recipient age.
50.5 Limits in effect on May 1, 2001, on the number of recipients who may reside in one
50.6 living unit shall remain in effect, regardless of the number of units in a building. The
50.7 commissioner shall not deny medical assistance enrollment based on building capacity
50.8 to an otherwise-qualified provider of waived services.

50.9 Sec. 16. Minnesota Statutes 2008, section 256B.5012, is amended by adding a
50.10 subdivision to read:

50.11 Subd. 9. **Rate increase effective June 1, 2010.** For rate periods beginning on or
50.12 after June 1, 2010, the commissioner shall increase the total operating payment rate for
50.13 each facility reimbursed under this section by \$8.74 per day. The increase shall not be
50.14 subject to any annual percentage increase.

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

50.16 Sec. 17. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23,
50.17 is amended to read:

50.18 **Subd. 23. Alternative services; elderly and disabled persons.** (a) The
50.19 commissioner may implement demonstration projects to create alternative integrated
50.20 delivery systems for acute and long-term care services to elderly persons and persons
50.21 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
50.22 coordination, improve access to quality services, and mitigate future cost increases.
50.23 The commissioner may seek federal authority to combine Medicare and Medicaid
50.24 capitation payments for the purpose of such demonstrations and may contract with
50.25 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
50.26 services shall be administered according to the terms and conditions of the federal contract
50.27 and demonstration provisions. For the purpose of administering medical assistance funds,
50.28 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
50.29 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
50.30 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
50.31 items B and C, which do not apply to persons enrolling in demonstrations under this
50.32 section. An initial open enrollment period may be provided. Persons who disenroll from
50.33 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
50.34 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and

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51.1 the health plan's participation is subsequently terminated for any reason, the person shall
51.2 be provided an opportunity to select a new health plan and shall have the right to change
51.3 health plans within the first 60 days of enrollment in the second health plan. Persons
51.4 required to participate in health plans under this section who fail to make a choice of
51.5 health plan shall not be randomly assigned to health plans under these demonstrations.
51.6 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
51.7 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
51.8 the commissioner may contract with managed care organizations, including counties, to
51.9 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
51.10 disabled persons only. For persons with a primary diagnosis of developmental disability,
51.11 serious and persistent mental illness, or serious emotional disturbance, the commissioner
51.12 must ensure that the county authority has approved the demonstration and contracting
51.13 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
51.14 commissioner shall not implement any demonstration project under this subdivision for
51.15 persons with a primary diagnosis of developmental disabilities, serious and persistent
51.16 mental illness, or serious emotional disturbance, without approval of the county board of
51.17 the county in which the demonstration is being implemented.

51.18 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
51.19 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
51.20 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
51.21 under this section projects for persons with developmental disabilities. The commissioner
51.22 may capitate payments for ICF/MR services, waived services for developmental
51.23 disabilities, including case management services, day training and habilitation and
51.24 alternative active treatment services, and other services as approved by the state and by the
51.25 federal government. Case management and active treatment must be individualized and
51.26 developed in accordance with a person-centered plan. Costs under these projects may not
51.27 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
51.28 and until four years after the pilot project implementation date, subcontractor participation
51.29 in the long-term care developmental disability pilot is limited to a nonprofit long-term
51.30 care system providing ICF/MR services, home and community-based waiver services,
51.31 and in-home services to no more than 120 consumers with developmental disabilities in
51.32 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
51.33 prior to expansion of the developmental disability pilot project. This paragraph expires
51.34 four years after the implementation date of the pilot project.

51.35 (c) Before implementation of a demonstration project for disabled persons, the
51.36 commissioner must provide information to appropriate committees of the house of

52.1 representatives and senate and must involve representatives of affected disability groups
52.2 in the design of the demonstration projects.

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

52.7 (e) The commissioner, in consultation with the commissioners of commerce and
52.8 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
52.9 according to federal laws and regulations governing that program and state laws or rules
52.10 applicable to participating providers. The process for approval of these programs shall
52.11 begin only after the commissioner receives grant money in an amount sufficient to cover
52.12 the state share of the administrative and actuarial costs to implement the programs during
52.13 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
52.14 account in the special revenue fund and are appropriated to the commissioner to be used
52.15 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
52.16 not required to be licensed or certified as a health plan company as defined in section
52.17 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
52.18 and found to be eligible for services under the elderly waiver or community alternatives
52.19 for disabled individuals or who are already eligible for Medicaid but meet level of
52.20 care criteria for receipt of waiver services may choose to enroll in the PACE program.
52.21 Medicare and Medicaid services will be provided according to this subdivision and
52.22 federal Medicare and Medicaid requirements governing PACE providers and programs.
52.23 PACE enrollees will receive Medicaid home and community-based services through the
52.24 PACE provider as an alternative to services for which they would otherwise be eligible
52.25 through home and community-based waiver programs and Medicaid State Plan Services.
52.26 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
52.27 costs that would have been incurred under fee-for-service or other relevant managed care
52.28 programs operated by the state.

52.29 (f) The commissioner shall seek federal approval to expand the Minnesota disability
52.30 health options (MnDHO) program established under this subdivision in stages, first to
52.31 regional population centers outside the seven-county metro area and then to all areas of
52.32 the state. Until July 1, 2009, expansion for MnDHO projects that include home and
52.33 community-based services is limited to the two projects and service areas in effect on
52.34 March 1, 2006. Enrollment in integrated MnDHO programs that include home and
52.35 community-based services shall remain voluntary. Costs for home and community-based
52.36 services included under MnDHO must not exceed costs that would have been incurred

53.1 under the fee-for-service program. Notwithstanding whether expansion occurs under
53.2 this paragraph, in determining MnDHO payment rates and risk adjustment methods ~~for~~
53.3 ~~contract years starting in 2012~~, the commissioner must consider the methods used to
53.4 determine county allocations for home and community-based program participants. If
53.5 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
53.6 for home and community-based services, the commissioner shall achieve the reduction
53.7 by maintaining the base rate for contract ~~years~~ year 2010 and 2011 for services provided
53.8 under the community alternatives for disabled individuals waiver at the same level as for
53.9 contract year 2009. The commissioner may apply other reductions to MnDHO rates to
53.10 implement decreases in provider payment rates required by state law. Effective December
53.11 31, 2010, enrollment and operation of the MnDHO program in effect during 2010 shall
53.12 cease. The commissioner may reopen the program provided all applicable conditions of
53.13 this section are met. In developing program specifications for expansion of integrated
53.14 programs, the commissioner shall involve and consult the state-level stakeholder group
53.15 established in subdivision 28, paragraph (d), including consultation on whether and how
53.16 to include home and community-based waiver programs. ~~Plans for further expansion of to~~
53.17 reopen MnDHO projects shall be presented to the chairs of the house of representatives
53.18 and senate committees with jurisdiction over health and human services policy and finance
53.19 ~~by February 1, 2007~~ prior to implementation.

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

53.24 Sec. 18. **REVISOR'S INSTRUCTION.**

53.25 The revisor shall edit Minnesota Statutes, section 256B.0917, subdivision 14, to
53.26 be effective July 1, 2011.

53.27 **ARTICLE 3**

53.28 **CHILDREN AND FAMILY SERVICES; DEPARTMENT OF HUMAN**
53.29 **SERVICES LICENSING**

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

53.32 Subdivision 1. **Fair hearing when disqualification is not ~~set aside~~ rescinded.** (a)
53.33 If the commissioner does not ~~set aside~~ rescind a disqualification of an individual under
53.34 section 245C.22 who is disqualified on the basis of a preponderance of evidence that the

54.1 individual committed an act or acts that meet the definition of any of the crimes listed in
54.2 section 245C.15; for a determination under section 626.556 or 626.557 of substantiated
54.3 maltreatment that was serious or recurring under section 245C.15; or for failure to make
54.4 required reports under section 626.556, subdivision 3; or 626.557, subdivision 3, pursuant
54.5 to section 245C.15, subdivision 4, paragraph (b), clause (1), the individual may request
54.6 a fair hearing under section 256.045, unless the disqualification is deemed conclusive
54.7 under section 245C.29.

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

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

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

54.21 (e) Notwithstanding paragraph (c), if the commissioner does not ~~set aside~~ rescind
54.22 a disqualification of an individual who was disqualified based on both a preponderance
54.23 of evidence and a conviction or admission, the individual may request a fair hearing
54.24 under section 256.045, unless the disqualifications are deemed conclusive under section
54.25 245C.29. The scope of the hearing conducted under section 256.045 with regard to the
54.26 disqualification based on a conviction or admission shall be limited solely to whether the
54.27 individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case,
54.28 the reconsideration decision under section 245C.22 is not the final agency decision for
54.29 purposes of appeal by the disqualified individual.

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

54.31 Subd. 2. **Consolidated fair hearing.** (a) If an individual who is disqualified on the
54.32 bases of serious or recurring maltreatment requests a fair hearing on the maltreatment
54.33 determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and
54.34 requests a fair hearing under this section on the disqualification, which has not been

55.1 ~~set aside rescinded~~, the scope of the fair hearing under section 256.045 shall include the
55.2 maltreatment determination and the disqualification.

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

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

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

55.9 Subd. 3. **Employees of public employer.** (a) If the commissioner does not ~~set~~
55.10 ~~aside rescind~~ the disqualification of an individual who is an employee of an employer, as
55.11 defined in section 179A.03, subdivision 15, the individual may request a contested case
55.12 hearing under chapter 14, unless the disqualification is deemed conclusive under section
55.13 245C.29. The request for a contested case hearing must be made in writing and must be
55.14 postmarked and sent within 30 calendar days after the employee receives notice that the
55.15 disqualification has not been ~~set aside rescinded~~. If the individual was disqualified based
55.16 on a conviction or admission to any crimes listed in section 245C.15, the scope of the
55.17 contested case hearing shall be limited solely to whether the individual poses a risk of
55.18 harm pursuant to section 245C.22.

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

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

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

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

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

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

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

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

56.17 (2) any patient or relative aggrieved by an order of the commissioner under section
56.18 252.27;

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

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

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

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

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

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

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

57.1 (10) except as provided under chapter 245C, an individual disqualified under
57.2 sections 245C.14 and 245C.15, which has not been ~~set aside~~ rescinded under sections
57.3 245C.22 and 245C.23, on the basis of serious or recurring maltreatment; a preponderance
57.4 of the evidence that the individual has committed an act or acts that meet the definition
57.5 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make
57.6 reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
57.7 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
57.8 this clause in which the basis for a disqualification is serious or recurring maltreatment,
57.9 which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, shall be
57.10 consolidated into a single fair hearing. In such cases, the scope of review by the human
57.11 services referee shall include both the maltreatment determination and the disqualification.
57.12 The failure to exercise the right to an administrative reconsideration shall not be a bar to a
57.13 hearing under this section if federal law provides an individual the right to a hearing to
57.14 dispute a finding of maltreatment. Individuals and organizations specified in this section
57.15 may contest the specified action, decision, or final disposition before the state agency by
57.16 submitting a written request for a hearing to the state agency within 30 days after receiving
57.17 written notice of the action, decision, or final disposition, or within 90 days of such written
57.18 notice if the applicant, recipient, patient, or relative shows good cause why the request
57.19 was not submitted within the 30-day time limit; or

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

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

58.1 action or criminal charge is dismissed or the criminal action overturned, the matter may be
58.2 considered in an administrative hearing.

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

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

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

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

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

58.21 Sec. 5. Minnesota Statutes 2008, section 256D.0515, is amended to read:

58.22 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

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

58.25 ~~(1) their gross income meets the federal Food Stamp requirements under United~~
58.26 ~~States Code, title 7, section 2014(c); and~~

58.27 ~~(2) they have financial resources, excluding vehicles, of less than \$7,000 is equal to~~
58.28 or less than 165 percent of the federal poverty guidelines for the same family size.

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

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

58.31 Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the
58.32 cash portion of the transitional standard as a result of the birth of a child, unless one of
58.33 the conditions under paragraph (b) is met. The child shall be considered a member of the

59.1 assistance unit according to subdivisions 1 to 3, but shall be excluded in determining
59.2 family size for purposes of determining the amount of the cash portion of the transitional
59.3 standard under subdivision 5. The child shall be included in determining family size for
59.4 purposes of determining the food portion of the transitional standard. The transitional
59.5 standard under this subdivision shall be the total of the cash and food portions as specified
59.6 in this paragraph. The family wage level under this subdivision shall be based on the
59.7 family size used to determine the food portion of the transitional standard.

59.8 (b) A child shall be included in determining family size for purposes of determining
59.9 the amount of the cash portion of the MFIP transitional standard when at least one of
59.10 the following conditions is met:

59.11 (1) for families receiving MFIP assistance on July 1, 2003, the child is born to the
59.12 adult parent before May 1, 2004;

59.13 (2) for families who apply for the diversionary work program under section 256J.95
59.14 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within
59.15 ten months of the date the family is eligible for assistance;

59.16 (3) the child was conceived as a result of a sexual assault or incest, provided that the
59.17 incident has been reported to a law enforcement agency;

59.18 (4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision
59.19 59, and the child, or multiple children, are the mother's first birth; ~~or~~

59.20 (5) the child is the mother's first child subsequent to a pregnancy that did not result
59.21 in a live birth; or

59.22 (6) any child previously excluded in determining family size under paragraph
59.23 (a) shall be included if the adult parent or parents have not received benefits from the
59.24 diversionary work program under section 256J.95 or MFIP assistance in the previous ten
59.25 months. An adult parent or parents who reapply and have received benefits from the
59.26 diversionary work program or MFIP assistance in the past ten months shall be under the
59.27 ten-month grace period of their previous application under clause (2).

59.28 (c) Income and resources of a child excluded under this subdivision, except child
59.29 support received or distributed on behalf of this child, must be considered using the same
59.30 policies as for other children when determining the grant amount of the assistance unit.

59.31 (d) The caregiver must assign support and cooperate with the child support
59.32 enforcement agency to establish paternity and collect child support on behalf of the
59.33 excluded child. Failure to cooperate results in the sanction specified in section 256J.46,
59.34 subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be
59.35 distributed according to section 256.741, subdivision 15.

60.1 (e) County agencies must inform applicants of the provisions under this subdivision
60.2 at the time of each application and at recertification.

60.3 (f) Children excluded under this provision shall be deemed MFIP recipients for
60.4 purposes of child care under chapter 119B.

60.5 **EFFECTIVE DATE.** This section is effective September 1, 2010.

60.6 Sec. 7. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is
60.7 amended to read:

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

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

60.15 (2) a person who:

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

60.18 (ii) has an IQ below 80 who has been assessed by a vocational specialist or a county
60.19 agency to be employable, but the condition severely limits the person's ability to obtain or
60.20 maintain suitable employment. The determination of IQ level must be made by a qualified
60.21 professional. In the case of a non-English-speaking person: (A) the determination must
60.22 be made by a qualified professional with experience conducting culturally appropriate
60.23 assessments, whenever possible; (B) the county may accept reports that identify an
60.24 IQ range as opposed to a specific score; (C) these reports must include a statement of
60.25 confidence in the results;

60.26 (3) a person who is determined by a qualified professional to be learning disabled,
60.27 and the condition severely limits the person's ability to obtain or maintain suitable
60.28 employment. For purposes of the initial approval of a learning disability extension, the
60.29 determination must have been made or confirmed within the previous 12 months. In the
60.30 case of a non-English-speaking person: (i) the determination must be made by a qualified
60.31 professional with experience conducting culturally appropriate assessments, whenever
60.32 possible; and (ii) these reports must include a statement of confidence in the results. If a
60.33 rehabilitation plan for a participant extended as learning disabled is developed or approved
60.34 by the county agency, the plan must be incorporated into the employment plan. However,

61.1 a rehabilitation plan does not replace the requirement to develop and comply with an
61.2 employment plan under section 256J.521; or

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

61.5 (b) For purposes of this ~~section~~ chapter, "severely limits the person's ability to
61.6 obtain or maintain suitable employment" means: (1) that a qualified professional has
61.7 determined that the person's condition prevents the person from working 20 or more hours
61.8 per week; or (2) for a person who meets the requirements of paragraph (a), clause (2),
61.9 item (ii), or paragraph (a), clause (3), of this subdivision, a qualified professional has
61.10 determined: (i) the person's condition significantly restricts the range of employment that
61.11 the person is able to perform; or (ii) significantly interferes with the person's ability to
61.12 obtain or maintain employment for 20 or more hours per week.

61.13 Sec. 8. Minnesota Statutes 2008, section 626.556, subdivision 10i, is amended to read:

61.14 Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative
61.15 reconsideration is not applicable in family assessments since no determination concerning
61.16 maltreatment is made. For investigations, except as provided under paragraph (e), an
61.17 individual or facility that the commissioner of human services, a local social service
61.18 agency, or the commissioner of education determines has maltreated a child, an interested
61.19 person acting on behalf of the child, regardless of the determination, who contests
61.20 the investigating agency's final determination regarding maltreatment, may request the
61.21 investigating agency to reconsider its final determination regarding maltreatment. The
61.22 request for reconsideration must be submitted in writing to the investigating agency within
61.23 15 calendar days after receipt of notice of the final determination regarding maltreatment
61.24 or, if the request is made by an interested person who is not entitled to notice, within
61.25 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the
61.26 request for reconsideration must be postmarked and sent to the investigating agency
61.27 within 15 calendar days of the individual's or facility's receipt of the final determination. If
61.28 the request for reconsideration is made by personal service, it must be received by the
61.29 investigating agency within 15 calendar days after the individual's or facility's receipt of the
61.30 final determination. Effective January 1, 2002, an individual who was determined to have
61.31 maltreated a child under this section and who was disqualified on the basis of serious or
61.32 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
61.33 of the maltreatment determination and the disqualification. The request for reconsideration
61.34 of the maltreatment determination and the disqualification must be submitted within 30
61.35 calendar days of the individual's receipt of the notice of disqualification under sections

62.1 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment
62.2 determination and the disqualification must be postmarked and sent to the investigating
62.3 agency within 30 calendar days of the individual's receipt of the maltreatment
62.4 determination and notice of disqualification. If the request for reconsideration is made by
62.5 personal service, it must be received by the investigating agency within 30 calendar days
62.6 after the individual's receipt of the notice of disqualification.

62.7 (b) Except as provided under paragraphs (e) and (f), if the investigating agency
62.8 denies the request or fails to act upon the request within 15 working days after receiving
62.9 the request for reconsideration, the person or facility entitled to a fair hearing under section
62.10 256.045 may submit to the commissioner of human services or the commissioner of
62.11 education a written request for a hearing under that section. Section 256.045 also governs
62.12 hearings requested to contest a final determination of the commissioner of education. For
62.13 reports involving maltreatment of a child in a facility, an interested person acting on behalf
62.14 of the child may request a review by the Child Maltreatment Review Panel under section
62.15 256.022 if the investigating agency denies the request or fails to act upon the request or
62.16 if the interested person contests a reconsidered determination. The investigating agency
62.17 shall notify persons who request reconsideration of their rights under this paragraph.
62.18 The request must be submitted in writing to the review panel and a copy sent to the
62.19 investigating agency within 30 calendar days of receipt of notice of a denial of a request
62.20 for reconsideration or of a reconsidered determination. The request must specifically
62.21 identify the aspects of the agency determination with which the person is dissatisfied.

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

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

62.31 (e) ~~Effective January 1, 2002,~~ If an individual was disqualified under sections
62.32 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was
62.33 serious or recurring, and the individual has requested reconsideration of the maltreatment
62.34 determination under paragraph (a) and requested reconsideration of the disqualification
62.35 under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and
62.36 reconsideration of the disqualification shall be consolidated into a single reconsideration.

63.1 If reconsideration of the maltreatment determination is denied or the disqualification is not
63.2 ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair
63.3 hearing under section 256.045. If an individual requests a fair hearing on the maltreatment
63.4 determination and the disqualification, the scope of the fair hearing shall include both the
63.5 maltreatment determination and the disqualification.

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

63.17 (1) a denial of a license under section 245A.05 or a licensing sanction under section
63.18 245A.07, is based on a determination that the license holder is responsible for maltreatment
63.19 or the disqualification of a license holder based on serious or recurring maltreatment;

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

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

63.24 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
63.25 determination or disqualification, but does not appeal the denial of a license or a licensing
63.26 sanction, reconsideration of the maltreatment determination shall be conducted under
63.27 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
63.28 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
63.29 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
63.30 626.557, subdivision 9d.

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

63.35 (g) For purposes of this subdivision, "interested person acting on behalf of the
63.36 child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult

64.1 stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been
64.2 determined to be the perpetrator of the maltreatment.

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

64.4 Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided
64.5 under paragraph (e), any individual or facility which a lead agency determines has
64.6 maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on
64.7 behalf of the vulnerable adult, regardless of the lead agency's determination, who contests
64.8 the lead agency's final disposition of an allegation of maltreatment, may request the
64.9 lead agency to reconsider its final disposition. The request for reconsideration must be
64.10 submitted in writing to the lead agency within 15 calendar days after receipt of notice of
64.11 final disposition or, if the request is made by an interested person who is not entitled to
64.12 notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable
64.13 adult's legal guardian. If mailed, the request for reconsideration must be postmarked and
64.14 sent to the lead agency within 15 calendar days of the individual's or facility's receipt of
64.15 the final disposition. If the request for reconsideration is made by personal service, it must
64.16 be received by the lead agency within 15 calendar days of the individual's or facility's
64.17 receipt of the final disposition. An individual who was determined to have maltreated a
64.18 vulnerable adult under this section and who was disqualified on the basis of serious or
64.19 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
64.20 of the maltreatment determination and the disqualification. The request for reconsideration
64.21 of the maltreatment determination and the disqualification must be submitted in writing
64.22 within 30 calendar days of the individual's receipt of the notice of disqualification
64.23 under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of
64.24 the maltreatment determination and the disqualification must be postmarked and sent
64.25 to the lead agency within 30 calendar days of the individual's receipt of the notice of
64.26 disqualification. If the request for reconsideration is made by personal service, it must be
64.27 received by the lead agency within 30 calendar days after the individual's receipt of the
64.28 notice of disqualification.

64.29 (b) Except as provided under paragraphs (e) and (f), if the lead agency denies the
64.30 request or fails to act upon the request within 15 working days after receiving the request
64.31 for reconsideration, the person or facility entitled to a fair hearing under section 256.045,
64.32 may submit to the commissioner of human services a written request for a hearing
64.33 under that statute. The vulnerable adult, or an interested person acting on behalf of the
64.34 vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review
64.35 Panel under section 256.021 if the lead agency denies the request or fails to act upon the

65.1 request, or if the vulnerable adult or interested person contests a reconsidered disposition.
65.2 The lead agency shall notify persons who request reconsideration of their rights under this
65.3 paragraph. The request must be submitted in writing to the review panel and a copy sent
65.4 to the lead agency within 30 calendar days of receipt of notice of a denial of a request for
65.5 reconsideration or of a reconsidered disposition. The request must specifically identify the
65.6 aspects of the agency determination with which the person is dissatisfied.

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

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

65.15 (e) If an individual was disqualified under sections 245C.14 and 245C.15, on
65.16 the basis of a determination of maltreatment, which was serious or recurring, and
65.17 the individual has requested reconsideration of the maltreatment determination under
65.18 paragraph (a) and reconsideration of the disqualification under sections 245C.21 to
65.19 245C.27, reconsideration of the maltreatment determination and requested reconsideration
65.20 of the disqualification shall be consolidated into a single reconsideration. If reconsideration
65.21 of the maltreatment determination is denied or if the disqualification is not ~~set aside~~
65.22 rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing
65.23 under section 256.045. If an individual requests a fair hearing on the maltreatment
65.24 determination and the disqualification, the scope of the fair hearing shall include both the
65.25 maltreatment determination and the disqualification.

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

66.1 (1) a denial of a license under section 245A.05, or a licensing sanction under section
66.2 245A.07, is based on a determination that the license holder is responsible for maltreatment
66.3 or the disqualification of a license holder based on serious or recurring maltreatment;

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

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

66.8 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
66.9 determination or disqualification, but does not appeal the denial of a license or a licensing
66.10 sanction, reconsideration of the maltreatment determination shall be conducted under
66.11 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
66.12 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
66.13 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
66.14 626.557, subdivision 9d.

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

66.19 (g) Until August 1, 2002, an individual or facility that was determined by the
66.20 commissioner of human services or the commissioner of health to be responsible for
66.21 neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August
66.22 1, 2001, that believes that the finding of neglect does not meet an amended definition of
66.23 neglect may request a reconsideration of the determination of neglect. The commissioner
66.24 of human services or the commissioner of health shall mail a notice to the last known
66.25 address of individuals who are eligible to seek this reconsideration. The request for
66.26 reconsideration must state how the established findings no longer meet the elements of
66.27 the definition of neglect. The commissioner shall review the request for reconsideration
66.28 and make a determination within 15 calendar days. The commissioner's decision on this
66.29 reconsideration is the final agency action.

66.30 (1) For purposes of compliance with the data destruction schedule under subdivision
66.31 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as
66.32 a result of a reconsideration under this paragraph, the date of the original finding of a
66.33 substantiated maltreatment must be used to calculate the destruction date.

66.34 (2) For purposes of any background studies under chapter 245C, when a
66.35 determination of substantiated maltreatment has been changed as a result of a
66.36 reconsideration under this paragraph, any prior disqualification of the individual under

67.1 chapter 245C that was based on this determination of maltreatment shall be rescinded,
67.2 and for future background studies under chapter 245C the commissioner must not use the
67.3 previous determination of substantiated maltreatment as a basis for disqualification or as a
67.4 basis for referring the individual's maltreatment history to a health-related licensing board
67.5 under section 245C.31.

67.6 **ARTICLE 4**

67.7 **DEPARTMENT OF HEALTH**

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

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

67.11 (a) Every health maintenance organization must directly allocate administrative expenses
67.12 to specific lines of business or products when such information is available. Remaining
67.13 expenses that cannot be directly allocated must be allocated based on other methods, as
67.14 recommended by the Advisory Group on Administrative Expenses. Health maintenance
67.15 organizations must submit this information using the reporting template provided by the
67.16 commissioner of health.

67.17 (b) Every health maintenance organization must allocate investment income based
67.18 on cumulative net income over time by business line or product and must submit this
67.19 information using the reporting template provided by the commissioner of health.

67.20 **EFFECTIVE DATE.** This section is effective January 1, 2013.

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

67.22 Subdivision 1. **Establishment.** The Advisory Group on Administrative Expenses
67.23 is established to make recommendations on the development of consistent guidelines
67.24 and reporting requirements, including development of a reporting template, for health
67.25 maintenance organizations and county-based purchasing plans that participate in publicly
67.26 funded programs.

67.27 Subd. 2. **Membership.** (a) The advisory group shall be chaired by the commissioner
67.28 of health and shall consist of ten members as follows:

67.29 (1) the commissioner of health or the commissioner's designee;

67.30 (2) the commissioner of human services or the commissioner's designee;

67.31 (3) the commissioner of commerce or the commissioner's designee;

67.32 (4) three members appointed by the commissioner of health to represent health
67.33 maintenance organizations and county-based purchasing plans;

68.1 (5) three members appointed by the commissioner of health to represent:
68.2 (i) hospitals;
68.3 (ii) physicians; and
68.4 (iii) other health care providers; and
68.5 (6) one member appointed by the commissioner of health to represent consumers.
68.6 (b) The appointments required under this subdivision shall be completed by
68.7 November 1, 2010.

68.8 Subd. 3. **Administration.** The commissioner of health shall convene the first
68.9 meeting of the advisory group by December 1, 2010, and shall provide administrative
68.10 support and staff. The commissioner of health may contract with a consultant to provide
68.11 professional assistance and expertise to the advisory group.

68.12 Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses
68.13 must report its recommendations, including any proposed legislation necessary to
68.14 implement the recommendations, to the commissioner of health and to the chairs and
68.15 ranking minority members of the legislative committees and divisions with jurisdiction
68.16 over health policy and finance by February 15, 2012.

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

68.19 Sec. 3. Minnesota Statutes 2008, section 62J.692, subdivision 4, is amended to read:

68.20 Subd. 4. **Distribution of funds.** (a) Following the distribution described under
68.21 paragraph (b), the commissioner shall annually distribute the available medical education
68.22 funds to all qualifying applicants based on a distribution formula that reflects a summation
68.23 of two factors:

68.24 (1) a public program volume factor, which is determined by the total volume of
68.25 public program revenue received by each training site as a percentage of all public
68.26 program revenue received by all training sites in the fund pool; and

68.27 (2) a supplemental public program volume factor, which is determined by providing
68.28 a supplemental payment of 20 percent of each training site's grant to training sites whose
68.29 public program revenue accounted for at least 0.98 percent of the total public program
68.30 revenue received by all eligible training sites. Grants to training sites whose public
68.31 program revenue accounted for less than 0.98 percent of the total public program revenue
68.32 received by all eligible training sites shall be reduced by an amount equal to the total
68.33 value of the supplemental payment.

68.34 Public program revenue for the distribution formula includes revenue from medical
68.35 assistance, prepaid medical assistance, general assistance medical care, and prepaid

69.1 general assistance medical care. Training sites that receive no public program revenue
69.2 are ineligible for funds available under this subdivision. For purposes of determining
69.3 training-site level grants to be distributed under paragraph (a), total statewide average
69.4 costs per trainee for medical residents is based on audited clinical training costs per trainee
69.5 in primary care clinical medical education programs for medical residents. Total statewide
69.6 average costs per trainee for dental residents is based on audited clinical training costs
69.7 per trainee in clinical medical education programs for dental students. Total statewide
69.8 average costs per trainee for pharmacy residents is based on audited clinical training costs
69.9 per trainee in clinical medical education programs for pharmacy students.

69.10 (b) \$5,350,000 of the available medical education funds shall be distributed as
69.11 follows:

69.12 (1) \$1,475,000 to the University of Minnesota Medical Center-Fairview;

69.13 (2) \$2,075,000 to the University of Minnesota School of Dentistry; and

69.14 (3) \$1,800,000 to the Academic Health Center. \$150,000 of the funds distributed
69.15 to the Academic Health Center under this paragraph shall be used for a program to
69.16 assist foreign-trained physicians to successfully compete for family medicine residency
69.17 programs at the University of Minnesota.

69.18 (c) Funds distributed shall not be used to displace current funding appropriations
69.19 from federal or state sources.

69.20 (d) Funds shall be distributed to the sponsoring institutions indicating the amount
69.21 to be distributed to each of the sponsor's clinical medical education programs based on
69.22 the criteria in this subdivision and in accordance with the commissioner's approval letter.
69.23 Each clinical medical education program must distribute funds allocated under paragraph
69.24 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
69.25 institutions, which are accredited through an organization recognized by the Department
69.26 of Education or the Centers for Medicare and Medicaid Services, may contract directly
69.27 with training sites to provide clinical training. To ensure the quality of clinical training,
69.28 those accredited sponsoring institutions must:

69.29 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
69.30 training conducted at sites; and

69.31 (2) take necessary action if the contract requirements are not met. Action may
69.32 include the withholding of payments under this section or the removal of students from
69.33 the site.

69.34 (e) Any funds not distributed in accordance with the commissioner's approval letter
69.35 must be returned to the medical education and research fund within 30 days of receiving

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70.1 notice from the commissioner. The commissioner shall distribute returned funds to the
70.2 appropriate training sites in accordance with the commissioner's approval letter.

70.3 (f) A maximum of \$150,000 of the funds dedicated to the commissioner under
70.4 section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
70.5 administrative expenses associated with implementing this section.

70.6 Sec. 4. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

70.7 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under
70.8 subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or
70.9 stillbirth record and for a certification that the vital record cannot be found. The local or
70.10 state registrar shall forward this amount to the commissioner of management and budget
70.11 for deposit into the account for the children's trust fund for the prevention of child abuse
70.12 established under section 256E.22. This surcharge shall not be charged under those
70.13 circumstances in which no fee for a certified birth or stillbirth record is permitted under
70.14 subdivision 1, paragraph (a). Upon certification by the commissioner of management and
70.15 budget that the assets in that fund exceed \$20,000,000, this surcharge shall be discontinued.

70.16 (b) In addition to any fee prescribed under subdivision 1, there shall be a
70.17 nonrefundable surcharge of \$10 for each certified birth record. The local or state registrar
70.18 shall forward this amount to the commissioner of management and budget for deposit in
70.19 the general fund. This surcharge shall not be charged under those circumstances in which
70.20 no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

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

70.22 Sec. 5. Minnesota Statutes 2008, section 144E.37, is amended to read:

70.23 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

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

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

70.30 Sec. 6. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is
70.31 amended to read:

71.1 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required
71.2 for food and beverage service establishments, youth camps, hotels, motels, lodging
71.3 establishments, public pools, and resorts licensed under this chapter. Food and beverage
71.4 service establishments must pay the highest applicable fee under paragraph (d), clause
71.5 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
71.6 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
71.7 licensed under this chapter for the same calendar year is one-half of the appropriate annual
71.8 license fee, plus any penalty that may be required. The license fee for operators opening
71.9 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
71.10 that may be required.

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

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

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

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

71.25 (i) prepackaged food that receives heat treatment and is served in the package;

71.26 (ii) frozen pizza that is heated and served;

71.27 (iii) a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

71.28 (iv) soft drinks, coffee, or nonalcoholic beverages; or

71.29 (v) cleaning for eating, drinking, or cooking utensils, when the only food served
71.30 is prepared off site.

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

71.34 (i) possesses food service equipment that consists of no more than a deep fat fryer, a
71.35 grill, two hot holding containers, and one or more microwave ovens;

71.36 (ii) serves dipped ice cream or soft serve frozen desserts;

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72.1 (iii) serves breakfast in an owner-occupied bed and breakfast establishment;

72.2 (iv) is a boarding establishment; or

72.3 (v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum
72.4 patron seating capacity of not more than 50.

72.5 (3) Medium establishment, \$310. "Medium establishment" means a fee category
72.6 that meets one or more of the following:

72.7 (i) possesses food service equipment that includes a range, oven, steam table, salad
72.8 bar, or salad preparation area;

72.9 (ii) possesses food service equipment that includes more than one deep fat fryer,
72.10 one grill, or two hot holding containers; or

72.11 (iii) is an establishment where food is prepared at one location and served at one or
72.12 more separate locations.

72.13 Establishments meeting criteria in clause (2), item (v), are not included in this fee
72.14 category.

72.15 (4) Large establishment, \$540. "Large establishment" means either:

72.16 (i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a
72.17 medium establishment, (B) seats more than 175 people, and (C) offers the full menu
72.18 selection an average of five or more days a week during the weeks of operation; or

72.19 (ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium
72.20 establishment, and (B) prepares and serves 500 or more meals per day.

72.21 (5) Other food and beverage service, including food carts, mobile food units,
72.22 seasonal temporary food stands, and seasonal permanent food stands, \$60.

72.23 (6) Beer or wine table service, \$60. "Beer or wine table service" means a fee
72.24 category where the only alcoholic beverage service is beer or wine, served to customers
72.25 seated at tables.

72.26 (7) Alcoholic beverage service, other than beer or wine table service, \$165.

72.27 "Alcohol beverage service, other than beer or wine table service" means a fee
72.28 category where alcoholic mixed drinks are served or where beer or wine are served from
72.29 a bar.

72.30 (8) Lodging per sleeping accommodation unit, \$10, including hotels, motels,
72.31 lodging establishments, and resorts, up to a maximum of \$1,000. "Lodging per sleeping
72.32 accommodation unit" means a fee category including the number of guest rooms, cottages,
72.33 or other rental units of a hotel, motel, lodging establishment, or resort; or the number of
72.34 beds in a dormitory.

72.35 (9) First public pool, \$325; each additional public pool, \$175. "Public pool" means a
72.36 fee category that has the meaning given in section 144.1222, subdivision 4.

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73.1 (10) First spa, \$175; each additional spa, \$100. "Spa pool" means a fee category that
73.2 has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

73.3 (11) Private sewer or water, \$60. "Individual private water" means a fee category
73.4 with a water supply other than a community public water supply as defined in Minnesota
73.5 Rules, chapter 4720. "Individual private sewer" means a fee category with an individual
73.6 sewage treatment system which uses subsurface treatment and disposal.

73.7 (12) Additional food service, \$150. "Additional food service" means a location at
73.8 a food service establishment, other than the primary food preparation and service area,
73.9 used to prepare or serve food to the public.

73.10 (13) Additional inspection fee, \$360. "Additional inspection fee" means a fee to
73.11 conduct the second inspection each year for elementary and secondary education facility
73.12 school lunch programs when required by the Richard B. Russell National School Lunch
73.13 Act.

73.14 (e) A fee for review of construction plans must accompany the initial license
73.15 application for restaurants, hotels, motels, lodging establishments, resorts, seasonal food
73.16 stands, and mobile food units. The fee for this construction plan review is as follows:

73.17	Service Area	Type	Fee
73.18	Food	limited food menu	\$275
73.19		small establishment	\$400
73.20		medium establishment	\$450
73.21		large food establishment	\$500
73.22		additional food service	\$150
73.23	Transient food service	food cart	\$250
73.24		seasonal permanent food stand	\$250
73.25		seasonal temporary food stand	\$250
73.26		mobile food unit	\$350
73.27	Alcohol	beer or wine table service	\$150
73.28		alcohol service from bar	\$250
73.29	Lodging	less than 25 rooms	\$375
73.30		25 to less than 100 rooms	\$400
73.31		100 rooms or more	\$500
73.32		less than five cabins	\$350
73.33		five to less than ten cabins	\$400
73.34		ten cabins or more	\$450

73.35 (f) When existing food and beverage service establishments, hotels, motels, lodging
73.36 establishments, resorts, seasonal food stands, and mobile food units are extensively
73.37 remodeled, a fee must be submitted with the remodeling plans. The fee for this
73.38 construction plan review is as follows:

74.1	Service Area	Type	Fee
74.2	Food	limited food menu	\$250
74.3		small establishment	\$300
74.4		medium establishment	\$350
74.5		large food establishment	\$400
74.6		additional food service	\$150
74.7		Transient food service	food cart
74.8	seasonal permanent food stand		\$250
74.9	seasonal temporary food stand		\$250
74.10	mobile food unit		\$250
74.11	Alcohol	beer or wine table service	\$150
74.12		alcohol service from bar	\$250
74.13	Lodging	less than 25 rooms	\$250
74.14		25 to less than 100 rooms	\$300
74.15		100 rooms or more	\$450
74.16		less than five cabins	\$250
74.17		five to less than ten cabins	\$350
74.18		ten cabins or more	\$400

74.19 (g) Special event food stands are not required to submit construction or remodeling
74.20 plans for review.

74.21 (h) Youth camps shall pay an annual single fee for food and lodging as follows:

74.22 (1) camps with up to 99 campers, \$325;

74.23 (2) camps with 100 to 199 campers, \$550; and

74.24 (3) camps with 200 or more campers, \$750.

74.25 (i) A youth camp which pays fees under paragraph (d) of this subdivision is not
74.26 required to pay fees under paragraph (h) of this subdivision.

74.27 Sec. 7. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is
74.28 amended to read:

74.29 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)

74.30 The following fees are required for manufactured home parks and recreational camping

74.31 areas licensed under this chapter. Recreational camping areas and manufactured home

74.32 parks shall pay the highest applicable base fee under paragraph ~~(e)~~ (b). The license fee

74.33 for new operators of a manufactured home park or recreational camping area previously

74.34 licensed under this chapter for the same calendar year is one-half of the appropriate annual

74.35 license fee, plus any penalty that may be required. The license fee for operators opening

74.36 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty

74.37 that may be required.

75.1 (b) All manufactured home parks and recreational camping areas shall pay the
75.2 following annual base fee:

75.3 (1) a manufactured home park, \$150; and

75.4 (2) a recreational camping area with:

75.5 (i) 24 or less sites, \$50;

75.6 (ii) 25 to 99 sites, \$212; and

75.7 (iii) 100 or more sites, \$300.

75.8 In addition to the base fee, manufactured home parks and recreational camping areas shall
75.9 pay \$4 for each licensed site. This paragraph does not apply to special event recreational
75.10 camping areas ~~or to~~. Operators of a manufactured home park or a recreational camping
75.11 area also licensed under section 157.16 for the same location shall pay only one base fee,
75.12 whichever is the highest of the base fees found in this section or section 157.16.

75.13 (c) In addition to the fee in paragraph (b), each manufactured home park or
75.14 recreational camping area shall pay an additional annual fee for each fee category
75.15 specified in this paragraph:

75.16 (1) Manufactured home parks and recreational camping areas with public swimming
75.17 pools and spas shall pay the appropriate fees specified in section 157.16.

75.18 (2) Individual private sewer or water, \$60. "Individual private water" means a fee
75.19 category with a water supply other than a community public water supply as defined in
75.20 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a
75.21 subsurface sewage treatment system which uses subsurface treatment and disposal.

75.22 (d) The following fees must accompany a plan review application for initial
75.23 construction of a manufactured home park or recreational camping area:

75.24 (1) for initial construction of less than 25 sites, \$375;

75.25 (2) for initial construction of 25 to 99 sites, \$400; and

75.26 (3) for initial construction of 100 or more sites, \$500.

75.27 (e) The following fees must accompany a plan review application when an existing
75.28 manufactured home park or recreational camping area is expanded:

75.29 (1) for expansion of less than 25 sites, \$250;

75.30 (2) for expansion of 25 to 99 sites, \$300; and

75.31 (3) for expansion of 100 or more sites, \$450.

75.32 **Sec. 8. HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
75.33 **REDUCTION; REPORTING REQUIREMENTS.**

75.34 (a) Minnesota health plans and county-based purchasing plans may complete an
75.35 inventory of existing data collection and reporting requirements for health plans and

76.1 county-based purchasing plans and submit to the commissioners of health and human
76.2 services a list of data, documentation, and reports that:

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

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

76.7 (3) are not currently being used by state agencies; or

76.8 (4) collect similar information more than once in different formats, at different
76.9 times, or by more than one state agency.

76.10 (b) The report to the commissioners may also identify the percentage of health
76.11 plan and county-based purchasing plan administrative time and expense attributed to
76.12 fulfilling reporting requirements, and include recommendations regarding ways to reduce
76.13 duplicative reporting requirements.

76.14 (c) Upon receipt, the commissioners shall submit the inventory and recommendations
76.15 to the chairs of the appropriate legislative committees, along with their comments
76.16 and recommendations as to whether any action should be taken by the legislature to
76.17 establish a consolidated and streamlined reporting system under which data, reports, and
76.18 documentation are collected only once, and only when needed for the state agencies to
76.19 fulfill their duties under law and applicable regulations.

76.20 Sec. 9. **TRANSFER.**

76.21 The powers and duties of the Emergency Medical Services Regulatory Board with
76.22 respect to the comprehensive advanced life-support educational program under Minnesota
76.23 Statutes, section 144E.37, are transferred to the commissioner of health under Minnesota
76.24 Statutes, section 15.039.

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

76.26 Sec. 10. **REVISOR'S INSTRUCTION.**

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

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

ARTICLE 5

GENERAL ASSISTANCE MEDICAL CARE AMENDMENTS

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

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

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

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

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

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

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

78.1 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
78.2 commissioner after consultation with representatives of pediatric dental providers and
78.3 consumers.

78.4 (c) Patients seen on a volunteer basis by the provider at a location other than
78.5 the provider's usual place of practice may be considered in meeting the participation
78.6 requirement in this section. The commissioner shall establish participation requirements
78.7 for health maintenance organizations. The commissioner shall provide lists of participating
78.8 medical assistance providers on a quarterly basis to the commissioner of management and
78.9 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
78.10 of the commissioners shall develop and implement procedures to exclude as participating
78.11 providers in the program or programs under their jurisdiction those providers who do
78.12 not participate in the medical assistance program. The commissioner of management
78.13 and budget shall implement this section through contracts with participating health and
78.14 dental carriers.

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

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

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

78.24 Sec. 2. Minnesota Statutes 2008, section 256B.69, subdivision 27, is amended to read:

78.25 Subd. 27. **Information for persons with limited English-language proficiency.**
78.26 Managed care contracts entered into under this section and ~~sections 256D.03, subdivision~~
78.27 ~~4, paragraph (c), and section 256L.12~~ must require demonstration providers to provide
78.28 language assistance to enrollees that ensures meaningful access to its programs and
78.29 services according to Title VI of the Civil Rights Act and federal regulations adopted
78.30 under that law or any guidance from the United States Department of Health and Human
78.31 Services.

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

78.33 Sec. 3. Minnesota Statutes 2008, section 256B.692, subdivision 1, is amended to read:

79.1 Subdivision 1. **In general.** County boards or groups of county boards may elect
79.2 to purchase or provide health care services on behalf of persons eligible for medical
79.3 assistance ~~and general assistance medical care~~ who would otherwise be required to or may
79.4 elect to participate in the prepaid medical assistance ~~or prepaid general assistance medical~~
79.5 ~~care programs~~ according to ~~sections~~ section 256B.69 and 256D.03. Counties that elect to
79.6 purchase or provide health care under this section must provide all services included in
79.7 prepaid managed care programs according to ~~sections~~ section 256B.69, subdivisions 1
79.8 to 22, ~~and 256D.03~~. County-based purchasing under this section is governed by section
79.9 256B.69, unless otherwise provided for under this section.

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

79.11 Sec. 4. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as
79.12 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

79.13 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
79.14 the general assistance medical care program shall be administered according to section
79.15 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
79.16 which shall continue to be administered under this section and funded under section
79.17 256D.031, subdivision 9, beginning June 1, 2010.

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

79.20 (1) are covered under the medical assistance program as described in section
79.21 256B.0625, subdivisions 13 and 13d; and

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

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

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

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

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

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

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

80.13 Sec. 6. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to
80.14 read:

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

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

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

80.19 Subd. 7. **Payments; rate setting for the hospital coordinated care delivery**
80.20 **system.** (a) Effective for general assistance medical care services, with the exception
80.21 of outpatient prescription drug coverage, provided on or after June 1, 2010, through a
80.22 coordinated care delivery system, the commissioner shall allocate the annual appropriation
80.23 for the coordinated care delivery system to hospitals participating under subdivision
80.24 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1,
80.25 2010. The payment shall be allocated among all hospitals qualified to participate on the
80.26 allocation date. ~~Each hospital or group of hospitals shall receive a pro rata share of the~~
80.27 ~~allocation based on the hospital's or group of hospitals' calendar year 2008 payments for~~
80.28 ~~general assistance medical care services, provided that, for the purposes of this allocation,~~
80.29 ~~payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical~~
80.30 ~~Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110~~
80.31 ~~percent of the actual amount.~~ as follows:

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81.1 (1) each hospital or group of hospitals shall be allocated an initial amount based on
81.2 the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for
81.3 general assistance medical care services to all participating hospitals;

81.4 (2) the initial allocations to Hennepin County Medical Center; Regions Hospital;
81.5 Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview,
81.6 shall be increased to 110 percent of the value determined in clause (1);

81.7 (3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata
81.8 amount in order to keep the allocations within the limit of available appropriations; and

81.9 (4) the amounts determined under clauses (1) to (3) shall be allocated to participating
81.10 hospitals.

81.11 The commissioner may prospectively reallocate payments to participating hospitals on
81.12 a biannual basis to ensure that final allocations reflect actual coordinated care delivery
81.13 system enrollment. The 2008 base year shall be updated by one calendar year each June 1,
81.14 beginning June 1, 2011.

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

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

81.25 ~~(e)~~ (d) The commissioner shall apply for federal matching funds under section
81.26 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

81.27 ~~(d)~~ (e) Outpatient prescription drug coverage is provided in accordance with section
81.28 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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

81.30 Sec. 8. Laws 2010, chapter 200, article 1, section 16, is amended by adding an
81.31 effective date to read:

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

81.33 Sec. 9. Laws 2010, chapter 200, article 1, section 21, is amended to read:

82.1 Sec. 21. **REPEALER.**

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

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

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

82.8 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
82.9 3, are repealed effective for federal fiscal year 2010.

82.10 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
82.11 4; and 256L.17, subdivision 7, are repealed ~~January 1, 2011~~ June 1, 2010.

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

82.13 Sec. 10. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

82.14 Subdivision 1. **Total Appropriation** \$ (7,985,000) \$ (93,128,000)

82.15 Appropriations by Fund

	2010	2011
82.16 General	34,807,000	118,493,000
82.17 Health Care Access	(42,792,000)	(211,621,000)

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

82.22 **Special Revenue Fund Transfers.**

82.23 (a) The commissioner shall transfer the
82.24 following amounts from special revenue
82.25 fund balances to the general fund by June
82.26 30 of each respective fiscal year: \$410,000
82.27 for fiscal year 2010, and \$412,000 for fiscal
82.28 year 2011.

82.29 (b) Actual transfers made under paragraph
82.30 (a) must be separately identified and reported
82.31 as part of the quarterly reporting of transfers
82.32 to the chairs of the relevant senate budget
82.33 division and house finance division.

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

83.2 Sec. 11. Laws 2010, chapter 200, article 2, section 2, subdivision 5, is amended to read:

83.3 Subd. 5. **Health Care Management**

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

83.6 Health Care Administration.	(2,998,000)	(5,270,000)
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83.7 **Base Adjustment.** The general fund base
83.8 for health care administration is reduced by
83.9 ~~\$182,000~~ \$36,000 in fiscal year 2012 and
83.10 ~~\$182,000~~ \$36,000 in fiscal year 2013.

83.11 Sec. 12. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

83.12 Subd. 8. **Transfers**

83.13 The commissioner must transfer \$29,538,000
83.14 in fiscal year 2010 and \$18,462,000 in fiscal
83.15 year 2011 from the health care access fund to
83.16 the general fund. This is a onetime transfer.

83.17 The commissioner must transfer \$4,800,000
83.18 from the consolidated chemical dependency
83.19 treatment fund to the general fund by June
83.20 30, 2010.

83.21 **Compulsive Gambling ~~Special Revenue~~**
83.22 **Administration.** The lottery prize fund
83.23 appropriation for compulsive gambling
83.24 administration is reduced by \$6,000 for fiscal
83.25 year 2010 and \$4,000 for fiscal year 2011
83.26 ~~must be transferred from the lottery prize~~
83.27 ~~fund appropriation for compulsive gambling~~
83.28 ~~administration to the general fund by June~~
83.29 ~~30 of each respective fiscal year. These are~~
83.30 onetime reductions.

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

ARTICLE 6

MISCELLANEOUS

Section 1. [62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.

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

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

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

Sec. 2. [137.32] MINNESOTA COUPLES ON THE BRINK PROJECT.

Subdivision 1. **Establishment.** Within the limits of available appropriations, the Board of Regents of the University of Minnesota is requested to develop and implement a Minnesota couples on the brink project, as provided for in this section. The regents may administer the project with federal grants, state appropriations, and in-kind services received for this purpose.

Subd. 2. **Purpose.** The purpose of the project is to develop, evaluate, and disseminate best practices for promoting successful reconciliation between married persons who are considering or have commenced a marriage dissolution proceeding and who choose to pursue reconciliation.

Subd. 3. **Implementation.** The regents shall:

(1) enter into contracts or manage a grant process for implementation of the project; and

(2) develop and implement an evaluation component for the project.

85.1 Sec. 3. Minnesota Statutes 2009 Supplement, section 150A.106, subdivision 1, is
85.2 amended to read:

85.3 Subdivision 1. **General.** (a) In order to be certified by the board to practice as an
85.4 advanced dental therapist, a person must:

85.5 (1) complete a dental therapy education program;

85.6 (2) pass an examination to demonstrate competency under the dental therapy scope
85.7 of practice;

85.8 (3) be licensed as a dental therapist;

85.9 (4) complete 2,000 hours of dental therapy clinical practice under direct or indirect
85.10 supervision;

85.11 (5) graduate from a master's advanced dental therapy education program;

85.12 (6) pass a board-approved certification examination to demonstrate competency
85.13 under the advanced scope of practice; and

85.14 (7) submit an application for certification as prescribed by the board.

85.15 (b) A dental therapy educational program may offer a combined dental therapy
85.16 and advanced dental therapy program if the combined program was in existence on
85.17 April 1, 2010. The combined program is exempt from board approval if the requirement
85.18 of section 150A.06, subdivision 1d, paragraph (b) is met. A graduate of a combined
85.19 program satisfies the requirements of paragraph (a), clauses (1) and (5), if the degree upon
85.20 graduation is a master's degree and the board shall issue a dental therapy license and an
85.21 advanced practice certification to a graduate of a combined program if the other licensure
85.22 and certification requirements are satisfied. As part of the combined program, the clinical
85.23 practice requirements in paragraph (a), clause (4), may be commenced before a dental
85.24 therapy license is granted.

85.25 Sec. 4. Minnesota Statutes 2009 Supplement, section 150A.06, subdivision 1d, is
85.26 amended to read:

85.27 Subd. 1d. **Dental therapists.** (a) A person of good moral character who has
85.28 graduated with a baccalaureate degree or a master's degree from a dental therapy education
85.29 program that has been approved by the board or accredited by the American Dental
85.30 Association Commission on Dental Accreditation or another board-approved national
85.31 accreditation organization may apply for licensure.

85.32 (b) Notwithstanding paragraph (a), a dental therapy education program in existence
85.33 on April 1, 2010, is exempt from the requirement of board approval and applicants who
85.34 have graduated from the program shall be licensed if the requirements of paragraph (c) are

86.1 satisfied. Programs identified in this paragraph must become accredited within two years
86.2 after the establishment of a recognized national accreditation program for dental therapists.

86.3 (c) The applicant must submit an application and fee as prescribed by the board and
86.4 a diploma or certificate from a dental therapy education program. Prior to being licensed,
86.5 the applicant must pass a comprehensive, competency-based clinical examination that is
86.6 approved by the board and administered independently of an institution providing dental
86.7 therapy education. The applicant must also pass an examination testing the applicant's
86.8 knowledge of the Minnesota laws and rules relating to the practice of dentistry. An
86.9 applicant who has failed the clinical examination twice is ineligible to retake the clinical
86.10 examination until further education and training are obtained as specified by the board. A
86.11 separate, nonrefundable fee may be charged for each time a person applies. An applicant
86.12 who passes the examination in compliance with subdivision 2b, abides by professional
86.13 ethical conduct requirements, and meets all the other requirements of the board shall
86.14 be licensed as a dental therapist.

86.15 Sec. 5. Minnesota Statutes 2008, section 152.126, as amended by Laws 2009, chapter
86.16 79, article 11, sections 9, 10, and 11, is amended to read:

86.17 **152.126 ~~SCHEDULE H AND H~~ CONTROLLED SUBSTANCES**
86.18 **PRESCRIPTION ELECTRONIC REPORTING SYSTEM.**

86.19 Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this
86.20 subdivision have the meanings given.

86.21 (a) "Board" means the Minnesota State Board of Pharmacy established under
86.22 chapter 151.

86.23 (b) "Controlled substances" means those substances listed in section 152.02,
86.24 subdivisions 3 to 5, and those substances defined by the board pursuant to section 152.02,
86.25 subdivisions 7, 8, and 12.

86.26 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
86.27 30. Dispensing does not include the direct administering of a controlled substance to a
86.28 patient by a licensed health care professional.

86.29 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
86.30 pursuant to a valid prescription. For the purposes of this section, a dispenser does not
86.31 include a licensed hospital pharmacy that distributes controlled substances for inpatient
86.32 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

86.33 (e) "Prescriber" means a licensed health care professional who is authorized to
86.34 prescribe a controlled substance under section 152.12, subdivision 1.

86.35 (f) "Prescription" has the meaning given in section 151.01, subdivision 16.

87.1 Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or
87.2 interfere with the legitimate prescribing of controlled substances for pain. No prescriber
87.3 shall be subject to disciplinary action by a health-related licensing board for prescribing a
87.4 controlled substance according to the provisions of section 152.125.

87.5 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish
87.6 by January 1, 2010, an electronic system for reporting the information required under
87.7 subdivision 4 for all controlled substances dispensed within the state.

87.8 (b) The board may contract with a vendor for the purpose of obtaining technical
87.9 assistance in the design, implementation, operation, and maintenance of the electronic
87.10 reporting system.

87.11 Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The
87.12 board shall convene an advisory committee. The committee must include at least one
87.13 representative of:

87.14 (1) the Department of Health;

87.15 (2) the Department of Human Services;

87.16 (3) each health-related licensing board that licenses prescribers;

87.17 (4) a professional medical association, which may include an association of pain
87.18 management and chemical dependency specialists;

87.19 (5) a professional pharmacy association;

87.20 (6) a professional nursing association;

87.21 (7) a professional dental association;

87.22 (8) a consumer privacy or security advocate; and

87.23 (9) a consumer or patient rights organization.

87.24 (b) The advisory committee shall advise the board on the development and operation
87.25 of the electronic reporting system, including, but not limited to:

87.26 (1) technical standards for electronic prescription drug reporting;

87.27 (2) proper analysis and interpretation of prescription monitoring data; and

87.28 (3) an evaluation process for the program.

87.29 ~~(c) The Board of Pharmacy, after consultation with the advisory committee, shall~~
87.30 ~~present recommendations and draft legislation on the issues addressed by the advisory~~
87.31 ~~committee under paragraph (b), to the legislature by December 15, 2007.~~

87.32 Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the
87.33 following data to the board or its designated vendor, subject to the notice required under
87.34 paragraph (d):

87.35 (1) name of the prescriber;

87.36 (2) national provider identifier of the prescriber;

- 88.1 (3) name of the dispenser;
- 88.2 (4) national provider identifier of the dispenser;
- 88.3 (5) prescription number;
- 88.4 (6) name of the patient for whom the prescription was written;
- 88.5 (7) address of the patient for whom the prescription was written;
- 88.6 (8) date of birth of the patient for whom the prescription was written;
- 88.7 (9) date the prescription was written;
- 88.8 (10) date the prescription was filled;
- 88.9 (11) name and strength of the controlled substance;
- 88.10 (12) quantity of controlled substance prescribed;
- 88.11 (13) quantity of controlled substance dispensed; and
- 88.12 (14) number of days supply.

88.13 (b) The dispenser must submit the required information by a procedure and in a
88.14 format established by the board. The board may allow dispensers to omit data listed in this
88.15 subdivision or may require the submission of data not listed in this subdivision provided
88.16 the omission or submission is necessary for the purpose of complying with the electronic
88.17 reporting or data transmission standards of the American Society for Automation in
88.18 Pharmacy, the National Council on Prescription Drug Programs, or other relevant national
88.19 standard-setting body.

88.20 (c) A dispenser is not required to submit this data for those controlled substance
88.21 prescriptions dispensed for:

- 88.22 (1) individuals residing in licensed skilled nursing or intermediate care facilities;
- 88.23 (2) individuals receiving assisted living services under chapter 144G or through a
88.24 medical assistance home and community-based waiver;
- 88.25 (3) individuals receiving medication intravenously;
- 88.26 (4) individuals receiving hospice and other palliative or end-of-life care; and
- 88.27 (5) individuals receiving services from a home care provider regulated under chapter
88.28 144A.

88.29 (d) A dispenser must not submit data under this subdivision unless a conspicuous
88.30 notice of the reporting requirements of this section is given to the patient for whom the
88.31 prescription was written.

88.32 **Subd. 5. Use of data by board.** (a) The board shall develop and maintain a database
88.33 of the data reported under subdivision 4. The board shall maintain data that could identify
88.34 an individual prescriber or dispenser in encrypted form. The database may be used by
88.35 permissible users identified under subdivision 6 for the identification of:

89.1 (1) individuals receiving prescriptions for controlled substances from prescribers
89.2 who subsequently obtain controlled substances from dispensers in quantities or with a
89.3 frequency inconsistent with generally recognized standards of use for those controlled
89.4 substances, including standards accepted by national and international pain management
89.5 associations; and

89.6 (2) individuals presenting forged or otherwise false or altered prescriptions for
89.7 controlled substances to dispensers.

89.8 (b) No permissible user identified under subdivision 6 may access the database
89.9 for the sole purpose of identifying prescribers of controlled substances for unusual or
89.10 excessive prescribing patterns without a valid search warrant or court order.

89.11 (c) No personnel of a state or federal occupational licensing board or agency may
89.12 access the database for the purpose of obtaining information to be used to initiate or
89.13 substantiate a disciplinary action against a prescriber.

89.14 (d) Data reported under subdivision 4 shall be retained by the board in the database
89.15 for a 12-month period, and shall be removed from the database no later than 12 months
89.16 from the date the last day of the month during which the data was received.

89.17 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
89.18 subdivision, the data submitted to the board under subdivision 4 is private data on
89.19 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

89.20 (b) Except as specified in subdivision 5, the following persons shall be considered
89.21 permissible users and may access the data submitted under subdivision 4 in the same or
89.22 similar manner, and for the same or similar purposes, as those persons who are authorized
89.23 to access similar private data on individuals under federal and state law:

89.24 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
89.25 delegated the task of accessing the data, to the extent the information relates specifically to
89.26 a current patient, to whom the prescriber is prescribing or considering prescribing any
89.27 controlled substance and with the provision that the prescriber remains responsible for the
89.28 use or misuse of data accessed by a delegated agent or employee;

89.29 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
89.30 delegated the task of accessing the data, to the extent the information relates specifically
89.31 to a current patient to whom that dispenser is dispensing or considering dispensing any
89.32 controlled substance and with the provision that the dispenser remains responsible for the
89.33 use or misuse of data accessed by a delegated agent or employee;

89.34 (3) an individual who is the recipient of a controlled substance prescription for
89.35 which data was submitted under subdivision 4, or a guardian of the individual, parent or

90.1 guardian of a minor, or health care agent of the individual acting under a health care
90.2 directive under chapter 145C;

90.3 (4) personnel of the board specifically assigned to conduct a bona fide investigation
90.4 of a specific licensee;

90.5 (5) personnel of the board engaged in the collection of controlled substance
90.6 prescription information as part of the assigned duties and responsibilities under this
90.7 section;

90.8 (6) authorized personnel of a vendor under contract with the board who are engaged
90.9 in the design, implementation, operation, and maintenance of the electronic reporting
90.10 system as part of the assigned duties and responsibilities of their employment, provided
90.11 that access to data is limited to the minimum amount necessary to carry out such duties
90.12 and responsibilities;

90.13 (7) federal, state, and local law enforcement authorities acting pursuant to a valid
90.14 search warrant; and

90.15 (8) personnel of the medical assistance program assigned to use the data collected
90.16 under this section to identify recipients whose usage of controlled substances may warrant
90.17 restriction to a single primary care physician, a single outpatient pharmacy, or a single
90.18 hospital.

90.19 For purposes of clause (3), access by an individual includes persons in the definition
90.20 of an individual under section 13.02.

90.21 (c) Any permissible user identified in paragraph (b), who directly accesses
90.22 the data electronically, shall implement and maintain a comprehensive information
90.23 security program that contains administrative, technical, and physical safeguards that
90.24 are appropriate to the user's size and complexity, and the sensitivity of the personal
90.25 information obtained. The permissible user shall identify reasonably foreseeable internal
90.26 and external risks to the security, confidentiality, and integrity of personal information
90.27 that could result in the unauthorized disclosure, misuse, or other compromise of the
90.28 information and assess the sufficiency of any safeguards in place to control the risks.

90.29 (d) The board shall not release data submitted under this section unless it is provided
90.30 with evidence, satisfactory to the board, that the person requesting the information is
90.31 entitled to receive the data.

90.32 (e) The board shall not release the name of a prescriber without the written consent
90.33 of the prescriber or a valid search warrant or court order. The board shall provide a
90.34 mechanism for a prescriber to submit to the board a signed consent authorizing the release
90.35 of the prescriber's name when data containing the prescriber's name is requested.

91.1 (f) The board shall maintain a log of all persons who access the data and shall ensure
91.2 that any permissible user complies with paragraph (c) prior to attaining direct access to
91.3 the data.

91.4 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into
91.5 pursuant to subdivision 2. A vendor shall not use data collected under this section for
91.6 any purpose not specified in this section.

91.7 Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to
91.8 the board as required under this section is subject to disciplinary action by the appropriate
91.9 health-related licensing board.

91.10 (b) A prescriber or dispenser authorized to access the data who knowingly discloses
91.11 the data in violation of state or federal laws relating to the privacy of health care data
91.12 shall be subject to disciplinary action by the appropriate health-related licensing board,
91.13 and appropriate civil penalties.

91.14 Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription
91.15 electronic reporting system to determine if the system is negatively impacting appropriate
91.16 prescribing practices of controlled substances. The board may contract with a vendor to
91.17 design and conduct the evaluation.

91.18 (b) The board shall submit the evaluation of the system to the legislature by ~~January~~
91.19 July 15, 2011.

91.20 Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A
91.21 pharmacist, prescriber, or other dispenser making a report to the program in good faith
91.22 under this section is immune from any civil, criminal, or administrative liability, which
91.23 might otherwise be incurred or imposed as a result of the report, or on the basis that the
91.24 pharmacist or prescriber did or did not seek or obtain or use information from the program.

91.25 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser
91.26 to obtain information about a patient from the program, and the pharmacist, prescriber,
91.27 or other dispenser, if acting in good faith, is immune from any civil, criminal, or
91.28 administrative liability that might otherwise be incurred or imposed for requesting,
91.29 receiving, or using information from the program.

91.30 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit
91.31 charitable foundations, the federal government, and other sources to fund the enhancement
91.32 and ongoing operations of the prescription electronic reporting system established under
91.33 this section. Any funds received shall be appropriated to the board for this purpose. The
91.34 board may not expend funds to enhance the program in a way that conflicts with this
91.35 section without seeking approval from the legislature.

92.1 (b) The administrative services unit for the health-related licensing boards shall
92.2 apportion between the Board of Medical Practice, the Board of Nursing, the Board of
92.3 Dentistry, the Board of Podiatric Medicine, the Board of Optometry, and the Board
92.4 of Pharmacy an amount to be paid through fees by each respective board. The amount
92.5 apportioned to each board shall equal each board's share of the annual appropriation to
92.6 the Board of Pharmacy from the state government special revenue fund for operating the
92.7 prescription electronic reporting system under this section. Each board's apportioned
92.8 share shall be based on the number of prescribers or dispensers that each board identified
92.9 in this paragraph licenses as a percentage of the total number of prescribers and dispensers
92.10 licensed collectively by these boards. Each respective board may adjust the fees that the
92.11 boards are required to collect to compensate for the amount apportioned to each board by
92.12 the administrative services unit.

92.13 Sec. 6. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision
92.14 to read:

92.15 Subd. 8. **State-operated services account.** The state-operated services account is
92.16 established in the special revenue fund. Revenue generated by new state-operated services
92.17 listed under this section established after July 1, 2010, that are not enterprise activities must
92.18 be deposited into the state-operated services account, unless otherwise specified in law:

- 92.19 (1) intensive residential treatment services;
92.20 (2) foster care services; and
92.21 (3) psychiatric extensive recovery treatment services.

92.22 Sec. 7. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

92.23 Subd. 2. **American Indian.** For purposes of services provided under section
92.24 254B.09, subdivision ~~7~~ 8, "American Indian" means a person who is a member of an
92.25 Indian tribe, and the commissioner shall use the definitions of "Indian" and "Indian tribe"
92.26 and "Indian organization" provided in Public Law 93-638. For purposes of services
92.27 provided under section 254B.09, subdivision ~~4~~ 6, "American Indian" means a resident of
92.28 federally recognized tribal lands who is recognized as an Indian person by the federally
92.29 recognized tribal governing body.

92.30 Sec. 8. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

92.31 Subdivision 1. **Chemical dependency treatment allocation.** The chemical
92.32 dependency ~~funds appropriated for allocation~~ treatment appropriation shall be placed in
92.33 a special revenue account. The commissioner shall annually transfer funds from the

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93.1 chemical dependency fund to pay for operation of the drug and alcohol abuse normative
93.2 evaluation system and to pay for all costs incurred by adding two positions for licensing
93.3 of chemical dependency treatment and rehabilitation programs located in hospitals for
93.4 which funds are not otherwise appropriated. ~~Six percent of the remaining money must~~
93.5 ~~be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The~~
93.6 ~~commissioner shall annually divide the money available in the chemical dependency~~
93.7 ~~fund that is not held in reserve by counties from a previous allocation, or allocated to the~~
93.8 ~~American Indian chemical dependency tribal account. Six percent of the remaining money~~
93.9 ~~must be reserved for the nonreservation American Indian chemical dependency allocation~~
93.10 ~~for treatment of American Indians by eligible vendors under section 254B.05, subdivision~~
93.11 ~~4. The remainder of the money must be allocated among the counties according to the~~
93.12 ~~following formula, using state demographer data and other data sources determined by~~
93.13 ~~the commissioner:~~

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

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

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

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

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

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

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

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

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

94.7 ~~(j) The remaining funds shall be allocated proportional to the county adjusted~~
94.8 ~~population in the special revenue account must be used according to the requirements~~
94.9 ~~in this chapter.~~

94.10 Sec. 9. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

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

94.19 Sec. 10. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

94.20 Subd. 4. **Division of costs.** Except for services provided by a county under
94.21 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
94.22 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for
94.23 ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services
94.24 provided to persons eligible for medical assistance under chapter 256B and general
94.25 assistance medical care under chapter 256D. Counties may use the indigent hospitalization
94.26 levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent
94.27 of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost
94.28 of payment and collections, must be distributed to the county that paid for a portion of
94.29 the treatment under this section. ~~If all funds allocated according to section 254B.02 are~~
94.30 ~~exhausted by a county and the county has met or exceeded the base level of expenditures~~
94.31 ~~under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the~~
94.32 ~~costs paid by the state under this section. The commissioner may refuse to pay state funds~~
94.33 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~
94.34 ~~financially responsible for the persons has exhausted its allocation.~~

95.1 Sec. 11. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
95.2 to read:

95.3 Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding
95.4 subdivision 4, for chemical dependency services provided on or after October 1, 2008, and
95.5 reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

95.6 Sec. 12. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

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

95.17 Sec. 13. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

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

95.29 Sec. 14. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

95.30 Subd. 8. **Payments to improve services to American Indians.** The commissioner
95.31 may set rates for chemical dependency services to American Indians according to the
95.32 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.

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96.1 These rates shall supersede rates set in county purchase of service agreements when
96.2 payments are made on behalf of clients eligible according to Public Law 94-437.

96.3 Sec. 15. Minnesota Statutes 2009 Supplement, section 517.08, subdivision 1b, is
96.4 amended to read:

96.5 Subd. 1b. **Term of license; fee; premarital education.** (a) The local registrar
96.6 shall examine upon oath the parties applying for a license relative to the legality of the
96.7 contemplated marriage. If one party is unable to appear in person, the party appearing
96.8 may complete the absent applicant's information. The local registrar shall provide a copy
96.9 of the marriage application to the party who is unable to appear, who must verify the
96.10 accuracy of the party's information in a notarized statement. The marriage license must
96.11 not be released until the verification statement has been received by the local registrar. If
96.12 at the expiration of a five-day period, on being satisfied that there is no legal impediment
96.13 to it, including the restriction contained in section 259.13, the local registrar shall issue
96.14 the license, containing the full names of the parties before and after marriage, and county
96.15 and state of residence, with the county seal attached, and make a record of the date of
96.16 issuance. The license shall be valid for a period of six months. Except as provided in
96.17 paragraph (c), the local registrar shall collect from the applicant a fee of ~~\$110~~ \$115 for
96.18 administering the oath, issuing, recording, and filing all papers required, and preparing
96.19 and transmitting to the state registrar of vital statistics the reports of marriage required
96.20 by this section. If the license should not be used within the period of six months due to
96.21 illness or other extenuating circumstances, it may be surrendered to the local registrar for
96.22 cancellation, and in that case a new license shall issue upon request of the parties of the
96.23 original license without fee. A local registrar who knowingly issues or signs a marriage
96.24 license in any manner other than as provided in this section shall pay to the parties
96.25 aggrieved an amount not to exceed \$1,000.

96.26 (b) In case of emergency or extraordinary circumstances, a judge of the district court
96.27 of the county in which the application is made may authorize the license to be issued at
96.28 any time before expiration of the five-day period required under paragraph (a). A waiver
96.29 of the five-day waiting period must be in the following form:

96.30 STATE OF MINNESOTA, COUNTY OF (insert county name)
96.31 APPLICATION FOR WAIVER OF MARRIAGE LICENSE WAITING PERIOD:
96.32 (legal names of the applicants)

96.33 Represent and state as follows:

96.34 That on (date of application) the applicants applied to the local
96.35 registrar of the above-named county for a license to marry.

97.1 That it is necessary that the license be issued before the expiration of five days
97.2 from the date of the application by reason of the following: (insert reason for requesting
97.3 waiver of waiting period)

97.4
97.5
97.6

97.7 WHEREAS, the applicants request that the judge waive the required five-day
97.8 waiting period and the local registrar be authorized and directed to issue the marriage
97.9 license immediately.

97.10 Date:
97.11
97.12

97.13 (Signatures of applicants)

97.14 Acknowledged before me on this day of
97.15

97.16 NOTARY PUBLIC

97.17 COURT ORDER AND AUTHORIZATION:

97.18 STATE OF MINNESOTA, COUNTY OF (insert county name)

97.19 After reviewing the above application, I am satisfied that an emergency or
97.20 extraordinary circumstance exists that justifies the issuance of the marriage license before
97.21 the expiration of five days from the date of the application. IT IS HEREBY ORDERED
97.22 that the local registrar is authorized and directed to issue the license forthwith.

97.23
97.24 (judge of district court)
97.25 (date).

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

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

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

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

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

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

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

98.20 Sec. 16. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws
98.21 2010, chapter 200, article 1, section 17, is amended to read:

98.22 Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected
98.23 pursuant to subdivision 1b, paragraph (a), \$25 must be retained by the county. The
98.24 local registrar must pay ~~\$85~~ \$90 to the commissioner of management and budget to be
98.25 deposited as follows:

98.26 (1) \$55 in the general fund;

98.27 (2) \$3 in the state government special revenue fund to be appropriated to the
98.28 commissioner of public safety for parenting time centers under section 119A.37;

98.29 (3) \$2 in the special revenue fund to be appropriated to the commissioner of health
98.30 for developing and implementing the MN ENABL program under section 145.9255; ~~and~~

98.31 (4) \$25 in the special revenue fund is appropriated to the commissioner of
98.32 employment and economic development for the displaced homemaker program under
98.33 section 116L.96; and

99.1 (5) \$5 in the special revenue fund, which is appropriated to the Board of Regents
99.2 of the University of Minnesota for the Minnesota couples on the brink project under
99.3 section 137.32.

99.4 (b) Of the \$40 fee under subdivision 1b, paragraph (b), \$25 must be retained by the
99.5 county. The local registrar must pay \$15 to the commissioner of management and budget
99.6 to be deposited as follows:

99.7 (1) \$5 as provided in paragraph (a), clauses (2) and (3); and

99.8 (2) \$10 in the special revenue fund is appropriated to the commissioner of
99.9 employment and economic development for the displaced homemaker program under
99.10 section 116L.96.

99.11 Sec. 17. Laws 2009, chapter 79, article 3, section 18, is amended to read:

99.12 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
99.13 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
99.14 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

99.15 In consultation with community partners, the commissioner of human services
99.16 shall develop an array of community-based services in the metro area to transform the
99.17 current services now provided to patients at the Anoka-Metro Regional Treatment Center.
99.18 ~~The community-based services may be provided in facilities with 16 or fewer beds, and~~
99.19 ~~must provide the appropriate level of care for the patients being admitted to the facilities~~
99.20 established in partnership with private and public hospital organizations, community
99.21 mental health centers and other mental health community services providers, and
99.22 community partnerships, and must be staffed by state employees. The planning for this
99.23 transition must be completed by October 1, ~~2009~~ 2010, with ~~an initial~~ a report detailing
99.24 the transition plan, services that will be provided, including incorporating peer specialists
99.25 where appropriate, the location of the services, and the number of patients that will be
99.26 served, to the committee chairs of health and human services by November 30, ~~2009~~ 2010;
99.27 ~~and a semiannual report on progress until the transition is completed.~~ The commissioner
99.28 of human services shall ~~solicit interest from~~ make a genuine effort to engage stakeholders
99.29 and potential community partners in the process. The individuals ~~working in~~ employed by
99.30 the community-based services ~~facilities~~ under this section are state employees supervised
99.31 by the commissioner of human services. No layoffs shall occur as a result of restructuring
99.32 under this section. Savings generated as a result of transitioning patients from the
99.33 Anoka-Metro Regional Treatment Center to community-based services may be used to
99.34 fund supportive housing staffed by state employees.

100.1 Sec. 18. **CASE MANAGEMENT RECOMMENDATIONS.**

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

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

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

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

100.15 In developing these recommendations, the commissioner of human services shall consider
100.16 the recommendations of the 2007 Redesigning Case Management Services for Persons
100.17 with Disabilities Report and consult with existing stakeholder groups, which include
100.18 representatives of counties, disability and senior advocacy groups, service providers, and
100.19 representatives of agencies that provide contacted case management.

100.20 This provision is effective the day following final enactment.

100.21 Sec. 19. **VETERINARY PRACTICE AND CONTROLLED SUBSTANCE**
100.22 **ABUSE STUDY.**

100.23 The Board of Pharmacy, in consultation with the Prescription Electronic Reporting
100.24 Advisory Committee and the Board of Veterinary Medical Practice, shall study the issue
100.25 of the diversion of controlled substances from veterinary practice and report to the chairs
100.26 and ranking minority members of the senate health and human services policy and finance
100.27 division and the house of representatives health care and human services policy and
100.28 finance division by December 15, 2011, on recommendations to include veterinarians in
100.29 the prescription electronic reporting system in Minnesota Statutes, section 152.126.

100.30 Sec. 20. **REPEALER.**

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

	<u>2010</u>	<u>2011</u>	<u>Total</u>
<u>General</u>	\$ 3,503,000	\$ 243,587,000	\$ 247,090,000
<u>State Government Special Revenue</u>	113,000	624,000	737,000
<u>Health Care Access</u>	998,000	27,534,000	28,532,000
<u>Federal TANF</u>	11,464,000	14,986,000	26,450,000
<u>Special Revenue</u>	-0-	93,000	93,000
<u>Total</u>	\$ 16,078,000	\$ 286,824,000	\$ 302,902,000

Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from appropriations listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions for the fiscal year ending June 30, 2010, are effective the day following final enactment unless a different effective date is explicit.

APPROPRIATIONS
Available for the Year
Ending June 30
2010 2011

Sec. 3. COMMISSIONER OF HUMAN SERVICES

<u>Subdivision 1. Total Appropriation</u>	<u>\$ 18,167,000</u>	<u>\$ 290,442,000</u>
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102.1	<u>Appropriations by Fund</u>	
102.2	<u>2010</u>	<u>2011</u>
102.3	<u>General</u>	<u>5,705,000</u> <u>247,961,000</u>
102.4	<u>Health Care Access</u>	<u>998,000</u> <u>27,495,000</u>
102.5	<u>Federal TANF</u>	<u>11,464,000</u> <u>14,986,000</u>

102.6 The appropriations for each purpose are
102.7 shown in the following subdivisions.

102.8 **TANF Financing and Maintenance of**
102.9 **Effort.** The commissioner, with the approval
102.10 of the commissioner of management and
102.11 budget, and after notification of the chairs
102.12 of the relevant senate budget division and
102.13 house of representatives finance division,
102.14 may adjust the amount of TANF transfers
102.15 between the MFIP transition year child care
102.16 assistance program and MFIP grant programs
102.17 within the fiscal year and within the current
102.18 biennium and the biennium ending June 30,
102.19 2013, to ensure that state and federal match
102.20 and maintenance of effort requirements are
102.21 met. These transfers and amounts shall be
102.22 reported to the chairs of the senate and house
102.23 of representatives Finance Committees, the
102.24 senate Health and Human Services Budget
102.25 Division, and the house of representatives
102.26 Health Care and Human Services Finance
102.27 Division and Early Childhood Finance and
102.28 Policy Division by December 1 of each
102.29 fiscal year. Notwithstanding any contrary
102.30 provision in this article, this paragraph
102.31 expires June 30, 2013.

102.32 **TANF Funding for the Working Family**
102.33 **Tax Credit.** In addition to the amounts
102.34 specified in Minnesota Statutes, section
102.35 290.0671, subdivision 6, \$18,964,000
102.36 of TANF funds in fiscal year 2010 are

103.1 appropriated to the commissioner to
103.2 reimburse the general fund for the cost of
103.3 the working family tax credit for eligible
103.4 families. With respect to the amounts
103.5 appropriated for fiscal year 2010, the
103.6 commissioner shall reimburse the general
103.7 fund by June 30, 2010. This paragraph is
103.8 effective the day following final enactment.

103.9 **TANF Transfer to Federal Child**

103.10 **Care and Development Fund.** Of the
103.11 TANF appropriation in fiscal year 2011,
103.12 \$12,500,000 is to the commissioner for
103.13 the purposes of MFIP and transition year
103.14 child care under Minnesota Statutes, section
103.15 119B.05. The commissioner shall authorize
103.16 the transfer of sufficient TANF funds to the
103.17 federal child care and development fund to
103.18 meet this appropriation and shall ensure that
103.19 all transferred funds are expended according
103.20 to federal child care and development fund
103.21 regulations.

103.22 **Special Revenue Fund Transfers.** (a) The
103.23 commissioner shall transfer the following
103.24 amounts from special revenue fund balances
103.25 to the general fund by June 30 of each
103.26 respective fiscal year: \$613,000 in fiscal year
103.27 2010, and \$493,000 in fiscal year 2011. This
103.28 provision is effective the day following final
103.29 enactment.

103.30 (b) The actual transfers made under
103.31 paragraph (a) must be separately identified
103.32 and reported as part of the quarterly reporting
103.33 of transfers to the chairs of the relevant senate
103.34 budget division and house of representatives
103.35 finance division.

104.1 **Supplemental Nutrition Assistance**
 104.2 **Program Enhanced Administrative**
 104.3 **Funding.** The funds available for
 104.4 administration of the Supplemental Nutrition
 104.5 Assistance Program under the Department
 104.6 of Defense Appropriations Act of 2010,
 104.7 Public Law 111-118, are appropriated
 104.8 to the commissioner to pay the actual
 104.9 costs of providing for increased eligibility
 104.10 determinations, caseload-related costs, timely
 104.11 application processing, and quality control.
 104.12 Of these funds, 20 percent shall be allocated
 104.13 to the commissioner and 80 percent shall
 104.14 be allocated to counties. The commissioner
 104.15 shall allocate the county portion based
 104.16 on recent caseload. Reimbursement shall
 104.17 be based on actual costs reported by
 104.18 counties through existing processes. Tribal
 104.19 reimbursement must be made from the state
 104.20 portion, based on a caseload factor equivalent
 104.21 to that of a county.

104.22 **Subd. 2. Agency Management**

104.23 **(a) Financial Operations** -0- 103,000

104.24 **Base Adjustment.** The general fund base is
 104.25 decreased by \$3,292,000 in fiscal year 2012
 104.26 and \$3,292,000 in fiscal year 2013.

104.27 **(b) Legal and Regulatory Operations** -0- (286,000)

104.28 **Moratorium of Premium Payments.** For
 104.29 fiscal year 2011, there shall be a moratorium
 104.30 on payments made by the commissioner
 104.31 to the Minnesota Joint Underwriting
 104.32 Association for personal injury liability
 104.33 insurance for providers under Minnesota
 104.34 Statutes, section 245.814. Notwithstanding
 104.35 Minnesota Statutes, section 62I.16, the

105.1 Minnesota Joint Underwriting Association
 105.2 shall continue to insure the providers under
 105.3 Minnesota Statutes, section 245.814. In
 105.4 fiscal year 2011, the amount of the general
 105.5 fund appropriation allocated to payments
 105.6 under Minnesota Statutes, section 245.814,
 105.7 is reduced by \$400,000. This is a onetime
 105.8 reduction in fiscal year 2011.

105.9 **Base Adjustment.** The general fund base
 105.10 is increased by \$382,000 in fiscal year 2012
 105.11 and \$382,000 in fiscal year 2013.

105.12 <u>(c) Management Operations</u>	<u>-0-</u>	<u>(114,000)</u>
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105.13 **Base Adjustment.** The general fund base is
 105.14 increased by \$18,000 in fiscal year 2012 and
 105.15 \$18,000 in fiscal year 2013.

105.16 <u>Subd. 3. Revenue and Pass-Through Revenue</u>		
105.17 <u>Expenditures</u>	<u>11,464,000</u>	<u>20,000,000</u>

105.18 These appropriations are from the federal
 105.19 TANF fund.

105.20 **Child Care Development Fund**

105.21 **Unexpended Balance.** In addition to
 105.22 the amount provided in this section, the
 105.23 commissioner shall carry over and expend
 105.24 in fiscal year 2011 \$7,500,000 of the TANF
 105.25 funds transferred in fiscal year 2010 that
 105.26 reflect the child care and development fund
 105.27 unexpended balance for the basic sliding
 105.28 fee child care assistance program under
 105.29 Minnesota Statutes, section 119B.03. The
 105.30 commissioner shall ensure that all funds are
 105.31 expended according to the federal child care
 105.32 and development fund regulations relating to
 105.33 the TANF transfers.

106.1 **Base Adjustment.** The general fund base is
106.2 increased by \$7,500,000 in fiscal year 2012
106.3 and \$7,500,000 in fiscal year 2013.

106.4 **TANF Transfer Correction.**

106.5 Notwithstanding any provisions of
106.6 Laws 2009, chapter 79, article 13, section 3,
106.7 subdivision 3, as amended by Laws 2009,
106.8 chapter 173, article 2, section 1, subdivision
106.9 3, the following TANF fund amounts are
106.10 appropriated to the commissioner for the
106.11 purposes of MFIP and transition year child
106.12 care under Minnesota Statutes, section
106.13 119B.05:

106.14 (1) fiscal year 2010, \$862,000;

106.15 (2) fiscal year 2011, \$978,000;

106.16 (3) fiscal year 2012, \$0; and

106.17 (4) fiscal year 2013, \$0.

106.18 Notwithstanding any contrary provision in
106.19 this article, this paragraph expires on June
106.20 30, 2013.

106.21 **Subd. 4. Economic Support Grants**

106.22 **(a) Support Services Grants** -0- -0-

106.23 **Base Adjustment.** The federal TANF fund
106.24 base is decreased by \$5,004,000 in fiscal year
106.25 2012 and \$5,004,000 in fiscal year 2013.

106.26 **(b) MFIP Child Care Assistance Grants** -0- 433,000

106.27 **Base Adjustment.** The general fund base is
106.28 increased by \$94,000 in fiscal year 2012 and
106.29 \$24,000 in fiscal year 2013.

106.30 **(c) Basic Sliding Fee Child Care Assistance**
106.31 **Grants**

107.1	<u>Appropriations by Fund</u>		
107.2	<u>General</u>	<u>-0-</u>	<u>(7,500,000)</u>
107.3	<u>Federal TANF</u>	<u>-0-</u>	<u>(5,014,000)</u>
107.4	<u>Base Adjustment.</u> <u>The general fund base</u>		
107.5	<u>is increased by \$2,699,000 in fiscal year</u>		
107.6	<u>2012 and \$2,699,000 in fiscal year 2013.</u>		
107.7	<u>The federal TANF fund base is increased</u>		
107.8	<u>by \$5,014,000 in fiscal year 2012 and</u>		
107.9	<u>\$5,014,000 in fiscal year 2013.</u>		
107.10	<u>(d) Child and Community Services Grants</u>	<u>-0-</u>	<u>(10,700,000)</u>
107.11	<u>This is a onetime reduction in fiscal year</u>		
107.12	<u>2011.</u>		
107.13	<u>(e) Group Residential Housing Grants</u>	<u>-0-</u>	<u>-0-</u>
107.14	<u>Reduction of Supplemental Service Rate.</u>		
107.15	<u>Effective July 1, 2011, to June 30, 2013,</u>		
107.16	<u>the commissioner shall decrease the group</u>		
107.17	<u>residential housing supplementary service</u>		
107.18	<u>rate under Minnesota Statutes, section</u>		
107.19	<u>256I.05, subdivision 1a, by five percent</u>		
107.20	<u>for services rendered on or after that date,</u>		
107.21	<u>except that reimbursement rates for a group</u>		
107.22	<u>residential housing facility reimbursed as a</u>		
107.23	<u>nursing facility shall not be reduced. The</u>		
107.24	<u>reduction in this paragraph is in addition to</u>		
107.25	<u>the reduction under Laws 2009, chapter 79,</u>		
107.26	<u>article 8, section 79, paragraph (b), clause</u>		
107.27	<u>(11).</u>		
107.28	<u>Base Adjustment.</u> <u>The general fund base is</u>		
107.29	<u>decreased by \$700,000 in fiscal year 2012</u>		
107.30	<u>and \$700,000 in fiscal year 2013.</u>		
107.31	<u>(f) Children's Mental Health Grants</u>	<u>(200,000)</u>	<u>(200,000)</u>
107.32	<u>(g) Other Children's and Economic Assistance</u>		
107.33	<u>Grants</u>	<u>-0-</u>	<u>-0-</u>

108.1 **Base Adjustment.** The general fund base is
 108.2 increased by \$130,000 in fiscal year 2012 and
 108.3 decreased by \$360,000 in fiscal year 2013.

108.4 **Subd. 5. Children and Economic Assistance**
 108.5 **Management**

108.6 **(a) Children and Economic Assistance**
 108.7 **Administration** -0- -0-

108.8 **Base Adjustment.** The federal TANF fund
 108.9 base is decreased by \$700,000 in fiscal year
 108.10 2012 and \$700,000 in fiscal year 2013.

108.11 **(b) Children and Economic Assistance**
 108.12 **Operations** -0- 196,000

108.13 **Base Adjustment.** The general fund base is
 108.14 decreased by \$13,000 in fiscal year 2012 and
 108.15 \$13,000 in fiscal year 2013.

108.16 **Subd. 6. Health Care Grants**

108.17 **(a) MinnesotaCare Grants** 998,000 15,312,000

108.18 This appropriation is from the health care
 108.19 access fund.

108.20 **Health Care Access Fund Transfer to**
 108.21 **General Fund.** The commissioner of
 108.22 management and budget shall transfer
 108.23 \$998,000 in fiscal year 2010 and
 108.24 \$217,265,000 in fiscal year 2011 from the
 108.25 health care access fund to the general fund.

108.26 This paragraph is effective the day following
 108.27 final enactment.

108.28 The base for this transfer is \$262,647,000 in
 108.29 fiscal year 2012 and \$174,772,000 in fiscal
 108.30 year 2013.

108.31 **MinnesotaCare Ratable Reduction.**
 108.32 Effective for services rendered on or
 108.33 after July 1, 2010, to December 31, 2013,
 108.34 MinnesotaCare payments to managed care

109.1 plans under Minnesota Statutes, section
 109.2 256L.12, for single adults and households
 109.3 without children whose income is greater
 109.4 than 75 percent of federal poverty guidelines
 109.5 shall be reduced by ten percent. Managed
 109.6 care plans shall not pass these payment
 109.7 reductions on to providers. Notwithstanding
 109.8 any contrary provision of this article, this
 109.9 paragraph shall expire on December 31,
 109.10 2013.

109.11 **(b) Medical Assistance Basic Health Care**
 109.12 **Grants - Families and Children**

109.13	<u>Appropriations by Fund</u>		
109.14	<u>General</u>	<u>-0-</u>	<u>(7,631,000)</u>
109.15	<u>Health Care Access</u>	<u>-0-</u>	<u>7,714,000</u>

109.16 **Critical Access Dental.** Of the general
 109.17 fund appropriation, \$731,000 in fiscal year
 109.18 2011 is to the commissioner for critical
 109.19 access dental provider reimbursement
 109.20 payments under Minnesota Statutes, section
 109.21 256B.76 subdivision 4. This is a onetime
 109.22 appropriation.

109.23 **Nonadministrative Rate Reduction.** For
 109.24 services rendered on or after July 1, 2010,
 109.25 to December 31, 2013, the commissioner
 109.26 shall reduce contract rates paid to managed
 109.27 care plans under Minnesota Statutes, sections
 109.28 256B.69 and 256L.12, and to county-based
 109.29 purchasing plans under Minnesota Statutes,
 109.30 section 256B.692, by three percent of the
 109.31 contract rate attributable to nonadministrative
 109.32 services in effect on June 30, 2010. Managed
 109.33 care plans shall not pass these rate reductions
 109.34 on to providers. Notwithstanding any
 109.35 contrary provision in this article, this rider
 109.36 expires on December 31, 2013.

110.1 (c) Medical Assistance Basic Health Care
110.2 Grants - Elderly and Disabled

110.3 Appropriations by Fund

110.4 General -0- (3,877,000)

110.5 Health Care Access -0- 4,319,000

110.6 MnDHO Transition. Of the general fund
110.7 appropriation for fiscal year 2011, \$250,000
110.8 is to the commissioner to be made available
110.9 to county agencies to assist in the transition
110.10 of the approximately 1,290 current MnDHO
110.11 members to the fee-for-service Medicaid
110.12 program or another managed care option by
110.13 January 1, 2011.

110.14 County agencies shall work with the
110.15 commissioner, health plans, and MnDHO
110.16 members and their legal representatives to
110.17 develop and implement transition plans that
110.18 include:

110.19 (1) identification of service needs of MnDHO
110.20 members based on the current assessment or
110.21 through the completion of a new assessment;

110.22 (2) identification of services currently
110.23 provided to MnDHO members and which
110.24 of those services will continue to be
110.25 reimbursable through fee-for-service
110.26 or another managed care option under
110.27 the Medicaid state plan or a home and
110.28 community-based waiver program;

110.29 (3) identification of service providers who do
110.30 not have a contract with the county or who
110.31 are currently reimbursed at a different rate
110.32 than the county contracted rate; and

110.33 (4) development of an individual service
110.34 plan that is within allowable waiver funding
110.35 limits.

111.1	<u>(d) General Assistance Medical Care Grants</u>	<u>-0-</u>	<u>(83,689,000)</u>
111.2	<u>(e) Other Health Care Grants</u>	<u>-0-</u>	<u>-0-</u>
111.3	<u>Cobra Carryforward.</u> <u>Unexpended funds</u>		
111.4	<u>appropriated in fiscal year 2010 for COBRA</u>		
111.5	<u>grants under Laws 2009, chapter 79, article</u>		
111.6	<u>5, section 78, do not cancel and are available</u>		
111.7	<u>to the commissioner for fiscal year 2011</u>		
111.8	<u>COBRA grant expenditures. Up to \$111,000</u>		
111.9	<u>of the fiscal year 2011 appropriation for</u>		
111.10	<u>COBRA grants provided in Laws 2009,</u>		
111.11	<u>chapter 79, article 13, section 3, subdivision</u>		
111.12	<u>6, may be used by the commissioner for costs</u>		
111.13	<u>related to administration of the COBRA</u>		
111.14	<u>grants.</u>		
111.15	<u>(f) Medical Assistance Health Care Grants;</u>		
111.16	<u>Adults Without Children</u>	<u>9,794,000</u>	<u>350,696,000</u>
111.17	<u>Medical Assistance Expansion.</u> <u>If the</u>		
111.18	<u>commissioner is not able to implement</u>		
111.19	<u>the medical assistance expansion for</u>		
111.20	<u>single adults under Minnesota Statutes,</u>		
111.21	<u>section 256B.055, subdivision 15, by June</u>		
111.22	<u>1, 2010, the commissioner shall make</u>		
111.23	<u>medical assistance payments to providers</u>		
111.24	<u>retroactively to June 1, 2010.</u>		
111.25	<u>Subd. 7. Health Care Management</u>		
111.26	<u>(a) Health Care Administration</u>	<u>-0-</u>	<u>218,000</u>
111.27	<u>Minnesota Senior Health Options</u>		
111.28	<u>Reimbursement.</u> <u>Effective July 1, 2011,</u>		
111.29	<u>federal administrative reimbursement</u>		
111.30	<u>resulting from the Minnesota senior</u>		
111.31	<u>health options project is appropriated</u>		
111.32	<u>to the commissioner for this activity.</u>		
111.33	<u>Notwithstanding any contrary provision, this</u>		
111.34	<u>provision expires June 30, 2013.</u>		

112.1 **Utilization Review.** Effective July 1,
 112.2 2011, federal administrative reimbursement
 112.3 resulting from prior authorization and
 112.4 inpatient admission certification by a
 112.5 professional review organization shall be
 112.6 dedicated to, and is appropriated to, the
 112.7 commissioner for these activities. A portion
 112.8 of these funds must be used for activities
 112.9 to decrease unnecessary pharmaceutical
 112.10 costs in medical assistance. Notwithstanding
 112.11 any contrary provision of this article, this
 112.12 paragraph expires June 30, 2013.

112.13 **Reporting Compliance.** The entities named
 112.14 in Minnesota Statutes, section 256B.199,
 112.15 paragraph (b), clause (1), shall comply with
 112.16 the requirements of that statute by promptly
 112.17 reporting on a quarterly basis certified public
 112.18 expenditures that may qualify for federal
 112.19 matching funds.

112.20 **Base Adjustment.** The general fund base is
 112.21 decreased by \$172,000 in fiscal year 2012
 112.22 and \$172,000 in fiscal year 2013.

112.23 **(b) Health Care Operations**

	<u>Appropriations by Fund</u>	
112.24		
112.25	<u>General</u>	<u>-0- 177,000</u>
112.26	<u>Health Care Access</u>	<u>-0- 150,000</u>

112.27 The general fund appropriation is a onetime
 112.28 appropriation in fiscal year 2011.

112.29 **Base Adjustment.** The health care access
 112.30 fund base for health care operations is
 112.31 decreased by \$755,000 in fiscal year 2012
 112.32 and \$893,000 in fiscal year 2013.

112.33 **Subd. 8. Continuing Care Grants**

112.34 **(a) Aging and Adult Services Grants** -0- (937,000)

113.1 **Base Adjustment.** The general fund base for
 113.2 aging and adult services grants is increased
 113.3 by \$1,124,000 in fiscal year 2012 and
 113.4 \$1,126,000 in fiscal year 2013.

113.5 **(b) Medical Assistance Long-Term Care**
 113.6 **Facilities Grants** -0- 10,173,000

113.7 **Variable Rate Adjustments.** Of this
 113.8 appropriation, \$683,000 in fiscal year 2011
 113.9 is to the commissioner for variable rate
 113.10 adjustments under Minnesota Statutes,
 113.11 section 256B.5013, subdivision 1, for
 113.12 services provided on or after July 1,
 113.13 2010, to June 30, 2011. This is a onetime
 113.14 appropriation.

113.15 **(c) Medical Assistance Long-Term Care**
 113.16 **Waivers and Home Care Grants** -0- (4,515,000)

113.17 **Manage Growth in Traumatic Brain**
 113.18 **Injury and Community Alternatives for**
 113.19 **Disabled Individuals Waivers.** During
 113.20 the fiscal year beginning July 1, 2010, the
 113.21 commissioner shall allocate money for home
 113.22 and community-based waiver programs
 113.23 under Minnesota Statutes, section 256B.49,
 113.24 to ensure a reduction in state spending that is
 113.25 equivalent to limiting the caseload growth
 113.26 of the TBI waiver to six allocations per
 113.27 month and the CADI waiver to 60 allocations
 113.28 per month. The limits do not apply: (1)
 113.29 when there is an approved plan for nursing
 113.30 facility bed closures for individuals under
 113.31 age 65 who require relocation due to the
 113.32 bed closure; (2) to fiscal year 2009 waiver
 113.33 allocations delayed due to unallotment; or (3)
 113.34 to transfers authorized by the commissioner
 113.35 from the personal care assistance program
 113.36 of individuals having a home care rating of

114.1 CS, MT, or HL. Priorities for the allocation
 114.2 of funds must be for individuals anticipated
 114.3 to be discharged from institutional settings or
 114.4 who are at imminent risk of a placement in
 114.5 an institutional setting.

114.6 **Manage Growth in the Developmental**
 114.7 **Disability (DD) Waiver.** The commissioner
 114.8 shall manage the growth in the DD waiver
 114.9 by limiting the allocations included in the
 114.10 November 2010 forecast to six additional
 114.11 diversion allocations each month for the
 114.12 calendar year that begins on January 1,
 114.13 2011. Additional allocations must be
 114.14 made available for transfers authorized by
 114.15 the commissioner from the personal care
 114.16 assistance program of individuals having a
 114.17 home care rating of CS, MT, or HL. This
 114.18 provision is effective through December 31,
 114.19 2011.

114.20 **(d) Adult Mental Health Grants** (3,500,000) -0-

114.21 **Compulsive Gambling Lottery Prize**
 114.22 **Fund.** The lottery prize fund appropriation
 114.23 for compulsive gambling is reduced by
 114.24 \$80,000 in fiscal year 2010 and \$79,000 in
 114.25 fiscal year 2011. This is a onetime reduction.

114.26 **Compulsive Gambling Special Revenue**
 114.27 **Account.** \$149,000 for fiscal year 2010
 114.28 and \$27,000 for fiscal year 2011 from
 114.29 the compulsive gambling special revenue
 114.30 account established under Minnesota
 114.31 Statutes, section 245.982, shall be transferred
 114.32 and deposited into the general fund by June
 114.33 30 of each respective fiscal year.

114.34 **(e) Chemical Dependency Entitlement Grants** -0- (1,738,000)

115.1	<u>(f) Chemical Dependency Nonentitlement</u>		
115.2	<u>Grants</u>	<u>(389,000)</u>	<u>-0-</u>
115.3	<u>(g) Other Continuing Care Grants</u>	<u>-0-</u>	<u>250,000</u>
115.4	<u>This is a onetime appropriation in fiscal year</u>		
115.5	<u>2011.</u>		
115.6	<u>Subd. 9. Continuing Care Management</u>	<u>-0-</u>	<u>303,000</u>
115.7	<u>Base Adjustment.</u> <u>The general fund base for</u>		
115.8	<u>continuing care management is increased by</u>		
115.9	<u>\$107,000 in fiscal year 2012 and \$99,000 in</u>		
115.10	<u>fiscal year 2013.</u>		
115.11	<u>Subd. 10. State-Operated Services</u>		
115.12	<u>Obsolete Laundry Depreciation Account.</u>		
115.13	<u>\$669,000, or the balance, whichever is</u>		
115.14	<u>greater, must be transferred from the</u>		
115.15	<u>state-operated services laundry depreciation</u>		
115.16	<u>account in the special revenue fund and</u>		
115.17	<u>deposited into the general fund by June 30,</u>		
115.18	<u>2010.</u>		
115.19	<u>Operating Budget Reductions.</u> <u>No</u>		
115.20	<u>operating budget reductions enacted in Laws</u>		
115.21	<u>2010, chapter 200, or in this act shall be</u>		
115.22	<u>allocated to state-operated services.</u>		
115.23	<u>Prohibition on Commingling Funds.</u>		
115.24	<u>The commissioner shall not commingle</u>		
115.25	<u>state-operated services funds and mental</u>		
115.26	<u>health funds and grants. The appropriations</u>		
115.27	<u>to the commissioner for state-operated</u>		
115.28	<u>services and mental health services and</u>		
115.29	<u>grants must not be consolidated in any</u>		
115.30	<u>manner or transferred within the Department</u>		
115.31	<u>of Human Services, without specific</u>		
115.32	<u>legislative approval. Notwithstanding</u>		
115.33	<u>any contrary provision in this article, this</u>		
115.34	<u>paragraph shall not expire.</u>		

116.1 (a) Adult Mental Health Services -0- 6,888,000

116.2 Base Adjustment. The general fund base is
116.3 decreased by \$12,286,000 in fiscal year 2012
116.4 and \$12,394,000 in fiscal year 2013.

116.5 Appropriation Requirements. (a)
116.6 The general fund appropriation to the
116.7 commissioner includes funding for the
116.8 following:

116.9 (1) to a community collaborative to begin
116.10 providing crisis center services in the
116.11 Mankato area that are comparable to
116.12 the crisis services provided prior to the
116.13 closure of the Mankato Crisis Center. The
116.14 commissioner shall recruit former employees
116.15 of the Mankato Crisis Center who were
116.16 recently laid off to staff the new crisis
116.17 services. The commissioner shall obtain
116.18 legislative approval prior to discontinuing
116.19 this funding;

116.20 (2) to maintain the building in Eveleth
116.21 that currently houses community transition
116.22 services and to establish a psychiatric
116.23 intensive therapeutic foster home as an
116.24 enterprise activity. The commissioner shall
116.25 request a waiver amendment to allow CADI
116.26 funding for psychiatric intensive therapeutic
116.27 foster care services provided in the same
116.28 location and building as the community
116.29 transition services. If the federal government
116.30 does not approve the waiver amendment, the
116.31 commissioner shall continue to pay the lease
116.32 for the building out of the state-operated
116.33 services budget until the commissioner of
116.34 administration subleases the space or until
116.35 the lease expires, and shall establish the

117.1 psychiatric intensive therapeutic foster home
117.2 at a different site. The commissioner shall
117.3 make diligent efforts to sublease the space;
117.4 (3) to restaff, reopen, and operate the
117.5 community behavioral health hospital with
117.6 hospital level of care in Wadena until June
117.7 30, 2011. The collections associated with
117.8 this hospital continue to be submitted to
117.9 the general fund until June 30, 2011. The
117.10 commissioner shall develop a conversion
117.11 plan and may convert the community
117.12 behavioral health hospital to psychiatric
117.13 extensive recovery treatment services
117.14 after June 30, 2011. This is a onetime
117.15 appropriation and expires on June 30, 2011;
117.16 (4) to continue the operation of the dental
117.17 clinics in Brainerd, Cambridge, Faribault,
117.18 Fergus Falls, and Willmar at the same level of
117.19 care and staffing that was in effect on March
117.20 1, 2010. The commissioner shall not proceed
117.21 with the planned closure of the dental
117.22 clinics, and shall not discontinue services or
117.23 downsize any of the state-operated dental
117.24 clinics without specific legislative approval.
117.25 The commissioner shall continue to bill
117.26 for services provided to obtain medical
117.27 assistance critical access dental payments
117.28 and cost-based payment rates as provided
117.29 in Minnesota Statutes, section 256B.76,
117.30 subdivision 2, and shall bill for services
117.31 provided three months retroactively from
117.32 the date of this act. This appropriation is
117.33 onetime;
117.34 (5) to convert the Minnesota
117.35 Neurorehabilitation Hospital in Brainerd

118.1 to a neurocognitive psychiatric extensive
118.2 recovery treatment service; and

118.3 (6) to convert the Minnesota extended
118.4 treatment options (METO) program to
118.5 the following community-based services
118.6 provided by state employees: (i) psychiatric
118.7 extensive recovery treatment services;
118.8 (ii) intensive transitional foster homes
118.9 as enterprise activities; and (iii) other
118.10 community-based support services. The
118.11 provisions under Minnesota Statutes, section
118.12 252.025, subdivision 7, are applicable to
118.13 the METO services established under this
118.14 clause. Notwithstanding Minnesota Statutes,
118.15 section 246.18, subdivision 8, any revenue
118.16 lost to the general fund by the conversion
118.17 of METO to new services must be replaced
118.18 by revenue from the new services to offset
118.19 the lost revenue to the general fund until
118.20 June 30, 2013. Any revenue generated in
118.21 excess of this amount shall be deposited into
118.22 the special revenue fund under Minnesota
118.23 Statutes, section 246.18, subdivision 8.

118.24 (b) The commissioner shall not move beds
118.25 from the Anoka-Metro Regional Treatment
118.26 Center to the psychiatric nursing facility
118.27 at St. Peter without specific legislative
118.28 approval.

118.29 (c) The commissioner shall implement
118.30 changes, including the following, to save a
118.31 minimum of \$6,006,000 beginning in fiscal
118.32 year 2011, and report to the legislature the
118.33 specific initiatives implemented and the
118.34 savings allocated to each one, including:

119.1 (1) maximizing budget savings through
119.2 strategic employee staffing; and
119.3 (2) identifying and implementing cost
119.4 reductions in cooperation with state-operated
119.5 services employees.

119.6 Base level funding is reduced by \$6,006,000
119.7 effective fiscal year 2011.

119.8 (d) The commissioner shall seek certification
119.9 or approval from the federal government for
119.10 the new services under paragraph (a) that are
119.11 eligible for federal financial participation
119.12 and deposit the revenue associated with
119.13 these new services in the account established
119.14 under Minnesota Statutes, section 246.18,
119.15 subdivision 8, unless otherwise specified.

119.16 (e) Notwithstanding any contrary provision
119.17 in this article, this rider shall not expire.

119.18 (b) Minnesota Sex Offender Services -0- (289,000)

119.19 **Sex Offender Services.** Base level funding
119.20 for Minnesota sex offender services is
119.21 reduced by \$837,000 in fiscal year 2012 and
119.22 \$837,000 in fiscal year 2013 for the 50-bed
119.23 sex offender treatment program within the
119.24 Moose Lake correctional facility in which
119.25 Department of Human Services staff from
119.26 Minnesota sex offender services provide
119.27 clinical treatment to incarcerated offenders.
119.28 This reduction shall become part of the base
119.29 for the Department of Human Services.

119.30 **Interagency Agreements.** The
119.31 commissioner shall terminate by June
119.32 30, 2010, all interagency agreements with
119.33 the Department of Corrections to provide
119.34 chemical dependency treatment services.

121.1 **Rural Hospital Capital Improvement**

121.2 **Grants.** Of the general fund reductions in
121.3 fiscal year 2010, \$1,755,000 is from the rural
121.4 hospital capital improvement grant program.
121.5 This paragraph is effective the day following
121.6 final enactment.

121.7 **Base Level Adjustment.** The general fund
121.8 base is decreased by \$207,000 in fiscal year
121.9 2012 and \$207,000 in fiscal year 2013. The
121.10 state government special revenue fund base
121.11 is decreased by \$2,000 in fiscal year 2012
121.12 and \$2,000 in fiscal year 2013.

121.13 **Comprehensive Advanced Life Support**

121.14 **Program.** Of the general fund appropriation,
121.15 \$377,000 in fiscal year 2011 is to the
121.16 commissioner for the comprehensive
121.17 advanced life support educational program.
121.18 For fiscal year 2012, base level funding for
121.19 this program shall be \$377,000.

121.20 **Birth Centers.** Of the appropriation in fiscal
121.21 year 2011 from the state government special
121.22 revenue fund, \$9,000 is to the commissioner
121.23 to license birth centers. Base level funding
121.24 for this activity shall be \$7,000 in fiscal year
121.25 2012 and \$7,000 in fiscal year 2013.

121.26 **Office of Unlicensed Health Care Practice.**

121.27 Of the general fund appropriation, \$74,000
121.28 in fiscal year 2011 is for the Office of
121.29 Unlicensed Complementary and Alternative
121.30 Health Care Practice. This is a onetime
121.31 appropriation.

121.32 **Section 125 Plans.** The remaining balance
121.33 from the Laws 2008, chapter 358, article 5,
121.34 section 4, subdivision 3, appropriation for

122.1	<u>Section 125 Plan Employer Incentives is</u>		
122.2	<u>canceled.</u>		
122.3	<u>Advisory Group on Administrative</u>		
122.4	<u>Expenses.</u> <u>Of the health care access fund</u>		
122.5	<u>appropriation for fiscal year 2011, \$39,000 is</u>		
122.6	<u>to the commissioner for the advisory group</u>		
122.7	<u>established under Minnesota Statutes, section</u>		
122.8	<u>62D.31. This is a onetime appropriation.</u>		
122.9	<u>Subd. 4. Health Protection</u>	<u>(349,000)</u>	<u>985,000</u>
122.10	<u>Base Adjustment.</u> <u>The general fund base</u>		
122.11	<u>is increased by \$194,000 in fiscal year 2012</u>		
122.12	<u>and \$738,000 in fiscal year 2013.</u>		
122.13	<u>Birth Defects Information System.</u> <u>Of the</u>		
122.14	<u>general fund appropriation for fiscal year</u>		
122.15	<u>2011, \$1,165,000 is for the Minnesota Birth</u>		
122.16	<u>Defects Information System established</u>		
122.17	<u>under Minnesota Statutes, section 144.2215.</u>		
122.18	<u>Subd. 5. Administrative Support Services</u>	<u>-0-</u>	<u>(100,000)</u>
122.19	<u>The general fund base is reduced by \$22,000</u>		
122.20	<u>in fiscal year 2012 and \$22,000 in fiscal year</u>		
122.21	<u>2013.</u>		
122.22	<u>Sec. 5. DEPARTMENT OF VETERANS</u>		
122.23	<u>AFFAIRS</u>	<u>\$ (50,000) \$</u>	<u>-0-</u>
122.24	<u>Cancellation of Prior Appropriation.</u>		
122.25	<u>By June 30, 2010, the commissioner of</u>		
122.26	<u>management and budget shall cancel the</u>		
122.27	<u>\$50,000 appropriation for fiscal year 2008 to</u>		
122.28	<u>the board in Laws 2007, chapter 147, article</u>		
122.29	<u>19, section 5, in the paragraph titled "Pay for</u>		
122.30	<u>Performance."</u>		
122.31	<u>Sec. 6. HEALTH-RELATED BOARDS</u>		
122.32	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 113,000 \$</u>	<u>615,000</u>

123.1 The appropriations in this section are from
 123.2 the state government special revenue fund.

123.3 The transfers in this section are onetime in
 123.4 the fiscal year 2010-2011 biennium.

123.5 The appropriations for each purpose are
 123.6 shown in the following subdivisions.

123.7 **Transfers.** In addition to transfers required
 123.8 under Laws 2009, chapter 79, article 13,
 123.9 section 5, subdivision 1, \$301,000 in fiscal
 123.10 year 2010 and \$442,000 in fiscal year
 123.11 2011 shall be transferred from the state
 123.12 government special revenue fund to the
 123.13 general fund. The boards must allocate
 123.14 this reduction to boards carrying a positive
 123.15 balance as of July 1, 2009.

123.16 <u>Subd. 2. Board of Marriage and Family</u>		
123.17 <u>Therapy</u>	<u>47,000</u>	<u>22,000</u>

123.18 **Operating Costs and Rulemaking.** Of
 123.19 this appropriation, \$22,000 in fiscal year
 123.20 2010 and \$22,000 in fiscal year 2011 are
 123.21 for operating costs. This is an ongoing
 123.22 appropriation. Of this appropriation, \$25,000
 123.23 in fiscal year 2010 is for rulemaking. This is
 123.24 a onetime appropriation.

123.25 <u>Subd. 3. Board of Nursing Home</u>		
123.26 <u>Administrators</u>	<u>51,000</u>	<u>61,000</u>

123.27 <u>Subd. 4. Board of Pharmacy</u>	<u>-0-</u>	<u>517,000</u>
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123.28 **Prescription Electronic Reporting.** Of
 123.29 the state government special revenue fund
 123.30 appropriation, \$517,000 in fiscal year 2011
 123.31 is to the board to operate the prescription
 123.32 electronic reporting system in Minnesota
 123.33 Statutes, section 152.126. Base level funding
 123.34 for this activity in fiscal year 2012 shall be
 123.35 \$356,000.

124.1	<u>Subd. 5. Board of Podiatry</u>		<u>15,000</u>	<u>15,000</u>
124.2	<u>Purpose. This appropriation is to pay health</u>			
124.3	<u>insurance coverage costs and to cover the</u>			
124.4	<u>cost of expert witnesses in disciplinary cases.</u>			
124.5	<u>This is a onetime appropriation.</u>			
124.6	<u>Subd. 6. Board of Dentistry</u>			
124.7	<u>Dental Therapy Program. Of the</u>			
124.8	<u>appropriation to the Board of Dentistry in</u>			
124.9	<u>Laws 2009, chapter 95, article 1, section 7,</u>			
124.10	<u>for fiscal year 2010, \$12,500 shall be awarded</u>			
124.11	<u>as a grant to the University of Minnesota</u>			
124.12	<u>School of Dentistry for the implementation</u>			
124.13	<u>of the university's dental therapy program</u>			
124.14	<u>and \$12,500 shall be awarded as a grant to</u>			
124.15	<u>Minnesota State Colleges and Universities</u>			
124.16	<u>for the implementation of Metropolitan State</u>			
124.17	<u>University's and Normandale Community</u>			
124.18	<u>College's advanced dental therapy program.</u>			
124.19	<u>Sec. 7. EMERGENCY MEDICAL SERVICES</u>			
124.20	<u>BOARD</u>	<u>\$</u>	<u>215,000</u>	<u>\$ (382,000)</u>
124.21	<u>Appropriation Transfer Repeal. Any</u>			
124.22	<u>portion of the \$250,000 appropriation in</u>			
124.23	<u>Laws 2009, chapter 79, article 13, section</u>			
124.24	<u>6, as amended by Laws 2009, chapter</u>			
124.25	<u>173, article 2, section 4, not yet expended</u>			
124.26	<u>or encumbered by the Department of</u>			
124.27	<u>Public Safety for a medical response unit</u>			
124.28	<u>reimbursement pilot program, estimated to</u>			
124.29	<u>be \$235,000, must be retained by or returned</u>			
124.30	<u>to the Emergency Medical Services Board to</u>			
124.31	<u>be spent for board purposes. This section is</u>			
124.32	<u>effective the day following final enactment.</u>			
124.33	<u>Sec. 8. UNIVERSITY OF MINNESOTA</u>	<u>\$</u>	<u>-0-</u>	<u>\$ 93,000</u>

125.1 This appropriation is from the special
125.2 revenue fund for the couples on the brink
125.3 program.

125.4 Sec. 9. **DEPARTMENT OF CORRECTIONS** \$ -0- \$ -0-

125.5 **Sex Offender Services.** From the general
125.6 fund appropriations to the commissioner
125.7 of corrections, the commissioner shall
125.8 transfer \$837,000 each year of the
125.9 biennium beginning on July 1, 2011, to the
125.10 commissioner of human services to provide
125.11 clinical treatment to incarcerated offenders.
125.12 This transfer shall become part of the base
125.13 for the Department of Corrections.

125.14 Sec. 10. **DEPARTMENT OF COMMERCE** \$ -0- \$ 19,000

125.15 **Health Plan Filings.** This appropriation is
125.16 for the review and approval of new health
125.17 plan filings due to Minnesota Statutes, section
125.18 62Q.545. This is a onetime appropriation in
125.19 fiscal year 2011.

125.20 Sec. 11. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

125.21 Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds
125.22 appropriated for this program, the administrative services unit must purchase medical
125.23 professional liability insurance, if available, for a health care provider who is registered in
125.24 accordance with subdivision 4 and who is not otherwise covered by a medical professional
125.25 liability insurance policy or self-insured plan either personally or through another facility
125.26 or employer. The administrative services unit is authorized to prorate payments or
125.27 otherwise limit the number of participants in the program if the costs of the insurance for
125.28 eligible providers exceed the funds appropriated for the program.

125.29 (b) Coverage purchased under this subdivision must be limited to the provision of
125.30 health care services performed by the provider for which the provider does not receive
125.31 direct monetary compensation.

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

127.1 available for ongoing development and
127.2 operations. Any computer project with a
127.3 total cost exceeding \$1,000,000, including,
127.4 but not limited to, a replacement for the
127.5 proposed HealthMatch system, shall not be
127.6 commenced without the express approval of
127.7 the legislature.

127.8 **HealthMatch Systems Project.** In fiscal
127.9 year 2010, \$3,054,000 shall be transferred
127.10 from the HealthMatch account in the state
127.11 systems account in the special revenue fund
127.12 to the general fund.

127.13 **Nonfederal Share Transfers.** The
127.14 nonfederal share of activities for which
127.15 federal administrative reimbursement is
127.16 appropriated to the commissioner may be
127.17 transferred to the special revenue fund.

127.18 **TANF Maintenance of Effort.**

127.19 (a) In order to meet the basic maintenance
127.20 of effort (MOE) requirements of the TANF
127.21 block grant specified under Code of Federal
127.22 Regulations, title 45, section 263.1, the
127.23 commissioner may only report nonfederal
127.24 money expended for allowable activities
127.25 listed in the following clauses as TANF/MOE
127.26 expenditures:

127.27 (1) MFIP cash, diversionary work program,
127.28 and food assistance benefits under Minnesota
127.29 Statutes, chapter 256J;

127.30 (2) the child care assistance programs
127.31 under Minnesota Statutes, sections 119B.03
127.32 and 119B.05, and county child care
127.33 administrative costs under Minnesota
127.34 Statutes, section 119B.15;

128.1 (3) state and county MFIP administrative
128.2 costs under Minnesota Statutes, chapters
128.3 256J and 256K;

128.4 (4) state, county, and tribal MFIP
128.5 employment services under Minnesota
128.6 Statutes, chapters 256J and 256K;

128.7 (5) expenditures made on behalf of
128.8 noncitizen MFIP recipients who qualify
128.9 for the medical assistance without federal
128.10 financial participation program under
128.11 Minnesota Statutes, section 256B.06,
128.12 subdivision 4, paragraphs (d), (e), and (j);
128.13 ~~and~~

128.14 (6) qualifying working family credit
128.15 expenditures under Minnesota Statutes,
128.16 section 290.0671; and

128.17 (7) qualifying Minnesota education credit
128.18 expenditures under Minnesota Statutes,
128.19 section 290.0674.

128.20 (b) The commissioner shall ensure that
128.21 sufficient qualified nonfederal expenditures
128.22 are made each year to meet the state's
128.23 TANF/MOE requirements. For the activities
128.24 listed in paragraph (a), clauses (2) to
128.25 (6), the commissioner may only report
128.26 expenditures that are excluded from the
128.27 definition of assistance under Code of
128.28 Federal Regulations, title 45, section 260.31.

128.29 (c) For fiscal years beginning with state
128.30 fiscal year 2003, the commissioner shall
128.31 ensure that the maintenance of effort used
128.32 by the commissioner of finance for the
128.33 February and November forecasts required
128.34 under Minnesota Statutes, section 16A.103,
128.35 contains expenditures under paragraph (a),

129.1 clause (1), equal to at least 16 percent of
129.2 the total required under Code of Federal
129.3 Regulations, title 45, section 263.1.

129.4 (d) For the federal fiscal years beginning on
129.5 or after October 1, 2007, the commissioner
129.6 may not claim an amount of TANF/MOE in
129.7 excess of the 75 percent standard in Code
129.8 of Federal Regulations, title 45, section
129.9 263.1(a)(2), except:

129.10 (1) to the extent necessary to meet the 80
129.11 percent standard under Code of Federal
129.12 Regulations, title 45, section 263.1(a)(1),
129.13 if it is determined by the commissioner
129.14 that the state will not meet the TANF work
129.15 participation target rate for the current year;

129.16 (2) to provide any additional amounts
129.17 under Code of Federal Regulations, title 45,
129.18 section 264.5, that relate to replacement of
129.19 TANF funds due to the operation of TANF
129.20 penalties; and

129.21 (3) to provide any additional amounts that
129.22 may contribute to avoiding or reducing
129.23 TANF work participation penalties through
129.24 the operation of the excess MOE provisions
129.25 of Code of Federal Regulations, title 45,
129.26 section 261.43 (a)(2).

129.27 For the purposes of clauses (1) to (3),
129.28 the commissioner may supplement the
129.29 MOE claim with working family credit
129.30 expenditures to the extent such expenditures
129.31 or other qualified expenditures are otherwise
129.32 available after considering the expenditures
129.33 allowed in this section.

129.34 (e) Minnesota Statutes, section 256.011,
129.35 subdivision 3, which requires that federal

130.1 grants or aids secured or obtained under that
130.2 subdivision be used to reduce any direct
130.3 appropriations provided by law, do not apply
130.4 if the grants or aids are federal TANF funds.

130.5 (f) Notwithstanding any contrary provision
130.6 in this article, this provision expires June 30,
130.7 2013.

130.8 **Working Family Credit Expenditures as**
130.9 **TANF/MOE.** The commissioner may claim
130.10 as TANF/MOE up to \$6,707,000 per year of
130.11 working family credit expenditures for fiscal
130.12 year 2010 through fiscal year 2011.

130.13 **Working Family Credit Expenditures**
130.14 **to be Claimed for TANF/MOE.** The
130.15 commissioner may count the following
130.16 amounts of working family credit expenditure
130.17 as TANF/MOE:

130.18 (1) fiscal year 2010, ~~\$50,973,000~~
130.19 \$50,897,000;

130.20 (2) fiscal year 2011, ~~\$53,793,000~~
130.21 \$54,243,000;

130.22 (3) fiscal year 2012, ~~\$23,516,000~~
130.23 \$23,345,000; and

130.24 (4) fiscal year 2013, ~~\$16,808,000~~
130.25 \$16,585,000.

130.26 Notwithstanding any contrary provision in
130.27 this article, this rider expires June 30, 2013.

130.28 **Food Stamps Employment and Training.**

130.29 (a) The commissioner shall apply for and
130.30 claim the maximum allowable federal
130.31 matching funds under United States Code,
130.32 title 7, section 2025, paragraph (h), for
130.33 state expenditures made on behalf of family
130.34 stabilization services participants voluntarily

131.1 engaged in food stamp employment and
131.2 training activities, where appropriate.

131.3 (b) Notwithstanding Minnesota Statutes,
131.4 sections 256D.051, subdivisions 1a, 6b,
131.5 and 6c, and 256J.626, federal food stamps
131.6 employment and training funds received
131.7 as reimbursement of MFIP consolidated
131.8 fund grant expenditures for diversionary
131.9 work program participants and child
131.10 care assistance program expenditures for
131.11 two-parent families must be deposited in the
131.12 general fund. The amount of funds must be
131.13 limited to \$3,350,000 in fiscal year 2010
131.14 and \$4,440,000 in fiscal years 2011 through
131.15 2013, contingent on approval by the federal
131.16 Food and Nutrition Service.

131.17 (c) Consistent with the receipt of these federal
131.18 funds, the commissioner may adjust the
131.19 level of working family credit expenditures
131.20 claimed as TANF maintenance of effort.
131.21 Notwithstanding any contrary provision in
131.22 this article, this rider expires June 30, 2013.

131.23 **ARRA Food Support Administration.**

131.24 The funds available for food support
131.25 administration under the American Recovery
131.26 and Reinvestment Act (ARRA) of 2009
131.27 are appropriated to the commissioner
131.28 to pay actual costs of implementing the
131.29 food support benefit increases, increased
131.30 eligibility determinations, and outreach. Of
131.31 these funds, 20 percent shall be allocated
131.32 to the commissioner and 80 percent shall
131.33 be allocated to counties. The commissioner
131.34 shall allocate the county portion based on
131.35 caseload. Reimbursement shall be based on

132.1 actual costs reported by counties through
132.2 existing processes. Tribal reimbursement
132.3 must be made from the state portion based
132.4 on a caseload factor equivalent to that of a
132.5 county.

132.6 **ARRA Food Support Benefit Increases.**

132.7 The funds provided for food support benefit
132.8 increases under the Supplemental Nutrition
132.9 Assistance Program provisions of the
132.10 American Recovery and Reinvestment Act
132.11 (ARRA) of 2009 must be used for benefit
132.12 increases beginning July 1, 2009.

132.13 **Emergency Fund for the TANF Program.**

132.14 TANF Emergency Contingency funds
132.15 available under the American Recovery
132.16 and Reinvestment Act of 2009 (Public Law
132.17 111-5) are appropriated to the commissioner.
132.18 The commissioner must request TANF
132.19 Emergency Contingency funds from the
132.20 Secretary of the Department of Health
132.21 and Human Services to the extent the
132.22 commissioner meets or expects to meet the
132.23 requirements of section 403(c) of the Social
132.24 Security Act. The commissioner must seek
132.25 to maximize such grants. The funds received
132.26 must be used as appropriated. Each county
132.27 must maintain the county's current level of
132.28 emergency assistance funding under the
132.29 MFIP consolidated fund and use the funds
132.30 under this paragraph to supplement existing
132.31 emergency assistance funding levels.

132.32 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
132.33 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

132.34 **Subd. 4. Children and Economic Assistance**
132.35 **Grants**

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

133.3 **(a) MFIP/DWP Grants**

133.4	Appropriations by Fund	
133.5	General	63,205,000 89,033,000
133.6	Federal TANF	100,818,000 84,538,000

133.7 **(b) Support Services Grants**

133.8	Appropriations by Fund	
133.9	General	8,715,000 12,498,000
133.10	Federal TANF	116,557,000 107,457,000

133.11 **MFIP Consolidated Fund.** The MFIP
133.12 consolidated fund TANF appropriation is
133.13 reduced by \$1,854,000 in fiscal year 2010
133.14 and fiscal year 2011.

133.15 Notwithstanding Minnesota Statutes, section
133.16 256J.626, subdivision 8, paragraph (b), the
133.17 commissioner shall reduce proportionately
133.18 the reimbursement to counties for
133.19 administrative expenses.

133.20 **Subsidized Employment Funding Through**
133.21 **ARRA.** The commissioner is authorized to
133.22 apply for TANF emergency fund grants for
133.23 subsidized employment activities. Growth
133.24 in expenditures for subsidized employment
133.25 within the supported work program and the
133.26 MFIP consolidated fund over the amount
133.27 expended in the calendar quarters in the
133.28 TANF emergency fund base year shall be
133.29 used to leverage the TANF emergency fund
133.30 grants for subsidized employment and to
133.31 fund supported work. The commissioner
133.32 shall develop procedures to maximize
133.33 reimbursement of these expenditures over the
133.34 TANF emergency fund base year quarters,
133.35 and may contract directly with employers

134.1 and providers to maximize these TANF
134.2 emergency fund grants.

134.3 **Supported Work.** Of the TANF
134.4 appropriation, \$4,700,000 in fiscal year 2010
134.5 and \$4,700,000 in fiscal year 2011 are to the
134.6 commissioner for supported work for MFIP
134.7 recipients and is available until expended.

134.8 Supported work includes paid transitional
134.9 work experience and a continuum of
134.10 employment assistance, including outreach
134.11 and recruitment, program orientation
134.12 and intake, testing and assessment, job
134.13 development and marketing, preworksite
134.14 training, supported worksite experience,
134.15 job coaching, and postplacement follow-up,
134.16 in addition to extensive case management
134.17 and referral services. This is a onetime
134.18 appropriation.

134.19 **Base Adjustment.** The general fund base
134.20 is reduced by \$3,783,000 in each of fiscal
134.21 years 2012 and 2013. The TANF fund base
134.22 is increased by \$5,004,000 in each of fiscal
134.23 years 2012 and 2013.

134.24 **Integrated Services Program Funding.**
134.25 The TANF appropriation for integrated
134.26 services program funding is \$1,250,000 in
134.27 fiscal year 2010 and \$0 in fiscal year 2011
134.28 and the base for fiscal years 2012 and 2013
134.29 is \$0.

134.30 **TANF Emergency Fund; Nonrecurrent**
134.31 **Short-Term Benefits.** (a) TANF emergency
134.32 contingency fund grants received due to
134.33 increases in expenditures for nonrecurrent
134.34 short-term benefits must be used to offset the
134.35 increase in these expenditures for counties

135.1 under the MFIP consolidated fund, under
135.2 Minnesota Statutes, section 256J.626,
135.3 and the diversionary work program. The
135.4 commissioner shall develop procedures
135.5 to maximize reimbursement of these
135.6 expenditures over the TANF emergency fund
135.7 base year quarters. Growth in expenditures
135.8 for the diversionary work program over the
135.9 amount expended in the calendar quarters in
135.10 the TANF emergency fund base year shall be
135.11 used to leverage these funds.

135.12 (b) To the extent that the commissioner
135.13 can claim eligible tax credit growth as
135.14 nonrecurrent short-term benefits, the
135.15 commissioner shall use those funds to
135.16 leverage the increased expenditures in
135.17 paragraph (a).

135.18 (c) TANF emergency funds for nonrecurrent
135.19 short-term benefits received in excess of the
135.20 amounts necessary for paragraphs (a) and (b)
135.21 shall be used to reimburse the general fund
135.22 for the costs of eligible tax credits in fiscal
135.23 year 2011. The amount of such funds shall
135.24 not exceed \$18,964,000 in fiscal year 2010.

135.25 (d) This rider is effective the day following
135.26 final enactment.

135.27 **(c) MFIP Child Care Assistance Grants** 61,171,000 65,214,000

135.28 **Acceleration of ARRA Child Care and**
135.29 **Development Fund Expenditure.** The
135.30 commissioner must liquidate all child care
135.31 and development money available under
135.32 the American Recovery and Reinvestment
135.33 Act (ARRA) of 2009, Public Law 111-5,
135.34 by September 30, 2010. In order to expend
135.35 those funds by September 30, 2010, the

136.1 commissioner may redesignate and expend
136.2 the ARRA child care and development funds
136.3 appropriated in fiscal year 2011 for purposes
136.4 under this section for related purposes that
136.5 will allow liquidation by September 30,
136.6 2010. Child care and development funds
136.7 otherwise available to the commissioner
136.8 for those related purposes shall be used to
136.9 fund the purposes from which the ARRA
136.10 child care and development funds had been
136.11 redesignated.

136.12 **School Readiness Service Agreements.**

136.13 \$400,000 in fiscal year 2010 and \$400,000
136.14 in fiscal year 2011 are from the federal
136.15 TANF fund to the commissioner of human
136.16 services consistent with federal regulations
136.17 for the purpose of school readiness service
136.18 agreements under Minnesota Statutes,
136.19 section 119B.231. This is a onetime
136.20 appropriation. Any unexpended balance the
136.21 first year is available in the second year.

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

40,100,000	45,092,000
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136.24 **School Readiness Service Agreements.**

136.25 \$257,000 in fiscal year 2010 and \$257,000
136.26 in fiscal year 2011 are from the general
136.27 fund for the purpose of school readiness
136.28 service agreements under Minnesota
136.29 Statutes, section 119B.231. This is a onetime
136.30 appropriation. Any unexpended balance the
136.31 first year is available in the second year.

136.32 **Child Care Development Fund**

136.33 **Unexpended Balance.** In addition to
136.34 the amount provided in this section, the
136.35 commissioner shall expend \$5,244,000 in
136.36 fiscal year 2010 from the federal child care

137.1 development fund unexpended balance
137.2 for basic sliding fee child care under
137.3 Minnesota Statutes, section 119B.03. The
137.4 commissioner shall ensure that all child
137.5 care and development funds are expended
137.6 according to the federal child care and
137.7 development fund regulations.

137.8 **Basic Sliding Fee.** \$4,000,000 in fiscal year
137.9 2010 and \$4,000,000 in fiscal year 2011 are
137.10 from the federal child care development
137.11 funds received from the American Recovery
137.12 and Reinvestment Act of 2009, Public
137.13 Law 111-5, to the commissioner of human
137.14 services consistent with federal regulations
137.15 for the purpose of basic sliding fee child care
137.16 assistance under Minnesota Statutes, section
137.17 119B.03. This is a onetime appropriation.
137.18 Any unexpended balance the first year is
137.19 available in the second year.

137.20 **Basic Sliding Fee Allocation for Calendar**
137.21 **Year 2010.** Notwithstanding Minnesota
137.22 Statutes, section 119B.03, subdivision 6,
137.23 in calendar year 2010, basic sliding fee
137.24 funds shall be distributed according to
137.25 this provision. Funds shall be allocated
137.26 first in amounts equal to each county's
137.27 guaranteed floor, according to Minnesota
137.28 Statutes, section 119B.03, subdivision 8,
137.29 with any remaining available funds allocated
137.30 according to the following formula:

137.31 (a) Up to one-fourth of the funds shall be
137.32 allocated in proportion to the number of
137.33 families participating in the transition year
137.34 child care program as reported during and
137.35 averaged over the most recent six months

138.1 completed at the time of the notice of
138.2 allocation. Funds in excess of the amount
138.3 necessary to serve all families in this category
138.4 shall be allocated according to paragraph (d).

138.5 (b) Up to three-fourths of the funds shall
138.6 be allocated in proportion to the average
138.7 of each county's most recent six months of
138.8 reported waiting list as defined in Minnesota
138.9 Statutes, section 119B.03, subdivision 2, and
138.10 the reinstatement list of those families whose
138.11 assistance was terminated with the approval
138.12 of the commissioner under Minnesota Rules,
138.13 part 3400.0183, subpart 1. Funds in excess
138.14 of the amount necessary to serve all families
138.15 in this category shall be allocated according
138.16 to paragraph (d).

138.17 (c) The amount necessary to serve all families
138.18 in paragraphs (a) and (b) shall be calculated
138.19 based on the basic sliding fee average cost of
138.20 care per family in the county with the highest
138.21 cost in the most recently completed calendar
138.22 year.

138.23 (d) Funds in excess of the amount necessary
138.24 to serve all families in paragraphs (a) and
138.25 (b) shall be allocated in proportion to each
138.26 county's total expenditures for the basic
138.27 sliding fee child care program reported
138.28 during the most recent fiscal year completed
138.29 at the time of the notice of allocation. To
138.30 the extent that funds are available, and
138.31 notwithstanding Minnesota Statutes, section
138.32 119B.03, subdivision 8, for the period
138.33 January 1, 2011, to December 31, 2011, each
138.34 county's guaranteed floor must be equal to its
138.35 original calendar year 2010 allocation.

139.1 **Base Adjustment.** The general fund base is
139.2 decreased by \$257,000 in each of fiscal years
139.3 2012 and 2013.

139.4 **(e) Child Care Development Grants** 1,487,000 1,487,000

139.5 **Family, friends, and neighbor grants.**

139.6 \$375,000 in fiscal year 2010 and \$375,000

139.7 in fiscal year 2011 are from the child

139.8 care development fund required targeted

139.9 quality funds for quality expansion and

139.10 infant/toddler from the American Recovery

139.11 and Reinvestment Act of 2009, Public

139.12 Law 111-5, to the commissioner of human

139.13 services for family, friends, and neighbor

139.14 grants under Minnesota Statutes, section

139.15 119B.232. This appropriation may be used

139.16 on programs receiving family, friends, and

139.17 neighbor grant funds as of June 30, 2009,

139.18 or on new programs or projects. This is a

139.19 onetime appropriation. Any unexpended

139.20 balance the first year is available in the

139.21 second year.

139.22 **Voluntary quality rating system training,**

139.23 **coaching, consultation, and supports.**

139.24 \$633,000 in fiscal year 2010 and \$633,000

139.25 in fiscal year 2011 are from the federal child

139.26 care development fund required targeted

139.27 quality funds for quality expansion and

139.28 infant/toddler from the American Recovery

139.29 and Reinvestment Act of 2009, Public

139.30 Law 111-5, to the commissioner of human

139.31 services consistent with federal regulations

139.32 for the purpose of providing grants to provide

139.33 statewide child-care provider training,

139.34 coaching, consultation, and supports to

139.35 prepare for the voluntary Minnesota quality

140.1 rating system rating tool. This is a onetime
 140.2 appropriation. Any unexpended balance the
 140.3 first year is available in the second year.

140.4 **Voluntary quality rating system.** \$184,000
 140.5 in fiscal year 2010 and \$1,200,000 in fiscal
 140.6 year 2011 are from the federal child care
 140.7 development fund required targeted funds for
 140.8 quality expansion and infant/toddler from the
 140.9 American Recovery and Reinvestment Act of
 140.10 2009, Public Law 111-5, to the commissioner
 140.11 of human services consistent with federal
 140.12 regulations for the purpose of implementing
 140.13 the voluntary Parent Aware quality star
 140.14 rating system pilot in coordination with the
 140.15 Minnesota Early Learning Foundation. The
 140.16 appropriation for the first year is to complete
 140.17 and promote the voluntary Parent Aware
 140.18 quality rating system pilot program through
 140.19 June 30, 2010, and the appropriation for
 140.20 the second year is to continue the voluntary
 140.21 Minnesota quality rating system pilot
 140.22 through June 30, 2011. This is a onetime
 140.23 appropriation. Any unexpended balance the
 140.24 first year is available in the second year.

140.25 **(f) Child Support Enforcement Grants** 3,705,000 3,705,000

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

140.27	Appropriations by Fund		
140.28	General	48,333,000	50,498,000
140.29	Federal TANF	340,000	240,000

140.30 **Base Adjustment.** The general fund base is
 140.31 decreased by \$5,371,000 in fiscal year 2012
 140.32 and decreased \$5,371,000 in fiscal year 2013.

140.33 **Privatized Adoption Grants.** Federal
 140.34 reimbursement for privatized adoption grant
 140.35 and foster care recruitment grant expenditures

141.1 is appropriated to the commissioner for
141.2 adoption grants and foster care and adoption
141.3 administrative purposes.

141.4 **Adoption Assistance Incentive Grants.**
141.5 Federal funds available during fiscal year
141.6 2010 and fiscal year 2011 for the adoption
141.7 incentive grants are appropriated to the
141.8 commissioner for postadoption services
141.9 including parent support groups.

141.10 **Adoption Assistance and Relative Custody**
141.11 **Assistance.** The commissioner may transfer
141.12 unencumbered appropriation balances for
141.13 adoption assistance and relative custody
141.14 assistance between fiscal years and between
141.15 programs.

141.16 **(h) Children and Community Services Grants** 67,663,000 67,542,000

141.17 **Targeted Case Management Temporary**
141.18 **Funding Adjustment.** The commissioner
141.19 shall recover from each county and tribe
141.20 receiving a targeted case management
141.21 temporary funding payment in fiscal year
141.22 2008 an amount equal to that payment. The
141.23 commissioner shall recover one-half of the
141.24 funds by February 1, 2010, and the remainder
141.25 by February 1, 2011. At the commissioner's
141.26 discretion and at the request of a county
141.27 or tribe, the commissioner may revise
141.28 the payment schedule, but full payment
141.29 must not be delayed beyond May 1, 2011.
141.30 The commissioner may use the recovery
141.31 procedure under Minnesota Statutes, section
141.32 256.017, to recover the funds. Recovered
141.33 funds must be deposited into the general
141.34 fund.

141.35 **(i) General Assistance Grants** 48,215,000 48,608,000

142.1 **General Assistance Standard.** The
142.2 commissioner shall set the monthly standard
142.3 of assistance for general assistance units
142.4 consisting of an adult recipient who is
142.5 childless and unmarried or living apart
142.6 from parents or a legal guardian at \$203.
142.7 The commissioner may reduce this amount
142.8 according to Laws 1997, chapter 85, article
142.9 3, section 54.

142.10 **Emergency General Assistance.** The
142.11 amount appropriated for emergency general
142.12 assistance funds is limited to no more
142.13 than \$7,889,812 in fiscal year 2010 and
142.14 \$7,889,812 in fiscal year 2011. Funds
142.15 to counties must be allocated by the
142.16 commissioner using the allocation method
142.17 specified in Minnesota Statutes, section
142.18 256D.06.

142.19	(j) Minnesota Supplemental Aid Grants	33,930,000	35,191,000
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142.20 **Emergency Minnesota Supplemental**
142.21 **Aid Funds.** The amount appropriated for
142.22 emergency Minnesota supplemental aid
142.23 funds is limited to no more than \$1,100,000
142.24 in fiscal year 2010 and \$1,100,000 in fiscal
142.25 year 2011. Funds to counties must be
142.26 allocated by the commissioner using the
142.27 allocation method specified in Minnesota
142.28 Statutes, section 256D.46.

142.29	(k) Group Residential Housing Grants	111,778,000	114,034,000
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142.30 **Group Residential Housing Costs**
142.31 **Refinanced.** (a) Effective July 1, 2011, the
142.32 commissioner shall increase the home and
142.33 community-based service rates and county
142.34 allocations provided to programs for persons
142.35 with disabilities established under section

143.1 1915(c) of the Social Security Act to the
143.2 extent that these programs will be paying
143.3 for the costs above the rate established
143.4 in Minnesota Statutes, section 256I.05,
143.5 subdivision 1.

143.6 (b) For persons receiving services under
143.7 Minnesota Statutes, section 245A.02, who
143.8 reside in licensed adult foster care beds
143.9 for which a difficulty of care payment
143.10 was being made under Minnesota Statutes,
143.11 section 256I.05, subdivision 1c, paragraph
143.12 (b), counties may request an exception to
143.13 the individual's service authorization not to
143.14 exceed the difference between the client's
143.15 monthly service expenditures plus the
143.16 amount of the difficulty of care payment.

143.17 **(l) Children's Mental Health Grants** 16,885,000 16,882,000

143.18 **Funding Usage.** Up to 75 percent of a fiscal
143.19 year's appropriation for children's mental
143.20 health grants may be used to fund allocations
143.21 in that portion of the fiscal year ending
143.22 December 31.

143.23 **(m) Other Children and Economic Assistance**
143.24 **Grants** 16,047,000 15,339,000

143.25 **Fraud Prevention Grants.** Of this
143.26 appropriation, \$228,000 in fiscal year 2010
143.27 and ~~\$228,000~~ \$379,000 in fiscal year 2011
143.28 is to the commissioner for fraud prevention
143.29 grants to counties.

143.30 **Homeless and Runaway Youth.** \$218,000
143.31 in fiscal year 2010 is for the Runaway
143.32 and Homeless Youth Act under Minnesota
143.33 Statutes, section 256K.45. Funds shall be
143.34 spent in each area of the continuum of care
143.35 to ensure that programs are meeting the

144.1 greatest need. Any unexpended balance in
144.2 the first year is available in the second year.
144.3 Beginning July 1, 2011, the base is increased
144.4 by \$119,000 each year.

144.5 **ARRA Homeless Youth Funds.** To the
144.6 extent permitted under federal law, the
144.7 commissioner shall designate \$2,500,000
144.8 of the Homeless Prevention and Rapid
144.9 Re-Housing Program funds provided under
144.10 the American Recovery and Reinvestment
144.11 Act of 2009, Public Law 111-5, for agencies
144.12 providing homelessness prevention and rapid
144.13 rehousing services to youth.

144.14 **Supportive Housing Services.** \$1,500,000
144.15 each year is for supportive services under
144.16 Minnesota Statutes, section 256K.26. This is
144.17 a onetime appropriation.

144.18 **Community Action Grants.** Community
144.19 action grants are reduced one time by
144.20 \$1,794,000 each year. This reduction is due
144.21 to the availability of federal funds under the
144.22 American Recovery and Reinvestment Act.

144.23 **Base Adjustment.** The general fund base
144.24 is increased by ~~\$773,000~~ \$903,000 in fiscal
144.25 year 2012 and ~~\$773,000~~ \$413,000 in fiscal
144.26 year 2013.

144.27 **Federal ARRA Funds for Existing**
144.28 **Programs.** (a) Federal funds received by the
144.29 commissioner for the emergency food and
144.30 shelter program from the American Recovery
144.31 and Reinvestment Act of 2009, Public
144.32 Law 111-5, but not previously approved
144.33 by the legislature are appropriated to the
144.34 commissioner for the purposes of the grant
144.35 program.

145.1 (b) Federal funds received by the
145.2 commissioner for the emergency shelter
145.3 grant program including the Homelessness
145.4 Prevention and Rapid Re-Housing
145.5 Program from the American Recovery and
145.6 Reinvestment Act of 2009, Public Law
145.7 111-5, are appropriated to the commissioner
145.8 for the purposes of the grant programs.

145.9 (c) Federal funds received by the
145.10 commissioner for the emergency food
145.11 assistance program from the American
145.12 Recovery and Reinvestment Act of 2009,
145.13 Public Law 111-5, are appropriated to the
145.14 commissioner for the purposes of the grant
145.15 program.

145.16 (d) Federal funds received by the
145.17 commissioner for senior congregate meals
145.18 and senior home-delivered meals from the
145.19 American Recovery and Reinvestment Act
145.20 of 2009, Public Law 111-5, are appropriated
145.21 to the commissioner for the Minnesota Board
145.22 on Aging, for purposes of the grant programs.

145.23 (e) Federal funds received by the
145.24 commissioner for the community services
145.25 block grant program from the American
145.26 Recovery and Reinvestment Act of 2009,
145.27 Public Law 111-5, are appropriated to the
145.28 commissioner for the purposes of the grant
145.29 program.

145.30 **Long-Term Homeless Supportive**
145.31 **Service Fund Appropriation.** To the
145.32 extent permitted under federal law, the
145.33 commissioner shall designate \$3,000,000
145.34 of the Homelessness Prevention and Rapid
145.35 Re-Housing Program funds provided under

146.1 the American Recovery and Reinvestment
146.2 Act of 2009, Public Law, 111-5, to the
146.3 long-term homeless service fund under
146.4 Minnesota Statutes, section 256K.26. This
146.5 appropriation shall become available by July
146.6 1, 2009. This paragraph is effective the day
146.7 following final enactment.

146.8 Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
146.9 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

146.10 **Subd. 8. Continuing Care Grants**

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

146.13	(a) Aging and Adult Services Grants	13,499,000	15,805,000
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146.14 **Base Adjustment.** The general fund base is
146.15 increased by \$5,751,000 in fiscal year 2012
146.16 and \$6,705,000 in fiscal year 2013.

146.17 **Information and Assistance**

146.18 **Reimbursement.** Federal administrative
146.19 reimbursement obtained from information
146.20 and assistance services provided by the
146.21 Senior LinkAge or Disability Linkage lines
146.22 to people who are identified as eligible for
146.23 medical assistance shall be appropriated to
146.24 the commissioner for this activity.

146.25 **Community Service Development Grant**

146.26 **Reduction.** Funding for community service
146.27 development grants must be reduced by
146.28 \$260,000 for fiscal year 2010; \$284,000 in
146.29 fiscal year 2011; \$43,000 in fiscal year 2012;
146.30 and \$43,000 in fiscal year 2013. Base level
146.31 funding shall be restored in fiscal year 2014.

146.32 **Community Service Development Grant**

146.33 **Community Initiative.** Funding for

147.1 community service development grants shall
 147.2 be used to offset the cost of aging support
 147.3 grants. Base level funding shall be restored
 147.4 in fiscal year 2014.

147.5 **Senior Nutrition Use of Federal Funds.**

147.6 For fiscal year 2010, general fund grants
 147.7 for home-delivered meals and congregate
 147.8 dining shall be reduced by \$500,000. The
 147.9 commissioner must replace these general
 147.10 fund reductions with equal amounts from
 147.11 federal funding for senior nutrition from the
 147.12 American Recovery and Reinvestment Act
 147.13 of 2009.

147.14 (b) Alternative Care Grants	50,234,000	48,576,000
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147.15 **Base Adjustment.** The general fund base is
 147.16 decreased by \$3,598,000 in fiscal year 2012
 147.17 and \$3,470,000 in fiscal year 2013.

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

147.23 (c) Medical Assistance Grants; Long-Term 147.24 Care Facilities.	367,444,000	419,749,000
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147.25 (d) Medical Assistance Long-Term Care 147.26 Waivers and Home Care Grants	853,567,000	1,039,517,000
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147.27 **Manage Growth in TBI and CADI**
 147.28 **Waivers.** During the fiscal years beginning
 147.29 on July 1, 2009, and July 1, 2010, the
 147.30 commissioner shall allocate money for home
 147.31 and community-based waiver programs
 147.32 under Minnesota Statutes, section 256B.49,
 147.33 to ensure a reduction in state spending that is
 147.34 equivalent to limiting the caseload growth of
 147.35 the TBI waiver to 12.5 allocations per month

148.1 each year of the biennium and the CADI
148.2 waiver to 95 allocations per month each year
148.3 of the biennium. Limits do not apply: (1)
148.4 when there is an approved plan for nursing
148.5 facility bed closures for individuals under
148.6 age 65 who require relocation due to the
148.7 bed closure; (2) to fiscal year 2009 waiver
148.8 allocations delayed due to unallotment; or (3)
148.9 to transfers authorized by the commissioner
148.10 from the personal care assistance program
148.11 of individuals having a home care rating
148.12 of "CS," "MT," or "HL." Priorities for the
148.13 allocation of funds must be for individuals
148.14 anticipated to be discharged from institutional
148.15 settings or who are at imminent risk of a
148.16 placement in an institutional setting.

148.17 **Manage Growth in DD Waiver.** The
148.18 commissioner shall manage the growth in
148.19 the DD waiver by limiting the allocations
148.20 included in the February 2009 forecast to 15
148.21 additional diversion allocations each month
148.22 for the calendar years that begin on January
148.23 1, 2010, and January 1, 2011. Additional
148.24 allocations must be made available for
148.25 transfers authorized by the commissioner
148.26 from the personal care program of individuals
148.27 having a home care rating of "CS," "MT,"
148.28 or "HL."

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

149.1 **Alternatives to Personal Care Assistance**
 149.2 **Services.** Base level funding of \$3,237,000
 149.3 in fiscal year 2012 and \$4,856,000 in
 149.4 fiscal year 2013 is to implement alternative
 149.5 services to personal care assistance services
 149.6 for persons with mental health and other
 149.7 behavioral challenges who can benefit
 149.8 from other services that more appropriately
 149.9 meet their needs and assist them in living
 149.10 independently in the community. These
 149.11 services may include, but not be limited to, a
 149.12 1915(i) state plan option.

149.13 **(e) Mental Health Grants**

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

149.18 **Funding Usage.** Up to 75 percent of a fiscal
 149.19 year's appropriation for adult mental health
 149.20 grants may be used to fund allocations in that
 149.21 portion of the fiscal year ending December
 149.22 31.

149.23 **(f) Deaf and Hard-of-Hearing Grants** 1,930,000 1,917,000

149.24 **(g) Chemical Dependency Entitlement Grants** 111,303,000 122,822,000

149.25 **Payments for Substance Abuse Treatment.**

149.26 For ~~services provided~~ placements beginning
 149.27 during fiscal years 2010 and 2011,
 149.28 county-negotiated rates and provider claims
 149.29 to the consolidated chemical dependency
 149.30 fund must not exceed the lesser of:
 149.31 (1) rates charged for these services on
 149.32 January 1, 2009; or

150.1 (2) 160 percent of the average rate on January
150.2 1, 2009, for each group of vendors with
150.3 similar attributes.
150.4 Effective July 1, 2010, rates that were above
150.5 the average rate on January 1, 2009, are
150.6 reduced by five percent from the rates in
150.7 effect on June 1, 2010. Services provided
150.8 under this section by state-operated services
150.9 are exempt from the rate reduction. For
150.10 services provided in fiscal years 2012
150.11 and 2013, ~~statewide average rates the~~
150.12 statewide aggregate payment under the
150.13 new rate methodology to be developed
150.14 under Minnesota Statutes, section 254B.12,150.15 must not exceed the ~~average rates charged~~
150.16 ~~for these services on January 1, 2009~~
150.17 projected aggregate payment under the
150.18 rates in effect for fiscal year 2011, plus a
150.19 state share increase of \$3,787,000 for fiscal
150.20 year 2012 and \$5,023,000 for fiscal year
150.21 2013. Notwithstanding any provision to the
150.22 contrary in this article, this provision expires
150.23 on June 30, 2013.

150.24 **Chemical Dependency Special Revenue**
150.25 **Account.** For fiscal year 2010, \$750,000
150.26 must be transferred from the consolidated
150.27 chemical dependency treatment fund
150.28 administrative account and deposited into the
150.29 general fund.

150.30 **County CD Share of MA Costs for**
150.31 **ARRA Compliance.** Notwithstanding the
150.32 provisions of Minnesota Statutes, chapter
150.33 254B, for chemical dependency services
150.34 provided during the period October 1, 2008,
150.35 to December 31, 2010, and reimbursed by

151.1 medical assistance at the enhanced federal
 151.2 matching rate provided under the American
 151.3 Recovery and Reinvestment Act of 2009, the
 151.4 county share is 30 percent of the nonfederal
 151.5 share. This provision is effective the day
 151.6 following final enactment.

151.7 **(h) Chemical Dependency Nonentitlement**
 151.8 **Grants** 1,729,000 1,729,000

151.9 **(i) Other Continuing Care Grants** 19,201,000 17,528,000

151.10 **Base Adjustment.** The general fund base is
 151.11 increased by \$2,639,000 in fiscal year 2012
 151.12 and increased by \$3,854,000 in fiscal year
 151.13 2013.

151.14 **Technology Grants.** \$650,000 in fiscal
 151.15 year 2010 and \$1,000,000 in fiscal year
 151.16 2011 are for technology grants, case
 151.17 consultation, evaluation, and consumer
 151.18 information grants related to developing and
 151.19 supporting alternatives to shift-staff foster
 151.20 care residential service models.

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

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

151.30 Sec. 15. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by
 151.31 Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

151.32 Subd. 8. **Board of Nursing Home**
 151.33 **Administrators** 1,211,000 1,023,000

152.1 **Administrative Services Unit - Operating**

152.2 **Costs.** Of this appropriation, \$524,000
152.3 in fiscal year 2010 and \$526,000 in
152.4 fiscal year 2011 are for operating costs
152.5 of the administrative services unit. The
152.6 administrative services unit may receive
152.7 and expend reimbursements for services
152.8 performed by other agencies.

152.9 **Administrative Services Unit - Retirement**

152.10 **Costs.** Of this appropriation in fiscal year
152.11 2010, \$201,000 is for onetime retirement
152.12 costs in the health-related boards. This
152.13 funding may be transferred to the health
152.14 boards incurring those costs for their
152.15 payment. These funds are available either
152.16 year of the biennium.

152.17 **Administrative Services Unit - Volunteer**

152.18 **Health Care Provider Program.** Of this
152.19 appropriation, ~~\$79,000~~ \$130,000 in fiscal
152.20 year 2010 and ~~\$89,000~~ \$150,000 in fiscal
152.21 year 2011 are to pay for medical professional
152.22 liability coverage required under Minnesota
152.23 Statutes, section 214.40.

152.24 **Administrative Services Unit - Contested**

152.25 **Cases and Other Legal Proceedings.** Of
152.26 this appropriation, \$200,000 in fiscal year
152.27 2010 and \$200,000 in fiscal year 2011 are
152.28 for costs of contested case hearings and other
152.29 unanticipated costs of legal proceedings
152.30 involving health-related boards funded
152.31 under this section and for unforeseen
152.32 expenditures of an urgent nature. Upon
152.33 certification of a health-related board to the
152.34 administrative services unit that the costs
152.35 will be incurred and that there is insufficient

153.1 money available to pay for the costs out of
153.2 money currently available to that board, the
153.3 administrative services unit is authorized
153.4 to transfer money from this appropriation
153.5 to the board for payment of those costs
153.6 with the approval of the commissioner of
153.7 finance. This appropriation does not cancel.
153.8 Any unencumbered and unspent balances
153.9 remain available for these expenditures in
153.10 subsequent fiscal years. The boards receiving
153.11 funds under this section shall include these
153.12 amounts when setting fees to cover their
153.13 costs.

153.14 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

153.15 All uncodified language contained in this article expires on June 30, 2011, unless a
153.16 different expiration date is explicit.

153.17 Sec. 17. **EFFECTIVE DATE.**

153.18 The provisions in this article are effective July 1, 2010, unless a different effective
153.19 date is explicit.

153.20 **ARTICLE 8**

153.21 **HUMAN SERVICES FORECAST ADJUSTMENTS**

153.22 Section 1. **SUMMARY OF APPROPRIATIONS.**

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

153.25		<u>2010</u>		<u>2011</u>		<u>Total</u>
153.26	<u>General</u>	\$	<u>(109,876,000)</u>	\$	<u>(28,344,000)</u>	\$ <u>(138,220,000)</u>
153.27	<u>Health Care Access</u>	\$	<u>99,654,000</u>	\$	<u>276,500,000</u>	\$ <u>376,154,000</u>
153.28	<u>Federal TANF</u>	\$	<u>(9,830,000)</u>	\$	<u>15,133,000</u>	\$ <u>5,303,000</u>
153.29	<u>Total</u>	\$	<u>(20,052,000)</u>	\$	<u>263,289,000</u>	\$ <u>243,237,000</u>

153.30 Sec. 2. **DEPARTMENT OF HUMAN SERVICES APPROPRIATION.**

153.31 The sums shown in the columns marked "Appropriations" are added to or, if shown
153.32 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,

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155.1	<u>General</u>	<u>7,916,000</u>	<u>(14,481,000)</u>
155.2	<u>Federal TANF</u>	<u>(10,220,000)</u>	<u>15,384,000</u>
155.3	<u>(b) MFIP Child Care Assistance Grants</u>	<u>(7,832,000)</u>	<u>2,579,000</u>
155.4	<u>(c) General Assistance Grants</u>	<u>875,000</u>	<u>1,339,000</u>
155.5	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>2,454,000</u>	<u>3,843,000</u>
155.6	<u>(e) Group Residential Housing Grants</u>	<u>1,076,000</u>	<u>2,580,000</u>
155.7	<u>Subd. 4. Basic Health Care Grants</u>		
155.8	<u>Appropriations by Fund</u>		
155.9	<u>General</u>	<u>(62,770,000)</u>	<u>29,192,000</u>
155.10	<u>Health Care Access</u>	<u>99,654,000</u>	<u>276,500,000</u>
155.11	<u>The amounts that may be spent from the</u>		
155.12	<u>appropriation for each purpose are as follows:</u>		
155.13	<u>(a) MinnesotaCare Grants</u>		
155.14	<u>Health Care Access</u>	<u>99,654,000</u>	<u>276,500,000</u>
155.15	<u>(b) Medical Assistance Basic Health Care -</u>		
155.16	<u>Families and Children</u>	<u>1,165,000</u>	<u>24,146,000</u>
155.17	<u>(c) Medical Assistance Basic Health Care -</u>		
155.18	<u>Elderly and Disabled</u>	<u>(63,935,000)</u>	<u>5,046,000</u>
155.19	<u>Subd. 5. Continuing Care Grants</u>		
155.20	<u>The amounts that may be spent from the</u>		
155.21	<u>appropriation for each purpose are as follows:</u>		
155.22	<u>(a) Medical Assistance Long-Term Care</u>		
155.23	<u>Facilities</u>	<u>(3,774,000)</u>	<u>(8,275,000)</u>
155.24	<u>(b) Medical Assistance Long-Term Care</u>		
155.25	<u>Waivers</u>	<u>(27,710,000)</u>	<u>(22,452,000)</u>
155.26	<u>(c) Chemical Dependency Entitlement Grants</u>		
		<u>(20,111,000)</u>	<u>(22,669,000)</u>
155.27	<u>Sec. 4. EFFECTIVE DATE.</u>		
155.28	<u>This article is effective the day following final enactment.</u>		

APPENDIX
Article locations in s2337-1

ARTICLE 1	HEALTH CARE	Page.Ln 2.2
ARTICLE 2	CONTINUING CARE	Page.Ln 37.1
ARTICLE 3	CHILDREN AND FAMILY SERVICES; DEPARTMENT OF HUMAN SERVICES LICENSING	Page.Ln 53.27
ARTICLE 4	DEPARTMENT OF HEALTH	Page.Ln 67.6
ARTICLE 5	GENERAL ASSISTANCE MEDICAL CARE AMENDMENTS	Page.Ln 77.1
ARTICLE 6	MISCELLANEOUS	Page.Ln 84.1
ARTICLE 7	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 101.1
ARTICLE 8	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 153.20

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subd. 2. **County adjustment; maximum allocation.** The commissioner shall determine the state money used by each county in fiscal year 1986, using all state data sources. If available records do not provide specific chemical dependency expenditures for every county, the commissioner shall determine the amount of state money using estimates based on available data. In state fiscal year 1988, a county must not be allocated more than 150 percent of the state money spent by or on behalf of the county in fiscal year 1986 for chemical dependency treatment services eligible for payment under section 254B.05 but not including expenditures made for persons eligible for placement under section 254B.09, subdivision 6. The allocation maximums must be increased by 25 percent each year. After fiscal year 1992, there must be no allocation maximum. The commissioner shall reallocate the excess over the maximum to counties allocated less than the fiscal year 1986 state money, using the following process:

(a) The allocation is divided by 1986 state expenditures to determine percentage of prior expenditure, and counties are ranked by percentage of prior expenditure less expenditures for persons eligible for placement under section 254B.09, subdivision 6.

(b) The allocation of the lowest ranked county is raised to the same percentage of prior expenditure as the second lowest ranked county. The allocation of these two counties is then raised to the percentage of prior expenditures of the third lowest ranked county.

(c) The operations under paragraph (b) are repeated with each county by ranking until the money in excess of the allocation maximum has been allocated.

Subd. 3. **Reserve account.** The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, at the end of each biennium, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Subd. 4. **Allocation spending limits.** Money allocated according to subdivision 1 and section 254B.09, subdivision 4, is available for payments for up to two years. The commissioner shall deduct payments from the most recent year allocation in which money is available. Allocations under this section that are not used within two years must be reallocated to the reserve account for payments under subdivision 3. Allocations under section 254B.09, subdivision 4, that are not used within two years must be reallocated for payments under section 254B.09, subdivision 5.

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subd. 4. **Tribal allocation.** Eighty-five percent of the American Indian chemical dependency tribal account must be allocated to the federally recognized American Indian tribal governing bodies that have entered into an agreement under subdivision 2 as follows: \$10,000 must be allocated to each governing body and the remainder must be allocated in direct proportion to the population of the reservation according to the most recently available estimates from the federal Bureau of Indian Affairs. When a tribal governing body has not entered into an agreement with the commissioner under subdivision 2, the county may use funds allocated to the reservation to pay for chemical dependency services for a current resident of the county and of the reservation.

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Subd. 5. **Tribal reserve account.** The commissioner shall reserve 15 percent of the American Indian chemical dependency tribal account. The reserve must be allocated to those tribal units that have used all money allocated under subdivision 4 according to agreements made under subdivision 2 and to counties submitting invoices for American Indians under subdivision 1 when all money allocated under subdivision 4 has been used. An American Indian tribal governing body or a county submitting invoices under subdivision 1 may receive not more than 30 percent of the reserve account in a year. The commissioner may refuse to make reserve payments for persons not eligible under section 254B.04, subdivision 1, if the tribal governing body responsible for treatment placement has exhausted its allocation. Money must be allocated as invoices are received.

Subd. 7. **Nonreservation Indian account.** The nonreservation American Indian chemical dependency allocation must be held in reserve by the commissioner in an account for treatment of Indians not residing on lands of a reservation receiving money under subdivision 4. This money must be used to pay for services certified by county invoice to have been provided to an American Indian eligible recipient. Money allocated under this subdivision may be used for payments on behalf of American Indian county residents only if, in addition to other placement standards, the county certifies that the placement was appropriate to the cultural orientation of the client. Any funds for treatment of nonreservation Indians remaining at the end of a fiscal year shall be reallocated under section 254B.02.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of \$1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

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(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial

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months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(q) Effective July 1, 2003, general assistance medical care emergency services end.

Subd. 3a. Claims; assignment of benefits. Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 5. Certain county agencies to pay state for county share. The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. Division of costs. The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does

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not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may

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initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Laws 2010, chapter 200, article 1, section 12

Sec. 12. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of \$1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

(b) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without approval or acquiescence of the United States Citizenship and Immigration Services.

(c) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources is ineligible for general assistance medical care.

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance

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medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(d) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include the noncitizen's sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare-certified rehabilitation agencies;
- (4) prescription drugs;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations;
- (7) hearing aids;
- (8) prosthetic devices, if not covered by veterans benefits;
- (9) laboratory and x-ray services;
- (10) physicians' services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services;
- (15) mental health services covered under chapter 256B;
- (16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;
- (17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;
- (18) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

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(19) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) \$25 for nonemergency visits to a hospital-based emergency room; and

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 5. Payment rates and contract modification; April 1, 2010, to May 31, 2010. (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

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

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

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

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

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(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

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

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

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

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

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

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

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

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

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

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system.

(a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery

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system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

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

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

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

Subd. 8. Temporary uncompensated care pool. (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to November 30, 2010.

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

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

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

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

Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

Subd. 10. Assistance for veterans. Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

EFFECTIVE DATE. This section is effective for services rendered on or after April 1, 2010.

Laws 2010, chapter 200, article 1, section 18

Sec. 18. **DRUG REBATE PROGRAM.**

APPENDIX

Repealed Minnesota Session Laws: s2337-1

The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph (cc), and 256D.03.

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

Laws 2010, chapter 200, article 1, section 19

Sec. 19. **TRANSITIONAL MINNESOTACARE PHASEOUT.**

For any applicant or recipient who meets the requirements of Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), before April 1, 2010, and who is not exempt under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (f), the commissioner of human services shall continue the process of enrolling the recipient in MinnesotaCare as required under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), and, upon the completion of enrollment, the recipient shall receive services under MinnesotaCare in accordance with Minnesota Statutes, section 256L.03. County agencies shall continue to perform all duties necessary to administer the MinnesotaCare program ongoing for individuals enrolled in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), including the redetermination of MinnesotaCare eligibility at renewal.

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