

CHAPTER 173—H.F.No. 1988

An act relating to state government; making technical health and human services changes; making health care program policy changes; changing health care eligibility provisions; authorizing rulemaking; requiring reports; changing appropriations; appropriating money; amending Minnesota Statutes 2008, sections 62J.2930, subdivision 3; 62J.497, subdivision 5, as added; 144.0724, subdivision 11, as added; 245.494, subdivision 3; 245A.11, subdivision 7a, as added; 245C.03, by adding a subdivision; 245C.04, subdivision 1, as amended, by adding a subdivision; 245C.05, subdivision 2b, as added; 245C.10, subdivision 5, as added, by adding a subdivision; 245C.21, subdivision 1a, as amended; 246.50, subdivision 3; 256.01, subdivision 18b, as added; 256.015, subdivision 7; 256.969, subdivisions 2b, as amended, 3a, 29, as added, by adding a subdivision; 256.975, subdivision 7, as amended; 256B.037, subdivision 5; 256B.056, subdivisions 1c, 3b, 3c, 6; 256B.057, subdivision 11, as added; 256B.06, subdivision 4, as amended; 256B.0625, subdivisions 3c, as amended, 13h, as amended, by adding subdivisions; 256B.0655, subdivision 4, as amended; 256B.0659, subdivisions 9, as added, 10, as added, 13, as added, 21, as added, 29, as added; 256B.0911, subdivision 1a, as amended; 256B.094, subdivision 3; 256B.195, subdivisions 1, 2, 3; 256B.441, subdivision 55, as amended; 256B.49, subdivision 11a, as added; 256B.69, subdivision 5a; 256B.756, as added; 256B.76, subdivision 1, as amended; 256B.77, subdivision 13; 256D.03, subdivisions 3, 4, as amended; 256J.575, subdivision 3, as amended; 256L.01, by adding a subdivision; 256L.03, subdivisions 3b, as added, 5; 256L.04, subdivision 1, as amended; 256L.05, subdivision 1c, as added; 256L.11, subdivision 1, as amended; 256L.15, subdivision 2; 402A.30, subdivision 4, as added; 626.556, subdivision 3c, as amended; Laws 2005, First Special Session chapter 4, article 8, sections 54; 61; 63; 66; 74; Laws 2009, chapter 79, article 2, section 36; article 5, sections 25; 52; article 8, sections 8; 13; 73; article 10, section 46; article 13, sections 3; 4; 5; 6; repealing Minnesota Statutes 2008, sections 256B.031; 256L.01, subdivision 4; Laws 2005, First Special Session chapter 4, article 8, sections 21; 22; 23; 24; Laws 2009, chapter 79, article 7, section 12; article 13, sections 7; 8.

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

ARTICLE 1

HEALTH AND HUMAN SERVICES TECHNICAL

Section 1. Minnesota Statutes 2008, section 62J.497, subdivision 5, as added by Laws 2009, chapter 79, article 4, section 6, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.**

(a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February

15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) No later than January 1, 2011, drug prior authorization requests must be accessible and submitted by health care providers, and accepted ~~and processed~~ by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 11, as added by Laws 2009, chapter 79, article 8, section 4, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(2) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(3) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(4) the person has had a qualifying nursing facility stay of at least 90 days; or

(5) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone upon discharge and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under sections 256B.0915 and 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

Sec. 3. Minnesota Statutes 2008, section 245A.11, subdivision 7a, as added by Laws 2009, chapter 79, article 1, section 4, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care license.**

(a) The commissioner may grant an applicant or license holder an adult foster care license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses monitoring technology to alert the license holder when an incident occurs that may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

(1) that the facility is under electronic monitoring; and

(2) the telephone number of the county's common entry point for making reports of suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the host county and lead county contract agency and the host county licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

(c) Before a license is issued by the commissioner, and for the duration of the license, the applicant or license holder must establish, maintain, and document the implementation of written policies and procedures addressing the requirements in paragraphs (d) through (f).

(d) The applicant or license holder must have policies and procedures that:

(1) establish characteristics of target populations that will be admitted into the home, and characteristics of populations that will not be accepted into the home;

(2) explain the discharge process when a foster care recipient requires overnight supervision or other services that cannot be provided by the license holder due to the limited hours that the license holder is on-site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on-site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2). The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill be to conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of people receiving foster care services in the home:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on-site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on-site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the ~~license~~ license holder in communicating with and assessing the needs related to care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the foster care recipient without requiring the initiation of the foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on-site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each foster care recipient's individualized plan of care, individual service plan under section 256B.092, subdivision 1b, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on-site for that foster care recipient.

(f) All placement agreements, individual service agreements, and plans applicable to the foster care recipient must clearly state that the adult foster care license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to health, safety, or rights of foster care recipients under paragraph (e), clause (1) or (2); and a signed informed consent from each foster care recipient or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

- (1) how any electronic monitoring is incorporated into the alternative supervision system;
- (2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;
- (3) how the license holder is trained on the use of the technology;
- (4) the event types and license holder response times established under paragraph (e);
- (5) how the license holder protects the foster care recipient's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A foster care recipient may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and
- (6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

(i) For the purposes of paragraphs (d) through (h), license holder has the meaning under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and contractors affiliated with the license holder.

(j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely determine what action the license holder needs to take to protect the well-being of the foster care recipient.

Sec. 4. Minnesota Statutes 2008, section 245C.03, is amended by adding a subdivision to read:

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall conduct background studies on any individual required under section 256B.4912 to have a background study completed under this chapter.

Sec. 5. Minnesota Statutes 2008, section 245C.04, subdivision 1, as amended by Laws 2009, chapter 79, article 1, section 8, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at reapplication for a license for family child care.

(c) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services for an adult foster care license holder that is also:

(1) registered under chapter 144D; or

(2) licensed to provide home and community-based services to people with disabilities at the foster care location and the license holder does not reside in the foster care residence; and

(3) the following conditions are met:

(i) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

(ii) the individual has been continuously affiliated with the license holder since the last study was conducted; and

(iii) the last study of the individual was conducted on or after October 1, 1995.

(d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall conduct a study of an individual required to be studied under section 245C.03, at the time of reapplication for a child foster care license. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, paragraph (a), clauses (1) to (5), 3, and 4.

(e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

(f) From January 1, 2010, to December 31, 2012, unless otherwise specified in paragraph (c), the commissioner shall conduct a study of an individual required to be studied under section 245C.03 at the time of reapplication for an adult foster care or family adult day services license: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b), for background studies conducted by the commissioner for all family adult day services and for adult foster care ~~and family adult day services~~ when the adult foster care license holder resides in the adult foster care or family adult day services residence; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.

(g) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly

affiliated with an adult foster care or family adult day services license holder: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b), for background studies conducted by the commissioner for all family adult day services and for adult foster care ~~and family adult day services~~ when the adult foster care license holder resides in the adult foster care ~~or family adult day services~~ residence; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

(h) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study forms to the commissioner before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

(i) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

Sec. 6. Minnesota Statutes 2008, section 245C.04, is amended by adding a subdivision to read:

Subd. 6. Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities. (a) Providers required to initiate background studies under section 256B.4912 must initiate a study before the individual begins in a position allowing direct contact with persons served by the provider.

(b) The commissioner shall conduct a background study annually of an individual required to be studied under section 245C.03, subdivision 6.

Sec. 7. Minnesota Statutes 2008, section 245C.05, subdivision 2b, as added by Laws 2009, chapter 79, article 1, section 9, is amended to read:

Subd. 2b. County agency to collect and forward information to the commissioner. For background studies related to all family adult day services and to adult foster care ~~and family adult day services~~ when the adult foster care license holder resides in the adult foster care ~~or family adult day services~~ residence, the county agency must collect the information required under subdivision 1 and forward it to the commissioner.

Sec. 8. Minnesota Statutes 2008, section 245C.10, subdivision 5, as added by Laws 2009, chapter 79, article 1, section 12, is amended to read:

Subd. 5. Adult foster care and family adult day services. The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 9. Minnesota Statutes 2008, section 245C.10, is amended by adding a subdivision to read:

Subd. 6. Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities. The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than \$20 per study.

Sec. 10. Minnesota Statutes 2008, section 245C.21, subdivision 1a, as amended by Laws 2009, chapter 79, article 1, section 16, is amended to read:

Subd. 1a. Submission of reconsideration request. (a) For disqualifications related to studies conducted by county agencies for family child care, and for disqualifications related to studies conducted by the commissioner for child foster care, adult foster care, and family adult day services, the individual shall submit the request for reconsideration to the county agency that initiated the background study.

(b) For disqualifications related to studies conducted by the commissioner for child foster care providers monitored by private licensing agencies under section 245A.16, the individual shall submit the request for reconsideration to the private agency that initiated the background study.

(c) A reconsideration request shall be submitted within 30 days of the individual's receipt of the disqualification notice or the time frames specified in subdivision 2, whichever time frame is shorter.

(d) The county or private agency shall forward the individual's request for reconsideration and provide the commissioner with a recommendation whether to set aside the individual's disqualification.

Sec. 11. Minnesota Statutes 2008, section 246.50, subdivision 3, is amended to read:

Subd. 3. State facility. "State facility" means any state facility owned or operated by the state of Minnesota and under the programmatic direction or fiscal control of the commissioner, except the Minnesota sex offender program under chapter 246B. State facility includes regional treatment centers; the state nursing homes; state-operated, community-based programs; and other facilities owned or operated by the state and under the commissioner's control.

Sec. 12. Minnesota Statutes 2008, section 256.01, subdivision 18b, as added by Laws 2009, chapter 79, article 5, section 7, is amended to read:

Subd. 18b. Protections for American Indians. Effective ~~February 18~~ July 1, 2009, the commissioner shall comply with the federal requirements in the American Recovery and Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding American Indians.

Sec. 13. Minnesota Statutes 2008, section 256.969, subdivision 2b, as amended by Laws 2009, chapter 79, article 5, section 11, is amended to read:

Subd. 2b. Operating payment rates. In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable

costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009, ~~and~~. For the first three months of the rebased period beginning January 1, 2011, rates shall be rebased at 74.25 percent of the full value of the rebasing percentage change. From April 1, 2011, to March 31, 2012, rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change. Effective April 1, 2012, rates shall be rebased at full value. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 14. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be no greater than \$3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

Sec. 15. Minnesota Statutes 2008, section 256.969, subdivision 29, as added by Laws 2009, chapter 79, article 5, section 15, is amended to read:

Subd. 29. Reimbursement for the fee increase for the early hearing detection and intervention program. ~~For services provided admissions occurring on or after July 1, 2010, in addition to any other payment under this section, the commissioner shall reimburse hospitals for the increase in the fee for the early hearing detection and intervention program described in section 144.125, subdivision 1, paid by the hospital for public program recipients payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under section 144.125, subdivision 1, that is paid by the hospital for public program recipients. This payment increase shall be in effect until the increase is fully recognized in the base year cost under subdivision 2b. This payment shall be included in payments to contracted managed care organizations.~~

Sec. 16. Minnesota Statutes 2008, section 256.975, subdivision 7, as amended by Laws 2009, chapter 79, article 8, section 16, is amended to read:

Subd. 7. Consumer information and assistance and long-term care options counseling; Senior LinkAge Line. (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices

about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

(9) incorporate information about housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information to the commissioner of human services that is consistent with information required by the commissioner of health under section 144G.06, the Uniform Consumer Information Guide. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

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

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

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

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

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

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

(i) long-term care consultation services under section 256B.0911, ~~subdivision 3~~;

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

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

Sec. 17. Minnesota Statutes 2008, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Except as provided in paragraphs (c) and (d), trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law 103-66.

(c) For purposes of paragraph (d), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

(d) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during

the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

EFFECTIVE DATE. This section is effective for pooled trust accounts established on or after January 1, 2011.

Sec. 18. Minnesota Statutes 2008, section 256B.057, subdivision 11, as added by Laws 2009, chapter 79, article 5, section 19, is amended to read:

Subd. 11. **Treatment for colorectal cancer.** (a) Medical assistance shall be paid for an individual who:

(1) has been screened for colorectal cancer by the colorectal cancer prevention demonstration project;

(2) according to the individual's treating health professional, needs treatment for colorectal cancer;

(3) meets income eligibility guidelines for the colorectal cancer prevention demonstration project;

(4) is under the age of 65; and

(5) is not otherwise eligible for medical assistance or covered under creditable coverage as defined under United States Code, title 42, section 300gg(a)(c), but without regard to paragraph (1)(F) of such section.

(b) Medical assistance provided under this subdivision shall be limited to services provided during the period that the individual receives treatment for colorectal cancer.

(c) An individual meeting the criteria in paragraph (a) is eligible for medical assistance without meeting the eligibility criteria relating to income and assets in section 256B.056, subdivisions 1a to 5b.

(d) This subdivision expires December 31, 2010.

Sec. 19. Minnesota Statutes 2008, section 256B.06, subdivision 4, as amended by Laws 2009, chapter 79, article 5, section 23, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) All qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation through November 30, 1996.

Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(i) refugees admitted to the United States according to United States Code, title 8, section 1157;

(ii) persons granted asylum according to United States Code, title 8, section 1158;

(iii) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(iv) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(v) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant women who are ~~qualified~~ noncitizens, ~~as~~ described in paragraph (b) or (e), are eligible

for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully present in the United States, as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the United States Citizenship and Immigration Services to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related care and services and routine prenatal care.

(h) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present as designated in paragraph (e) and who are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(j) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

(k) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

Sec. 20. Minnesota Statutes 2008, section 256B.0625, subdivision 3c, as amended by Laws 2009, chapter 79, article 5, section 26, is amended to read:

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

(b) The commissioner shall establish a dental subcommittee to operate under the Health Services Policy Committee. The dental subcommittee consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental subcommittee shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance, MinnesotaCare, and general assistance medical care programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

(d) The Health Services Policy Committee shall monitor and track the practice patterns of physicians providing services to medical assistance, MinnesotaCare, and general assistance medical care enrollees under fee-for-service, managed care, and county-based purchasing. The committee shall focus on services or specialties for which there is a high variation in utilization across physicians, or which are associated with high medical costs. The commissioner, based upon the findings of the committee, shall regularly notify physicians whose practice patterns indicate higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the ~~committee~~ commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make this data available to the committee.

(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.

Sec. 21. Minnesota Statutes 2008, section 256B.0625, subdivision 13h, as amended by Laws 2009, chapter 79, article 5, section 31, is amended to read:

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

- (1) performing or obtaining necessary assessments of the patient's health status;
- (2) formulating a medication treatment plan;
- (3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
- (4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
- (5) documenting the care delivered and communicating essential information to the patient's other primary care providers;
- (6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;
- (7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and
- (8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2008, section 256B.0655, subdivision 4, as amended by Laws 2009, chapter 79, article 8, section 28, is amended to read:

Subd. 4. **Authorization; personal care assistance and qualified professional.**

(a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in section 256B.0651, subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in sections 256B.0651, subdivision 11, and 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) number of complex health-related ~~functions~~ needs as defined in section 256B.0659; and

(3) number of behavior descriptions as defined in section 256B.0659.

(c) The methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659.

(d) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

Sec. 23. Minnesota Statutes 2008, section 256B.0659, subdivision 9, as added by Laws 2009, chapter 79, article 8, section 31, is amended to read:

Subd. 9. **Responsible party; generally.** (a) "Responsible party," ~~effective January 1, 2010,~~ means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(b) A responsible party must be 18 years of age, actively participate in planning and directing of personal care assistance services, and attend all assessments for the recipient.

(c) A responsible party must not be the:

(1) personal care assistant;

(2) home care provider agency owner or staff; or

(3) county staff acting as part of employment.

(d) A licensed family foster parent who lives with the recipient may be the responsible party as long as the family foster parent meets the other responsible party requirements.

(e) A responsible party is required when:

(1) the person is a minor according to section 524.5-102, subdivision 10;

(2) the person is an incapacitated adult according to section 524.5-102, subdivision 6, resulting in a court-appointed guardian; or

(3) the assessment according to section 256B.0655, subdivision 1b, determines that the recipient is in need of a responsible party to direct the recipient's care.

(f) There may be two persons designated as the responsible party for reasons such as divided households and court-ordered custodies. Each person named as responsible party must meet the program criteria and responsibilities.

(g) The recipient or the recipient's legal representative shall appoint a responsible party if necessary to direct and supervise the care provided to the recipient. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and personal care assistance care plan.

Sec. 24. Minnesota Statutes 2008, section 256B.0659, subdivision 10, as added by Laws 2009, chapter 79, article 8, section 31, is amended to read:

Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall enter into a written agreement with a personal care assistance provider agency, on a form determined by the commissioner, to perform the following duties:

(1) be available while care is provided in a method agreed upon by the individual or the individual's legal representative and documented in the recipient's personal care assistance care plan;

(2) monitor personal care assistance services to ensure the recipient's personal care assistance care plan is being followed; and

(3) review and sign personal care assistance time sheets after services are provided to provide verification of the personal care assistance services.

Failure to provide the support required by the recipient must result in a referral to the county common entry point.

(b) Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of the responsible party, ~~except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party.~~ The responsible party must ensure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the personal care assistance care plan. The responsible party must communicate to the personal care assistance provider agency about the need for a delegate responsible party, including the name of the delegated responsible party, dates the delegated responsible party will be living with the recipient, and contact numbers.

Sec. 25. Minnesota Statutes 2008, section 256B.0659, subdivision 13, as added by Laws 2009, chapter 79, article 8, section 31, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must be employed by a personal care assistance provider agency and meet the definition under section 256B.0625, subdivision 19c. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective January 1, 2010, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required trainings as an employee with a personal care assistance provider agency do not need to repeat the required trainings if they are hired by another agency, if they have completed the training within the last three years.

Sec. 26. Minnesota Statutes 2008, section 256B.0659, subdivision 21, as added by Laws 2009, chapter 79, article 8, section 31, is amended to read:

Subd. 21. Requirements for initial enrollment of personal care assistance provider agencies. (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage in the amount of \$50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less;

(3) proof of fidelity bond coverage in the amount of \$20,000;

(4) proof of workers' compensation insurance coverage;

(5) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template ~~and~~ for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(8) a list of all trainings and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(10) documentation of the agency's marketing practices;

(11) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services; and

(12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning upon enactment of this section.

(c) All personal care assistance provider agencies shall complete mandatory training as determined by the commissioner before enrollment as a provider. Personal care assistance provider agencies are required to send all owners, qualified professionals employed by the agency, and all other managing employees to the initial and subsequent trainings. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective upon enactment of this section. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of the effective date of this section. Any new owners, new qualified professionals, and new managing employees are required to complete mandatory training as a requisite of hiring.

Sec. 27. Minnesota Statutes ..., section 256B.0659, subdivision 29, as added by Laws 2009, chapter 79, article 8, section 31, is amended to read:

Subd. 29. **Transitional assistance.** The commissioner, counties, health plans, tribes, and personal care assistance providers shall work together to provide transitional assistance for recipients and families to come into compliance with the new requirements of this section that may require a change in living arrangement no later than August 10, 2010 ~~and ensure the personal care assistance services are not provided by the housing provider.~~

Sec. 28. Minnesota Statutes 2008, section 256B.0911, subdivision 1a, as amended by Laws 2009, chapter 79, article 8, section 33, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations on cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated screening to determine the need for a institutional level of care under section 256B.0911, subdivision 4, paragraph (a);

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in section 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), based on assessment and support plan development with appropriate referrals;

(8) providing recommendations for nursing facility placement when there are no cost-effective community services available; and

(9) assistance to transition people back to community settings after facility admission.

(b) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(c) "Minnesota health care programs" means the medical assistance program under chapter 256B and the alternative care program under section 256B.0913.

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

Sec. 29. Minnesota Statutes 2008, section 256B.441, subdivision 55, as amended by Laws 2009, chapter 79, article 8, section 61, is amended to read:

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period year beginning October 1, 2009, ~~through September 30, 2013~~, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434.

For rate years beginning October 1, 2010; October 1, 2011; and October 1, 2012, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

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

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2008, section 256B.49, subdivision 11a, as added by Laws 2009, chapter 79, article 8, section 64, is amended to read:

Subd. 11a. **Waivered services ~~waiting list statewide priorities.~~** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(b) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options.

(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.

Sec. 31. Minnesota Statutes 2008, section 256B.756, as added by Laws 2009, chapter 79, article 5, section 50, is amended to read:

256B.756 REIMBURSEMENT RATES FOR BIRTHS.

Subdivision 1. **Facility Provider rate.** (a) Notwithstanding section ~~256.969~~ 256B.76, effective for services provided on or after October 1, 2009, the ~~facility~~ payment rate for the following ~~diagnosis-related groups, as they fall within the diagnostic categories:~~ (1) 371 cesarean section without complicating diagnosis, (2) 372 vaginal delivery with complicating diagnosis, and (3) 373 vaginal delivery without complicating diagnosis, shall be calculated as provided in professional services related to labor, delivery, and antepartum and postpartum care when provided for any of the diagnostic categories identified in paragraph (b) shall be calculated using the methodology specified in paragraph (b).

(b) The commissioner shall calculate a single rate for ~~all of the diagnostic related groups specified in paragraph (a)~~ the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean sections without complicating diagnosis; (2)

372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis. The rate shall be consistent with an increase in the proportion of births by vaginal delivery and a reduction in the percentage of births by cesarean section. The calculated single rate must be based on an expected increase in the number of vaginal births and expected reduction in the number of cesarean section such that the reduction in cesarean sections is less than or equal to one standard deviation below the average in the frequency of cesarean births for Minnesota health care program clients at hospitals performing greater than 50 deliveries per year. not reflect a shift of greater than five percent in the current proportion of all births delivered vaginally and by cesarean section.

(c) The rates described in this subdivision do not include newborn care.

~~Subd. 2. **Provider rate.** Notwithstanding section 256B.76, effective for services provided on or after October 1, 2009, the payment rate for professional services related to labor, delivery, and antepartum and postpartum care when provided for any of the diagnostic categories identified in subdivision 1, paragraph (a), shall be calculated using the methodology specified in subdivision 1, paragraph (b).~~

Subd. 3. **Health plans.** Payments to managed care and county-based purchasing plans under sections 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in subdivisions subdivision 1 and 2.

Subd. 4. **Prior authorization.** Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

Sec. 32. Minnesota Statutes 2008, section 256B.76, subdivision 1, as amended by Laws 2009, chapter 79, article 5, section 51, is amended to read:

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

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

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. This reduction does not apply to office or other outpatient ~~services (procedure codes 99201 to 99215) visits, preventive medicine services (procedure codes 99381 to 99412) visits~~ and family planning ~~services visits~~ billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care specialties practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family practice, or by an advanced practice registered nurse or physician assistant practicing in pediatrics, geriatrics, or family practice medicine. This reduction does not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

Sec. 33. Minnesota Statutes 2008, section 256D.03, subdivision 4, as amended by Laws 2009, chapter 79, article 5, section 53, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations provided by a physician or optometrist;
- (7) hearing aids;
- (8) prosthetic devices;
- (9) laboratory and X-ray services;
- (10) physician's services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services as covered under the medical assistance program;
- (15) mental health services covered under chapter 256B;
- (16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;
- (17) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(19) 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;

(20) 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;

(21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(22) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(23) 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.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult

with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

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

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) \$25 for eyeglasses;

(2) \$25 for nonemergency visits to a hospital-based emergency room;

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

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

(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.

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, 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. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

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

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

(k) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by \$3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

(u) Effective for services provided on or after July 1, 2009, total payment rates for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

Sec. 34. Minnesota Statutes 2008, section 256J.575, subdivision 3, as amended by Laws 2009, chapter 79, article 2, section 23, is amended to read:

Subd. 3. **Eligibility.** (a) The following MFIP participants are eligible for the services under this section:

(1) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3, except that it is not necessary for the participant to have reached or be approaching 60 months of eligibility for this section to apply;

(2) a participant who is applying for Supplemental Security Income or Social Security disability insurance;

(3) a participant who is a noncitizen who has been in the United States for 12 or fewer months; and

(4) a participant who is age 60 or older.

(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.

(c) A participant under paragraph (a), clause (3), must be provided with English as a second language opportunities and skills training for up to 12 months. After 12 months, the case manager and participant must determine whether the participant should continue with English as a second language classes or skills training, or both, and continue to receive family stabilization services.

(d) If a county agency or employment services provider has information that an MFIP participant may meet the eligibility criteria set forth in this subdivision, the county agency or employment services provider must assist the participant in obtaining the documentation necessary to determine eligibility. ~~Until necessary documentation is obtained, the participant must be treated as an eligible participant under subdivisions 5 to 7.~~

Sec. 35. Minnesota Statutes 2008, section 256L.03, subdivision 3b, as added by Laws 2009, chapter 79, article 5, section 54, is amended to read:

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

EFFECTIVE DATE. This section is effective January 1, 2010, or upon federal approval, whichever is later.

Sec. 36. Minnesota Statutes 2008, section 256L.04, subdivision 1, as amended by Laws 2009, chapter 79, article 5, section 55, is amended to read:

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

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

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

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.

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

(f) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision 8, are exempt from the eligibility requirements of this subdivision.

EFFECTIVE DATE. Paragraph (f) is effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 37. Minnesota Statutes 2008, section 256L.05, subdivision 1c, as added by Laws 2009, chapter 79, article 5, section 60, is amended to read:

Subd. 1c. **Open enrollment and streamlined application and enrollment process.** (a) The commissioner and local agencies working in partnership must develop a streamlined and efficient application and enrollment process for medical assistance and MinnesotaCare enrollees that meets the criteria specified in this subdivision.

(b) The commissioners of human services and education shall provide recommendations to the legislature by January 15, 2010, on the creation of an open enrollment process for medical assistance and MinnesotaCare that is coordinated with the public education system. The recommendations must:

(1) be developed in consultation with medical assistance and MinnesotaCare enrollees and representatives from organizations that advocate on behalf of children and families, low-income persons and minority populations, counties, school administrators and nurses, health plans, and health care providers;

(2) be based on enrollment and renewal procedures best practices, ~~including express lane eligibility as required under subdivision 1d;~~

(3) simplify the enrollment and renewal processes wherever possible; and

(4) establish a process:

(i) to disseminate information on medical assistance and MinnesotaCare to all children in the public education system, including prekindergarten programs; and

(ii) for the commissioner of human services to enroll children and other household members who are eligible.

The commissioner of human services in coordination with the commissioner of education shall implement an open enrollment process by August 1, 2010, to be effective beginning with the 2010-2011 school year.

(c) The commissioner and local agencies shall develop an online application process for medical assistance and MinnesotaCare.

(d) The commissioner shall develop an application for children that is easily understandable and does not exceed four pages in length.

(e) The commissioner of human services shall present to the legislature, by January 15, 2010, an implementation plan for the open enrollment period and online application process.

EFFECTIVE DATE. This section is effective July 1, ~~2010~~ 2009, or upon federal approval, which must be requested by the commissioner, whichever is later.

Sec. 38. Minnesota Statutes 2008, section 256L.11, subdivision 1, as amended by Laws 2009, chapter 79, article 5, section 67, is amended to read:

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

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

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

Sec. 39. Minnesota Statutes 2008, section 626.556, subdivision 3c, as amended by Laws 2009, chapter 79, article 8, section 74, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, ~~and unlicensed personal care assistance provider organizations providing services and receiving reimbursements under chapter 256B~~ and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245B, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.46.

(d) The commissioners of human services, public safety, and education must jointly submit a written report by January 15, 2007, to the education policy and finance committees of the legislature recommending the most efficient and effective allocation of agency responsibility for assessing or investigating reports of maltreatment and must specifically address allegations of maltreatment that currently are not the responsibility of a designated agency.

Sec. 40. Laws 2009, chapter 79, article 2, section 36, is amended to read:

Sec. 36. **REPEALER.**

Minnesota Statutes 2008, section 256I.06, subdivision 9, is repealed.

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

Sec. 41. Laws 2009, chapter 79, article 5, section 25, is amended to read:

Sec. 25. Minnesota Statutes 2008, section 256B.0625, subdivision 3, is amended to read:

Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.

(b) Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature, " except that rates paid to physicians for the medical direction of a certified registered nurse anesthetist shall be the same as the rate paid to the certified registered nurse anesthetist under medical direction.

(c) Medical assistance does not cover physicians' services related to the provision of care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

(d) Medical assistance does not cover physicians' services related to the provision of care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

(e) The payment limitations in this subdivision shall also apply to MinnesotaCare and general assistance medical care.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Sec. 42. Laws 2009, chapter 79, article 5, section 52, is amended to read:

Sec. 52. **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, prior to third-party liability and spenddown calculation. Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

Sec. 43. Laws 2009, chapter 79, article 8, section 8, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~the day following final enactment~~ July 1, 2009.

Sec. 44. Laws 2009, chapter 79, article 8, section 13, is amended to read:

Sec. 13. **256.0281 INTERAGENCY DATA EXCHANGE.**

The Department of Human Services, the Department of Health, and the Office of the Ombudsman for Mental Health and Developmental Disabilities may establish interagency agreements governing the electronic exchange of data on providers and individuals collected, maintained, or used by each agency when such exchange is outlined by each agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

(1) to improve provider enrollment processes for home and community-based services and state plan home care services;

(2) to improve quality management of providers between state agencies;

(3) to establish and maintain provider eligibility to participate as providers under Minnesota health care programs; or

(4) to meet the quality assurance reporting requirements under federal law under section 1915(c) of the Social Security Act related to home and community-based waiver programs.

Each interagency agreement must include provisions to ensure anonymity of individuals, including mandated reporters, and must outline the specific uses of and access to shared data within each agency. Electronic interfaces between source data systems developed under these interagency agreements must incorporate these provisions as well as other ~~HPPA~~ HIPAA provisions related to individual data.

Sec. 45. Laws 2009, chapter 79, article 8, section 73, is amended to read:

Sec. 73. Minnesota Statutes 2008, section 256D.44, subdivision 5, is amended to read:

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

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(g) Notwithstanding this subdivision, recipients of home and community-based services may relocate to services without 24-hour supervision and receive the equivalent of the recipient's group residential housing allocation in Minnesota supplemental assistance shelter needy funding if the cost of the services and housing is equal to or less than provided to the recipient in home and community-based services and the relocation is the recipient's choice and is approved by the recipient or guardian.~~

~~(h) To access housing and services as provided in paragraph (g), the recipient may choose housing that may or may not be owned, operated, or controlled by the recipient's service provider.~~

~~(i) The provisions in paragraphs (g) and (h) are effective to June 30, 2011. The commissioner shall assess the development of publicly owned housing, other housing alternatives, and whether a public equity housing fund may be established that would maintain the state's interest, to the extent paid from group residential housing and Minnesota supplemental aid shelter needy funds in provider-owned housing so that when sold, the state would recover its share for a public equity fund to be used for future public needs under this chapter. The commissioner shall report findings and recommendations to the legislative committees and budget divisions with jurisdiction over health and human services policy and financing by January 15, 2012.~~

~~(j) In selecting prospective services needed by recipients for whom home and community-based services have been authorized, the recipient and the recipient's guardian shall first consider alternatives to home and community-based services. Minnesota supplemental aid shelter needy funding for recipients who utilize Minnesota supplemental aid shelter needy funding as provided in this section shall remain permanent unless the recipient with the recipient's guardian later chooses to access home and community-based services.~~

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may or may not be owned, operated, or controlled by the recipient's service provider if the housing is located in a multifamily building of six or more units. The maximum number of units that may be used by recipients of this program shall be 50 percent of the units in a building. The department shall develop an exception process to the 50 percent maximum. This paragraph expires on June 30, 2011.

Sec. 46. Minnesota Statutes 2008, section 402A.30, subdivision 4, as added by Laws 2009, chapter 79, article 9, section 6, is amended to read:

Subd. 4. **Process for establishing a service delivery authority.** (a) The county or consortium of counties proposing to form a service delivery authority shall, in conjunction with the commissioner, ~~prevent present~~ a proposed memorandum of understanding to the council accompanied by a resolution from the board of commissioners of each participating county stating the county's intent to participate in a service delivery authority.

(b) The council shall certify a county or consortium of counties as a service delivery authority if:

(1) the conditions in subdivision 2, paragraphs (a) and (b), are met; and

(2) the county or consortium of counties are:

(i) a single county with a population of 55,000 or more;

(ii) a consortium of counties with a total combined population of 55,000 or more and the counties comprising the consortium are in reasonable geographic proximity; or

(iii) four or more counties in reasonable geographic proximity without regard to population.

The council may recommend that the commissioner of human services exempt a single county or multicounty service delivery authority from the minimum population

standard if that service delivery authority can demonstrate that it can otherwise meet the requirements of this chapter.

(c) After the council has certified a county or consortium of counties as a service delivery authority, the commissioner may enter into the memoranda of understanding with the participating counties to form the service delivery authority.

Sec. 47. Laws 2009, chapter 79, article 10, section 46, is amended to read:

Sec. 46. FEASIBILITY PILOT PROJECT FOR CANCER SURVEILLANCE.

The commissioner of health must provide a grant to the Hennepin County Medical Center for a one-year feasibility pilot project to collect occupational, residential, and military service history data from newly diagnosed cancer patients at the Hennepin County Medical Center's Cancer Center. ~~Funding for this grant shall come from the Department of Health's current resources for the Chronic Disease and Environmental Epidemiology Section.~~

Under this pilot project, Hennepin County Medical Center will design an expansion of its existing cancer registry to include the collection of additional data, including the cancer patient's occupational, residential, and military service history. Patient consent is required for collection of these additional data. The consent must be in writing and must contain notice informing the patient about private and confidential data concerning the patient pursuant to Minnesota Statutes, section 13.04, subdivision 2. The patient is entitled to opt out of the project at any time. The data collection expansion may also include the cancer patient's possible toxic environmental exposure history, if known. The purpose of this pilot project is to determine the following:

- (1) the feasibility of collecting these data on a statewide scale;
- (2) the potential design of a self-administered patient questionnaire template; and
- (3) necessary qualifications for staff who will collect these data.

Hennepin County Medical Center must report the results of this pilot project to the legislature by October 1, 2010.

Sec. 48. EXPOSURE LEVELS STUDY.

The commissioner of health shall work with appropriate local, state, and federal agencies to determine whether the levels of exposure to pentachlorophenol (PCP) in Minneapolis neighborhoods where utility poles treated with PCP, creosote, or probable human carcinogens are installed, exceed human health risk limits or maximum contaminant levels for residents, utility workers, and others who handle the treated poles.

Sec. 49. REPEALER.

Laws 2009, chapter 79, article 7, section 12, is repealed.

ARTICLE 2

TECHNICAL APPROPRIATION CHANGES

Section 1. Laws 2009, chapter 79, article 13, section 3, is amended to read:

Sec. 3. HUMAN SERVICES

Subdivision 1. Total Appropriation	\$	5,230,100,000 <u>5,225,451,000</u>	\$	5,997,715,000 <u>6,002,864,000</u>
---	----	--	----	--

Appropriations by Fund		
	2010	2011
General	4,376,839,000 <u>4,375,689,000</u>	5,211,018,000 <u>5,209,765,000</u>
State Government	1,315,000	
Special Revenue	<u>565,000</u>	565,000
Health Care Access	450,792,000 <u>450,662,000</u>	527,489,000 <u>527,411,000</u>
Federal TANF	289,487,000 <u>286,770,000</u>	256,978,000 <u>263,458,000</u>
Lottery Prize	1,665,000	1,665,000
Federal Fund	110,000,000	0

Receipts for Systems Projects.

Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary, except that any transfers to one project that exceed \$1,000,000 or multiple transfers to one project that exceed \$1,000,000 in total require the express approval of the legislature. The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations. Any computer project with a total cost exceeding \$1,000,000, including,

but not limited to, a replacement for the proposed HealthMatch system, shall not be commenced without the express approval of the legislature.

HealthMatch Systems Project. In fiscal year 2010, \$3,054,000 shall be transferred from the HealthMatch account in the state systems account in the special revenue fund to the general fund.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); and

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures to the extent such expenditures or other qualified expenditures are otherwise available after considering the expenditures allowed in this section.

(e) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(f) Notwithstanding any contrary provision in this article, this provision expires June 30, 2013.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to \$6,707,000 per year of working family credit expenditures for fiscal year 2010 through fiscal year 2011.

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following amounts of working family credit expenditure as TANF/MOE:

- | | | | |
|-----|-------------|-------|---|
| (1) | fiscal year | 2010, | \$30,217,000
<u>\$50,973,000;</u> |
| (2) | fiscal year | 2011, | \$55,596,000
<u>\$53,793,000;</u> |
| (3) | fiscal year | 2012, | \$28,519,000
<u>\$23,516,000;</u> and |
| (4) | fiscal year | 2013, | \$22,138,000
<u>\$16,808,000.</u> |

Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

~~**TANF Transfer to Federal Child Care and Development Fund.** The following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:~~

- ~~(1) fiscal year 2010, \$5,909,000;~~
~~(2) fiscal year 2011, \$9,808,000;~~

~~(3) fiscal year 2012, \$10,826,000, and~~

~~(4) fiscal year 2013, \$4,026,000.~~

~~The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.~~

Food Stamps Employment and Training.

(a) The commissioner shall apply for and claim the maximum allowable federal matching funds under United States Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family stabilization services participants voluntarily engaged in food stamp employment and training activities, where appropriate.

(b) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures for two-parent families must be deposited in the general fund. The amount of funds must be limited to \$3,350,000 in fiscal year 2010 and \$4,440,000 in fiscal years 2011 through 2013, contingent on approval by the federal Food and Nutrition Service.

(c) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

ARRA Food Support Administration.

The funds available for food support administration under the American Recovery and Reinvestment Act (ARRA) of 2009 are appropriated to the commissioner to pay actual costs of implementing the food support benefit increases, increased eligibility determinations, and outreach. Of these funds, 20 percent shall be allocated

to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion based on a caseload factor equivalent to that of a county.

ARRA Food Support Benefit Increases.

The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Emergency Fund for the TANF Program.

TANF Emergency Contingency funds available under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) are appropriated to the commissioner. The commissioner must request TANF Emergency Contingency funds from the Secretary of the Department of Health and Human Services to the extent the commissioner meets or expects to meet the requirements of section 403(c) of the Social Security Act. The commissioner must seek to maximize such grants. The funds received must be used as appropriated. Each county must maintain the county's current level of emergency assistance funding under the MFIP consolidated fund and use the funds under this paragraph to supplement existing emergency assistance funding levels.

Subd. 2. Agency Management

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

(a) Financial Operations

	Appropriations by Fund	
General	3,380,000	3,908,000
Health Care Access	1,281,000	1,016,000
Federal TANF	122,000	122,000

(b) Legal and Regulatory Operations

Appropriations by Fund		
General	13,749,000	13,534,000
State Government		
Special Revenue	440,000	440,000
Health Care Access	943,000	943,000
Federal TANF	100,000	100,000

Base Adjustment. The general fund base is decreased by \$180,000 in fiscal year 2012 and \$180,000 in fiscal year 2013.

(c) Management Operations

Appropriations by Fund		
General	4,334,000	4,562,000
Health Care Access	242,000	242,000

Lease Cost Reduction. Base level funding to the commissioner shall be reduced by \$381,000 in fiscal year 2010, and \$153,000 in fiscal year 2011, to reflect a reduction in lease costs related to the Minnehaha Avenue building.

Base Adjustment. The general fund base is increased by \$153,000 in each of fiscal years 2012 and 2013.

(d) Information Technology Operations

Appropriations by Fund		
General	28,077,000	28,077,000
Health Care Access	4,856,000	4,868,000

Subd. 3. Revenue and Pass-Through Revenue	65,746,000	67,068,000
Expenditures	<u>68,337,000</u>	<u>70,505,000</u>

This appropriation is from the federal TANF fund.

TANF Transfer to Federal Child Care and Development Fund. The following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and

transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2010, \$6,531,000;

(2) fiscal year 2011, \$10,241,000;

(3) fiscal year 2012, \$10,826,000; and

(4) fiscal year 2013, \$4,046,000.

The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Subd. 4. **Children and Economic Assistance Grants**

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

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	63,205,000	89,033,000
	100,404,000	85,789,000
Federal TANF	<u>100,818,000</u>	<u>84,538,000</u>

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	12,498,000
	121,257,000	102,757,000
Federal TANF	<u>116,557,000</u>	<u>107,457,000</u>

MFIP Consolidated Fund. The MFIP consolidated fund TANF appropriation is reduced by \$1,854,000 in fiscal year ~~2011~~ 2010 and fiscal year ~~2012~~ 2011.

Notwithstanding Minnesota Statutes, section 256J.626, subdivision 8, paragraph (b), the commissioner shall reduce proportionately the reimbursement to counties for administrative expenses.

Subsidized Employment Funding Through

ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

Supported Work. Of the TANF appropriation, ~~\$6,400,000~~ \$4,700,000 in fiscal year ~~2011~~ 2010 and \$4,700,000 in fiscal year 2011 are to the commissioner for supported work for MFIP recipients and is available until expended. Supported work includes paid transitional work experience and a continuum of employment assistance, including outreach and recruitment, program orientation and intake, testing and assessment, job development and marketing, preworksite training, supported worksite experience, job coaching, and postplacement follow-up, in addition to extensive case management and referral services. This is a onetime appropriation.

Base Adjustment. The general fund base is reduced by \$3,783,000 in each of fiscal years 2012 and 2013. The TANF fund base is increased by ~~\$9,704,000~~ \$5,004,000 in each of fiscal years 2012 and 2013.

Integrated Services Program Funding.

The TANF appropriation for integrated services program funding is \$1,250,000 in fiscal year 2010 and ~~\$2,500,000~~ \$0 in fiscal year 2011 and the base for fiscal years 2012 and 2013 is \$0.

TANF Emergency Fund; Nonrecurrent Short-Term Benefits. TANF emergency contingency fund grants received due to

increases in expenditures for nonrecurrent short-term benefits must be used to offset the increase in these expenditures for counties under the MFIP consolidated fund, under Minnesota Statutes, section 256J.626, and the diversionary work program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters. Growth in expenditures for the diversionary work program over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage these funds.

(c) MFIP Child Care Assistance Grants 61,171,000 65,214,000

Appropriations by Fund		
General	61,171,000	65,214,000
Federal TANF	1,022,000	406,000

~~**ARRA Child Care Development Block Grant Funds.** The funds available from the child care development block grant under ARRA must be used for MFIP child care to the extent that those funds are not earmarked for quality expansion or to improve the quality of infant and toddler care.~~

Acceleration of ARRA Child Care and Development Fund Expenditure. The commissioner must liquidate all child care and development money available under the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5, by September 30, 2010. In order to expend those funds by September 30, 2010, the commissioner may redesignate and expend the ARRA child care and development funds appropriated in fiscal year 2011 for purposes under this section for related purposes that will allow liquidation by September 30, 2010. Child care and development funds otherwise available to the commissioner for those related purposes shall be used to fund the purposes from which the ARRA child care and development funds had been redesignated.

School Readiness Service Agreements.
\$400,000 in fiscal year 2010 and \$400,000
in fiscal year 2011 are from the federal
TANF fund to the commissioner of human
services consistent with federal regulations
for the purpose of school readiness service
agreements under Minnesota Statutes, section
119B.231. This is a onetime appropriation.
Any unexpended balance the first year is
available in the second year.

(d) Basic Sliding Fee Child Care Assistance Grants	40,104,000	45,096,000
	<u>40,100,000</u>	<u>45,092,000</u>

~~**Base Adjustment.** The general fund base is decreased by \$260,000 in each of fiscal years 2012 and 2013.~~

School Readiness Service Agreements.
~~\$261,000~~ \$257,000 in fiscal year 2010 and
~~\$261,000~~ \$257,000 in fiscal year 2011 are
 from the federal child care development
 funds received from the American Recovery
 and Reinvestment Act of 2009, Public Law
 111-5, to the commissioner of human services
 consistent with federal regulations, general
fund for the purpose of school readiness
 service agreements under Minnesota
 Statutes, section 119B.231. This is a onetime
 appropriation. Any unexpended balance the
 first year is available in the second year.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend \$5,244,000 in fiscal year 2010 from the federal child care development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

Basic Sliding Fee. ~~\$7,045,000~~ \$4,000,000 in fiscal year 2010 and ~~\$6,974,000~~ \$4,000,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner

of human services consistent with federal regulations for the purpose of basic sliding fee child care assistance under Minnesota Statutes, section 119B.03. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Basic Sliding Fee Allocation for Calendar Year 2010. Notwithstanding Minnesota Statutes, section 119B.03, subdivision 6, in calendar year 2010, basic sliding fee funds shall be distributed according to this provision. Funds shall be allocated first in amounts equal to each county's guaranteed floor, according to Minnesota Statutes, section 119B.03, subdivision 8, with any remaining available funds allocated according to the following formula:

(a) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(b) Up to three-fourths of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in Minnesota Statutes, section 119B.03, subdivision 2, and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(c) The amount necessary to serve all families in paragraphs (a) and (b) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

(d) Funds in excess of the amount necessary to serve all families in paragraphs (a) and (b) shall be allocated in proportion to each

county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation. To the extent that funds are available, and notwithstanding Minnesota Statutes, section 119B.03, subdivision 8, for the period January 1, 2011, to December 31, 2011, each county's guaranteed floor must be equal to its original calendar year 2010 allocation.

Base Adjustment. The general fund base is decreased by \$257,000 in each of fiscal years 2012 and 2013.

(e) Child Care Development Grants

1,487,000

1,487,000

Family, friends, and neighbor grants. \$375,000 in fiscal year 2010 and \$375,000 in fiscal year 2011 are from the child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services for family, friends, and neighbor grants under Minnesota Statutes, section 119B.232. This appropriation may be used on programs receiving family, friends, and neighbor grant funds as of June 30, 2009, or on new programs or projects. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system training, coaching, consultation, and supports. \$633,000 in fiscal year 2010 and \$633,000 in fiscal year 2011 are from the federal child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of providing grants to provide statewide child-care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system rating tool. This is a onetime

appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system. \$184,000 in fiscal year 2010 and \$1,200,000 in fiscal year 2011 are from the federal child care development fund required targeted funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of implementing the voluntary Parent Aware quality star rating system pilot in coordination with the Minnesota Early Learning Foundation. The appropriation for the first year is to complete and promote the voluntary Parent Aware quality rating system pilot program through June 30, 2010, and the appropriation for the second year is to continue the voluntary Minnesota quality rating system pilot through June 30, 2011. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(f) Child Support Enforcement Grants 3,705,000 3,705,000

(g) Children's Services Grants

Appropriations by Fund

General	48,333,000	50,498,000
Federal TANF	340,000	240,000

Base Adjustment. The general fund base is decreased by \$5,371,000 in fiscal year 2012 and ~~increased \$8,737,000~~ decreased \$5,371,000 in fiscal year 2013.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for ~~these~~ purposes

postadoption services including parent support groups.

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

(h) Children and Community Services Grants

67,663,000

67,542,000

Targeted Case Management Temporary Funding Adjustment. The commissioner shall recover from each county and tribe receiving a targeted case management temporary funding payment in fiscal year 2008 an amount equal to that payment. The commissioner shall recover one-half of the funds by February 1, 2010, and the remainder by February 1, 2011. At the commissioner's discretion and at the request of a county or tribe, the commissioner may revise the payment schedule, but full payment must not be delayed beyond May 1, 2011. The commissioner may use the recovery procedure under Minnesota Statutes, section 256.017, to recover the funds. Recovered funds must be deposited into the general fund.

(i) General Assistance Grants

48,215,000

48,608,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at \$203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than \$7,889,812 in fiscal year 2010 and \$7,889,812 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method

specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants 33,930,000 35,191,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than \$1,100,000 in fiscal year 2010 and \$1,100,000 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(k) Group Residential Housing Grants 111,778,000 114,034,000

Group Residential Housing Costs Refinanced. (a) Effective July 1, 2011, the commissioner shall increase the home and community-based service rates and county allocations provided to programs for persons with disabilities established under section 1915(c) of the Social Security Act to the extent that these programs will be paying for the costs above the rate established in Minnesota Statutes, section 256I.05, subdivision 1.

(b) For persons receiving services under Minnesota Statutes, section 245A.02, who reside in licensed adult foster care beds for which a difficulty of care payment was being made under Minnesota Statutes, section 256I.05, subdivision 1c, paragraph (b), counties may request an exception to the individual's service authorization not to exceed the difference between the client's monthly service expenditures plus the amount of the difficulty of care payment.

(l) Children's Mental Health Grants 16,885,000 16,882,000

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

(m) Other Children and Economic Assistance Grants

16,047,000

15,339,000

Fraud Prevention Grants. Of this appropriation, ~~\$379,000~~ \$228,000 in fiscal year 2010 and ~~\$379,000~~ \$228,000 in fiscal year 2011 is to the commissioner for fraud prevention grants to counties.

Homeless and Runaway Youth. \$218,000 in fiscal year 2010 is for the Runaway and Homeless Youth Act under Minnesota Statutes, section 256K.45. Funds shall be spent in each area of the continuum of care to ensure that programs are meeting the greatest need. Any unexpended balance in the first year is available in the second year. Beginning July 1, 2011, the base is increased by \$119,000 each year.

ARRA Homeless Youth Funds. To the extent permitted under federal law, the commissioner shall designate \$2,500,000 of the Homeless Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, for agencies providing homelessness prevention and rapid rehousing services to youth.

Supportive Housing Services. \$1,500,000 each year is for supportive services under Minnesota Statutes, section 256K.26. This is a onetime appropriation. ~~Beginning in fiscal year 2012, the base is increased by \$68,000 per year.~~

Community Action Grants. Community action grants are reduced one time by ~~\$1,764,000~~ \$1,794,000 each year. This reduction is due to the availability of federal funds under the American Recovery and Reinvestment Act.

Base Adjustment. The general fund base is increased by \$773,000 in fiscal year 2012 and \$773,000 in fiscal year 2013.

Federal ARRA Funds for Existing Programs. (a) Federal funds received by the commissioner for the emergency food and shelter program from the American Recovery and Reinvestment Act of 2009, Public

Law 111-5, but not previously approved by the legislature are appropriated to the commissioner for the purposes of the grant program.

(b) Federal funds received by the commissioner for the emergency shelter grant program including the Homelessness Prevention and Rapid Re-Housing Program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

(c) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

(d) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

(e) Federal funds received by the commissioner for the community services block grant program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

Long-Term Homeless Supportive Service Fund Appropriation. To the extent permitted under federal law, the commissioner shall designate \$3,000,000 of the Homelessness Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law, 111-5, to the long-term homeless service fund under Minnesota Statutes, section 256K.26. This appropriation shall become available by July 1, 2009. This paragraph is effective the day following final enactment.

**Subd. 5. Children and Economic Assistance
Management**

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

**(a) Children and Economic Assistance
Administration**

Appropriations by Fund		
General	10,318,000	10,308,000
Federal TANF	496,000	496,000

Base Adjustment. The federal TANF base is increased by \$700,000 in each of fiscal years 2012 and 2013.

School Readiness Service Agreements. ~~\$406,000~~ \$106,000 in fiscal year 2010 and ~~\$406,000~~ \$241,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231, and the voluntary quality rating system in Minnesota Statutes, section 119B.231, subdivision 3e. This is a onetime appropriation. ~~Any unexpended balance the first year is available in the second year.~~

**(b) Children and Economic Assistance
Operations**

Appropriations by Fund		
General	33,590,000	33,423,000
Health Care Access	361,000	361,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to \$310,000 each year in fiscal years 2010 and 2011 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions

and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

~~**School Readiness Service Agreements.** \$106,000 in fiscal year 2010 and \$241,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation.~~

~~**Use of Federal Stabilization Funds.** \$33,000,000 in fiscal year 2010 is appropriated from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.~~

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

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

	391,915,000	485,448,000
(a) MinnesotaCare Grants	<u>391,785,000</u>	<u>485,370,000</u>

This appropriation is from the health care access fund.

	751,988,000	973,088,000
(b) MA Basic Health Care Grants - Families and Children	<u>751,166,000</u>	<u>972,901,000</u>

Medical Education Research Costs (MERC). Of these funds, the commissioner of human services shall transfer \$38,000,000 in fiscal year 2010 to the medical education research fund. These funds must restore the fiscal year 2009 unallotment of the transfers under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), for the July 1, 2008, through June 30, 2009, period.

Newborn Screening Fee. Of the general fund appropriation, \$34,000 in fiscal year 2011 is to the commissioner for the hospital

reimbursement increase described under Minnesota Statutes, section 256.969, subdivision ~~28~~ 29.

Local Share Payment Modification Required for ARRA Compliance.

Effective retroactively from July 1, 2009 ~~July 1, 2009~~ October 1, 2008, to December 31, 2010, Hennepin County's monthly contribution to the nonfederal share of medical assistance costs must be reduced to the percentage required on September 1, 2008, to meet federal requirements for enhanced federal match under the American Reinvestment and Recovery Act (ARRA) of 2009. Notwithstanding the requirements of Minnesota Statutes, section 256B.19, subdivision 1c, paragraph (d), for the period beginning ~~July 1, 2009~~ October 1, 2008, to December 31, 2010, Hennepin County's monthly payment under that provision is reduced to \$434,688. This provision is effective the day following final enactment.

Capitation Payments.

Effective retroactively from July 1, 2009 ~~July 1, 2009~~ October 1, 2008, to December 31, 2010, notwithstanding the provisions of Minnesota Statutes 2008, section 256B.19, subdivision 1c, paragraph (c), the commissioner shall increase capitation payments made to the Metropolitan Health Plan under Minnesota Statutes 2008, section 256B.69, by \$6,800,000 to recognize higher than average medical education costs. The increased amount includes federal matching funds. This provision is effective the day following final enactment.

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

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

~~970,183,000~~
969,992,000

~~1,142,310,000~~
1,141,575,000

Minnesota Disability Health Options.

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

Hospital Fee-for-Service Payment Delay.

Payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for Minnesota health care program enrollees must be delayed as follows: for fiscal year 2011, payments in the month of June equal to \$15,937,000 must be included in the first payment of fiscal year 2012 and for fiscal year 2013, payments in the month of June equal to \$6,666,000 must be included in the first payment of fiscal year 2014. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires December 31, 2014.

Nonhospital Fee-for-Service Payment Delay.

Payments from the Medicaid Management Information System that would otherwise have been made for nonhospital acute care services for Minnesota health care program enrollees must be delayed as follows: payments in the month of June equal to \$23,438,000 for fiscal year 2011 must be included in the first payment for fiscal year 2012, and payments in the month of June equal to \$27,156,000 for fiscal year 2013 must be included in the first payment for fiscal year 2014. This payment delay must not include nursing facilities, intermediate care facilities for persons with developmental disabilities, home and community-based services, prepaid health plans, personal care provider organizations, and home health agencies. The provisions of Minnesota

Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires December 31, 2014.

	345,223,000	
(d) General Assistance Medical Care Grants	<u>344,907,000</u>	381,081,000

*** (The preceding text "381,081,000" was indicated as vetoed by the Governor.)**

(e) Other Health Care Grants

	Appropriations by Fund	
General	295,000	295,000
Health Care Access	23,533,000	7,080,000

Base Adjustment. The health care access fund base is reduced to ~~\$190,000~~ in each of fiscal years 2012 and 2013 by \$6,890,000 in fiscal year 2012 and \$6,890,000 in fiscal year 2013.

Subd. 7. Health Care Management

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

(a) Health Care Administration

	Appropriations by Fund	
	7,831,000	7,742,000
General	<u>7,880,000</u>	<u>7,786,000</u>
Health Care Access	1,812,000	906,000

Base Adjustment. The general fund base is increased by \$44,000 in fiscal year 2012 and increased by \$44,000 in fiscal year 2013.

(b) Health Care Operations

	Appropriations by Fund	
General	19,914,000	18,949,000
Health Care Access	25,099,000	25,875,000

Base Adjustment. The health care access fund base is increased by \$1,006,000 in fiscal year 2012 and \$1,781,000 in fiscal year

2013. The general fund base is decreased by \$237,000 in fiscal year 2012 and \$237,000 in fiscal year 2013.

Subd. 8. Continuing Care Grants

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

~~(a) Aging and Adult Services Grants~~

Appropriations by Fund		
General	13,488,000	15,779,000
Federal	500,000	0

<u>(a) Aging and Adult Services Grants</u>	<u>13,499,000</u>	<u>15,805,000</u>
---	-------------------	-------------------

Base Adjustment. The general fund base is increased by \$5,751,000 in fiscal year 2012 and \$6,705,000 in fiscal year 2013.

Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by ~~\$251,000~~ \$260,000 for fiscal year 2010; ~~\$266,000~~ \$284,000 in fiscal year 2011; ~~\$25,000~~ \$43,000 in fiscal year 2012; and ~~\$25,000~~ \$43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

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

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by \$500,000. The

commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

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

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

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

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
--	-------------	-------------

(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	854,373,000	1,043,411,000
	<u>853,567,000</u>	<u>1,039,517,000</u>

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

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

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

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

(e) Mental Health Grants

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

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

(f) Deaf and Hard-of-Hearing Grants 1,930,000 1,917,000

(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000
---	-------------	-------------

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

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

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period ~~July 1, 2009~~ October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
--	-----------	-----------

~~**Base Adjustment.** The general fund base is decreased by \$3,000 in each of fiscal years 2012 and 2013.~~

	18,272,000	13,139,000
(i) Other Continuing Care Grants	<u>19,201,000</u>	<u>17,528,000</u>

Base Adjustment. The general fund base is increased by ~~\$7,028,000~~ \$2,639,000 in fiscal year 2012 and increased by ~~\$8,243,000~~ \$3,854,000 in fiscal year 2013.

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

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

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

Subd. 9. Continuing Care Management

Appropriations by Fund		
General	24,927,000	25,314,000
State Government	875,000	
Special Revenue	<u>125,000</u>	125,000
Lottery Prize	157,000	157,000

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

County Maintenance of Effort. \$350,000 in fiscal year 2010 is from the general fund for the State-County Results Accountability and Service Delivery Reform under Minnesota Statutes, chapter 402A.

Base Adjustment. The general fund base is decreased \$2,697,000 in fiscal year 2012 and \$2,791,000 in fiscal year 2013.

Subd. 10. State-Operated Services

~~258,794,000~~

~~266,191,000~~

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

Transfer Authority Related to State-Operated Services. Money appropriated to finance state-operated services may be transferred between the fiscal years of the biennium with the approval of the commissioner of finance.

County Past Due Receivables. The commissioner is authorized to withhold county federal administrative reimbursement when the county of financial responsibility for cost-of-care payments due the state under Minnesota Statutes, section 246.54 or 253B.045, is 90 days past due. The commissioner shall deposit the withheld federal administrative earnings for the county into the general fund to settle the claims with the county of financial responsibility. The process for withholding funds is governed by Minnesota Statutes, section 256.017.

Forecast and Census Data. The commissioner shall include census data and fiscal projections for state-operated services and Minnesota sex offender services with the November and February budget forecasts. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

(a) Adult Mental Health Services

~~107,702,000~~

106,702,000

107,201,000

Appropriation Limitation. No part of the appropriation in this article to the commissioner for mental health treatment services provided by state-operated services shall be used for the Minnesota sex offender program.

Community Behavioral Health Hospitals. Under Minnesota Statutes, section 246.51, subdivision 1, a determination order for the clients served in a community behavioral health hospital operated by the commissioner of human services is only required when a client's third-party coverage has been exhausted.

Base Adjustment. The general fund base is decreased by \$500,000 for fiscal year 2012 and by \$500,000 for fiscal year 2013.

(b) Minnesota Sex Offender Services

Appropriations by Fund		
General	38,348,000	67,503,000
Federal Fund	26,495,000	0

Use of Federal Stabilization Funds. Of this appropriation, \$26,495,000 in fiscal year 2010 is from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.

(c) Minnesota Security Hospital and METO Services

Appropriations by Fund		
	230,000,000	
General	<u>230,000</u>	83,735,000
	83,504,000	
Federal Fund	<u>83,505,000</u>	0

Minnesota Security Hospital. For the purposes of enhancing the safety of the public, improving supervision, and enhancing community-based mental health treatment, state-operated services may establish additional community capacity for providing treatment and supervision of clients who have been ordered into a less restrictive alternative of care from the state-operated services transitional services program consistent with Minnesota Statutes, section 246.014.

Use of Federal Stabilization Funds. \$83,505,000 in fiscal year 2010 is appropriated from the fiscal stabilization account in the federal fund to the commissioner. This appropriation must not be used for any activity or service for which federal reimbursement is claimed. This is a onetime appropriation.

Sec. 2. Laws 2009, chapter 79, article 13, section 4, is amended to read:

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** \$ **165,717,000** \$ **161,841,000**

Appropriations by Fund

	2010	2011
General	69,366,000	63,884,000
State Government		
Special Revenue	45,415,000	45,415,000
Health Care Access	39,203,000	40,809,000
Federal TANF	11,733,000	11,733,000

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

Appropriations by Fund

General	44,814,000	39,671,000
State Government		1,304,000
Special Revenue	1,033,000	<u>1,033,000</u>
Federal TANF	11,733,000	11,733,000
Health Care Access	21,642,000	28,719,000

~~**Newborn Screening Fee.** Of the general fund appropriation, \$300,000 in fiscal year 2011 is to the commissioner for the purpose of providing support services to families as required under Minnesota Statutes, section 144.966, subdivision 3a. \$74,000 of this appropriation in fiscal year 2011 and \$51,000 of this appropriation in subsequent fiscal years may be used by the commissioner for administrative costs associated with increasing the fee, contract administration, program oversight, and provide follow-up to families who need assistance beyond those available through the contractor.~~

Support Services for Families With Children Who are Deaf or Have Hearing Loss. Of the general fund amount, \$16,000 in fiscal year 2010 and \$284,000 in fiscal year 2011 is for support services to families with children who are deaf or have hearing loss. Of this amount, in fiscal year 2011, \$223,000 is for grants and the balance is for

administrative costs. Base funding in fiscal years 2012 and 2013 is \$300,000 each year. Of this amount, \$241,000 each year is for grants and the balance is for administrative costs.

Funding Usage. Up to 75 percent of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program. The general fund reduction of \$5,193,000 in fiscal year 2011 for local public health grants is onetime and the base funding for local public health grants for fiscal year 2012 is increased by \$5,193,000.

Colorectal Screening. ~~\$88,000~~ \$188,000 in fiscal year 2010 and \$62,000 in fiscal year 2011 are for grants to the Hennepin County Medical Center and MeritCare Bemidji for colorectal screening demonstration projects.

Feasibility Pilot Project for Cancer Surveillance. Of the general fund appropriation for fiscal year 2010, \$100,000 is to the commissioner to provide grant funding to cover the cost of one full-time equivalent position at the Hennepin County Medical Center to carry out the feasibility pilot project.

American Recovery and Reinvestment Act Funds. Federal funds received by the commissioner for WIC program management information systems from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purpose of the grant.

TANF Appropriations. (1) \$1,156,000 of the TANF funds are appropriated each year to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) \$3,579,000 of the TANF funds are appropriated each year to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) \$2,000,000 of the TANF funds are appropriated each year to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) \$4,998,000 of the TANF funds are appropriated each year to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. \$4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. \$998,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a. The commissioner may use five percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and may use ten percent of the funds appropriated each fiscal year to provide training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

Base Adjustment. The general fund base is increased by \$10,302,000 for fiscal year 2012 and increased by \$5,109,000 for fiscal year 2013. The health care access fund base is reduced to \$1,719,000 for both fiscal years 2012 and 2013.

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

Subd. 3. Policy Quality and Compliance

Appropriations by Fund		
		7,242,000
General	7,491,000	<u>7,243,000</u>
State Government		
Special Revenue	14,173,000	14,173,000
Health Care Access	17,561,000	12,090,000

Community-Based Health Care

Demonstration Project. Notwithstanding

the provisions of Laws 2007, chapter 147, article 19, section 3, subdivision 6, paragraph (e), base level funding to the commissioner for the demonstration project grant described in Minnesota Statutes, section 62Q.80, subdivision 1a, shall be zero for fiscal years 2011 and 2012.

Medical Education and Research Cost Federal Compliance.

Notwithstanding Laws 2008, chapter 363, article 18, section 4, subdivision 3, the base level funding for the commissioner to distribute to the Mayo Clinic for transitional funding while federal compliance changes are made to the medical education and research cost funding distribution formula shall be \$0 for fiscal years 2010 and 2011.

Autism Clinical Research.

The commissioner, in partnership with a Minnesota research institution, shall apply for funds available for research grants under the American Recovery and Reinvestment Act (ARRA) of 2009 in order to expand research and treatment of autism spectrum disorders.

Health Information Technology. (a) Of the health care access fund appropriation, \$4,000,000 is to fund the revolving loan account under Minnesota Statutes, section 62J.496. This appropriation must not be expended unless it is matched with federal funding under the federal Health Information Technology for Economic and Clinical Health (HITECH) Act. This appropriation must not be included in the agency's base budget for the fiscal year beginning July 1, 2012.

(b) On or before June 30, 2013, \$1,200,000 shall be transferred from the revolving loan account under Minnesota Statutes, section 62J.496, to the health care access fund. This is a onetime transfer and must not be included in the agency's base budget for the fiscal year beginning July 1, 2014.

Base Adjustment. The general fund base is \$8,243,000 in fiscal year 2012 and \$8,243,000 in fiscal year 2013. The health

care access fund base is \$10,950,000 in fiscal year 2012 and \$6,816,000 in fiscal year 2013.

Subd. 4. Health Protection

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

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

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

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

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

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

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

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

Subd. 5. Administrative Support Services	7,190,000	7,190,000
---	-----------	-----------

Sec. 3. Laws 2009, chapter 79, article 13, section 5, is amended to read:

Sec. 5. HEALTH-RELATED BOARDS

		15,017,000	14,831,000
Subdivision 1. Total Appropriation	\$	<u>14,034,000</u>	\$ <u>13,848,000</u>

This appropriation is from the state government special revenue fund.

Transfer. In fiscal year ~~2010~~ 2011, \$6,000,000 shall be transferred from the state government special revenue fund to the general fund. The boards must allocate this reduction to boards carrying a positive balance as of July 1, 2009.

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

Subd. 2. Board of Chiropractic Examiners	447,000	447,000
Subd. 3. Board of Dentistry	1,009,000	1,009,000
Subd. 4. Board of Dietetic and Nutrition Practice	105,000	105,000
Subd. 5. Board of Marriage and Family Therapy	137,000	137,000
	3,674,000	3,674,000
Subd. 6. Board of Medical Practice	<u>3,682,000</u>	<u>3,682,000</u>
	4,217,000	4,219,000
Subd. 7. Board of Nursing	<u>3,287,000</u>	<u>3,289,000</u>
	1,146,000	958,000
Subd. 8. Board of Nursing Home Administrators	<u>1,211,000</u>	<u>1,023,000</u>

Administrative Services Unit - Operating

Costs. Of this appropriation, \$524,000 in fiscal year 2010 and \$526,000 in fiscal year 2011 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement

Costs. Of this appropriation in fiscal year 2010, \$201,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, \$79,000 in fiscal year 2010 and \$89,000 in fiscal year 2011 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, \$200,000 in fiscal year 2010 and \$200,000 in fiscal year 2011 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Subd. 9. Board of Optometry	101,000	101,000
	1,413,000	1,413,000
Subd. 10. Board of Pharmacy	<u>1,388,000</u>	<u>1,388,000</u>
Subd. 11. Board of Physical Therapy	295,000	295,000
Subd. 12. Board of Podiatry	56,000	56,000
Subd. 13. Board of Psychology	806,000	806,000
	1,022,000	1,022,000
Subd. 14. Board of Social Work	<u>921,000</u>	<u>921,000</u>
Subd. 15. Board of Veterinary Medicine	195,000	195,000
Subd. 16. Board of Behavioral Health and Therapy	394,000	394,000

Sec. 4. Laws 2009, chapter 79, article 13, section 6, is amended to read:

Sec. 6. EMERGENCY MEDICAL SERVICES BOARD		4,378,000	3,828,000
	\$	<u>3,928,000</u>	\$ <u>3,828,000</u>

Appropriations by Fund

	2010	2011
	3,674,000	
General	<u>3,224,000</u>	3,124,000
State Government		
Special Revenue	704,000	704,000

Longevity Award and Incentive Program.

Of the general fund appropriation, \$700,000 in fiscal year 2010 and \$700,000 in fiscal year 2011 are to the board for the Cooper/Sams volunteer ambulance program, under Minnesota Statutes, section 144E.40.

Transfer. In fiscal year 2010, \$6,182,000 is transferred from the Cooper/Sams volunteer ambulance trust, established under Minnesota Statutes, section 144E.42, to the general fund.

Health Professional Services Program.

\$704,000 in fiscal year 2010 and \$704,000 in fiscal year 2011 from the state government special revenue fund are for the health professional services program.

Comprehensive Advanced Life-Support Educational (CALS) Program.

\$100,000 in the first year from the ~~Cooper/Sams volunteer ambulance trust~~ general fund is for the comprehensive advanced life-support educational (CALS) program established under Minnesota Statutes, section 144E.37. This appropriation is to extend availability and affordability of the CALS program for rural emergency medical personnel and to assist hospital staff in attaining the credentialing levels necessary for implementation of the statewide trauma system.

Veterans Paramedic Apprenticeship Program.

Of this appropriation, \$200,000 in the first year is from the general fund for transfer to the commissioner of veterans affairs for a grant to the Minnesota

Ambulance Association to implement a veterans paramedic apprenticeship program to reintegrate returning military medics into Minnesota's workforce in the field of paramedic and emergency services, thereby guaranteeing returning military medics gainful employment with livable wages and benefits. This appropriation is available until expended.

Medical Response Unit Reimbursement Pilot Program. (a) \$250,000 in the first year is from the general fund for a transfer to the Department of Public Safety for a medical response unit reimbursement pilot program. Of this appropriation, \$75,000 is for administrative costs to the Department of Public Safety, including providing contract staff support and technical assistance to the pilot program partners if necessary.

(b) Of the amount in paragraph (a), \$175,000 is to be used to provide a predetermined reimbursement amount to the participating medical response units. The Department of Public Safety or its contract designee will develop an agreement with the medical response units outlining reimbursement and program requirements to include HIPAA compliance while participating in the pilot program.

Sec. 5. **REPEALER.**

Laws 2009, chapter 79, article 13, sections 7; and 8, are repealed.

ARTICLE 3

HEALTH CARE ELIGIBILITY

Section 1. Minnesota Statutes 2008, section 62J.2930, subdivision 3, is amended to read:

Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

- (1) assist enrollees in understanding their rights;
- (2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;
- (3) provide information on coverage options in each region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 2008, section 245.494, subdivision 3, is amended to read:

Subd. 3. **Duties of the commissioner of human services.** The commissioner of human services, in consultation with the Integrated Fund Task Force, shall:

(1) in the first quarter of 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, identify all medical assistance and MinnesotaCare resources devoted to mental health services for children in the target population including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services in the total health capitation of prepaid plans under contract with the commissioner to provide medical assistance services under section 256B.69;

(2) assist each children's mental health collaborative to determine an actuarially feasible operational target population;

(3) ensure that a prepaid health plan that contracts with the commissioner to provide medical assistance or MinnesotaCare services shall pass through the identified resources to a collaborative or collaboratives upon the collaboratives meeting the requirements of section 245.4933 to serve the collaborative's operational target population. The commissioner shall, through an independent actuarial analysis, specify differential rates the prepaid health plan must pay the collaborative based upon severity, functioning, and other risk factors, taking into consideration the fee-for-service experience of children excluded from prepaid medical assistance participation;

(4) ensure that a children's mental health collaborative that enters into an agreement with a prepaid health plan under contract with the commissioner shall accept medical assistance recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the agreement between the collaborative and the commissioner;

(5) ensure that a children's mental health collaborative that receives resources passed through a prepaid health plan under contract with the commissioner shall be subject to the quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(6) ensure that any prepaid health plan that contracts with the commissioner, including a plan that contracts under section 256B.69, must enter into an agreement with any collaborative operating in the same service delivery area that:

(i) meets the requirements of section 245.4933;

(ii) is willing to accept the rate determined by the commissioner to provide medical assistance services; and

(iii) requests to contract with the prepaid health plan;

(7) ensure that no agreement between a health plan and a collaborative shall terminate the legal responsibility of the health plan to assure that all activities under the contract are carried out. The agreement may require the collaborative to indemnify the health plan for activities that are not carried out;

(8) ensure that where a collaborative enters into an agreement with the commissioner to provide medical assistance and MinnesotaCare services a separate capitation rate will be determined through an independent actuarial analysis which is based upon the factors set forth in clause (3) to be paid to a collaborative for children in the operational target population who are eligible for medical assistance but not included in the prepaid health plan contract with the commissioner;

(9) ensure that in counties where no prepaid health plan contract to provide medical assistance or MinnesotaCare services exists, a children's mental health collaborative that meets the requirements of section 245.4933 shall:

(i) be paid a capitated rate, actuarially determined, that is based upon the collaborative's operational target population;

(ii) accept medical assistance or MinnesotaCare recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the contract between the collaborative and the commissioner; and

(iii) comply with quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(10) subject to federal approval, in the development of rates for local children's mental health collaboratives, the commissioner shall consider, and may adjust, trend and utilization factors, to reflect changes in mental health service utilization and access;

(11) consider changes in mental health service utilization, access, and price, and determine the actuarial value of the services in the maintenance of rates for local children's mental health collaborative provided services, subject to federal approval;

(12) provide written notice to any prepaid health plan operating within the service delivery area of a children's mental health collaborative of the collaborative's existence within 30 days of the commissioner's receipt of notice of the collaborative's formation;

(13) ensure that in a geographic area where both a prepaid health plan including those established under either section 256B.69 or 256L.12 and a local children's mental health collaborative exist, medical assistance and MinnesotaCare recipients in the operational target population who are enrolled in prepaid health plans will have the choice to receive mental health services through either the prepaid health plan or the collaborative that has a contract with the prepaid health plan, according to the terms of the contract;

(14) develop a mechanism for integrating medical assistance resources for mental health service with MinnesotaCare and any other state and local resources available for services for children in the operational target population, and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(15) gather data needed to manage mental health care including evaluation data and data necessary to establish a separate capitation rate for children's mental health services if that option is selected;

(16) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.495 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.495;

(17) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including administration and outreach that may be eligible for federal financial participation under medical assistance and other federal programs;

(18) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.495;

(19) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.495 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(20) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care and for individualized rehabilitation services;

(21) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund;

(22) ensure that family members who are enrolled in a prepaid health plan and whose children are receiving mental health services through a local children's mental health collaborative file complaints about mental health services needed by the family members, the commissioner shall comply with section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20. A collaborative may assist a family to make a complaint; and

(23) facilitate a smooth transition for children receiving prepaid medical assistance or MinnesotaCare services through a children's mental health collaborative who become enrolled in a prepaid health plan.

Sec. 3. Minnesota Statutes 2008, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the ~~Department~~ commissioner of human services;

(1) any state agency or third party payer shall cooperate ~~with the department in by~~ furnishing information to help establish a third party liability. ~~Upon the request of the~~

~~Department of Human Services or county child support or human service agencies, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;~~

(2) any employer or third party payer shall cooperate in by furnishing a data file containing information about group health insurance plans plan or medical benefit plans available to plan coverage of its employees or insureds within 60 days of the request.

(b) For purposes of section 176.191, subdivision 4, the Department commissioner of labor and industry may allow the Department commissioner of human services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the Department commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138(d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The Department commissioner of human services and county agencies shall limit its use of information gained from agencies, third party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 4. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

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

rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

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

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

Payments made to managed care plans shall be reduced for services provided on or after July 1, 2010, to reflect this reduction.

Sec. 5. Minnesota Statutes 2008, section 256B.037, subdivision 5, is amended to read:

Subd. 5. **Other contracts permitted.** Nothing in this section prohibits the commissioner from contracting with an organization for comprehensive health services, including dental services, under ~~section 256B.031~~, sections 256B.035, 256B.69, or 256D.03, subdivision 4, paragraph (c).

Sec. 6. Minnesota Statutes 2008, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: \$90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) 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.

(e) For children age 18 or under, annual gifts of \$2,000 or less by a tax-exempt organization to or for the benefit of the child with a life-threatening illness must be disregarded from income.

Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than \$20,000 in total net assets, and a household of one person must not own more than \$10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they

must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business up to \$200,000 are not considered;
- (3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;
- (4) ~~one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual~~ assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;
- (5) court-ordered settlements up to \$10,000 are not considered;
- (6) individual retirement accounts and funds are not considered; and
- (7) assets owned by children are not considered.

Sec. 8. Minnesota Statutes 2008, section 256B.056, subdivision 6, is amended to read:

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses from any other 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. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or the state" includes prepaid health plans under contract with the commissioner according to sections ~~256B.031~~, 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Sec. 9. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug Utilization Review Board is established. The board must be comprised of at least three

but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative. The remainder must be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the board must be appointed by the commissioner, shall serve three-year terms, and may be reappointed by the commissioner. The board shall annually elect a chair from among its members.

(b) The board must be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board.

(c) The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to:

(i) receive public comment regarding drug utilization review criteria and standards;
and

(ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

(d) The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

(e) The board shall report to the commissioner annually on the date the drug utilization review annual report is due to the Centers for Medicare and Medicaid Services. This report must cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of \$100 per meeting and reimbursement for mileage must be paid to each board member in attendance.

(f) This subdivision is exempt from the provisions of section 15.059. Notwithstanding section 15.059, subdivision 5, the board is permanent and does not expire.

Sec. 10. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 53. **Centers of excellence.** For complex medical procedures with a high degree of variation in outcomes, for which the Medicare program requires facilities providing the services to meet certain criteria as a condition of coverage, the commissioner may develop centers of excellence facility criteria in consultation with the Health Services Policy Committee, section 256B.0625, subdivision 3c. The criteria must reflect facility traits that have been linked to superior patient safety and outcomes for the procedures in question, and must be based on the best available empirical evidence. For medical assistance recipients enrolled on a fee-for-service basis, the commissioner may make coverage for these procedures conditional upon the facility providing the services meeting the specified criteria. Only facilities meeting the criteria may be reimbursed for the procedures in question.

EFFECTIVE DATE. This section is effective August 1, 2009, or upon federal approval, whichever is later.

Sec. 11. Minnesota Statutes 2008, section 256B.094, subdivision 3, is amended to read:

Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where a prepaid medical assistance provider has contracted under section ~~256B.031~~ or 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county or tribal social services arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county or tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county or tribal social services may not seek reimbursement from the prepaid provider.

Sec. 12. Minnesota Statutes 2008, section 256B.195, subdivision 1, is amended to read:

Subdivision 1. **Federal approval required.** ~~Sections~~ Section 145.9268; ~~256.969, subdivision 26,~~ and this section are contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals and community clinics authorized under

this section. These sections are also contingent on current payment, by the government entities, of intergovernmental transfers under section 256B.19 and this section.

Sec. 13. Minnesota Statutes 2008, section 256B.195, subdivision 2, is amended to read:

Subd. 2. **Payments from governmental entities.** (a) In addition to any payment required under section 256B.19, effective July 15, 2001, the following government entities shall make the payments indicated ~~before noon on the 15th of each month~~ annually:

(1) Hennepin County, ~~\$2,000,000~~ \$24,000,000; and

(2) Ramsey County, ~~\$1,000,000~~ \$12,000,000.

(b) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs. Of these payments, Hennepin County shall pay 71 percent directly to Hennepin County Medical Center, and Ramsey County shall pay 71 percent directly to Regions Hospital. The counties must provide certification to the commissioner of payments to hospitals under this subdivision.

Sec. 14. Minnesota Statutes 2008, section 256B.195, subdivision 3, is amended to read:

Subd. 3. **Payments to certain safety net providers.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated ~~after noon on the 15th of each month~~ annually:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions Hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates. The allocation in paragraph (b), clause (1), item (ii), to increase hospital payments under section 256.969, subdivision 26, shall not limit payments under that section.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

(1) if the payments under subdivision 5 are approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments; or

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

Sec. 15. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs

under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

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

(2) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph. The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

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

Sec. 16. Minnesota Statutes 2008, section 256B.77, subdivision 13, is amended to read:

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, and advocacy services provided by the ombudsman for mental health and developmental disabilities established in sections 245.91 to 245.97. The managed care ombudsman and the ombudsman for mental health and developmental disabilities shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the Office of Ombudsman for Mental Health and Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

Sec. 17. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

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 ~~as~~ as for applicants and recipients defined in paragraph ~~(b)~~ (c), except as provided in paragraph ~~(c)~~ (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; ~~or,~~

~~(iii)~~ (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.

~~(b)~~ (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 ~~(c)~~ (f).

~~(c)~~ (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.

~~(d)~~ (e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph ~~(c)~~ (d), an individual must complete a new application.

~~(c)~~ (f) Applicants and recipients eligible under paragraph (a), clause ~~(b)~~ (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 ~~(f)~~(k);
- (7) receive treatment funded pursuant to section 254B.02; or
- (8) reside in the Minnesota sex offender program defined in chapter 246B.

~~(f)~~(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.

~~(g)~~(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph ~~(c)~~(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 ~~(c)~~(d), ~~(e)~~(f), and ~~(f)~~(g).

~~(h)~~(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.

~~(i)~~(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.

~~(j)~~ (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.

~~(k)~~ (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.

~~(l)~~ (m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

~~(m)~~ (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.

~~(n)~~ (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(a)(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.

~~(o)~~ (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.

~~(p)~~ (q) Effective July 1, 2003, general assistance medical care emergency services end.

Sec. 18. Minnesota Statutes 2008, section 256L.01, is amended by adding a subdivision to read:

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

EFFECTIVE DATE. This section is effective August 1, 2009, except that the amendment made to the "gross individual or gross family income" for farm self-employed is effective July 1, 2009, or upon federal approval, whichever is later.

Sec. 19. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:

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

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual ~~and \$3,000 per family~~;

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

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

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

(5) \$6 for nonemergency visits to a hospital-based emergency room.

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

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

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

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

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 20. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of \$4. For purposes of paragraph (d), "minimum" means a monthly premium of \$4.

(d) The following premium scale is established for individuals and families with gross family incomes of ~~300~~ 275 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	<u>\$4 or 1.1% of family income, whichever is greater</u>

55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274% <u>249-275%</u>	7.2%
275-300%	8.0%

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Laws 2005, First Special Session chapter 4, article 8, section 54, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later 2009.

Sec. 22. Laws 2005, First Special Session chapter 4, article 8, section 61, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later 2009.

Sec. 23. Laws 2005, First Special Session chapter 4, article 8, section 63, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later 2009.

Sec. 24. Laws 2005, First Special Session chapter 4, article 8, section 66, the effective date, is amended to read:

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2007, or upon HealthMatch implementation, whichever is later 2009, and paragraph (e) is effective September 1, 2006.

Sec. 25. Laws 2005, First Special Session chapter 4, article 8, section 74, the effective date, is amended to read:

EFFECTIVE DATE. The amendment to paragraph (a) changing gross family or individual income to monthly gross family or individual income is effective August 1, 2007, or upon implementation of HealthMatch, whichever is later 2009. The amendment to paragraph (a) related to premium adjustments and changes of income and the amendment to paragraph (c) are effective September 1, 2005, or upon federal approval,

whichever is later. ~~Prior to the implementation of HealthMatch, The commissioner shall implement this section to the fullest extent possible, including the use of manual processing. Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.~~

Sec. 26. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256B.031; and 256L.01, subdivision 4, are repealed.

(b) Laws 2005, First Special Session chapter 4, article 8, sections 21; 22; 23; and 24, are repealed.

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

Presented to the governor May 21, 2009

Signed by the governor May 22, 2009, 4:05 p.m.