1.1 A bill for an act
1.2 relating to state government; making technical health and human services
1.3 changes; making health care program policy changes; changing health care
1.4 eligibility provisions; authorizing rulemaking; requiring reports; changing
1.5 appropriations; appropriating money; amending Minnesota Statutes 2008,
1.6 sections 62J.2930, subdivision 3; 62J.497, subdivision 5, as added; 144.0724,
1.7 subdivision 11, as added; 245.494, subdivision 3; 245A.11, subdivision 7a,
1.8 as added; 245C.03, by adding a subdivision; 245C.04, subdivision 1, as
1.9 amended, by adding a subdivision; 245C.05, subdivision 2b, as added; 245C.10,
1.10 subdivision 5, as added, by adding a subdivision; 245C.21, subdivision 1a, as
1.11 amended; 246.50, subdivision 3; 256.01, subdivision 18b, as added; 256.015,
1.12 subdivision 7; 256.969, subdivisions 2b, as amended, 3a, 29, as added, by adding
1.13 a subdivision; 256.975, subdivision 7, as amended; 256B.037, subdivision 5;
1.14 256B.056, subdivisions 1c, 3b, 3c, 6; 256B.057, subdivision 11, as added;
1.15 256B.06, subdivision 4, as amended; 256B.0625, subdivisions 3c, as amended,
1.16 13h, as amended, by adding subdivisions; 256B.0655, subdivision 4, as amended;
1.17 256B.0659, subdivisions 9, as added, 10, as added, 13, as added, 21, as added,
1.18 29, as added; 256B.0911, subdivision 1a, as amended; 256B.094, subdivision
1.19 3; 256B.195, subdivisions 1, 2, 3; 256B.441, subdivision 55, as amended;
1.20 256B.49, subdivision 11a, as added; 256B.69, subdivision 5a; 256B.756, as
1.21 added; 256B.76, subdivision 1, as amended; 256B.77, subdivision 13; 256D.03,
1.22 subdivisions 3, 4, as amended; 256J.575, subdivision 3, as amended; 256L.01,
1.23 by adding a subdivision; 256L.03, subdivisions 3b, as added, 5; 256L.04,
1.24 subdivision 1, as amended; 256L.05, subdivision 1c, as added; 256L.11,
1.25 subdivision 1, as amended; 256L.15, subdivision 2; 402A.30, subdivision 4, as
1.26 added; 626.556, subdivision 3c, as amended; Laws 2005, First Special Session
1.27 chapter 4, article 8, sections 54; 61; 63; 66; 74; Laws 2009, chapter 79, article
1.28 2, section 36; article 5, sections 25; 52; article 8, sections 8; 13; 73; article 10,
1.29 section 46; article 13, sections 3; 4; 5; 6; repealing Minnesota Statutes 2008,
1.30 sections 256B.031; 256L.01, subdivision 4; Laws 2005, First Special Session
1.31 chapter 4, article 8, sections 21; 22; 23; 24; Laws 2009, chapter 79, article 7,
1.32 section 12; article 13, sections 7; 8.

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

2.1 **ARTICLE 1**
2.2 **HEALTH AND HUMAN SERVICES TECHNICAL**

2.3 Section 1. Minnesota Statutes 2008, section 62J.497, subdivision 5, as added by Laws
2.4 2009, chapter 79, article 4, section 6, is amended to read:
2.5 Subd. 5. **Electronic drug prior authorization standardization and transmission.**
2.6 (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory
2.7 Committee and the Minnesota Administrative Uniformity Committee, shall, by February
2.8 15, 2010, identify an outline on how best to standardize drug prior authorization request
2.9 transactions between providers and group purchasers with the goal of maximizing
2.10 administrative simplification and efficiency in preparation for electronic transmissions.
2.11 (b) No later than January 1, 2011, drug prior authorization requests must be
2.12 accessible and submitted by health care providers, and accepted ~~and processed~~ by group
2.13 purchasers, electronically through secure electronic transmissions. Facsimile shall not be
2.14 considered electronic transmission.

2.15 Sec. 2. Minnesota Statutes 2008, section 144.0724, subdivision 11, as added by Laws
2.16 2009, chapter 79, article 8, section 4, is amended to read:
2.17 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance
2.18 payment of long-term care services, a recipient must be determined, using assessments
2.19 defined in subdivision 4, to meet one of the following nursing facility level of care criteria:
2.20 (1) the person needs the assistance of another person or constant supervision to begin
2.21 and complete at least four of the following activities of living: bathing, bed mobility,
2.22 dressing, eating, grooming, toileting, transferring, and walking;
2.23 (2) the person needs the assistance of another person or constant supervision to begin
2.24 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;
2.25 (3) the person has significant difficulty with memory, using information, daily
2.26 decision making, or behavioral needs that require intervention;
2.27 (4) the person has had a qualifying nursing facility stay of at least 90 days; or
2.28 (5) the person is determined to be at risk for nursing facility admission or
2.29 readmission through a face-to-face long-term care consultation assessment as specified
2.30 in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care
2.31 organization under contract with the Department of Human Services. The person is
2.32 considered at risk under this clause if the person currently lives alone or will live alone
2.33 upon discharge and also meets one of the following criteria:
2.34 (i) the person has experienced a fall resulting in a fracture;

3.1 (ii) the person has been determined to be at risk of maltreatment or neglect,
3.2 including self-neglect; or
3.3 (iii) the person has a sensory impairment that substantially impacts functional ability
3.4 and maintenance of a community residence.
3.5 (b) The assessment used to establish medical assistance payment for nursing facility
3.6 services must be the most recent assessment performed under subdivision 4, paragraph
3.7 (b), that occurred no more than 90 calendar days before the effective date of medical
3.8 assistance eligibility for payment of long-term care services. In no case shall medical
3.9 assistance payment for long-term care services occur prior to the date of the determination
3.10 of nursing facility level of care.
3.11 (c) The assessment used to establish medical assistance payment for long-term care
3.12 services provided under sections 256B.0915 and 256B.49 and alternative care payment
3.13 for services provided under section 256B.0913 must be the most recent face-to-face
3.14 assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred
3.15 no more than 60 calendar days before the effective date of medical assistance eligibility
3.16 for payment of long-term care services.

3.17 Sec. 3. Minnesota Statutes 2008, section 245A.11, subdivision 7a, as added by Laws
3.18 2009, chapter 79, article 1, section 4, is amended to read:
3.19 Subd. 7a. **Alternate overnight supervision technology; adult foster care license.**
3.20 (a) The commissioner may grant an applicant or license holder an adult foster care license
3.21 for a residence that does not have a caregiver in the residence during normal sleeping
3.22 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, but uses
3.23 monitoring technology to alert the license holder when an incident occurs that may
3.24 jeopardize the health, safety, or rights of a foster care recipient. The applicant or license
3.25 holder must comply with all other requirements under Minnesota Rules, parts 9555.5105
3.26 to 9555.6265, and the requirements under this subdivision. The license printed by the
3.27 commissioner must state in bold and large font:
3.28 (1) that the facility is under electronic monitoring; and
3.29 (2) the telephone number of the county's common entry point for making reports of
3.30 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.
3.31 (b) Applications for a license under this section must be submitted directly to
3.32 the Department of Human Services licensing division. The licensing division must
3.33 immediately notify the host county and lead county contract agency and the host county
3.34 licensing agency. The licensing division must collaborate with the county licensing
3.35 agency in the review of the application and the licensing of the program.

4.1 (c) Before a license is issued by the commissioner, and for the duration of the
4.2 license, the applicant or license holder must establish, maintain, and document the
4.3 implementation of written policies and procedures addressing the requirements in
4.4 paragraphs (d) through (f).
4.5 (d) The applicant or license holder must have policies and procedures that:
4.6 (1) establish characteristics of target populations that will be admitted into the home,
4.7 and characteristics of populations that will not be accepted into the home;
4.8 (2) explain the discharge process when a foster care recipient requires overnight
4.9 supervision or other services that cannot be provided by the license holder due to the
4.10 limited hours that the license holder is on-site;
4.11 (3) describe the types of events to which the program will respond with a physical
4.12 presence when those events occur in the home during time when staff are not on-site, and
4.13 how the license holder's response plan meets the requirements in paragraph (e), clause
4.14 (1) or (2);
4.15 (4) establish a process for documenting a review of the implementation and
4.16 effectiveness of the response protocol for the response required under paragraph (e),
4.17 clause (1) or (2). The documentation must include:
4.18 (i) a description of the triggering incident;
4.19 (ii) the date and time of the triggering incident;
4.20 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);
4.21 (iv) whether the response met the resident's needs;
4.22 (v) whether the existing policies and response protocols were followed; and
4.23 (vi) whether the existing policies and protocols are adequate or need modification.
4.24 When no physical presence response is completed for a three-month period, the
4.25 license holder's written policies and procedures must require a physical presence response
4.26 drill be to conducted for which the effectiveness of the response protocol under paragraph
4.27 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and
4.28 (5) establish that emergency and nonemergency phone numbers are posted in a
4.29 prominent location in a common area of the home where they can be easily observed by a
4.30 person responding to an incident who is not otherwise affiliated with the home.
4.31 (e) The license holder must document and include in the license application which
4.32 response alternative under clause (1) or (2) is in place for responding to situations that
4.33 present a serious risk to the health, safety, or rights of people receiving foster care services
4.34 in the home:
4.35 (1) response alternative (1) requires only the technology to provide an electronic
4.36 notification or alert to the license holder that an event is underway that requires a response.

5.1 Under this alternative, no more than ten minutes will pass before the license holder will be
5.2 physically present on-site to respond to the situation; or
5.3 (2) response alternative (2) requires the electronic notification and alert system
5.4 under alternative (1), but more than ten minutes may pass before the license holder is
5.5 present on-site to respond to the situation. Under alternative (2), all of the following
5.6 conditions are met:
5.7 (i) the license holder has a written description of the interactive technological
5.8 applications that will assist the ~~licenser~~ license holder in communicating with and assessing
5.9 the needs related to care, health, and safety of the foster care recipients. This interactive
5.10 technology must permit the license holder to remotely assess the well being of the foster
5.11 care recipient without requiring the initiation of the foster care recipient. Requiring the
5.12 foster care recipient to initiate a telephone call does not meet this requirement;
5.13 (ii) the license holder documents how the remote license holder is qualified and
5.14 capable of meeting the needs of the foster care recipients and assessing foster care
5.15 recipients' needs under item (i) during the absence of the license holder on-site;
5.16 (iii) the license holder maintains written procedures to dispatch emergency response
5.17 personnel to the site in the event of an identified emergency; and
5.18 (iv) each foster care recipient's individualized plan of care, individual service plan
5.19 under section 256B.092, subdivision 1b, if required, or individual resident placement
5.20 agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the
5.21 maximum response time, which may be greater than ten minutes, for the license holder
5.22 to be on-site for that foster care recipient.
5.23 (f) All placement agreements, individual service agreements, and plans applicable
5.24 to the foster care recipient must clearly state that the adult foster care license category is
5.25 a program without the presence of a caregiver in the residence during normal sleeping
5.26 hours; the protocols in place for responding to situations that present a serious risk
5.27 to health, safety, or rights of foster care recipients under paragraph (e), clause (1) or
5.28 (2); and a signed informed consent from each foster care recipient or the person's
5.29 legal representative documenting the person's or legal representative's agreement with
5.30 placement in the program. If electronic monitoring technology is used in the home, the
5.31 informed consent form must also explain the following:
5.32 (1) how any electronic monitoring is incorporated into the alternative supervision
5.33 system;
5.34 (2) the backup system for any electronic monitoring in times of electrical outages or
5.35 other equipment malfunctions;
5.36 (3) how the license holder is trained on the use of the technology;

6.1 (4) the event types and license holder response times established under paragraph (e);
6.2 (5) how the license holder protects the foster care recipient's privacy related to
6.3 electronic monitoring and related to any electronically recorded data generated by the
6.4 monitoring system. A foster care recipient may not be removed from a program under
6.5 this subdivision for failure to consent to electronic monitoring. The consent form must
6.6 explain where and how the electronically recorded data is stored, with whom it will be
6.7 shared, and how long it is retained; and
6.8 (6) the risks and benefits of the alternative overnight supervision system.
6.9 The written explanations under clauses (1) to (6) may be accomplished through
6.10 cross-references to other policies and procedures as long as they are explained to the
6.11 person giving consent, and the person giving consent is offered a copy.
6.12 (g) Nothing in this section requires the applicant or license holder to develop or
6.13 maintain separate or duplicative polices, procedures, documentation, consent forms, or
6.14 individual plans that may be required for other licensing standards, if the requirements of
6.15 this section are incorporated into those documents.
6.16 (h) The commissioner may grant variances to the requirements of this section
6.17 according to section 245A.04, subdivision 9.
6.18 (i) For the purposes of paragraphs (d) through (h), license holder has the meaning
6.19 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
6.20 contractors affiliated with the license holder.
6.21 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
6.22 remotely determine what action the license holder needs to take to protect the well-being
6.23 of the foster care recipient.

6.24 Sec. 4. Minnesota Statutes 2008, section 245C.03, is amended by adding a subdivision
6.25 to read:
6.26 Subd. 6. **Unlicensed home and community-based waiver providers of service to**
6.27 **seniors and individuals with disabilities.** The commissioner shall conduct background
6.28 studies on any individual required under section 256B.4912 to have a background study
6.29 completed under this chapter.

6.30 Sec. 5. Minnesota Statutes 2008, section 245C.04, subdivision 1, as amended by Laws
6.31 2009, chapter 79, article 1, section 8, is amended to read:
6.32 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a
6.33 background study of an individual required to be studied under section 245C.03,
6.34 subdivision 1, at least upon application for initial license for all license types.

7.1 (b) The commissioner shall conduct a background study of an individual required
7.2 to be studied under section 245C.03, subdivision 1, at reapplication for a license for
7.3 family child care.
7.4 (c) The commissioner is not required to conduct a study of an individual at the time
7.5 of reapplication for a license if the individual's background study was completed by the
7.6 commissioner of human services for an adult foster care license holder that is also:
7.7 (1) registered under chapter 144D; or
7.8 (2) licensed to provide home and community-based services to people with
7.9 disabilities at the foster care location and the license holder does not reside in the foster
7.10 care residence; and
7.11 (3) the following conditions are met:
7.12 (i) a study of the individual was conducted either at the time of initial licensure or
7.13 when the individual became affiliated with the license holder;
7.14 (ii) the individual has been continuously affiliated with the license holder since
7.15 the last study was conducted; and
7.16 (iii) the last study of the individual was conducted on or after October 1, 1995.
7.17 (d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall
7.18 conduct a study of an individual required to be studied under section 245C.03, at the
7.19 time of reapplication for a child foster care license. The county or private agency shall
7.20 collect and forward to the commissioner the information required under section 245C.05,
7.21 subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background
7.22 study conducted by the commissioner of human services under this paragraph must
7.23 include a review of the information required under section 245C.08, subdivisions 1,
7.24 paragraph (a), clauses (1) to (5), 3, and 4.
7.25 (e) The commissioner of human services shall conduct a background study of an
7.26 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2)
7.27 to (6), who is newly affiliated with a child foster care license holder. The county or
7.28 private agency shall collect and forward to the commissioner the information required
7.29 under section 245C.05, subdivisions 1 and 5. The background study conducted by the
7.30 commissioner of human services under this paragraph must include a review of the
7.31 information required under section 245C.08, subdivisions 1, 3, and 4.
7.32 (f) From January 1, 2010, to December 31, 2012, unless otherwise specified in
7.33 paragraph (c), the commissioner shall conduct a study of an individual required to be
7.34 studied under section 245C.03 at the time of reapplication for an adult foster care or family
7.35 adult day services license: (1) the county shall collect and forward to the commissioner
7.36 the information required under section 245C.05, subdivision 1, paragraphs (a) and (b),

8.1 and subdivision 5, paragraphs (a) and (b), for background studies conducted by the
8.2 commissioner for all family adult day services and for adult foster care ~~and family adult~~
8.3 ~~day services~~ when the adult foster care license holder resides in the adult foster care
8.4 or family adult day services residence; (2) the license holder shall collect and forward
8.5 to the commissioner the information required under section 245C.05, subdivisions 1,
8.6 paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by
8.7 the commissioner for adult foster care when the license holder does not reside in the adult
8.8 foster care residence; and (3) the background study conducted by the commissioner under
8.9 this paragraph must include a review of the information required under section 245C.08,
8.10 subdivision 1, paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.

8.11 (g) The commissioner shall conduct a background study of an individual specified
8.12 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
8.13 affiliated with an adult foster care or family adult day services license holder: (1) the
8.14 county shall collect and forward to the commissioner the information required under
8.15 section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a)
8.16 and (b), for background studies conducted by the commissioner for all family adult day
8.17 services and for adult foster care ~~and family adult day services~~ when the adult foster care
8.18 license holder resides in the adult foster care ~~or family adult day services~~ residence; (2)
8.19 the license holder shall collect and forward to the commissioner the information required
8.20 under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a)
8.21 and (b), for background studies conducted by the commissioner for adult foster care
8.22 when the license holder does not reside in the adult foster care residence; and (3) the
8.23 background study conducted by the commissioner under this paragraph must include a
8.24 review of the information required under section 245C.08, subdivision 1, paragraph (a),
8.25 and subdivisions 3 and 4.

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

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

8.33 Sec. 6. Minnesota Statutes 2008, section 245C.04, is amended by adding a subdivision
8.34 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

10.1 related to studies conducted by the commissioner for child foster care, adult foster care,
10.2 and family adult day services, the individual shall submit the request for reconsideration
10.3 to the county agency that initiated the background study.

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

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

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

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

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

10.21 Sec. 12. Minnesota Statutes 2008, section 256.01, subdivision 18b, as added by Laws
10.22 2009, chapter 79, article 5, section 7, is amended to read:

10.23 Subd. 18b. **Protections for American Indians.** Effective ~~February 18~~ July 1,
10.24 2009, the commissioner shall comply with the federal requirements in the American
10.25 Recovery and Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding
10.26 American Indians.

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

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

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

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

11.16 Subd. 28. **Payment rates for births.** (a) For admissions occurring on or after
11.17 October 1, 2009, the total operating and property payment rate, excluding disproportionate
11.18 population adjustment, for the following diagnosis-related groups, as they fall within
11.19 the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2)
11.20 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without
11.21 complicating diagnosis, shall be no greater than $3,528.

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

11.23 (c) Payments to managed care and county-based purchasing plans under section
11.24 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October
11.25 1, 2009, to reflect the adjustments in paragraph (a).

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

11.28 Sec. 15. Minnesota Statutes 2008, section 256.969, subdivision 29, as added by Laws
11.29 2009, chapter 79, article 5, section 15, is amended to read:

11.30 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
11.31 **and intervention program.** For ~~services provided~~ admissions occurring on or after
11.32 July 1, 2010, ~~in addition to any other payment under this section, the commissioner~~
11.33 ~~shall reimburse hospitals for the increase in the fee for the early hearing detection and~~
11.34 ~~intervention program described in section 144.125, subdivision 1, paid by the hospital~~

12.1 ~~for public program recipients~~ payment rates shall be adjusted to include the increase to
12.2 the fee that is effective on July 1, 2010, for the early hearing detection and intervention
12.3 program recipients under section 144.125, subdivision 1, that is paid by the hospital for
12.4 public program recipients. This payment increase shall be in effect until the increase
12.5 is fully recognized in the base year cost under subdivision 2b. This payment shall be
12.6 included in payments to contracted managed care organizations.

12.7 Sec. 16. Minnesota Statutes 2008, section 256.975, subdivision 7, as amended by Laws
12.8 2009, chapter 79, article 8, section 16, is amended to read:
12.9 Subd. 7. **Consumer information and assistance and long-term care options**
12.10 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
12.11 statewide service to aid older Minnesotans and their families in making informed choices
12.12 about long-term care options and health care benefits. Language services to persons with
12.13 limited English language skills may be made available. The service, known as Senior
12.14 LinkAge Line, must be available during business hours through a statewide toll-free
12.15 number and must also be available through the Internet.
12.16 (b) The service must provide long-term care options counseling by assisting older
12.17 adults, caregivers, and providers in accessing information and options counseling about
12.18 choices in long-term care services that are purchased through private providers or available
12.19 through public options. The service must:
12.20 (1) develop a comprehensive database that includes detailed listings in both
12.21 consumer- and provider-oriented formats;
12.22 (2) make the database accessible on the Internet and through other telecommunication
12.23 and media-related tools;
12.24 (3) link callers to interactive long-term care screening tools and make these tools
12.25 available through the Internet by integrating the tools with the database;
12.26 (4) develop community education materials with a focus on planning for long-term
12.27 care and evaluating independent living, housing, and service options;
12.28 (5) conduct an outreach campaign to assist older adults and their caregivers in
12.29 finding information on the Internet and through other means of communication;
12.30 (6) implement a messaging system for overflow callers and respond to these callers
12.31 by the next business day;
12.32 (7) link callers with county human services and other providers to receive more
12.33 in-depth assistance and consultation related to long-term care options;
12.34 (8) link callers with quality profiles for nursing facilities and other providers
12.35 developed by the commissioner of health;

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

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

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

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

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

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

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

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

14.1 (ii) designated care coordinators of contracted entities under section 256B.035 for
14.2 persons who are enrolled in a managed care plan; or
14.3 (iii) the long-term care consultation team for those who are appropriate for relocation
14.4 service coordination due to high-risk factors or psychological or physical disability.

14.5 Sec. 17. Minnesota Statutes 2008, section 256B.056, subdivision 3b, is amended to
14.6 read:
14.7 Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a
14.8 revocable or irrevocable trust, or similar legal device, established on or before August
14.9 10, 1993, by a person or the person's spouse under the terms of which the person
14.10 receives or could receive payments from the trust principal or income and the trustee
14.11 has discretion in making payments to the person from the trust principal or income.
14.12 Notwithstanding that definition, a medical assistance qualifying trust does not include:
14.13 (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person
14.14 with a developmental disability living in an intermediate care facility for persons with
14.15 developmental disabilities; or (3) a trust set up by a person with payments made by the
14.16 Social Security Administration pursuant to the United States Supreme Court decision in
14.17 Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a
14.18 trustee of a medical assistance qualifying trust may make to a person under the terms of
14.19 the trust is considered to be available assets to the person, without regard to whether the
14.20 trustee actually makes the maximum payments to the person and without regard to the
14.21 purpose for which the medical assistance qualifying trust was established.
14.22 (b) Except as provided in paragraphs (c) and (d), trusts established after August 10,
14.23 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation
14.24 Act of 1993 (OBRA), Public Law 103-66.
14.25 (c) For purposes of paragraph (d), a pooled trust means a trust established under
14.26 United States Code, title 42, section 1396p(d)(4)(C).
14.27 (d) A beneficiary's interest in a pooled trust is considered an available asset unless
14.28 the trust provides that upon the death of the beneficiary or termination of the trust during
14.29 the beneficiary's lifetime, whichever is sooner, the department receives any amount, up
14.30 to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining
14.31 in the beneficiary's trust account after a deduction for reasonable administrative fees
14.32 and expenses, and an additional remainder amount. The retained remainder amount
14.33 of the subaccount must not exceed ten percent of the account value at the time of the
14.34 beneficiary's death or termination of the trust, and must only be used for the benefit of
14.35 disabled individuals who have a beneficiary interest in the pooled trust.

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

15.3 Sec. 18. Minnesota Statutes 2008, section 256B.057, subdivision 11, as added by Laws
15.4 2009, chapter 79, article 5, section 19, is amended to read:
15.5 Subd. 11. **Treatment for colorectal cancer.** (a) Medical assistance shall be paid for
15.6 an individual who:
15.7 (1) has been screened for colorectal cancer by the colorectal cancer prevention
15.8 demonstration project;
15.9 (2) according to the individual's treating health professional, needs treatment for
15.10 colorectal cancer;
15.11 (3) meets income eligibility guidelines for the colorectal cancer prevention
15.12 demonstration project;
15.13 (4) is under the age of 65; and
15.14 (5) is not otherwise eligible for medical assistance or covered under creditable
15.15 coverage as defined under United States Code, title 42, section 300gg~~(a)~~(c), but without
15.16 regard to paragraph (1)(F) of such section.
15.17 (b) Medical assistance provided under this subdivision shall be limited to services
15.18 provided during the period that the individual receives treatment for colorectal cancer.
15.19 (c) An individual meeting the criteria in paragraph (a) is eligible for medical
15.20 assistance without meeting the eligibility criteria relating to income and assets in section
15.21 256B.056, subdivisions 1a to 5b.
15.22 (d) This subdivision expires December 31, 2010.

15.23 Sec. 19. Minnesota Statutes 2008, section 256B.06, subdivision 4, as amended by
15.24 Laws 2009, chapter 79, article 5, section 23, is amended to read:
15.25 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
15.26 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
15.27 other persons residing lawfully in the United States. Citizens or nationals of the United
15.28 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
15.29 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
15.30 Public Law 109-171.
15.31 (b) "Qualified noncitizen" means a person who meets one of the following
15.32 immigration criteria:
15.33 (1) admitted for lawful permanent residence according to United States Code, title 8;

16.1 (2) admitted to the United States as a refugee according to United States Code,
16.2 title 8, section 1157;
16.3 (3) granted asylum according to United States Code, title 8, section 1158;
16.4 (4) granted withholding of deportation according to United States Code, title 8,
16.5 section 1253(h);
16.6 (5) paroled for a period of at least one year according to United States Code, title 8,
16.7 section 1182(d)(5);
16.8 (6) granted conditional entrant status according to United States Code, title 8,
16.9 section 1153(a)(7);
16.10 (7) determined to be a battered noncitizen by the United States Attorney General
16.11 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
16.12 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
16.13 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
16.14 States Attorney General according to the Illegal Immigration Reform and Immigrant
16.15 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
16.16 Public Law 104-200; or
16.17 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
16.18 Law 96-422, the Refugee Education Assistance Act of 1980.
16.19 (c) All qualified noncitizens who were residing in the United States before August
16.20 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
16.21 medical assistance with federal financial participation.
16.22 (d) All qualified noncitizens who entered the United States on or after August 22,
16.23 1996, and who otherwise meet the eligibility requirements of this chapter, are eligible for
16.24 medical assistance with federal financial participation through November 30, 1996.
16.25 Beginning December 1, 1996, qualified noncitizens who entered the United States
16.26 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
16.27 chapter are eligible for medical assistance with federal participation for five years if they
16.28 meet one of the following criteria:
16.29 (i) refugees admitted to the United States according to United States Code, title 8,
16.30 section 1157;
16.31 (ii) persons granted asylum according to United States Code, title 8, section 1158;
16.32 (iii) persons granted withholding of deportation according to United States Code,
16.33 title 8, section 1253(h);
16.34 (iv) veterans of the United States armed forces with an honorable discharge for
16.35 a reason other than noncitizen status, their spouses and unmarried minor dependent
16.36 children; or

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

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

17.6 Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant
17.7 women who are ~~qualified~~ noncitizens~~, as~~ described in paragraph (b) or (e), are eligible
17.8 for medical assistance with federal financial participation as provided by the federal
17.9 Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

17.10 (e) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who
17.11 are lawfully present in the United States, as defined in Code of Federal Regulations, title
17.12 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are
17.13 eligible for medical assistance under clauses (1) to (3). These individuals must cooperate
17.14 with the United States Citizenship and Immigration Services to pursue any applicable
17.15 immigration status, including citizenship, that would qualify them for medical assistance
17.16 with federal financial participation.

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

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

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

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

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

17.34 (h) For purposes of this subdivision, the term "emergency medical condition" means
17.35 a medical condition that meets the requirements of United States Code, title 42, section
17.36 1396b(v).

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

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

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

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

18.24 Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after
18.25 receiving recommendations from professional physician associations, professional
18.26 associations representing licensed nonphysician health care professionals, and consumer
18.27 groups, shall establish a 13-member Health Services Policy Committee, which consists of
18.28 12 voting members and one nonvoting member. The Health Services Policy Committee
18.29 shall advise the commissioner regarding health services pertaining to the administration
18.30 of health care benefits covered under the medical assistance, general assistance medical
18.31 care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at
18.32 least quarterly. The Health Services Policy Committee shall annually elect a physician
18.33 chair from among its members, who shall work directly with the commissioner's medical
18.34 director, to establish the agenda for each meeting. The Health Services Policy Committee
18.35 shall also recommend criteria for verifying centers of excellence for specific aspects of

19.1 medical care where a specific set of combined services, a volume of patients necessary to
19.2 maintain a high level of competency, or a specific level of technical capacity is associated
19.3 with improved health outcomes.
19.4 (b) The commissioner shall establish a dental subcommittee to operate under the
19.5 Health Services Policy Committee. The dental subcommittee consists of general dentists,
19.6 dental specialists, safety net providers, dental hygienists, health plan company and
19.7 county and public health representatives, health researchers, consumers, and a designee
19.8 of the commissioner of health. The dental subcommittee shall advise the commissioner
19.9 regarding:
19.10 (1) the critical access dental program under section 256B.76, subdivision 4, including
19.11 but not limited to criteria for designating and terminating critical access dental providers;
19.12 (2) any changes to the critical access dental provider program necessary to comply
19.13 with program expenditure limits;
19.14 (3) dental coverage policy based on evidence, quality, continuity of care, and best
19.15 practices;
19.16 (4) the development of dental delivery models; and
19.17 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).
19.18 (c) The Health Services Policy Committee shall study approaches to making
19.19 provider reimbursement under the medical assistance, MinnesotaCare, and general
19.20 assistance medical care programs contingent on patient participation in a patient-centered
19.21 decision-making process, and shall evaluate the impact of these approaches on health
19.22 care quality, patient satisfaction, and health care costs. The committee shall present
19.23 findings and recommendations to the commissioner and the legislative committees with
19.24 jurisdiction over health care by January 15, 2010.
19.25 (d) The Health Services Policy Committee shall monitor and track the practice
19.26 patterns of physicians providing services to medical assistance, MinnesotaCare, and
19.27 general assistance medical care enrollees under fee-for-service, managed care, and
19.28 county-based purchasing. The committee shall focus on services or specialties for which
19.29 there is a high variation in utilization across physicians, or which are associated with
19.30 high medical costs. The commissioner, based upon the findings of the committee, shall
19.31 regularly notify physicians whose practice patterns indicate higher than average utilization
19.32 or costs. Managed care and county-based purchasing plans shall provide the ~~committee~~
19.33 commissioner with utilization and cost data necessary to implement this paragraph, and
19.34 the commissioner shall make this data available to the committee.
19.35 (e) The Health Services Policy Committee shall review caesarean section rates
19.36 for the fee-for-service medical assistance population. The committee may develop best

20.1 practices policies related to the minimization of caesarean sections, including but not
20.2 limited to standards and guidelines for health care providers and health care facilities.

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

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

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

20.16 (2) formulating a medication treatment plan;

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

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

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

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

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

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

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

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

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

20.34 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
20.35 completed a structured and comprehensive education program approved by the Board of

21.1 Pharmacy and the American Council of Pharmaceutical Education for the provision and
21.2 documentation of pharmaceutical care management services that has both clinical and
21.3 didactic elements;

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

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

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

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

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

21.28 Subd. 4. **Authorization; personal care assistance and qualified professional.**
21.29 (a) All personal care assistance services, supervision by a qualified professional, and
21.30 additional services beyond the limits established in section 256B.0651, subdivision 11,
21.31 must be authorized by the commissioner or the commissioner's designee before services
21.32 begin except for the assessments established in sections 256B.0651, subdivision 11, and
21.33 256B.0911. The authorization for personal care assistance and qualified professional
21.34 services under section 256B.0659 must be completed within 30 days after receiving
21.35 a complete request.

22.1 (b) The amount of personal care assistance services authorized must be based
22.2 on the recipient's home care rating. The home care rating shall be determined by the
22.3 commissioner or the commissioner's designee based on information submitted to the
22.4 commissioner identifying the following:
22.5 (1) total number of dependencies of activities of daily living as defined in section
22.6 256B.0659;
22.7 (2) number of complex health-related ~~functions~~ needs as defined in section
22.8 256B.0659; and
22.9 (3) number of behavior descriptions as defined in section 256B.0659.
22.10 (c) The methodology to determine total time for personal care assistance services for
22.11 each home care rating is based on the median paid units per day for each home care rating
22.12 from fiscal year 2007 data for the personal care assistance program. Each home care rating
22.13 has a base level of hours assigned. Additional time is added through the assessment and
22.14 identification of the following:
22.15 (1) 30 additional minutes per day for a dependency in each critical activity of daily
22.16 living as defined in section 256B.0659;
22.17 (2) 30 additional minutes per day for each complex health-related function as
22.18 defined in section 256B.0659; and
22.19 (3) 30 additional minutes per day for each behavior issue as defined in section
22.20 256B.0659.
22.21 (d) A limit of 96 units of qualified professional supervision may be authorized for
22.22 each recipient receiving personal care assistance services. A request to the commissioner
22.23 to exceed this total in a calendar year must be requested by the personal care provider
22.24 agency on a form approved by the commissioner.

22.25 Sec. 23. Minnesota Statutes 2008, section 256B.0659, subdivision 9, as added by Laws
22.26 2009, chapter 79, article 8, section 31, is amended to read:
22.27 Subd. 9. **Responsible party; generally.** (a) "Responsible party~~,~~" ~~effective January~~
22.28 ~~1, 2010,~~ means an individual who is capable of providing the support necessary to assist
22.29 the recipient to live in the community.
22.30 (b) A responsible party must be 18 years of age, actively participate in planning and
22.31 directing of personal care assistance services, and attend all assessments for the recipient.
22.32 (c) A responsible party must not be the:
22.33 (1) personal care assistant;
22.34 (2) home care provider agency owner or staff; or
22.35 (3) county staff acting as part of employment.

23.1 (d) A licensed family foster parent who lives with the recipient may be the
23.2 responsible party as long as the family foster parent meets the other responsible party
23.3 requirements.
23.4 (e) A responsible party is required when:
23.5 (1) the person is a minor according to section 524.5-102, subdivision 10;
23.6 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
23.7 6, resulting in a court-appointed guardian; or
23.8 (3) the assessment according to section 256B.0655, subdivision 1b, determines that
23.9 the recipient is in need of a responsible party to direct the recipient's care.
23.10 (f) There may be two persons designated as the responsible party for reasons such
23.11 as divided households and court-ordered custodies. Each person named as responsible
23.12 party must meet the program criteria and responsibilities.
23.13 (g) The recipient or the recipient's legal representative shall appoint a responsible
23.14 party if necessary to direct and supervise the care provided to the recipient. The
23.15 responsible party must be identified at the time of assessment and listed on the recipient's
23.16 service agreement and personal care assistance care plan.

23.17 Sec. 24. Minnesota Statutes 2008, section 256B.0659, subdivision 10, as added by
23.18 Laws 2009, chapter 79, article 8, section 31, is amended to read:
23.19 Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall
23.20 enter into a written agreement with a personal care assistance provider agency, on a form
23.21 determined by the commissioner, to perform the following duties:
23.22 (1) be available while care is provided in a method agreed upon by the individual
23.23 or the individual's legal representative and documented in the recipient's personal care
23.24 assistance care plan;
23.25 (2) monitor personal care assistance services to ensure the recipient's personal care
23.26 assistance care plan is being followed; and
23.27 (3) review and sign personal care assistance time sheets after services are provided
23.28 to provide verification of the personal care assistance services.

23.29 Failure to provide the support required by the recipient must result in a referral to the
23.30 county common entry point.
23.31 (b) Responsible parties who are parents of minors or guardians of minors or
23.32 incapacitated persons may delegate the responsibility to another adult who is not the
23.33 personal care assistant during a temporary absence of at least 24 hours but not more
23.34 than six months. The person delegated as a responsible party must be able to meet the
23.35 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;

26.1 (8) a list of all trainings and classes that the personal care assistance provider agency
26.2 requires of its staff providing personal care assistance services;
26.3 (9) documentation that the personal care assistance provider agency and staff have
26.4 successfully completed all the training required by this section;
26.5 (10) documentation of the agency's marketing practices;
26.6 (11) disclosure of ownership, leasing, or management of all residential properties
26.7 that is used or could be used for providing home care services; and
26.8 (12) documentation that the agency will use the following percentages of revenue
26.9 generated from the medical assistance rate paid for personal care assistance services
26.10 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
26.11 personal care assistance choice option and 72.5 percent of revenue from other personal
26.12 care assistance providers.
26.13 (b) Personal care assistance provider agencies shall provide the information specified
26.14 in paragraph (a) to the commissioner at the time the personal care assistance provider
26.15 agency enrolls as a vendor or upon request from the commissioner. The commissioner
26.16 shall collect the information specified in paragraph (a) from all personal care assistance
26.17 providers beginning upon enactment of this section.
26.18 (c) All personal care assistance provider agencies shall complete mandatory training
26.19 as determined by the commissioner before enrollment as a provider. Personal care
26.20 assistance provider agencies are required to send all owners, qualified professionals
26.21 employed by the agency, and all other managing employees to the initial and subsequent
26.22 trainings. Personal care assistance provider agency billing staff shall complete training
26.23 about personal care assistance program financial management. This training is effective
26.24 upon enactment of this section. Any personal care assistance provider agency enrolled
26.25 before that date shall, if it has not already, complete the provider training within 18 months
26.26 of the effective date of this section. Any new owners, new qualified professionals, and new
26.27 managing employees are required to complete mandatory training as a requisite of hiring.

26.28 Sec. 27. Minnesota Statutes ..., section 256B.0659, subdivision 29, as added by Laws
26.29 2009, chapter 79, article 8, section 31, is amended to read:
26.30 Subd. 29. **Transitional assistance.** The commissioner, counties, health plans, tribes,
26.31 and personal care assistance providers shall work together to provide transitional assistance
26.32 for recipients and families to come into compliance with the new requirements of this
26.33 section that may require a change in living arrangement no later than August 10, 2010 ~~and~~
26.34 ~~ensure the personal care assistance services are not provided by the housing provider~~.

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

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

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

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

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

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

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

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

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

27.17 (7) determination of home and community-based waiver service eligibility including
27.18 level of care determination for individuals who need an institutional level of care as
27.19 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including
27.20 state plan home care services identified in section 256B.0625, subdivisions 6, 7, and
27.21 19, paragraphs (a) and (c), based on assessment and support plan development with
27.22 appropriate referrals;

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

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

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

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

27.33 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
27.34 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~~ <u>year</u> 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. <u>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.</u> 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

29.1 compared to its operating payment rate on September 30, 2008, computed using rates with
29.2 a RUG's weight of 1.00, shall receive the maximum percentage increase.

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

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

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

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

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

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

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

29.28 Sec. 30. Minnesota Statutes 2008, section 256B.49, subdivision 11a, as added by Laws
29.29 2009, chapter 79, article 8, section 64, is amended to read:

29.30 Subd. 11a. **Waivered services ~~waiting list~~ statewide priorities.** (a) The
29.31 commissioner shall establish statewide priorities for individuals on the waiting list for
29.32 CAC, CADI, and TBI waiver services, as of January 1, 2010. The statewide priorities
29.33 must include, but are not limited to, individuals who continue to have a need for waiver
29.34 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

32.1 except that payment rates for home health agency services shall be the rates in effect
32.2 on September 30, 1992.

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

32.8 (c) Effective for services rendered on or after July 1, 2009, payment rates for
32.9 physician and professional services shall be reduced by five percent over the rates in effect
32.10 on June 30, 2009. This reduction does not apply to office or other outpatient ~~services~~
32.11 ~~(procedure codes 99201 to 99215)~~ visits, preventive medicine ~~services (procedure codes~~
32.12 ~~99381 to 99412)~~ visits and family planning ~~services~~ visits billed by physicians, advanced
32.13 practice nurses, or physician assistants in a family planning agency or in one of the
32.14 following primary care ~~specialties~~ practices: general practice, general internal medicine,
32.15 general pediatrics, general geriatrics, and family ~~practice, or by an advanced practice~~
32.16 ~~registered nurse or physician assistant practicing in pediatrics, geriatrics, or family practice~~
32.17 medicine. This reduction does not apply to federally qualified health centers, rural health
32.18 centers, and Indian health services. Effective October 1, 2009, payments made to managed
32.19 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
32.20 256L.12 shall reflect the payment reduction described in this paragraph.

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

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

32.26 (1) inpatient hospital services;

32.27 (2) outpatient hospital services;

32.28 (3) services provided by Medicare certified rehabilitation agencies;

32.29 (4) prescription drugs and other products recommended through the process
32.30 established in section 256B.0625, subdivision 13;

32.31 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
32.32 for diabetics to monitor blood sugar level;

32.33 (6) eyeglasses and eye examinations provided by a physician or optometrist;

32.34 (7) hearing aids;

32.35 (8) prosthetic devices;

33.1 (9) laboratory and X-ray services;
33.2 (10) physician's services;
33.3 (11) medical transportation except special transportation;
33.4 (12) chiropractic services as covered under the medical assistance program;
33.5 (13) podiatric services;
33.6 (14) dental services as covered under the medical assistance program;
33.7 (15) mental health services covered under chapter 256B;
33.8 (16) prescribed medications for persons who have been diagnosed as mentally ill as
33.9 necessary to prevent more restrictive institutionalization;
33.10 (17) medical supplies and equipment, and Medicare premiums, coinsurance and
33.11 deductible payments;
33.12 (18) medical equipment not specifically listed in this paragraph when the use of
33.13 the equipment will prevent the need for costlier services that are reimbursable under
33.14 this subdivision;
33.15 (19) services performed by a certified pediatric nurse practitioner, a certified family
33.16 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
33.17 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
33.18 practitioner in independent practice, if (1) the service is otherwise covered under this
33.19 chapter as a physician service, (2) the service provided on an inpatient basis is not included
33.20 as part of the cost for inpatient services included in the operating payment rate, and (3) the
33.21 service is within the scope of practice of the nurse practitioner's license as a registered
33.22 nurse, as defined in section 148.171;
33.23 (20) services of a certified public health nurse or a registered nurse practicing in
33.24 a public health nursing clinic that is a department of, or that operates under the direct
33.25 authority of, a unit of government, if the service is within the scope of practice of the
33.26 public health nurse's license as a registered nurse, as defined in section 148.171;
33.27 (21) telemedicine consultations, to the extent they are covered under section
33.28 256B.0625, subdivision 3b;
33.29 (22) care coordination and patient education services provided by a community
33.30 health worker according to section 256B.0625, subdivision 49; and
33.31 (23) regardless of the number of employees that an enrolled health care provider
33.32 may have, sign language interpreter services when provided by an enrolled health care
33.33 provider during the course of providing a direct, person-to-person covered health care
33.34 service to an enrolled recipient who has a hearing loss and uses interpreting services.
33.35 (ii) Effective October 1, 2003, for a person who is eligible under subdivision 3,
33.36 paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited

34.1 to inpatient hospital services, including physician services provided during the inpatient
34.2 hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

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

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

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

34.26 (i) are covered under the medical assistance program as described in section
34.27 256B.0625, subdivisions 13 and 13d; and

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

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

34.35 (1) $25 for eyeglasses;

34.36 (2) $25 for nonemergency visits to a hospital-based emergency room;

35.1 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
35.2 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
35.3 shall apply to antipsychotic drugs when used for the treatment of mental illness; and
35.4 (4) 50 percent coinsurance on restorative dental services.
35.5 (f) Recipients eligible under subdivision 3, paragraph (a), shall include the following
35.6 co-payments for services provided on or after January 1, 2009:
35.7 (1) $25 for nonemergency visits to a hospital-based emergency room; and
35.8 (2) $3 per brand-name drug prescription and $1 per generic drug prescription,
35.9 subject to a $7 per month maximum for prescription drug co-payments. No co-payments
35.10 shall apply to antipsychotic drugs when used for the treatment of mental illness.
35.11 (g) MS 2007 Supp [Expired]
35.12 (h) Effective January 1, 2009, co-payments shall be limited to one per day per
35.13 provider for nonemergency visits to a hospital-based emergency room. Recipients of
35.14 general assistance medical care are responsible for all co-payments in this subdivision.
35.15 The general assistance medical care reimbursement to the provider shall be reduced by the
35.16 amount of the co-payment, except that reimbursement for prescription drugs shall not be
35.17 reduced once a recipient has reached the $7 per month maximum for prescription drug
35.18 co-payments. The provider collects the co-payment from the recipient. Providers may not
35.19 deny services to recipients who are unable to pay the co-payment.
35.20 (i) General assistance medical care reimbursement to fee-for-service providers
35.21 and payments to managed care plans shall not be increased as a result of the removal of
35.22 the co-payments effective January 1, 2009.
35.23 (j) Any county may, from its own resources, provide medical payments for which
35.24 state payments are not made.
35.25 (k) Chemical dependency services that are reimbursed under chapter 254B must not
35.26 be reimbursed under general assistance medical care.
35.27 (l) The maximum payment for new vendors enrolled in the general assistance
35.28 medical care program after the base year shall be determined from the average usual and
35.29 customary charge of the same vendor type enrolled in the base year.
35.30 (m) The conditions of payment for services under this subdivision are the same
35.31 as the conditions specified in rules adopted under chapter 256B governing the medical
35.32 assistance program, unless otherwise provided by statute or rule.
35.33 (n) Inpatient and outpatient payments shall be reduced by five percent, effective July
35.34 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003,
35.35 and incorporated by reference in paragraph (l).

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

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

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

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

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

36.15 (t) Payments for mental health services added as covered benefits after December
36.16 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

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

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

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

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

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

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

37.1 (3) a participant who is a noncitizen who has been in the United States for 12 or
37.2 fewer months; and
37.3 (4) a participant who is age 60 or older.
37.4 (b) Families must meet all other eligibility requirements for MFIP established in
37.5 this chapter. Families are eligible for financial assistance to the same extent as if they
37.6 were participating in MFIP.
37.7 (c) A participant under paragraph (a), clause (3), must be provided with English as a
37.8 second language opportunities and skills training for up to 12 months. After 12 months,
37.9 the case manager and participant must determine whether the participant should continue
37.10 with English as a second language classes or skills training, or both, and continue to
37.11 receive family stabilization services.
37.12 (d) If a county agency or employment services provider has information that
37.13 an MFIP participant may meet the eligibility criteria set forth in this subdivision, the
37.14 county agency or employment services provider must assist the participant in obtaining
37.15 the documentation necessary to determine eligibility. ~~Until necessary documentation is~~
37.16 ~~obtained, the participant must be treated as an eligible participant under subdivisions 5 to 7.~~

37.17 Sec. 35. Minnesota Statutes 2008, section 256L.03, subdivision 3b, as added by Laws
37.18 2009, chapter 79, article 5, section 54, is amended to read:
37.19 Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic
37.20 services: medically necessary exams, manual manipulation of the spine, and x-rays.

37.21 **EFFECTIVE DATE.** This section is effective January 1, 2010<u>, or upon federal</u>
37.22 <u>approval, whichever is later</u>.

37.23 Sec. 36. Minnesota Statutes 2008, section 256L.04, subdivision 1, as amended by Laws
37.24 2009, chapter 79, article 5, section 55, is amended to read:
37.25 Subdivision 1. **Families with children.** (a) Families with children with family
37.26 income equal to or less than 275 percent of the federal poverty guidelines for the
37.27 applicable family size shall be eligible for MinnesotaCare according to this section. All
37.28 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
37.29 to enrollment under section 256L.07, shall apply unless otherwise specified.
37.30 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
37.31 if the children are eligible. Children may be enrolled separately without enrollment by
37.32 parents. However, if one parent in the household enrolls, both parents must enroll, unless
37.33 other insurance is available. If one child from a family is enrolled, all children must
37.34 be enrolled, unless other insurance is available. If one spouse in a household enrolls,

38.1 the other spouse in the household must also enroll, unless other insurance is available.
38.2 Families cannot choose to enroll only certain uninsured members.

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

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

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

38.11 (f) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision
38.12 8, are exempt from the eligibility requirements of this subdivision.

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

38.15 Sec. 37. Minnesota Statutes 2008, section 256L.05, subdivision 1c, as added by Laws
38.16 2009, chapter 79, article 5, section 60, is amended to read:

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

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

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

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

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

38.32 (4) establish a process:

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

39.1 (ii) for the commissioner of human services to enroll children and other household
39.2 members who are eligible.
39.3 The commissioner of human services in coordination with the commissioner of
39.4 education shall implement an open enrollment process by August 1, 2010, to be effective
39.5 beginning with the 2010-2011 school year.
39.6 (c) The commissioner and local agencies shall develop an online application process
39.7 for medical assistance and MinnesotaCare.
39.8 (d) The commissioner shall develop an application for children that is easily
39.9 understandable and does not exceed four pages in length.
39.10 (e) The commissioner of human services shall present to the legislature, by January
39.11 15, 2010, an implementation plan for the open enrollment period and online application
39.12 process.

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

39.15 Sec. 38. Minnesota Statutes 2008, section 256L.11, subdivision 1, as amended by Laws
39.16 2009, chapter 79, article 5, section 67, is amended to read:
39.17 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers under
39.18 sections 256L.01 to 256L.11 shall be at the same rates and conditions established for
39.19 medical assistance, except as provided in subdivisions 2 to 6.
39.20 (b) Effective for services provided on or after July 1, 2009, total payments for basic
39.21 care services shall be reduced by three percent, in accordance with section 256B.766.
39.22 Payments made to managed care and county-based purchasing plans shall be reduced for
39.23 services provided on or after October 1, 2009, to reflect this reduction.
39.24 (c) Effective for services provided on or after July 1, 2009, payment rates for
39.25 physician and professional services shall be reduced as described under section 256B.76,
39.26 subdivision 1, paragraph (c). Payments made to managed care and county-based
39.27 purchasing plans shall be reduced for services provided on or after October 1, 2009,
39.28 to reflect this reduction.

39.29 Sec. 39. Minnesota Statutes 2008, section 626.556, subdivision 3c, as amended by
39.30 Laws 2009, chapter 79, article 8, section 74, is amended to read:
39.31 Subd. 3c. **Local welfare agency, Department of Human Services or Department**
39.32 **of Health responsible for assessing or investigating reports of maltreatment.** (a)
39.33 The county local welfare agency is the agency responsible for assessing or investigating
39.34 allegations of maltreatment in child foster care, family child care, legally unlicensed child

40.1 care, juvenile correctional facilities licensed under section 241.021 located in the local
40.2 welfare agency's county, ~~and unlicensed personal care assistance provider organizations~~
40.3 ~~providing services and receiving reimbursements under chapter 256B~~and reports involving
40.4 children served by an unlicensed personal care provider organization under section
40.5 256B.0659. Copies of findings related to personal care provider organizations under
40.6 section 256B.0659 must be forwarded to the Department of Human Services provider
40.7 enrollment.

40.8 (b) The Department of Human Services is the agency responsible for assessing or
40.9 investigating allegations of maltreatment in facilities licensed under chapters 245A and
40.10 245B, except for child foster care and family child care.

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

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

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

40.21 Sec. 36. **REPEALER.**

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

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

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

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

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

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

41.1 (c) Medical assistance does not cover physicians' services related to the provision of
41.2 care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1),
41.3 (2), (3), and (5), and subdivision 7, clause (1).

41.4 (d) Medical assistance does not cover physicians' services related to the provision of
41.5 care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision
41.6 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the
41.7 physicians' services are billed by a physician who delivered care that contributed to or
41.8 caused the adverse health care event or hospital-acquired condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43.1 (7) gluten-free diet, 25 percent of thrifty food plan;
43.2 (8) lactose-free diet, 25 percent of thrifty food plan;
43.3 (9) antidumping diet, 15 percent of thrifty food plan;
43.4 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
43.5 (11) ketogenic diet, 25 percent of thrifty food plan.
43.6 (b) Payment for nonrecurring special needs must be allowed for necessary home
43.7 repairs or necessary repairs or replacement of household furniture and appliances using
43.8 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
43.9 as long as other funding sources are not available.
43.10 (c) A fee for guardian or conservator service is allowed at a reasonable rate
43.11 negotiated by the county or approved by the court. This rate shall not exceed five percent
43.12 of the assistance unit's gross monthly income up to a maximum of $100 per month. If the
43.13 guardian or conservator is a member of the county agency staff, no fee is allowed.
43.14 (d) The county agency shall continue to pay a monthly allowance of $68 for
43.15 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
43.16 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
43.17 until the person has not received Minnesota supplemental aid for one full calendar month
43.18 or until the person's living arrangement changes and the person no longer meets the criteria
43.19 for the restaurant meal allowance, whichever occurs first.
43.20 (e) A fee of ten percent of the recipient's gross income or $25, whichever is less,
43.21 is allowed for representative payee services provided by an agency that meets the
43.22 requirements under SSI regulations to charge a fee for representative payee services. This
43.23 special need is available to all recipients of Minnesota supplemental aid regardless of
43.24 their living arrangement.
43.25 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
43.26 maximum allotment authorized by the federal Food Stamp Program for a single individual
43.27 which is in effect on the first day of July of each year will be added to the standards of
43.28 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
43.29 as shelter needy and are: (i) relocating from an institution, or an adult mental health
43.30 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
43.31 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
43.32 community-based waiver recipients living in their own home or rented or leased apartment
43.33 which is not owned, operated, or controlled by a provider of service not related by blood
43.34 or marriage.
43.35 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
43.36 shelter needy benefit under this paragraph is considered a household of one. An eligible

44.1 individual who receives this benefit prior to age 65 may continue to receive the benefit
44.2 after the age of 65.

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

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

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

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

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

44.35 (g) Notwithstanding this subdivision, to access housing and services as provided in
44.36 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~~

46.1 ~~Department of Health's current resources for the Chronic Disease and Environmental~~
46.2 ~~Epidemiology Section.~~

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

46.12 (1) the feasibility of collecting these data on a statewide scale;

46.13 (2) the potential design of a self-administered patient questionnaire template; and

46.14 (3) necessary qualifications for staff who will collect these data.

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

46.17 Sec. 48. **EXPOSURE LEVELS STUDY.**

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

46.23 Sec. 49. **REPEALER.**

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

46.25 **ARTICLE 2**
46.26 **TECHNICAL APPROPRIATION CHANGES**

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

46.28 Sec. 3. **HUMAN SERVICES**

46.29			~~5,230,100,000~~	~~5,997,715,000~~
46.30 Subdivision 1. **Total Appropriation**	$		5,225,451,000 $	6,002,864,000

46.31 Appropriations by Fund
46.32 2010 2011

Line	Fund		
47.1		~~4,376,839,000~~	~~5,211,018,000~~
47.2	General	4,375,689,000	5,209,765,000
47.3	State Government	~~1,315,000~~	
47.4	Special Revenue	565,000	565,000
47.5		~~450,792,000~~	~~527,489,000~~
47.6	Health Care Access	450,662,000	527,411,000
47.7		~~289,487,000~~	~~256,978,000~~
47.8	Federal TANF	286,770,000	263,458,000
47.9	Lottery Prize	1,665,000	1,665,000
47.10	Federal Fund	110,000,000	0

47.11 **Receipts for Systems Projects.**

47.12 Appropriations and federal receipts for
47.13 information systems projects for MAXIS,
47.14 PRISM, MMIS, and SSIS must be deposited
47.15 in the state system account authorized in
47.16 Minnesota Statutes, section 256.014. Money
47.17 appropriated for computer projects approved
47.18 by the Minnesota Office of Enterprise
47.19 Technology, funded by the legislature, and
47.20 approved by the commissioner of finance,
47.21 may be transferred from one project to
47.22 another and from development to operations
47.23 as the commissioner of human services
47.24 considers necessary, except that any transfers
47.25 to one project that exceed $1,000,000 or
47.26 multiple transfers to one project that exceed
47.27 $1,000,000 in total require the express
47.28 approval of the legislature. The preceding
47.29 requirement for legislative approval does not
47.30 apply to transfers made to establish a project's
47.31 initial operating budget each year; instead,
47.32 the requirements of section 11, subdivision
47.33 2, of this article apply to those transfers. Any
47.34 unexpended balance in the appropriation
47.35 for these projects does not cancel but is
47.36 available for ongoing development and
47.37 operations. Any computer project with a
47.38 total cost exceeding $1,000,000, including,

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

48.5 **HealthMatch Systems Project.** In fiscal
48.6 year 2010, $3,054,000 shall be transferred
48.7 from the HealthMatch account in the state
48.8 systems account in the special revenue fund
48.9 to the general fund.

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

48.15 **TANF Maintenance of Effort.**

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

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

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

48.32 (3) state and county MFIP administrative
48.33 costs under Minnesota Statutes, chapters
48.34 256J and 256K;

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

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

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

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

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

49.33 (d) For the federal fiscal years beginning on
49.34 or after October 1, 2007, the commissioner
49.35 may not claim an amount of TANF/MOE in

50.1 excess of the 75 percent standard in Code
50.2 of Federal Regulations, title 45, section
50.3 263.1(a)(2), except:

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

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

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

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

50.28 (e) Minnesota Statutes, section 256.011,
50.29 subdivision 3, which requires that federal
50.30 grants or aids secured or obtained under that
50.31 subdivision be used to reduce any direct
50.32 appropriations provided by law, do not apply
50.33 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~~ $50,973,000;

(2) fiscal year 2011, ~~$55,596,000~~ $53,793,000;

(3) fiscal year 2012, ~~$28,519,000~~ $23,516,000; and

(4) fiscal year 2013, ~~$22,138,000~~ $16,808,000.

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.~~

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

52.8 **Food Stamps Employment and Training.**
52.9 (a) The commissioner shall apply for and
52.10 claim the maximum allowable federal
52.11 matching funds under United States Code,
52.12 title 7, section 2025, paragraph (h), for
52.13 state expenditures made on behalf of family
52.14 stabilization services participants voluntarily
52.15 engaged in food stamp employment and
52.16 training activities, where appropriate.

52.17 (b) Notwithstanding Minnesota Statutes,
52.18 sections 256D.051, subdivisions 1a, 6b,
52.19 and 6c, and 256J.626, federal food stamps
52.20 employment and training funds received
52.21 as reimbursement of MFIP consolidated
52.22 fund grant expenditures for diversionary
52.23 work program participants and child
52.24 care assistance program expenditures for
52.25 two-parent families must be deposited in the
52.26 general fund. The amount of funds must be
52.27 limited to $3,350,000 in fiscal year 2010
52.28 and $4,440,000 in fiscal years 2011 through
52.29 2013, contingent on approval by the federal
52.30 Food and Nutrition Service.

52.31 (c) Consistent with the receipt of these federal
52.32 funds, the commissioner may adjust the
52.33 level of working family credit expenditures
52.34 claimed as TANF maintenance of effort.

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

53.3 **ARRA Food Support Administration.**
53.4 The funds available for food support
53.5 administration under the American Recovery
53.6 and Reinvestment Act (ARRA) of 2009
53.7 are appropriated to the commissioner
53.8 to pay actual costs of implementing the
53.9 food support benefit increases, increased
53.10 eligibility determinations, and outreach. Of
53.11 these funds, 20 percent shall be allocated
53.12 to the commissioner and 80 percent shall
53.13 be allocated to counties. The commissioner
53.14 shall allocate the county portion based on
53.15 caseload. Reimbursement shall be based on
53.16 actual costs reported by counties through
53.17 existing processes. Tribal reimbursement
53.18 must be made from the state portion based
53.19 on a caseload factor equivalent to that of a
53.20 county.

53.21 **ARRA Food Support Benefit Increases.**
53.22 The funds provided for food support benefit
53.23 increases under the Supplemental Nutrition
53.24 Assistance Program provisions of the
53.25 American Recovery and Reinvestment Act
53.26 (ARRA) of 2009 must be used for benefit
53.27 increases beginning July 1, 2009.

53.28 **Emergency Fund for the TANF Program.**
53.29 TANF Emergency Contingency funds
53.30 available under the American Recovery
53.31 and Reinvestment Act of 2009 (Public Law
53.32 111-5) are appropriated to the commissioner.
53.33 The commissioner must request TANF
53.34 Emergency Contingency funds from the
53.35 Secretary of the Department of Health

54.1 and Human Services to the extent the
54.2 commissioner meets or expects to meet the
54.3 requirements of section 403(c) of the Social
54.4 Security Act. The commissioner must seek
54.5 to maximize such grants. The funds received
54.6 must be used as appropriated. Each county
54.7 must maintain the county's current level of
54.8 emergency assistance funding under the
54.9 MFIP consolidated fund and use the funds
54.10 under this paragraph to supplement existing
54.11 emergency assistance funding levels.

54.12 Subd. 2. **Agency Management**

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

54.15 **(a) Financial Operations**

54.16 Appropriations by Fund

54.17	General	3,380,000	3,908,000
54.18	Health Care Access	1,281,000	1,016,000
54.19	Federal TANF	122,000	122,000

54.20 **(b) Legal and Regulatory Operations**

54.21 Appropriations by Fund

54.22	General	13,749,000	13,534,000
54.23 54.24	State Government Special Revenue	440,000	440,000
54.25	Health Care Access	943,000	943,000
54.26	Federal TANF	100,000	100,000

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

54.30 **(c) Management Operations**

54.31 Appropriations by Fund

54.32	General	4,334,000	4,562,000
54.33	Health Care Access	242,000	242,000

54.34 **Lease Cost Reduction.** Base level funding
54.35 to the commissioner shall be reduced by

55.1 $381,000 in fiscal year 2010, and $153,000
55.2 in fiscal year 2011, to reflect a reduction in
55.3 lease costs related to the Minnehaha Avenue
55.4 building.

55.5 **Base Adjustment.** The general fund base is
55.6 increased by $153,000 in each of fiscal years
55.7 2012 and 2013.

55.8 **(d) Information Technology Operations**

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

55.12 55.13	Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	~~65,746,000~~ 68,337,000	~~67,068,000~~ 70,505,000

55.14 This appropriation is from the federal TANF
55.15 fund.

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

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

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

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

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

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

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

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

56.3 **(a) MFIP/DWP Grants**

56.4	Appropriations by Fund		
56.5	General	63,205,000	89,033,000
56.6		~~100,404,000~~	~~85,789,000~~
56.7	Federal TANF	100,818,000	84,538,000

56.8 **(b) Support Services Grants**

56.9	Appropriations by Fund		
56.10	General	8,715,000	12,498,000
56.11		~~121,257,000~~	~~102,757,000~~
56.12	Federal TANF	116,557,000	107,457,000

56.13 **MFIP Consolidated Fund.** The MFIP
56.14 consolidated fund TANF appropriation is
56.15 reduced by $1,854,000 in fiscal year ~~2011~~
56.16 2010 and fiscal year ~~2012~~ 2011.

56.17 Notwithstanding Minnesota Statutes, section
56.18 256J.626, subdivision 8, paragraph (b), the
56.19 commissioner shall reduce proportionately
56.20 the reimbursement to counties for
56.21 administrative expenses.

56.22 **Subsidized Employment Funding Through**
56.23 **ARRA.** The commissioner is authorized to
56.24 apply for TANF emergency fund grants for
56.25 subsidized employment activities. Growth
56.26 in expenditures for subsidized employment
56.27 within the supported work program and the
56.28 MFIP consolidated fund over the amount
56.29 expended in the calendar quarters in the
56.30 TANF emergency fund base year shall be
56.31 used to leverage the TANF emergency fund
56.32 grants for subsidized employment and to
56.33 fund supported work. The commissioner
56.34 shall develop procedures to maximize
56.35 reimbursement of these expenditures over the
56.36 TANF emergency fund base year quarters,

57.1 and may contract directly with employers
57.2 and providers to maximize these TANF
57.3 emergency fund grants.

57.4 **Supported Work.** Of the TANF
57.5 appropriation, ~~$6,400,000~~ $4,700,000 in
57.6 fiscal year ~~2011 is~~ 2010 and $4,700,000 in
57.7 fiscal year 2011 are to the commissioner for
57.8 supported work for MFIP recipients and is
57.9 available until expended. Supported work
57.10 includes paid transitional work experience
57.11 and a continuum of employment assistance,
57.12 including outreach and recruitment,
57.13 program orientation and intake, testing and
57.14 assessment, job development and marketing,
57.15 preworksite training, supported worksite
57.16 experience, job coaching, and postplacement
57.17 follow-up, in addition to extensive case
57.18 management and referral services. This is a
57.19 onetime appropriation.

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

57.25 **Integrated Services Program Funding.**
57.26 The TANF appropriation for integrated
57.27 services program funding is $1,250,000 in
57.28 fiscal year 2010 and ~~$2,500,000~~ $0 in fiscal
57.29 year 2011 and the base for fiscal years 2012
57.30 and 2013 is $0.

57.31 **TANF Emergency Fund; Nonrecurrent**
57.32 **Short-Term Benefits.** TANF emergency
57.33 contingency fund grants received due to
57.34 increases in expenditures for nonrecurrent
57.35 short-term benefits must be used to offset the

58.1 increase in these expenditures for counties
58.2 under the MFIP consolidated fund, under
58.3 Minnesota Statutes, section 256J.626,
58.4 and the diversionary work program. The
58.5 commissioner shall develop procedures
58.6 to maximize reimbursement of these
58.7 expenditures over the TANF emergency fund
58.8 base year quarters. Growth in expenditures
58.9 for the diversionary work program over the
58.10 amount expended in the calendar quarters in
58.11 the TANF emergency fund base year shall be
58.12 used to leverage these funds.

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

58.14 ~~Appropriations by Fund~~

58.15	~~General~~	~~61,171,000~~	~~65,214,000~~
58.16	~~Federal TANF~~	~~1,022,000~~	~~406,000~~

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

58.24 **Acceleration of ARRA Child Care and**
58.25 **Development Fund Expenditure.** The
58.26 commissioner must liquidate all child care
58.27 and development money available under
58.28 the American Recovery and Reinvestment
58.29 Act (ARRA) of 2009, Public Law 111-5,
58.30 by September 30, 2010. In order to expend
58.31 those funds by September 30, 2010, the
58.32 commissioner may redesignate and expend
58.33 the ARRA child care and development funds
58.34 appropriated in fiscal year 2011 for purposes
58.35 under this section for related purposes that

59.1 will allow liquidation by September 30,
59.2 2010. Child care and development funds
59.3 otherwise available to the commissioner
59.4 for those related purposes shall be used to
59.5 fund the purposes from which the ARRA
59.6 child care and development funds had been
59.7 redesignated.

59.8 **School Readiness Service Agreements.**
59.9 $400,000 in fiscal year 2010 and $400,000
59.10 in fiscal year 2011 are from the federal
59.11 TANF fund to the commissioner of human
59.12 services consistent with federal regulations
59.13 for the purpose of school readiness service
59.14 agreements under Minnesota Statutes, section
59.15 119B.231. This is a onetime appropriation.
59.16 Any unexpended balance the first year is
59.17 available in the second year.

59.18 **(d) Basic Sliding Fee Child Care Assistance**	~~40,104,000~~	~~45,096,000~~
59.19 **Grants**	40,100,000	45,092,000

59.20 ~~**Base Adjustment.** The general fund base is~~
59.21 ~~decreased by $260,000 in each of fiscal years~~
59.22 ~~2012 and 2013.~~

59.23 **School Readiness Service Agreements.**
59.24 ~~$261,000~~ $257,000 in fiscal year 2010 and
59.25 ~~$261,000~~ $257,000 in fiscal year 2011 are
59.26 from the ~~federal child care development~~
59.27 ~~funds received from the American Recovery~~
59.28 ~~and Reinvestment Act of 2009, Public Law~~
59.29 ~~111-5, to the commissioner of human services~~
59.30 ~~consistent with federal regulations~~ general
59.31 fund for the purpose of school readiness
59.32 service agreements under Minnesota
59.33 Statutes, section 119B.231. This is a onetime
59.34 appropriation. Any unexpended balance the
59.35 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:

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

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

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

61.28 (d) Funds in excess of the amount necessary
61.29 to serve all families in paragraphs (a) and
61.30 (b) shall be allocated in proportion to each
61.31 county's total expenditures for the basic
61.32 sliding fee child care program reported
61.33 during the most recent fiscal year completed
61.34 at the time of the notice of allocation. To
61.35 the extent that funds are available, and

62.1 notwithstanding Minnesota Statutes, section
62.2 119B.03, subdivision 8, for the period
62.3 January 1, 2011, to December 31, 2011, each
62.4 county's guaranteed floor must be equal to its
62.5 original calendar year 2010 allocation.

62.6 **Base Adjustment.** The general fund base is
62.7 decreased by $257,000 in each of fiscal years
62.8 2012 and 2013.

62.9 **(e) Child Care Development Grants**	1,487,000	1,487,000

62.10 **Family, friends, and neighbor grants.**
62.11 $375,000 in fiscal year 2010 and $375,000
62.12 in fiscal year 2011 are from the child
62.13 care development fund required targeted
62.14 quality funds for quality expansion and
62.15 infant/toddler from the American Recovery
62.16 and Reinvestment Act of 2009, Public
62.17 Law 111-5, to the commissioner of human
62.18 services for family, friends, and neighbor
62.19 grants under Minnesota Statutes, section
62.20 119B.232. This appropriation may be used
62.21 on programs receiving family, friends, and
62.22 neighbor grant funds as of June 30, 2009,
62.23 or on new programs or projects. This is a
62.24 onetime appropriation. Any unexpended
62.25 balance the first year is available in the
62.26 second year.

62.27 **Voluntary quality rating system training,**
62.28 **coaching, consultation, and supports.**
62.29 $633,000 in fiscal year 2010 and $633,000
62.30 in fiscal year 2011 are from the federal child
62.31 care development fund required targeted
62.32 quality funds for quality expansion and
62.33 infant/toddler from the American Recovery
62.34 and Reinvestment Act of 2009, Public
62.35 Law 111-5, to the commissioner of human

63.1 services consistent with federal regulations
63.2 for the purpose of providing grants to provide
63.3 statewide child-care provider training,
63.4 coaching, consultation, and supports to
63.5 prepare for the voluntary Minnesota quality
63.6 rating system rating tool. This is a onetime
63.7 appropriation. Any unexpended balance the
63.8 first year is available in the second year.

63.9 **Voluntary quality rating system.** $184,000
63.10 in fiscal year 2010 and $1,200,000 in fiscal
63.11 year 2011 are from the federal child care
63.12 development fund required targeted funds for
63.13 quality expansion and infant/toddler from the
63.14 American Recovery and Reinvestment Act of
63.15 2009, Public Law 111-5, to the commissioner
63.16 of human services consistent with federal
63.17 regulations for the purpose of implementing
63.18 the voluntary Parent Aware quality star
63.19 rating system pilot in coordination with the
63.20 Minnesota Early Learning Foundation. The
63.21 appropriation for the first year is to complete
63.22 and promote the voluntary Parent Aware
63.23 quality rating system pilot program through
63.24 June 30, 2010, and the appropriation for
63.25 the second year is to continue the voluntary
63.26 Minnesota quality rating system pilot
63.27 through June 30, 2011. This is a onetime
63.28 appropriation. Any unexpended balance the
63.29 first year is available in the second year.

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

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

63.32 Appropriations by Fund

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

64.1 **Base Adjustment.** The general fund base
64.2 is decreased by $5,371,000 in fiscal year
64.3 2012 and ~~increased $8,737,000~~ decreased
64.4 $5,371,000 in fiscal year 2013.

64.5 **Privatized Adoption Grants.** Federal
64.6 reimbursement for privatized adoption grant
64.7 and foster care recruitment grant expenditures
64.8 is appropriated to the commissioner for
64.9 adoption grants and foster care and adoption
64.10 administrative purposes.

64.11 **Adoption Assistance Incentive Grants.**
64.12 Federal funds available during fiscal
64.13 year 2010 and fiscal year 2011 for the
64.14 adoption incentive grants are appropriated
64.15 to the commissioner for ~~these purposes~~
64.16 postadoption services including parent
64.17 support groups.

64.18 **Adoption Assistance and Relative Custody**
64.19 **Assistance.** The commissioner may transfer
64.20 unencumbered appropriation balances for
64.21 adoption assistance and relative custody
64.22 assistance between fiscal years and between
64.23 programs.

64.24	**(h) Children and Community Services Grants**	67,663,000	67,542,000

64.25 **Targeted Case Management Temporary**
64.26 **Funding Adjustment.** The commissioner
64.27 shall recover from each county and tribe
64.28 receiving a targeted case management
64.29 temporary funding payment in fiscal year
64.30 2008 an amount equal to that payment. The
64.31 commissioner shall recover one-half of the
64.32 funds by February 1, 2010, and the remainder
64.33 by February 1, 2011. At the commissioner's
64.34 discretion and at the request of a county
64.35 or tribe, the commissioner may revise

65.1 the payment schedule, but full payment
65.2 must not be delayed beyond May 1, 2011.
65.3 The commissioner may use the recovery
65.4 procedure under Minnesota Statutes, section
65.5 256.017, to recover the funds. Recovered
65.6 funds must be deposited into the general
65.7 fund.

65.8 **(i) General Assistance Grants**	48,215,000	48,608,000

65.9 **General Assistance Standard.** The
65.10 commissioner shall set the monthly standard
65.11 of assistance for general assistance units
65.12 consisting of an adult recipient who is
65.13 childless and unmarried or living apart
65.14 from parents or a legal guardian at $203.
65.15 The commissioner may reduce this amount
65.16 according to Laws 1997, chapter 85, article
65.17 3, section 54.

65.18 **Emergency General Assistance.** The
65.19 amount appropriated for emergency general
65.20 assistance funds is limited to no more
65.21 than $7,889,812 in fiscal year 2010 and
65.22 $7,889,812 in fiscal year 2011. Funds
65.23 to counties must be allocated by the
65.24 commissioner using the allocation method
65.25 specified in Minnesota Statutes, section
65.26 256D.06.

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

65.28 **Emergency Minnesota Supplemental**
65.29 **Aid Funds.** The amount appropriated for
65.30 emergency Minnesota supplemental aid
65.31 funds is limited to no more than $1,100,000
65.32 in fiscal year 2010 and $1,100,000 in fiscal
65.33 year 2011. Funds to counties must be
65.34 allocated by the commissioner using the

66.1 allocation method specified in Minnesota
66.2 Statutes, section 256D.46.

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

66.4 **Group Residential Housing Costs**
66.5 **Refinanced.** (a) Effective July 1, 2011, the
66.6 commissioner shall increase the home and
66.7 community-based service rates and county
66.8 allocations provided to programs for persons
66.9 with disabilities established under section
66.10 1915(c) of the Social Security Act to the
66.11 extent that these programs will be paying
66.12 for the costs above the rate established
66.13 in Minnesota Statutes, section 256I.05,
66.14 subdivision 1.

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

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

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

66.32 66.33	**(m) Other Children and Economic Assistance Grants**	16,047,000	15,339,000

66.34 **Fraud Prevention Grants.** Of this
66.35 appropriation, ~~$379,000~~ $228,000 in fiscal

67.1 year 2010 and ~~$379,000~~ $228,000 in fiscal
67.2 year 2011 is to the commissioner for fraud
67.3 prevention grants to counties.

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

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

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

67.29 **Community Action Grants.** Community
67.30 action grants are reduced one time by
67.31 ~~$1,764,000~~ $1,794,000 each year. This
67.32 reduction is due to the availability of federal
67.33 funds under the American Recovery and
67.34 Reinvestment Act.

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

68.4 **Federal ARRA Funds for Existing**
68.5 **Programs.** (a) Federal funds received by the
68.6 commissioner for the emergency food and
68.7 shelter program from the American Recovery
68.8 and Reinvestment Act of 2009, Public
68.9 Law 111-5, but not previously approved
68.10 by the legislature are appropriated to the
68.11 commissioner for the purposes of the grant
68.12 program.

68.13 (b) Federal funds received by the
68.14 commissioner for the emergency shelter
68.15 grant program including the Homelessness
68.16 Prevention and Rapid Re-Housing
68.17 Program from the American Recovery and
68.18 Reinvestment Act of 2009, Public Law
68.19 111-5, are appropriated to the commissioner
68.20 for the purposes of the grant programs.

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

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

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

69.8 **Long-Term Homeless Supportive**
69.9 **Service Fund Appropriation.** To the
69.10 extent permitted under federal law, the
69.11 commissioner shall designate $3,000,000
69.12 of the Homelessness Prevention and Rapid
69.13 Re-Housing Program funds provided under
69.14 the American Recovery and Reinvestment
69.15 Act of 2009, Public Law, 111-5, to the
69.16 long-term homeless service fund under
69.17 Minnesota Statutes, section 256K.26. This
69.18 appropriation shall become available by July
69.19 1, 2009. This paragraph is effective the day
69.20 following final enactment.

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

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

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

69.27 Appropriations by Fund

69.28 General	10,318,000	10,308,000
69.29 Federal TANF	496,000	496,000

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

69.33 **School Readiness Service Agreements.**
69.34 ~~$406,000~~ $106,000 in fiscal year 2010 and
69.35 ~~$406,000~~ $241,000 in fiscal year 2011 are

70.1 from the federal child care development
70.2 funds received from the American Recovery
70.3 and Reinvestment Act of 2009, Public
70.4 Law 111-5, to the commissioner of human
70.5 services consistent with federal regulations
70.6 for the purpose of school readiness service
70.7 agreements under Minnesota Statutes,
70.8 section 119B.231, and the voluntary quality
70.9 rating system in Minnesota Statutes, section
70.10 119B.231, subdivision 3e. This is a onetime
70.11 appropriation. ~~Any unexpended balance the~~
70.12 ~~first year is available in the second year.~~

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

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

70.18 **Financial Institution Data Match and**
70.19 **Payment of Fees.** The commissioner is
70.20 authorized to allocate up to $310,000 each
70.21 year in fiscal years 2010 and 2011 from the
70.22 PRISM special revenue account to make
70.23 payments to financial institutions in exchange
70.24 for performing data matches between account
70.25 information held by financial institutions
70.26 and the public authority's database of child
70.27 support obligors as authorized by Minnesota
70.28 Statutes, section 13B.06, subdivision 7.

70.29 ~~**School Readiness Service Agreements.**~~
70.30 ~~$106,000 in fiscal year 2010 and $241,000~~
70.31 ~~in fiscal year 2011 are from the federal~~
70.32 ~~child care development funds received from~~
70.33 ~~the American Recovery and Reinvestment~~
70.34 ~~Act of 2009, Public Law 111-5, to the~~
70.35 ~~commissioner of human services consistent~~
70.36 ~~with federal regulations for the purpose of~~

71.1 ~~school readiness service agreements under~~
71.2 ~~Minnesota Statutes, section 119B.231. This~~
71.3 ~~is a onetime appropriation.~~

71.4 ~~**Use of Federal Stabilization Funds.**~~
71.5 ~~$33,000,000 in fiscal year 2010 is~~
71.6 ~~appropriated from the fiscal stabilization~~
71.7 ~~account in the federal fund to the~~
71.8 ~~commissioner. This appropriation must not~~
71.9 ~~be used for any activity or service for which~~
71.10 ~~federal reimbursement is claimed. This is a~~
71.11 ~~onetime appropriation.~~

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

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

71.15	~~391,915,000~~	~~485,448,000~~
71.16 **(a) MinnesotaCare Grants**	<u>391,785,000</u>	<u>485,370,000</u>

71.17 This appropriation is from the health care
71.18 access fund.

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

71.21 **Medical Education Research Costs**
71.22 **(MERC).** Of these funds, the commissioner
71.23 of human services shall transfer $38,000,000
71.24 in fiscal year 2010 to the medical education
71.25 research fund. These funds must restore the
71.26 fiscal year 2009 unallotment of the transfers
71.27 under Minnesota Statutes, section 256B.69,
71.28 subdivision 5c, paragraph (a), for the July 1,
71.29 2008, through June 30, 2009, period.

71.30 **Newborn Screening Fee.** Of the general
71.31 fund appropriation, $34,000 in fiscal year
71.32 2011 is to the commissioner for the hospital
71.33 reimbursement increase described under
71.34 Minnesota Statutes, section 256.969,
71.35 subdivision ~~28~~ <u>29</u>.

72.1 **Local Share Payment Modification**
72.2 **Required for ARRA Compliance.**
72.3 Effective retroactively from ~~July 1, 2009~~
72.4 October 1, 2008, to December 31, 2010,
72.5 Hennepin County's monthly contribution to
72.6 the nonfederal share of medical assistance
72.7 costs must be reduced to the percentage
72.8 required on September 1, 2008, to meet
72.9 federal requirements for enhanced federal
72.10 match under the American Reinvestment
72.11 and Recovery Act (ARRA) of 2009.
72.12 Notwithstanding the requirements of
72.13 Minnesota Statutes, section 256B.19,
72.14 subdivision 1c, paragraph (d), for the period
72.15 beginning ~~July 1, 2009~~ October 1, 2008,
72.16 to December 31, 2010, Hennepin County's
72.17 monthly payment under that provision is
72.18 reduced to $434,688. This provision is
72.19 effective the day following final enactment.

72.20 **Capitation Payments.** Effective
72.21 retroactively from ~~July 1, 2009~~ October 1,
72.22 2008, to December 31, 2010, notwithstanding
72.23 the provisions of Minnesota Statutes 2008,
72.24 section 256B.19, subdivision 1c, paragraph
72.25 (c), the commissioner shall increase
72.26 capitation payments made to the Metropolitan
72.27 Health Plan under Minnesota Statutes 2008,
72.28 section 256B.69, by $6,800,000 to recognize
72.29 higher than average medical education
72.30 costs. The increased amount includes federal
72.31 matching funds. This provision is effective
72.32 the day following final enactment.

72.33 **Use of Savings.** Any savings derived
72.34 from implementation of the prohibition in
72.35 Minnesota Statutes, section 256B.032, on the
72.36 enrollment of low-quality, high-cost health

73.1 care providers as vendors of state health care
73.2 program services shall be used to offset on a
73.3 pro rata basis the reimbursement reductions
73.4 for basic care services in Minnesota Statutes,
73.5 section 256B.766.

73.6 **(c) MA Basic Health Care Grants - Elderly and** 73.7 **Disabled**	~~970,183,000~~ 969,992,000	~~1,142,310,000~~ 1,141,575,000

73.8 **Minnesota Disability Health Options.**
73.9 Notwithstanding Minnesota Statutes, section
73.10 256B.69, subdivision 5a, paragraph (b), for
73.11 the period beginning July 1, 2009, to June
73.12 30, 2011, the monthly enrollment of persons
73.13 receiving home and community-based
73.14 waivered services under Minnesota
73.15 Disability Health Options shall not exceed
73.16 1,000. If the budget neutrality provision
73.17 in Minnesota Statutes, section 256B.69,
73.18 subdivision 23, paragraph (f), is reached
73.19 prior to June 30, 2013, the commissioner may
73.20 waive this monthly enrollment requirement.

73.21 **Hospital Fee-for-Service Payment Delay.**
73.22 Payments from the Medicaid Management
73.23 Information System that would otherwise
73.24 have been made for inpatient hospital
73.25 services for Minnesota health care program
73.26 enrollees must be delayed as follows: for
73.27 fiscal year 2011, payments in the month of
73.28 June equal to $15,937,000 must be included
73.29 in the first payment of fiscal year 2012 and
73.30 for fiscal year 2013, payments in the month
73.31 of June equal to $6,666,000 must be included
73.32 in the first payment of fiscal year 2014. The
73.33 provisions of Minnesota Statutes, section
73.34 16A.124, do not apply to these delayed
73.35 payments. Notwithstanding any contrary

74.1 provision in this article, this paragraph
74.2 expires December 31, 2014.

74.3 **Nonhospital Fee-for-Service Payment**
74.4 **Delay.** Payments from the Medicaid
74.5 Management Information System that would
74.6 otherwise have been made for nonhospital
74.7 acute care services for Minnesota health
74.8 care program enrollees must be delayed as
74.9 follows: payments in the month of June equal
74.10 to $23,438,000 for fiscal year 2011 must be
74.11 included in the first payment for fiscal year
74.12 2012, and payments in the month of June
74.13 equal to $27,156,000 for fiscal year 2013
74.14 must be included in the first payment for
74.15 fiscal year 2014. This payment delay must
74.16 not include nursing facilities, intermediate
74.17 care facilities for persons with developmental
74.18 disabilities, home and community-based
74.19 services, prepaid health plans, personal care
74.20 provider organizations, and home health
74.21 agencies. The provisions of Minnesota
74.22 Statutes, section 16A.124, do not apply to
74.23 these delayed payments. Notwithstanding
74.24 any contrary provision in this article, this
74.25 paragraph expires December 31, 2014.

74.26 ~~345,223,000~~
74.27 **(d) General Assistance Medical Care Grants** 344,907,000 381,081,000

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

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

74.30 Appropriations by Fund

74.31 General	295,000	295,000
74.32 Health Care Access	23,533,000	7,080,000

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

75.1 in fiscal year 2012 and $6,890,000 in fiscal
75.2 year 2013.

75.3 Subd. 7. **Health Care Management**

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

75.6 **(a) Health Care Administration**

75.7 Appropriations by Fund

75.8		~~7,831,000~~	~~7,742,000~~
75.9	General	7,880,000	7,786,000
75.10	Health Care Access	1,812,000	906,000

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

75.14 **(b) Health Care Operations**

75.15 Appropriations by Fund

75.16	General	19,914,000	18,949,000
75.17	Health Care Access	25,099,000	25,875,000

75.18 **Base Adjustment.** The health care access
75.19 fund base is increased by $1,006,000 in
75.20 fiscal year 2012 and $1,781,000 in fiscal year
75.21 2013. The general fund base is decreased by
75.22 $237,000 in fiscal year 2012 and $237,000 in
75.23 fiscal year 2013.

75.24 Subd. 8. **Continuing Care Grants**

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

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

75.28 ~~Appropriations by Fund~~

75.29	~~General~~	~~13,488,000~~	~~15,779,000~~
75.30	~~Federal~~	~~500,000~~	~~0~~

75.31	**(a) Aging and Adult Services Grants**	13,499,000	15,805,000

75.32 **Base Adjustment.** The general fund base is
75.33 increased by $5,751,000 in fiscal year 2012
75.34 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

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

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

77.9 77.10	**(c) Medical Assistance Grants; Long-Term Care Facilities.**	367,444,000	419,749,000
77.11 77.12	**(d) Medical Assistance Long-Term Care Waivers and Home Care Grants**	~~854,373,000~~ 853,567,000	~~1,043,411,000~~ 1,039,517,000

77.13 **Manage Growth in TBI and CADI**
77.14 **Waivers.** During the fiscal years beginning
77.15 on July 1, 2009, and July 1, 2010, the
77.16 commissioner shall allocate money for home
77.17 and community-based waiver programs
77.18 under Minnesota Statutes, section 256B.49,
77.19 to ensure a reduction in state spending that is
77.20 equivalent to limiting the caseload growth of
77.21 the TBI waiver to 12.5 allocations per month
77.22 each year of the biennium and the CADI
77.23 waiver to 95 allocations per month each year
77.24 of the biennium. Limits do not apply: (1)
77.25 when there is an approved plan for nursing
77.26 facility bed closures for individuals under
77.27 age 65 who require relocation due to the
77.28 bed closure; (2) to fiscal year 2009 waiver
77.29 allocations delayed due to unallotment; or (3)
77.30 to transfers authorized by the commissioner
77.31 from the personal care assistance program
77.32 of individuals having a home care rating
77.33 of "CS," "MT," or "HL." Priorities for the
77.34 allocation of funds must be for individuals
77.35 anticipated to be discharged from institutional

78.1 settings or who are at imminent risk of a
78.2 placement in an institutional setting.

78.3 **Manage Growth in DD Waiver.** The
78.4 commissioner shall manage the growth in
78.5 the DD waiver by limiting the allocations
78.6 included in the February 2009 forecast to 15
78.7 additional diversion allocations each month
78.8 for the calendar years that begin on January
78.9 1, 2010, and January 1, 2011. Additional
78.10 allocations must be made available for
78.11 transfers authorized by the commissioner
78.12 from the personal care program of individuals
78.13 having a home care rating of "CS," "MT,"
78.14 or "HL."

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

78.23 **Alternatives to Personal Care Assistance**
78.24 **Services.** Base level funding of $3,237,000
78.25 in fiscal year 2012 and $4,856,000 in
78.26 fiscal year 2013 is to implement alternative
78.27 services to personal care assistance services
78.28 for persons with mental health and other
78.29 behavioral challenges who can benefit
78.30 from other services that more appropriately
78.31 meet their needs and assist them in living
78.32 independently in the community. These
78.33 services may include, but not be limited to, a
78.34 1915(i) state plan option.

78.35 **(e) Mental Health Grants**

79.1 Appropriations by Fund

79.2 General	77,739,000	77,739,000
79.3 Health Care Access	750,000	750,000
79.4 Lottery Prize	1,508,000	1,508,000

79.5 **Funding Usage.** Up to 75 percent of a fiscal
79.6 year's appropriation for adult mental health
79.7 grants may be used to fund allocations in that
79.8 portion of the fiscal year ending December
79.9 31.

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

79.12 **Payments for Substance Abuse Treatment.**
79.13 For services provided during fiscal years
79.14 2010 and 2011, county-negotiated rates and
79.15 provider claims to the consolidated chemical
79.16 dependency fund must not exceed rates
79.17 charged for these services on January 1,
79.18 2009. For services provided in fiscal years
79.19 2012 and 2013, statewide average rates under
79.20 the new rate methodology to be developed
79.21 under Minnesota Statutes, section 254B.12,
79.22 must not exceed the average rates charged
79.23 for these services on January 1, 2009, plus a
79.24 state share increase of $3,787,000 for fiscal
79.25 year 2012 and $5,023,000 for fiscal year
79.26 2013. Notwithstanding any provision to the
79.27 contrary in this article, this provision expires
79.28 on June 30, 2013.

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

80.1 **County CD Share of MA Costs for**
80.2 **ARRA Compliance.** Notwithstanding the
80.3 provisions of Minnesota Statutes, chapter
80.4 254B, for chemical dependency services
80.5 provided during the period ~~July 1, 2009~~
80.6 October 1, 2008, to December 31, 2010,
80.7 and reimbursed by medical assistance
80.8 at the enhanced federal matching rate
80.9 provided under the American Recovery and
80.10 Reinvestment Act of 2009, the county share
80.11 is 30 percent of the nonfederal share. This
80.12 provision is effective the day following final
80.13 enactment.

80.14 **(h) Chemical Dependency Nonentitlement** 80.15 **Grants**	1,729,000	1,729,000

80.16 ~~**Base Adjustment.** The general fund base is~~
80.17 ~~decreased by $3,000 in each of fiscal years~~
80.18 ~~2012 and 2013.~~

80.19	~~18,272,000~~	~~13,139,000~~
80.20 **(i) Other Continuing Care Grants**	19,201,000	17,528,000

80.21 **Base Adjustment.** The general fund base
80.22 is increased by ~~$7,028,000~~ $2,639,000 in
80.23 fiscal year 2012 and increased by ~~$8,243,000~~
80.24 $3,854,000 in fiscal year 2013.

80.25 **Technology Grants.** $650,000 in fiscal
80.26 year 2010 and $1,000,000 in fiscal year
80.27 2011 are for technology grants, case
80.28 consultation, evaluation, and consumer
80.29 information grants related to developing and
80.30 supporting alternatives to shift-staff foster
80.31 care residential service models.

80.32 **Other Continuing Care Grants; HIV**
80.33 **Grants.** Money appropriated for the HIV
80.34 drug and insurance grant program in fiscal

81.1 year 2010 may be used in either year of the
81.2 biennium.

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

81.7 Subd. 9. **Continuing Care Management**

	Appropriations by Fund	
81.9 General	24,927,000	25,314,000
81.10 State Government	~~875,000~~	
81.11 Special Revenue	125,000	125,000
81.12 Lottery Prize	157,000	157,000

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

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

81.22 **Base Adjustment.** The general fund base is
81.23 decreased $2,697,000 in fiscal year 2012 and
81.24 $2,791,000 in fiscal year 2013.

81.25 Subd. 10. **State-Operated Services** ~~258,794,000~~ ~~266,191,000~~

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

81.28 **Transfer Authority Related to**
81.29 **State-Operated Services.** Money
81.30 appropriated to finance state-operated
81.31 services may be transferred between the
81.32 fiscal years of the biennium with the approval
81.33 of the commissioner of finance.

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

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

82.21		~~107,702,000~~	
82.22	**(a) Adult Mental Health Services**	106,702,000	107,201,000

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

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

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

83.4 **(b) Minnesota Sex Offender Services**

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

83.8 **Use of Federal Stabilization Funds.** Of
83.9 this appropriation, $26,495,000 in fiscal year
83.10 2010 is from the fiscal stabilization account
83.11 in the federal fund to the commissioner.
83.12 This appropriation must not be used for
83.13 any activity or service for which federal
83.14 reimbursement is claimed. This is a onetime
83.15 appropriation.

83.16 **(c) Minnesota Security Hospital and METO**
83.17 **Services**

83.18	Appropriations by Fund		
83.19		~~230,000,000~~	
83.20	General	230,000	83,735,000
83.21		~~83,504,000~~	
83.22	Federal Fund	83,505,000	0

83.23 **Minnesota Security Hospital.** For the
83.24 purposes of enhancing the safety of
83.25 the public, improving supervision, and
83.26 enhancing community-based mental health
83.27 treatment, state-operated services may
83.28 establish additional community capacity
83.29 for providing treatment and supervision
83.30 of clients who have been ordered into a
83.31 less restrictive alternative of care from the
83.32 state-operated services transitional services
83.33 program consistent with Minnesota Statutes,
83.34 section 246.014.

83.35 **Use of Federal Stabilization Funds.**
83.36 $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 Special Revenue	1,033,000	~~1,304,000~~ 1,033,000
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

86.1 Medical Center to carry out the feasibility
86.2 pilot project.

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

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

86.14 (2) $3,579,000 of the TANF funds are
86.15 appropriated each year to the commissioner
86.16 for home visiting and nutritional services
86.17 listed under Minnesota Statutes, section
86.18 145.882, subdivision 7, clauses (6) and (7).
86.19 Funds must be distributed to community
86.20 health boards according to Minnesota
86.21 Statutes, section 145A.131, subdivision 1.

86.22 (3) $2,000,000 of the TANF funds are
86.23 appropriated each year to the commissioner
86.24 for decreasing racial and ethnic disparities
86.25 in infant mortality rates under Minnesota
86.26 Statutes, section 145.928, subdivision 7.

86.27 (4) $4,998,000 of the TANF funds are
86.28 appropriated each year to the commissioner
86.29 for the family home visiting grant program
86.30 according to Minnesota Statutes, section
86.31 145A.17. $4,000,000 of the funding must
86.32 be distributed to community health boards
86.33 according to Minnesota Statutes, section
86.34 145A.131, subdivision 1. $998,000 of
86.35 the funding must be distributed to tribal

87.1 governments based on Minnesota Statutes,
87.2 section 145A.14, subdivision 2a. The
87.3 commissioner may use five percent of
87.4 the funds appropriated each fiscal year to
87.5 conduct the ongoing evaluations required
87.6 under Minnesota Statutes, section 145A.17,
87.7 subdivision 7, and may use ten percent of
87.8 the funds appropriated each fiscal year to
87.9 provide training and technical assistance as
87.10 required under Minnesota Statutes, section
87.11 145A.17, subdivisions 4 and 5.

87.12 **Base Adjustment.** The general fund base
87.13 is increased by $10,302,000 for fiscal year
87.14 2012 and increased by $5,109,000 for fiscal
87.15 year 2013. The health care access fund base
87.16 is reduced to $1,719,000 for both fiscal years
87.17 2012 and 2013.

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

87.22 Subd. 3. **Policy Quality and Compliance**

87.23 Appropriations by Fund

Line	Fund		
87.24			~~7,242,000~~
87.25	General	7,491,000	<u>7,243,000</u>
87.26–87.27	State Government Special Revenue	14,173,000	14,173,000
87.28	Health Care Access	17,561,000	12,090,000

87.29 **Community-Based Health Care**
87.30 **Demonstration Project.** Notwithstanding
87.31 the provisions of Laws 2007, chapter 147,
87.32 article 19, section 3, subdivision 6, paragraph
87.33 (e), base level funding to the commissioner
87.34 for the demonstration project grant described
87.35 in Minnesota Statutes, section 62Q.80,

88.1 subdivision 1a, shall be zero for fiscal years
88.2 2011 and 2012.

88.3 **Medical Education and Research Cost**
88.4 **Federal Compliance.** Notwithstanding
88.5 Laws 2008, chapter 363, article 18, section
88.6 4, subdivision 3, the base level funding
88.7 for the commissioner to distribute to the
88.8 Mayo Clinic for transitional funding while
88.9 federal compliance changes are made to the
88.10 medical education and research cost funding
88.11 distribution formula shall be $0 for fiscal
88.12 years 2010 and 2011.

88.13 **Autism Clinical Research.** The
88.14 commissioner, in partnership with a
88.15 Minnesota research institution, shall apply
88.16 for funds available for research grants under
88.17 the American Recovery and Reinvestment
88.18 Act (ARRA) of 2009 in order to expand
88.19 research and treatment of autism spectrum
88.20 disorders.

88.21 **Health Information Technology.** (a) Of
88.22 the health care access fund appropriation,
88.23 $4,000,000 is to fund the revolving loan
88.24 account under Minnesota Statutes, section
88.25 62J.496. This appropriation must not be
88.26 expended unless it is matched with federal
88.27 funding under the federal Health Information
88.28 Technology for Economic and Clinical
88.29 Health (HITECH) Act. This appropriation
88.30 must not be included in the agency's base
88.31 budget for the fiscal year beginning July 1,
88.32 2012.

88.33 (b) On or before June 30, 2013, $1,200,000
88.34 shall be transferred from the revolving loan
88.35 account under Minnesota Statutes, section

89.1 62J.496, to the health care access fund.
89.2 This is a onetime transfer and must not be
89.3 included in the agency's base budget for the
89.4 fiscal year beginning July 1, 2014.

89.5 **Base Adjustment.** The general fund
89.6 base is $8,243,000 in fiscal year 2012 and
89.7 $8,243,000 in fiscal year 2013. The health
89.8 care access fund base is $10,950,000 in fiscal
89.9 year 2012 and $6,816,000 in fiscal year 2013.

89.10 Subd. 4. **Health Protection**

89.11 Appropriations by Fund

89.12	General	9,871,000	9,780,000
89.13 89.14	State Government Special Revenue	30,209,000	30,209,000

89.15 **Base Adjustment.** The general fund base is
89.16 reduced by $50,000 in each of fiscal years
89.17 2012 and 2013.

89.18 **Health Protection Appropriations.** (a)
89.19 $163,000 each year is for the lead abatement
89.20 grant program.

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

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

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

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

89.30 **American Recovery and Reinvestment**
89.31 **Act Funds.** Federal funds received
89.32 by the commissioner for immunization
89.33 operations from the American Recovery
89.34 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**

Subdivision 1. **Total Appropriation**	$ ~~15,017,000~~ 14,034,000	$ ~~14,831,000~~ 13,848,000

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
Subd. 6. **Board of Medical Practice**	~~3,674,000~~ 3,682,000	~~3,674,000~~ 3,682,000
Subd. 7. **Board of Nursing**	~~4,217,000~~ 3,287,000	~~4,219,000~~ 3,289,000
Subd. 8. **Board of Nursing Home Administrators**	~~1,146,000~~ 1,211,000	~~958,000~~ 1,023,000

Administrative Services Unit - Operating Costs. Of this appropriation, $524,000 in fiscal year 2010 and $526,000 in

91.1 fiscal year 2011 are for operating costs
91.2 of the administrative services unit. The
91.3 administrative services unit may receive
91.4 and expend reimbursements for services
91.5 performed by other agencies.

91.6 **Administrative Services Unit - Retirement**
91.7 **Costs.** Of this appropriation in fiscal year
91.8 2010, $201,000 is for onetime retirement
91.9 costs in the health-related boards. This
91.10 funding may be transferred to the health
91.11 boards incurring those costs for their
91.12 payment. These funds are available either
91.13 year of the biennium.

91.14 **Administrative Services Unit - Volunteer**
91.15 **Health Care Provider Program.** Of this
91.16 appropriation, $79,000 in fiscal year 2010
91.17 and $89,000 in fiscal year 2011 are to pay
91.18 for medical professional liability coverage
91.19 required under Minnesota Statutes, section
91.20 214.40.

91.21 **Administrative Services Unit - Contested**
91.22 **Cases and Other Legal Proceedings.** Of
91.23 this appropriation, $200,000 in fiscal year
91.24 2010 and $200,000 in fiscal year 2011
91.25 are for costs of contested case hearings
91.26 and other unanticipated costs of legal
91.27 proceedings involving health-related
91.28 boards funded under this section. Upon
91.29 certification of a health-related board to the
91.30 administrative services unit that the costs
91.31 will be incurred and that there is insufficient
91.32 money available to pay for the costs out of
91.33 money currently available to that board, the
91.34 administrative services unit is authorized
91.35 to transfer money from this appropriation

92.1 to the board for payment of those costs
92.2 with the approval of the commissioner of
92.3 finance. This appropriation does not cancel.
92.4 Any unencumbered and unspent balances
92.5 remain available for these expenditures in
92.6 subsequent fiscal years.

Line	Item		2010		2011
92.7	Subd. 9. **Board of Optometry**		101,000		101,000
92.8 92.9	Subd. 10. **Board of Pharmacy**		~~1,413,000~~ 1,388,000		~~1,413,000~~ 1,388,000
92.10	Subd. 11. **Board of Physical Therapy**		295,000		295,000
92.11	Subd. 12. **Board of Podiatry**		56,000		56,000
92.12	Subd. 13. **Board of Psychology**		806,000		806,000
92.13 92.14	Subd. 14. **Board of Social Work**		~~1,022,000~~ 921,000		~~1,022,000~~ 921,000
92.15	Subd. 15. **Board of Veterinary Medicine**		195,000		195,000
92.16 92.17	Subd. 16. **Board of Behavioral Health and Therapy**		394,000		394,000

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

Line	Item				
92.19 92.20	Sec. 6. **EMERGENCY MEDICAL SERVICES BOARD**	$	~~4,378,000~~ 3,928,000	$	~~3,828,000~~ 3,828,000

92.21 Appropriations by Fund

Line		2010	2011
92.22		2010	2011
92.23 92.24	General	~~3,674,000~~ 3,224,000	3,124,000
92.25 92.26	State Government Special Revenue	704,000	704 ,000

92.27 **Longevity Award and Incentive Program.**
92.28 Of the general fund appropriation, $700,000
92.29 in fiscal year 2010 and $700,000 in fiscal year
92.30 2011 are to the board for the Cooper/Sams
92.31 volunteer ambulance program, under
92.32 Minnesota Statutes, section 144E.40.

92.33 **Transfer.** In fiscal year 2010, $6,182,000
92.34 is transferred from the Cooper/Sams

93.1 volunteer ambulance trust, established under
93.2 Minnesota Statutes, section 144E.42, to the
93.3 general fund.

93.4 **Health Professional Services Program.**
93.5 $704,000 in fiscal year 2010 and $704,000 in
93.6 fiscal year 2011 from the state government
93.7 special revenue fund are for the health
93.8 professional services program.

93.9 **Comprehensive Advanced Life-Support**
93.10 **Educational (CALS) Program.** $100,000
93.11 in the first year from the ~~Cooper/Sams~~
93.12 ~~volunteer ambulance trust~~ general fund is
93.13 for the comprehensive advanced life-support
93.14 educational (CALS) program established
93.15 under Minnesota Statutes, section 144E.37.
93.16 This appropriation is to extend availability
93.17 and affordability of the CALS program
93.18 for rural emergency medical personnel
93.19 and to assist hospital staff in attaining
93.20 the credentialing levels necessary for
93.21 implementation of the statewide trauma
93.22 system.

93.23 **Veterans Paramedic Apprenticeship**
93.24 **Program.** Of this appropriation, $200,000
93.25 in the first year is from the general fund for
93.26 transfer to the commissioner of veterans
93.27 affairs for a grant to the Minnesota
93.28 Ambulance Association to implement a
93.29 veterans paramedic apprenticeship program
93.30 to reintegrate returning military medics
93.31 into Minnesota's workforce in the field of
93.32 paramedic and emergency services, thereby
93.33 guaranteeing returning military medics
93.34 gainful employment with livable wages and

94.1 benefits. This appropriation is available until
94.2 expended.

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

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

94.23 Sec. 5. **REPEALER.**

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

94.25 **ARTICLE 3**

94.26 **HEALTH CARE ELIGIBILITY**

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

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

94.32 (1) assist enrollees in understanding their rights;

95.1 (2) explain and assist in the use of all available complaint systems, including internal
95.2 complaint systems within health carriers, community integrated service networks, and
95.3 the Departments of Health and Commerce;
95.4 (3) provide information on coverage options in each region of the state;
95.5 (4) provide information on the availability of purchasing pools and enrollee
95.6 subsidies; and
95.7 (5) help consumers use the health care system to obtain coverage.
95.8 (b) The information clearinghouse or other entity designated by the commissioner
95.9 for the purposes of this subdivision shall not:
95.10 (1) provide legal services to consumers;
95.11 (2) represent a consumer or enrollee; or
95.12 (3) serve as an advocate for consumers in disputes with health plan companies.
95.13 (c) Nothing in this subdivision shall interfere with the ombudsman program
95.14 established under section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, or other
95.15 existing ombudsman programs.

95.16 Sec. 2. Minnesota Statutes 2008, section 245.494, subdivision 3, is amended to read:
95.17 Subd. 3. **Duties of the commissioner of human services.** The commissioner of
95.18 human services, in consultation with the Integrated Fund Task Force, shall:
95.19 (1) in the first quarter of 1994, in areas where a local children's mental health
95.20 collaborative has been established, based on an independent actuarial analysis, identify all
95.21 medical assistance and MinnesotaCare resources devoted to mental health services for
95.22 children in the target population including inpatient, outpatient, medication management,
95.23 services under the rehabilitation option, and related physician services in the total health
95.24 capitation of prepaid plans under contract with the commissioner to provide medical
95.25 assistance services under section 256B.69;
95.26 (2) assist each children's mental health collaborative to determine an actuarially
95.27 feasible operational target population;
95.28 (3) ensure that a prepaid health plan that contracts with the commissioner to provide
95.29 medical assistance or MinnesotaCare services shall pass through the identified resources
95.30 to a collaborative or collaboratives upon the collaboratives meeting the requirements
95.31 of section 245.4933 to serve the collaborative's operational target population. The
95.32 commissioner shall, through an independent actuarial analysis, specify differential rates
95.33 the prepaid health plan must pay the collaborative based upon severity, functioning, and
95.34 other risk factors, taking into consideration the fee-for-service experience of children
95.35 excluded from prepaid medical assistance participation;

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

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

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

96.14 (i) meets the requirements of section 245.4933;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

97.26 (16) by January 1, 1994, develop a model contract for providers of mental health
97.27 managed care that meets the requirements set out in sections 245.491 to 245.495 and
97.28 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995,
97.29 the commissioner of human services shall not enter into or extend any contract for any
97.30 prepaid plan that would impede the implementation of sections 245.491 to 245.495;

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

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

98.1 (19) provide technical assistance to help local children's mental health collaboratives
98.2 certify local expenditures for federal financial participation, using due diligence in order to
98.3 meet implementation timelines for sections 245.491 to 245.495 and recommend necessary
98.4 legislation to enhance federal revenue, provide clinical and management flexibility, and
98.5 otherwise meet the goals of local children's mental health collaboratives and request
98.6 necessary state plan amendments to maximize the availability of medical assistance for
98.7 activities undertaken by the local children's mental health collaborative;
98.8 (20) take all steps necessary to secure medical assistance reimbursement under the
98.9 rehabilitation option for family community support services and therapeutic support of
98.10 foster care and for individualized rehabilitation services;
98.11 (21) provide a mechanism to identify separately the reimbursement to a county
98.12 for child welfare targeted case management provided to children served by the local
98.13 collaborative for purposes of subsequent transfer by the county to the integrated fund;
98.14 (22) ensure that family members who are enrolled in a prepaid health plan and
98.15 whose children are receiving mental health services through a local children's mental
98.16 health collaborative file complaints about mental health services needed by the family
98.17 members, the commissioner shall comply with section ~~256B.031, subdivision 6~~ 256B.69,
98.18 subdivision 20. A collaborative may assist a family to make a complaint; and
98.19 (23) facilitate a smooth transition for children receiving prepaid medical assistance
98.20 or MinnesotaCare services through a children's mental health collaborative who become
98.21 enrolled in a prepaid health plan.

98.22 Sec. 3. Minnesota Statutes 2008, section 256.015, subdivision 7, is amended to read:
98.23 Subd. 7. **Cooperation with information requests required.** (a) Upon the request
98.24 of the ~~Department~~ commissioner of human services~~,~~:
98.25 (1) any state agency or third party payer shall cooperate ~~with the department in~~ by
98.26 furnishing information to help establish a third party liability~~. Upon the request of the~~
98.27 ~~Department of Human Services or county child support or human service agencies~~, as
98.28 required by the federal Deficit Reduction Act of 2005, Public Law 109-171;
98.29 (2) any employer or third party payer shall cooperate ~~in~~ by furnishing a data file
98.30 containing information about group health insurance ~~plans~~ plan or medical benefit ~~plans~~
98.31 ~~available to~~ plan coverage of its employees or insureds within 60 days of the request.
98.32 (b) For purposes of section 176.191, subdivision 4, the ~~Department~~ commissioner
98.33 of labor and industry may allow the ~~Department~~ commissioner of human services and
98.34 county agencies direct access and data matching on information relating to workers'
98.35 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

100.1 preceding the rate year. The rate setting data must reflect the admissions data used to
100.2 establish relative values. Base year changes from 1981 to the base year established for the
100.3 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
100.4 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
100.5 1. The commissioner may adjust base year cost, relative value, and case mix index data
100.6 to exclude the costs of services that have been discontinued by the October 1 of the year
100.7 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
100.8 that encompass portions of two or more rate years shall have payments established based
100.9 on payment rates in effect at the time of admission unless the date of admission preceded
100.10 the rate year in effect by six months or more. In this case, operating payment rates for
100.11 services rendered during the rate year in effect and established based on the date of
100.12 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

100.21 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
100.22 fee-for-service admissions occurring on or after ~~July~~ August 1, 2005, made to hospitals
100.23 for inpatient services before third-party liability and spenddown, is reduced 6.0 percent
100.24 from the current statutory rates. Mental health services within diagnosis related groups
100.25 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
100.26 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
100.27 assistance does not include general assistance medical care. Payments made to managed
100.28 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
100.29 this reduction.

100.30 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
100.31 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
100.32 to hospitals for inpatient services before third-party liability and spenddown, is reduced
100.33 3.46 percent from the current statutory rates. Mental health services with diagnosis related
100.34 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
100.35 paragraph. Payments made to managed care plans shall be reduced for services provided
100.36 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

101.1 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
101.2 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
101.3 to hospitals for inpatient services before third-party liability and spenddown, is reduced
101.4 1.9 percent from the current statutory rates. Mental health services with diagnosis related
101.5 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
101.6 paragraph. Payments made to managed care plans shall be reduced for services provided
101.7 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.
101.8 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
101.9 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
101.10 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
101.11 from the current statutory rates. Mental health services with diagnosis related groups
101.12 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
101.13 Payments made to managed care plans shall be reduced for services provided on or after
101.14 July 1, 2010, to reflect this reduction.

101.15 Sec. 5. Minnesota Statutes 2008, section 256B.037, subdivision 5, is amended to read:
101.16 Subd. 5. **Other contracts permitted.** Nothing in this section prohibits the
101.17 commissioner from contracting with an organization for comprehensive health services,
101.18 including dental services, under ~~section 256B.031,~~ sections 256B.035, 256B.69, or
101.19 256D.03, subdivision 4, paragraph (c).

101.20 Sec. 6. Minnesota Statutes 2008, section 256B.056, subdivision 1c, is amended to read:
101.21 Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003
101.22 c 14 art 12 s 17]
101.23 (2) For applications processed within one calendar month prior to July 1, 2003,
101.24 eligibility shall be determined by applying the income standards and methodologies in
101.25 effect prior to July 1, 2003, for any months in the six-month budget period before July
101.26 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any
101.27 months in the six-month budget period on or after that date. The income standards for
101.28 each month shall be added together and compared to the applicant's total countable income
101.29 for the six-month budget period to determine eligibility.
101.30 (3) For children ages one through 18 whose eligibility is determined under section
101.31 256B.057, subdivision 2, the following deductions shall be applied to income counted
101.32 toward the child's eligibility as allowed under the state's AFDC plan in effect as of July
101.33 16, 1996: $90 work expense, dependent care, and child support paid under court order.
101.34 This clause is effective October 1, 2003.

102.1 (b) For families with children whose eligibility is determined using the standard
102.2 specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable
102.3 earned income shall be disregarded for up to four months and the following deductions
102.4 shall be applied to each individual's income counted toward eligibility as allowed under
102.5 the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid
102.6 under court order.
102.7 (c) If the four-month disregard in paragraph (b) has been applied to the wage
102.8 earner's income for four months, the disregard shall not be applied again until the wage
102.9 earner's income has not been considered in determining medical assistance eligibility for
102.10 12 consecutive months.
102.11 (d) The commissioner shall adjust the income standards under this section each July
102.12 1 by the annual update of the federal poverty guidelines following publication by the
102.13 United States Department of Health and Human Services.
102.14 (e) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt
102.15 organization to or for the benefit of the child with a life-threatening illness must be
102.16 disregarded from income.

102.17 Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to read:
102.18 Subd. 3c. **Asset limitations for families and children.** A household of two or more
102.19 persons must not own more than $20,000 in total net assets, and a household of one
102.20 person must not own more than $10,000 in total net assets. In addition to these maximum
102.21 amounts, an eligible individual or family may accrue interest on these amounts, but they
102.22 must be reduced to the maximum at the time of an eligibility redetermination. The value of
102.23 assets that are not considered in determining eligibility for medical assistance for families
102.24 and children is the value of those assets excluded under the AFDC state plan as of July 16,
102.25 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
102.26 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:
102.27 (1) household goods and personal effects are not considered;
102.28 (2) capital and operating assets of a trade or business up to $200,000 are not
102.29 considered;
102.30 (3) one motor vehicle is excluded for each person of legal driving age who is
102.31 employed or seeking employment;
102.32 (4) ~~one burial plot and all other burial expenses equal to the supplemental security~~
102.33 ~~income program asset limit are not considered for each individual~~ assets designated as
102.34 burial expenses are excluded to the same extent they are excluded by the Supplemental
102.35 Security Income program;

103.1 (5) court-ordered settlements up to $10,000 are not considered;
103.2 (6) individual retirement accounts and funds are not considered; and
103.3 (7) assets owned by children are not considered.

103.4 Sec. 8. Minnesota Statutes 2008, section 256B.056, subdivision 6, is amended to read:
103.5 Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person
103.6 must have applied or must agree to apply all proceeds received or receivable by the person
103.7 or the person's legal representative from any third party liable for the costs of medical
103.8 care. By accepting or receiving assistance, the person is deemed to have assigned the
103.9 person's rights to medical support and third party payments as required by title 19 of
103.10 the Social Security Act. Persons must cooperate with the state in establishing paternity
103.11 and obtaining third party payments. By accepting medical assistance, a person assigns
103.12 to the Department of Human Services all rights the person may have to medical support
103.13 or payments for medical expenses from any other person or entity on their own or their
103.14 dependent's behalf and agrees to cooperate with the state in establishing paternity and
103.15 obtaining third party payments. Any rights or amounts so assigned shall be applied against
103.16 the cost of medical care paid for under this chapter. Any assignment takes effect upon
103.17 the determination that the applicant is eligible for medical assistance and up to three
103.18 months prior to the date of application if the applicant is determined eligible for and
103.19 receives medical assistance benefits. The application must contain a statement explaining
103.20 this assignment. For the purposes of this section, "the Department of Human Services or
103.21 the state" includes prepaid health plans under contract with the commissioner according
103.22 to sections ~~256B.031,~~ 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12;
103.23 children's mental health collaboratives under section 245.493; demonstration projects for
103.24 persons with disabilities under section 256B.77; nursing facilities under the alternative
103.25 payment demonstration project under section 256B.434; and the county-based purchasing
103.26 entities under section 256B.692.

103.27 Sec. 9. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
103.28 subdivision to read:
103.29 Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug
103.30 Utilization Review Board is established. The board must be comprised of at least three
103.31 but no more than four licensed physicians actively engaged in the practice of medicine
103.32 in Minnesota; at least three licensed pharmacists actively engaged in the practice of
103.33 pharmacy in Minnesota; and one consumer representative. The remainder must be made
103.34 up of health care professionals who are licensed in their field and have recognized

104.1 knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered
104.2 outpatient drugs. Members of the board must be appointed by the commissioner, shall
104.3 serve three-year terms, and may be reappointed by the commissioner. The board shall
104.4 annually elect a chair from among its members.

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

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

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

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

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

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

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

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

104.22 (7) establish and implement an ongoing process to:

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

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

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

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

104.32 (e) The board shall report to the commissioner annually on the date the drug
104.33 utilization review annual report is due to the Centers for Medicare and Medicaid Services.
104.34 This report must cover the preceding federal fiscal year. The commissioner shall make the
104.35 report available to the public upon request. The report must include information on the
104.36 activities of the board and the program; the effectiveness of implemented interventions;

105.1 administrative costs; and any fiscal impact resulting from the program. An honorarium
105.2 of $100 per meeting and reimbursement for mileage must be paid to each board member
105.3 in attendance.

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

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

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

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

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

105.22 Subd. 3. **Coordination and provision of services.** (a) In a county or reservation
105.23 where a prepaid medical assistance provider has contracted under section ~~256B.031 or~~
105.24 256B.69 to provide mental health services, the case management provider shall coordinate
105.25 with the prepaid provider to ensure that all necessary mental health services required
105.26 under the contract are provided to recipients of case management services.

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

105.31 (c) The case management provider may bill the provider of prepaid health care
105.32 services for any mental health services provided to a recipient of case management
105.33 services which the county or tribal social services arranges for or provides and which are
105.34 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

107.1 (2) to Regions Hospital, any federal matching funds available to match the payments
107.2 received by the hospital under subdivision 2, to increase payments for medical assistance
107.3 admissions and to recognize higher medical assistance costs in institutions that provide
107.4 high levels of charity care.

107.5 (b) Effective July 15, 2001, the following percentages of the transfers under
107.6 subdivision 2 shall be retained by the commissioner for deposit each month into the
107.7 general fund:

107.8 (1) 18 percent, plus any federal matching funds, shall be allocated for the following
107.9 purposes:

107.10 (i) during the fiscal year beginning July 1, 2001, of the amount available under
107.11 this clause, 39.7 percent shall be allocated to make increased hospital payments under
107.12 section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts
107.13 due from small rural hospitals, as defined in section 144.148, for overpayments under
107.14 section 256.969, subdivision 5a, resulting from a determination that medical assistance
107.15 and general assistance payments exceeded the charge limit during the period from 1994 to
107.16 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital
107.17 capital improvement grants under section 144.148; and

107.18 (ii) during fiscal years beginning on or after July 1, 2002, of the amount available
107.19 under this clause, 55 percent shall be allocated to make increased hospital payments under
107.20 section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of
107.21 health for rural hospital capital improvement grants under section 144.148; and

107.22 (2) 11 percent shall be allocated to the commissioner of health to fund community
107.23 clinic grants under section 145.9268.

107.24 (c) This subdivision shall apply to fee-for-service payments only and shall not
107.25 increase capitation payments or payments made based on average rates. The allocation in
107.26 paragraph (b), clause (1), item (ii), to increase hospital payments under section 256.969,
107.27 subdivision 26, shall not limit payments under that section.

107.28 (d) Medical assistance rate or payment changes, including those required to obtain
107.29 federal financial participation under section 62J.692, subdivision 8, shall precede the
107.30 determination of intergovernmental transfer amounts determined in this subdivision.
107.31 Participation in the intergovernmental transfer program shall not result in the offset of
107.32 any health care provider's receipt of medical assistance payment increases other than
107.33 limits resulting from hospital-specific charge limits and limits on disproportionate share
107.34 hospital payments.

107.35 (e) Effective July 1, 2003, if the amount available for allocation under paragraph
107.36 (b) is greater than the amounts available during March 2003, after any increase in

108.1 intergovernmental transfers and payments that result from section 256.969, subdivision
108.2 3a, paragraph (c), are paid to the general fund, any additional amounts available under this
108.3 subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to
108.4 increase medical assistance payments, subject to hospital-specific charge limits and limits
108.5 on disproportionate share hospital payments, as follows:

108.6 (1) if the payments under subdivision 5 are approved, the amount shall be paid to
108.7 the largest ten percent of hospitals as measured by 2001 payments for medical assistance,
108.8 general assistance medical care, and MinnesotaCare in the nonstate government hospital
108.9 category. Payments shall be allocated according to each hospital's proportionate share
108.10 of the 2001 payments; or

108.11 (2) if the payments under subdivision 5 are not approved, the amount shall be paid to
108.12 the largest ten percent of hospitals as measured by 2001 payments for medical assistance,
108.13 general assistance medical care, and MinnesotaCare in the nonstate government category
108.14 and to the largest ten percent of hospitals as measured by payments for medical assistance,
108.15 general assistance medical care, and MinnesotaCare in the nongovernment hospital
108.16 category. Payments shall be allocated according to each hospital's proportionate
108.17 share of the 2001 payments in their respective category of nonstate government and
108.18 nongovernment. The commissioner shall determine which hospitals are in the nonstate
108.19 government and nongovernment hospital categories.

108.20 Sec. 15. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

108.21 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
108.22 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
108.23 basis beginning January 1, 1996. Managed care contracts which were in effect on June
108.24 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
108.25 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
108.26 commissioner may issue separate contracts with requirements specific to services to
108.27 medical assistance recipients age 65 and older.

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

108.33 (c) Effective for services rendered on or after January 1, 2003, the commissioner
108.34 shall withhold five percent of managed care plan payments under this section for the
108.35 prepaid medical assistance and general assistance medical care programs pending

109.1 completion of performance targets. Each performance target must be quantifiable,
109.2 objective, measurable, and reasonably attainable, except in the case of a performance
109.3 target based on a federal or state law or rule. Criteria for assessment of each performance
109.4 target must be outlined in writing prior to the contract effective date. The managed
109.5 care plan must demonstrate, to the commissioner's satisfaction, that the data submitted
109.6 regarding attainment of the performance target is accurate. The commissioner shall
109.7 periodically change the administrative measures used as performance targets in order
109.8 to improve plan performance across a broader range of administrative services. The
109.9 performance targets must include measurement of plan efforts to contain spending
109.10 on health care services and administrative activities. The commissioner may adopt
109.11 plan-specific performance targets that take into account factors affecting only one plan,
109.12 including characteristics of the plan's enrollee population. The withheld funds must be
109.13 returned no sooner than July of the following year if performance targets in the contract
109.14 are achieved. The commissioner may exclude special demonstration projects under
109.15 subdivision 23. A managed care plan or a county-based purchasing plan under section
109.16 256B.692 may include as admitted assets under section 62D.044 any amount withheld
109.17 under this paragraph that is reasonably expected to be returned.

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

109.23 (2) A managed care plan or a county-based purchasing plan under section 256B.692
109.24 may include as admitted assets under section 62D.044 any amount withheld under
109.25 this paragraph. The return of the withhold under this paragraph is not subject to the
109.26 requirements of paragraph (c).

109.27 (e) Contracts between the commissioner and a prepaid health plan are exempt from
109.28 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
109.29 (a), and 7.

109.30 Sec. 16. Minnesota Statutes 2008, section 256B.77, subdivision 13, is amended to read:

109.31 Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services
109.32 established in section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, and advocacy
109.33 services provided by the ombudsman for mental health and developmental disabilities
109.34 established in sections 245.91 to 245.97. The managed care ombudsman and the
109.35 ombudsman for mental health and developmental disabilities shall coordinate services

110.1 provided to avoid duplication of services. For purposes of the demonstration project,
110.2 the powers and responsibilities of the Office of Ombudsman for Mental Health and
110.3 Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded
110.4 to include all eligible individuals, health plan companies, agencies, and providers
110.5 participating in the demonstration project.

110.6 Sec. 17. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:
110.7 Subd. 3. **General assistance medical care; eligibility.** (a) General assistance
110.8 medical care may be paid for any person who is not eligible for medical assistance under
110.9 chapter 256B, including eligibility for medical assistance based on a spenddown of excess
110.10 income according to section 256B.056, subdivision 5, or MinnesotaCare ~~as~~ for applicants
110.11 and recipients defined in paragraph ~~(b)~~ (c), except as provided in paragraph ~~(c)~~ (d), and:
110.12 (1) who is receiving assistance under section 256D.05, except for families with
110.13 children who are eligible under Minnesota family investment program (MFIP), or who is
110.14 having a payment made on the person's behalf under sections 256I.01 to 256I.06; or
110.15 (2) who is a resident of Minnesota; and
110.16 (i) who has gross countable income not in excess of 75 percent of the federal poverty
110.17 guidelines for the family size, using a six-month budget period and whose equity in assets
110.18 is not in excess of $1,000 per assistance unit. General assistance medical care is not
110.19 available for applicants or enrollees who are otherwise eligible for medical assistance but
110.20 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
110.21 terminated and transferred to medical assistance. Exempt assets, the reduction of excess
110.22 assets, and the waiver of excess assets must conform to the medical assistance program in
110.23 section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum
110.24 amount of undistributed funds in a trust that could be distributed to or on behalf of the
110.25 beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the
110.26 terms of the trust, must be applied toward the asset maximum; or
110.27 (ii) who has gross countable income above 75 percent of the federal poverty
110.28 guidelines but not in excess of 175 percent of the federal poverty guidelines for the
110.29 family size, using a six-month budget period, whose equity in assets is not in excess
110.30 of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient
110.31 hospitalization~~; or~~.
110.32 ~~(iii)~~ (b) the commissioner shall adjust the income standards under this section each
110.33 July 1 by the annual update of the federal poverty guidelines following publication by the
110.34 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 ~~(e)~~ (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.

~~(e)~~ (f) Applicants and recipients eligible under paragraph (a), clause ~~(1)~~ (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 ~~(j)~~ (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

112.1 this subdivision are met, eligibility for general assistance medical care shall be available
112.2 in any month during which MinnesotaCare enrollment is pending. Upon notification of
112.3 eligibility for MinnesotaCare, notice of termination for eligibility for general assistance
112.4 medical care shall be sent to an applicant or recipient. If all other eligibility requirements
112.5 of this subdivision are met, eligibility for general assistance medical care shall be available
112.6 until enrollment in MinnesotaCare subject to the provisions of paragraphs ~~(c)~~ (d), ~~(e)~~ (f),
112.7 and ~~(f)~~ (g).

112.8 ~~(h)~~ (i) The date of an initial Minnesota health care program application necessary
112.9 to begin a determination of eligibility shall be the date the applicant has provided a
112.10 name, address, and Social Security number, signed and dated, to the county agency
112.11 or the Department of Human Services. If the applicant is unable to provide a name,
112.12 address, Social Security number, and signature when health care is delivered due to a
112.13 medical condition or disability, a health care provider may act on an applicant's behalf to
112.14 establish the date of an initial Minnesota health care program application by providing
112.15 the county agency or Department of Human Services with provider identification and a
112.16 temporary unique identifier for the applicant. The applicant must complete the remainder
112.17 of the application and provide necessary verification before eligibility can be determined.
112.18 The applicant must complete the application within the time periods required under the
112.19 medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart
112.20 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining
112.21 verification if necessary.

112.22 ~~(i)~~ (j) County agencies are authorized to use all automated databases containing
112.23 information regarding recipients' or applicants' income in order to determine eligibility for
112.24 general assistance medical care or MinnesotaCare. Such use shall be considered sufficient
112.25 in order to determine eligibility and premium payments by the county agency.

112.26 ~~(j)~~ (k) General assistance medical care is not available for a person in a correctional
112.27 facility unless the person is detained by law for less than one year in a county correctional
112.28 or detention facility as a person accused or convicted of a crime, or admitted as an
112.29 inpatient to a hospital on a criminal hold order, and the person is a recipient of general
112.30 assistance medical care at the time the person is detained by law or admitted on a criminal
112.31 hold order and as long as the person continues to meet other eligibility requirements
112.32 of this subdivision.

112.33 ~~(k)~~ (l) General assistance medical care is not available for applicants or recipients
112.34 who do not cooperate with the county agency to meet the requirements of medical
112.35 assistance.

113.1 ~~(l)~~ (m) In determining the amount of assets of an individual eligible under paragraph
113.2 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including
113.3 an asset excluded under paragraph (a), that was given away, sold, or disposed of for
113.4 less than fair market value within the 60 months preceding application for general
113.5 assistance medical care or during the period of eligibility. Any transfer described in this
113.6 paragraph shall be presumed to have been for the purpose of establishing eligibility for
113.7 general assistance medical care, unless the individual furnishes convincing evidence to
113.8 establish that the transaction was exclusively for another purpose. For purposes of this
113.9 paragraph, the value of the asset or interest shall be the fair market value at the time it
113.10 was given away, sold, or disposed of, less the amount of compensation received. For any
113.11 uncompensated transfer, the number of months of ineligibility, including partial months,
113.12 shall be calculated by dividing the uncompensated transfer amount by the average monthly
113.13 per person payment made by the medical assistance program to skilled nursing facilities
113.14 for the previous calendar year. The individual shall remain ineligible until this fixed period
113.15 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
113.16 benefits after 30 months from the date of the transfer shall not result in eligibility unless
113.17 and until the period of ineligibility has expired. The period of ineligibility begins in the
113.18 month the transfer was reported to the county agency, or if the transfer was not reported,
113.19 the month in which the county agency discovered the transfer, whichever comes first. For
113.20 applicants, the period of ineligibility begins on the date of the first approved application.

113.21 ~~(m)~~ (n) When determining eligibility for any state benefits under this subdivision,
113.22 the income and resources of all noncitizens shall be deemed to include their sponsor's
113.23 income and resources as defined in the Personal Responsibility and Work Opportunity
113.24 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
113.25 subsequently set out in federal rules.

113.26 ~~(n)~~ (o) Undocumented noncitizens and nonimmigrants are ineligible for general
113.27 assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual
113.28 in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and
113.29 an undocumented noncitizen is an individual who resides in the United States without the
113.30 approval or acquiescence of the United States Citizenship and Immigration Services.

113.31 ~~(o)~~ (p) Notwithstanding any other provision of law, a noncitizen who is ineligible for
113.32 medical assistance due to the deeming of a sponsor's income and resources, is ineligible
113.33 for general assistance medical care.

113.34 ~~(p)~~ (q) Effective July 1, 2003, general assistance medical care emergency services
113.35 end.

114.1 Sec. 18. Minnesota Statutes 2008, section 256L.01, is amended by adding a subdivision
114.2 to read:
114.3 Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross
114.4 family income" for nonfarm self-employed means income calculated for the 12-month
114.5 period of eligibility using as a baseline the adjusted gross income reported on the
114.6 applicant's federal income tax form for the previous year and adding back in depreciation,
114.7 and carryover net operating loss amounts that apply to the business in which the family is
114.8 currently engaged.
114.9 (b) "Gross individual or gross family income" for farm self-employed means income
114.10 calculated for the 12-month period of eligibility using as the baseline the adjusted gross
114.11 income reported on the applicant's federal income tax form for the previous year.
114.12 (c) "Gross individual or gross family income" means the total income for all family
114.13 members, calculated for the 12-month period of eligibility.

114.14 **EFFECTIVE DATE.** This section is effective August 1, 2009, except that the
114.15 amendment made to the "gross individual or gross family income" for farm self-employed
114.16 is effective July 1, 2009, or upon federal approval, whichever is later.

114.17 Sec. 19. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:
114.18 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
114.19 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
114.20 coinsurance requirements for all enrollees:
114.21 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
114.22 subject to an annual inpatient out-of-pocket maximum of $1,000 per individual ~~and~~
114.23 ~~$3,000 per family~~;
114.24 (2) $3 per prescription for adult enrollees;
114.25 (3) $25 for eyeglasses for adult enrollees;
114.26 (4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
114.27 episode of service which is required because of a recipient's symptoms, diagnosis, or
114.28 established illness, and which is delivered in an ambulatory setting by a physician or
114.29 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
114.30 audiologist, optician, or optometrist; and
114.31 (5) $6 for nonemergency visits to a hospital-based emergency room.
114.32 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
114.33 children under the age of 21.
114.34 (c) Paragraph (a) does not apply to pregnant women and children under the age of 21.
114.35 (d) Paragraph (a), clause (4), does not apply to mental health services.

115.1 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal
115.2 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,
115.3 and who are not pregnant shall be financially responsible for the coinsurance amount, if
115.4 applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.
115.5 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
115.6 or changes from one prepaid health plan to another during a calendar year, any charges
115.7 submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket
115.8 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
115.9 prior to enrollment, or prior to the change in health plans, shall be disregarded.

115.10 Sec. 20. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:
115.11 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
115.12 commissioner shall establish a sliding fee scale to determine the percentage of monthly
115.13 gross individual or family income that households at different income levels must pay to
115.14 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
115.15 on the enrollee's monthly gross individual or family income. The sliding fee scale must
115.16 contain separate tables based on enrollment of one, two, or three or more persons. Until
115.17 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
115.18 individual or family income for individuals or families with incomes below the limits for
115.19 the medical assistance program for families and children in effect on January 1, 1999, and
115.20 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
115.21 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
115.22 the medical assistance income limit for families and children in effect on January 1, 1999,
115.23 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
115.24 family size of five. The sliding fee scale for a family of five must be used for families of
115.25 more than five. The sliding fee scale and percentages are not subject to the provisions of
115.26 chapter 14. If a family or individual reports increased income after enrollment, premiums
115.27 shall be adjusted at the time the change in income is reported.
115.28 (b) Children in families whose gross income is above 275 percent of the federal
115.29 poverty guidelines shall pay the maximum premium. The maximum premium is defined
115.30 as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare
115.31 cases paid the maximum premium, the total revenue would equal the total cost of
115.32 MinnesotaCare medical coverage and administration. In this calculation, administrative
115.33 costs shall be assumed to equal ten percent of the total. The costs of medical coverage
115.34 for pregnant women and children under age two and the enrollees in these groups shall
115.35 be excluded from the total. The maximum premium for two enrollees shall be twice the

116.1 maximum premium for one, and the maximum premium for three or more enrollees shall
116.2 be three times the maximum premium for one.

116.3 (c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according
116.4 to the premium scale specified in paragraph (d) with the exception that children in families
116.5 with income at or below 150 percent of the federal poverty guidelines shall pay a monthly
116.6 premium of $4. For purposes of paragraph (d), "minimum" means a monthly premium
116.7 of $4.

116.8 (d) The following premium scale is established for individuals and families with
116.9 gross family incomes of ~~300~~ 275 percent of the federal poverty guidelines or less:

	Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
116.10-116.11	**Federal Poverty Guideline Range**	**Percent of Average Gross Monthly Income**
116.12	0-45%	minimum
116.13-116.14	46-54%	$4 or 1.1% of family income, whichever is greater
116.15	55-81%	1.6%
116.16	82-109%	2.2%
116.17	110-136%	2.9%
116.18	137-164%	3.6%
116.19	165-191%	4.6%
116.20	192-219%	5.6%
116.21	220-248%	6.5%
116.22	~~249-274%~~ 249-275%	7.2%
116.23	~~275-300%~~	~~8.0%~~

116.24 **EFFECTIVE DATE.** This section is effective January 1, 2009, or upon federal
116.25 approval, whichever is later. The commissioner of human services shall notify the revisor
116.26 of statutes when federal approval is obtained.

116.27 Sec. 21. Laws 2005, First Special Session chapter 4, article 8, section 54, the effective
116.28 date, is amended to read:

116.29 **EFFECTIVE DATE.** This section is effective August 1, ~~2007, or upon HealthMatch~~
116.30 ~~implementation, whichever is later~~ 2009.

116.31 Sec. 22. Laws 2005, First Special Session chapter 4, article 8, section 61, the effective
116.32 date, is amended to read:

116.33 **EFFECTIVE DATE.** This section is effective August 1, ~~2007, or upon HealthMatch~~
116.34 ~~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.

APPENDIX
Article locations in H1988-3

ARTICLE 1	HEALTH AND HUMAN SERVICES TECHNICAL	Page.Ln 2.1
ARTICLE 2	TECHNICAL APPROPRIATION CHANGES	Page.Ln 46.25
ARTICLE 3	HEALTH CARE ELIGIBILITY	Page.Ln 94.25

256B.031 PREPAID HEALTH PLANS.

Subdivision 1. **Contracts.** The commissioner may contract with health insurers licensed and operating under chapters 60A and 62A, nonprofit health service plans licensed and operating under chapter 62C, health maintenance organizations licensed and operating under chapter 62D, and vendors of medical care and organizations participating in prepaid programs under section 256D.03, subdivision 4, clause (b), to provide medical services to medical assistance recipients. Notwithstanding any other law, health insurers may enter into contracts with the commissioner under this section. As a condition of the contract, health insurers and health service plan corporations must agree to comply with the requirements of section 62D.04, subdivision 1, clauses (a), (b), (c), (d), and (f), and provide a complaint procedure that satisfies the requirements of section 62D.11. Nothing in this section permits health insurers not licensed as health maintenance organizations under chapter 62D to offer a prepaid health plan as defined in section 256B.02, subdivision 12, to persons other than those receiving medical assistance or general assistance medical care under this section. 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. Contracts must specify the services that are included in the per capita rate. Contracts must specify those services that are to be eligible for risk sharing between the prepaid health plan and the state. Contracts must also state that payment must be made within 60 days after the month of coverage.

Subd. 2. **Services.** State contracts for these services must assure recipients of at least the comprehensive health services defined in sections 256B.02, subdivision 8, and 256B.0625, except services defined in section 256B.0625, subdivisions 2, 5, 18, and 19a, and except services defined as chemical dependency services and mental health services.

Contracts under this section must include provision for assessing pregnant women to determine their risk of poor pregnancy outcome. Contracts must also include provision for treatment of women found to be at risk of poor pregnancy outcome.

Subd. 3. **Information required.** Prepaid health plans under contract must provide information to the commissioner according to the contract specifications. The information must include, at a minimum, the number of people receiving services, the number of encounters, the types of services received, evidence of an operating quality assurance program, and information about the use of and actual recoveries of available third-party resources. A plan under contract to provide services in a county must provide the county agency with the most current listing of the health care providers whose services are covered by the plan.

Subd. 4. **Prepaid health plan rates.** For payments made during calendar year 1988, the monthly maximum allowable rate established by the commissioner of human services for payment to prepaid health plans must not exceed 90 percent of the projected average monthly per capita fee-for-service medical assistance costs for state fiscal year 1988 for recipients of the aid to families with dependent children program formerly codified in sections 256.72 to 256.87. The base year for projecting the average monthly per capita fee-for-service medical assistance costs is state fiscal year 1986. A maximum allowable per capita rate must be established collectively for Anoka, Carver, Dakota, Hennepin, Ramsey, St. Louis, Scott, and Washington Counties. A separate maximum allowable per capita rate must be established collectively for all other counties. The maximum allowable per capita rate may be adjusted to reflect utilization differences among eligible classes of recipients. For payments made during calendar year 1989, the maximum allowable rate must be calculated in the same way as 1988 rates, except the base year is state fiscal year 1987. For payments made during calendar 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. Rates established for prepaid health plans must be based on the services that the prepaid health plan provides under contract with the commissioner.

Subd. 5. **Free choice limited.** (a) The commissioner may require recipients of the Minnesota family investment program to enroll in a prepaid health plan and receive services from or through the prepaid health plan, with the following exceptions:

(1) recipients who are refugees and whose health services are reimbursed 100 percent by the federal government; and

(2) recipients who are placed in a foster home or facility. If placement occurs before the seventh day prior to the end of any month, the recipient will be disenrolled from the recipient's prepaid health plan effective the first day of the following month. If placement occurs after the seventh day before the end of any month, that recipient will be disenrolled from the prepaid health plan on the first day of the second month following placement. The prepaid health plan must provide all services set forth in subdivision 2 during the interim period.

Enrollment in a prepaid health plan is mandatory only when recipients have a choice of at least two prepaid health plans.

(b) Recipients who become eligible on or after December 1, 1987, must choose a health plan within 30 days of the date eligibility is determined. At the time of application, the local agency shall ask the recipient whether the recipient has a primary health care provider. If the recipient has not chosen a health plan within 30 days but has provided the local agency with the name of a primary health care provider, the local agency shall determine whether the provider participates in a prepaid health plan available to the recipient and, if so, the local agency shall select that plan on the recipient's behalf. If the recipient has not provided the name of a primary health care provider who participates in an available prepaid health plan, commissioner shall randomly assign the recipient to a health plan.

(c) If possible, the local agency shall ask whether the recipient has a primary health care provider and the procedures under paragraph (b) shall apply. If a recipient does not choose a prepaid health plan by this date, the commissioner shall randomly assign the recipient to a health plan.

(d) The commissioner shall request a waiver from the federal Centers for Medicare and Medicaid Services to limit a recipient's ability to change health plans to once every six or 12 months. If such a waiver is obtained, each recipient must be enrolled in the health plan for a minimum of six or 12 months. A recipient may change health plans once within the first 60 days after initial enrollment.

(e) Women who are receiving medical assistance due to pregnancy and later become eligible for the Minnesota family investment program are not required to choose a prepaid health plan until 60 days postpartum. An infant born as a result of that pregnancy must be enrolled in a prepaid health plan at the same time as the mother.

(f) If third-party coverage is available to a recipient through enrollment in a prepaid health plan through employment, through coverage by the former spouse, or if a duty of support has been imposed by law, order, decree, or judgment of a court under chapter 518A, the obligee or recipient shall participate in the prepaid health plan in which the obligee has enrolled provided that the commissioner has contracted with the plan.

Subd. 6. **Ombudsman.** The commissioner shall designate an ombudsman to advocate for persons required to enroll in prepaid health plans under this section. The ombudsman shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsman program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 7. **Services pending appeal.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Subd. 8. **Case management.** The commissioner shall prepare a report to the legislature by January 1988, that describes the issues involved in successfully implementing a case management system in counties where the commissioner has fewer than two prepaid health plans under contract to provide health care services to eligible classes of recipients. In the report the commissioner shall address which health care providers could be case managers, the responsibilities of the case manager, the assumption of risk by the case manager, the services to be provided either directly or by referral, reimbursement concerns, federal waivers that may be required, and other issues that may affect the quality and cost of care under such a system.

Subd. 9. **Prepayment coordinator.** The local agency shall designate a prepayment coordinator to assist the state agency in implementing this section, section 256B.69, and section 256D.03, subdivision 4. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 6.

Subd. 10. **Impact on public or teaching hospitals and community clinics.** (a) 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, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

Subd. 11. **Reimbursement limitation; providers not with prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

256L.01 DEFINITIONS.

Subd. 4. **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 the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(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.

Laws 2005, First Special Session chapter 4, article 8, section 21

Sec. 21. Minnesota Statutes 2004, section 256B.056, subdivision 5, is amended to read:

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the last business day of the month in order to be eligible for this option in the following month.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 22

Sec. 22. Minnesota Statutes 2004, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. **Individuals on fixed or excluded income.** Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 23

Sec. 23. Minnesota Statutes 2004, section 256B.056, subdivision 5b, is amended to read:

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income every six months. The six-month period begins the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 24

Sec. 24. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2009, chapter 79, article 13, section 7

Sec. 7. **DEPARTMENT OF VETERANS AFFAIRS** $ 200,000 $ 0

Veterans Paramedic Apprenticeship Program. Of this appropriation, $200,000 in the first year is from the Cooper/Sams volunteer ambulance trust 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.

Laws 2009, chapter 79, article 13, section 8

Sec. 8. **DEPARTMENT OF PUBLIC SAFETY** $ 250,000 $ 0

Medical Response Unit Reimbursement Pilot Program. (a) $250,000 in the first year is from the Cooper/Sams volunteer ambulance trust 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.

Laws 2009, chapter 79, article 7, section 12

Sec. 12. **[254B.11] MAXIMUM RATES.**

The commissioner shall publish maximum rates for vendors of the consolidated chemical dependency treatment fund by July 1 of each year for implementation the following January 1. Rates for calendar year 2010 must not exceed 185 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. Unless a new rate methodology is developed under section 254B.12, rates for services provided on and after July 1, 2011, must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. Payment for services provided by Indian Health Services or by agencies operated by Indian tribes for medical assistance-eligible individuals must be governed by the applicable federal rate methodology.