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HOUSE OF REPRESENTATIVES

**EIGHTY-SIXTH
SESSION**

HOUSE FILE No. 2614

February 4, 2010

Authored by Huntley

The bill was read for the first time and referred to the Committee on Finance

April 28, 2010

Committee Recommendation and Adoption of Report:

To Pass as Amended and re-referred to the Committee on Ways and Means

May 3, 2010

Committee Recommendation and Adoption of Report:

To Pass as Amended

Read Second Time

A bill for an act

1.1 relating to state government; licensing; state health care programs; continuing
1.2 care; children and family services; health reform; Department of Health;
1.3 public health; assessing administrative penalties; requiring reports; making
1.4 supplemental and contingent appropriations and reductions for the Departments
1.5 of Health and Human Services and other health-related boards and councils;
1.6 amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision;
1.7 62J.07, subdivision 2, by adding a subdivision; 62J.38; 62Q.19, subdivision 1;
1.8 62Q.76, subdivision 1; 62U.05; 119B.025, subdivision 1; 119B.09, subdivision 4;
1.9 119B.11, subdivision 1; 144.226, subdivision 3; 144.291, subdivision 2; 144.293,
1.10 subdivision 4; 144.651, subdivision 2; 144.9504, by adding a subdivision;
1.11 144A.51, subdivision 5; 144E.37; 214.40, subdivision 7; 245C.27, subdivision
1.12 2; 245C.28, subdivision 3; 254B.01, subdivision 2; 254B.02, subdivisions 1,
1.13 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4;
1.14 254B.06, subdivision 2; 254B.09, subdivision 8; 256.01, by adding a subdivision;
1.15 256.9657, subdivision 3; 256.969, subdivision 21; 256B.04, subdivision 14;
1.16 256B.055, by adding a subdivision; 256B.056, subdivision 4; 256B.057,
1.17 subdivision 9; 256B.0625, subdivisions 8, 8a, 8b, 18a, 22, 31, by adding
1.18 subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644, as amended; 256B.0754,
1.19 by adding a subdivision; 256B.0915, subdivision 3b; 256B.19, subdivision 1c;
1.20 256B.69, subdivisions 20, as amended, 27, by adding subdivisions; 256B.692,
1.21 subdivision 1; 256B.75; 256B.76, subdivisions 2, 4, by adding a subdivision;
1.22 256D.03, subdivision 3b; 256D.0515; 256I.05, by adding a subdivision; 256J.20,
1.23 subdivision 3; 256J.24, subdivision 10; 256J.37, subdivision 3a; 256L.02,
1.24 subdivision 3; 256L.03, subdivision 3, by adding a subdivision; 256L.04,
1.25 subdivision 7; 256L.05, by adding a subdivision; 256L.07, subdivision 1, by
1.26 adding a subdivision; 256L.12, subdivisions 5, 6, 9; 256L.15, subdivision 1;
1.27 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009
1.28 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision;
1.29 157.16, subdivision 3; 245C.27, subdivision 1; 252.025, subdivision 7; 252.27,
1.30 subdivision 2a; 256.045, subdivision 3; 256.969, subdivision 3a; 256B.0625,
1.31 subdivisions 9, 13e; 256B.0653, subdivision 5; 256B.0911, subdivision 1a;
1.32 256B.0915, subdivision 3a; 256B.69, subdivisions 5a, 23; 256B.76, subdivision
1.33 1; 256B.766; 256D.03, subdivision 3, as amended; 256J.425, subdivision
1.34 3; 256L.03, subdivision 5; 256L.11, subdivision 1; 327.15, subdivision 3;
1.35 Laws 2005, First Special Session chapter 4, article 8, section 66, as amended;
1.36 Laws 2009, chapter 79, article 3, section 18; article 5, sections 17; 18; 22; 75,
1.37 subdivision 1; 78, subdivision 5; article 8, sections 2; 51; article 13, sections 3,
1.38 subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5,
1.39

2.1 subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17; Laws
 2.2 2010, chapter 200, article 1, sections 12, subdivisions 6, 7, 8; 13, subdivision
 2.3 1b; 16; 21; article 2, section 2, subdivisions 1, 8; proposing coding for new law
 2.4 in Minnesota Statutes, chapters 62A; 62D; 62E; 62J; 62Q; 144; 245; 254B;
 2.5 256; 256B; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions
 2.6 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8;
 2.7 Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; Laws
 2.8 2009, chapter 79, article 7, section 26, subdivision 3; Laws 2010, chapter 200,
 2.9 article 1, sections 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9; 18; 19.

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

2.11 **ARTICLE 1**

2.12 **DHS LICENSING**

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

2.15 Subdivision 1. **Fair hearing ~~when disqualification is not set aside.~~** ~~(a) If the~~
 2.16 ~~commissioner does not set aside a disqualification of an individual under section 245C.22~~
 2.17 (a) An individual who is disqualified on the basis of a preponderance of evidence that the
 2.18 individual committed an act or acts that meet the definition of any of the crimes listed in
 2.19 section 245C.15; for a determination under section 626.556 or 626.557 of substantiated
 2.20 maltreatment that was serious or recurring under section 245C.15; or for failure to make
 2.21 required reports under section 626.556, subdivision 3; or 626.557, subdivision 3, pursuant
 2.22 to section 245C.15, subdivision 4, paragraph (b), clause (1), the individual may request
 2.23 a fair hearing under section 256.045 following a reconsideration decision issued under
 2.24 section 245C.23, unless the disqualification is deemed conclusive under section 245C.29.

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

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

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

3.1 (e) Notwithstanding paragraph (c), if the commissioner does not set aside a
3.2 disqualification of an individual who was disqualified based on both a preponderance
3.3 of evidence and a conviction or admission, the individual may request a fair hearing
3.4 under section 256.045, unless the disqualifications are deemed conclusive under section
3.5 245C.29. The scope of the hearing conducted under section 256.045 with regard to the
3.6 disqualification based on a conviction or admission shall be limited solely to whether the
3.7 individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case,
3.8 the reconsideration decision under section 245C.22 is not the final agency decision for
3.9 purposes of appeal by the disqualified individual.

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

3.11 Subd. 2. **Consolidated fair hearing following a reconsideration decision.** (a) If an
3.12 individual who is disqualified on the bases of serious or recurring maltreatment requests
3.13 a fair hearing on the maltreatment determination under section 626.556, subdivision
3.14 10i, or 626.557, subdivision 9d, and requests a fair hearing under this section on the
3.15 disqualification, ~~which has not been set aside~~ following a reconsideration decision under
3.16 section 245C.23, the scope of the fair hearing under section 256.045 shall include the
3.17 maltreatment determination and the disqualification.

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

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

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

3.24 Subd. 3. **Employees of public employer.** (a) ~~If the commissioner does not set aside~~
3.25 ~~the disqualification of an~~ A disqualified individual who is an employee of an employer,
3.26 as defined in section 179A.03, subdivision 15, ~~the individual~~ may request a contested
3.27 case hearing under chapter 14 following a reconsideration determination under section
3.28 245C.23, unless the disqualification is deemed conclusive under section 245C.29. The
3.29 request for a contested case hearing must be made in writing and must be postmarked and
3.30 sent within 30 calendar days after the employee receives notice ~~that the disqualification~~
3.31 ~~has not been set aside~~ of the reconsideration decision. If the individual was disqualified
3.32 based on a conviction or admission to any crimes listed in section 245C.15, the scope of
3.33 the contested case hearing shall be limited solely to whether the individual poses a risk of
3.34 harm pursuant to section 245C.22.

4.1 ~~(b) If the commissioner does not set aside a disqualification that is~~ (b) When an
4.2 individual is disqualified based on a maltreatment determination, the scope of the contested
4.3 case hearing under paragraph (a) must include the maltreatment determination and the
4.4 disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

4.5 (c) Rules adopted under this chapter may not preclude an employee in a contested
4.6 case hearing for a disqualification from submitting evidence concerning information
4.7 gathered under this chapter.

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

4.13 (e) In determining whether the disqualification should be set aside, the administrative
4.14 law judge shall consider all of the characteristics that cause the individual to be disqualified
4.15 in order to determine whether the individual poses a risk of harm. The administrative law
4.16 judge's recommendation and the commissioner's order to set aside a disqualification that is
4.17 the subject of the hearing constitutes a determination that the individual does not pose a
4.18 risk of harm and that the individual may provide direct contact services in the individual
4.19 program specified in the set aside.

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

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

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

4.29 (2) any patient or relative aggrieved by an order of the commissioner under section
4.30 252.27;

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

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

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

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

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

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

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

5.13 (10) except as provided under chapter 245C, an individual disqualified under sections
5.14 245C.14 and 245C.15, ~~which has not been set aside under sections 245C.22 and following~~
5.15 a reconsideration decision under section 245C.23, on the basis of serious or recurring
5.16 maltreatment; a preponderance of the evidence that the individual has committed an act or
5.17 acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions
5.18 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or
5.19 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4)
5.20 or (9) and a disqualification under this clause in which the basis for a disqualification is
5.21 serious or recurring maltreatment, ~~which has not been set aside under sections 245C.22~~
5.22 and 245C.23 and the individual remains disqualified following a reconsideration decision,
5.23 shall be consolidated into a single fair hearing. In such cases, the scope of review by
5.24 the human services referee shall include both the maltreatment determination and the
5.25 disqualification. The failure to exercise the right to an administrative reconsideration shall
5.26 not be a bar to a hearing under this section if federal law provides an individual the right to
5.27 a hearing to dispute a finding of maltreatment. Individuals and organizations specified in
5.28 this section may contest the specified action, decision, or final disposition before the state
5.29 agency by submitting a written request for a hearing to the state agency within 30 days
5.30 after receiving written notice of the action, decision, or final disposition, or within 90 days
5.31 of such written notice if the applicant, recipient, patient, or relative shows good cause why
5.32 the request was not submitted within the 30-day time limit; or

5.33 (11) any person with an outstanding debt resulting from receipt of public assistance,
5.34 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
5.35 Department of Human Services or a county agency. The scope of the appeal is the validity

6.1 of the claimant agency's intention to request a setoff of a refund under chapter 270A
6.2 against the debt.

6.3 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
6.4 (10), is the only administrative appeal to the final agency determination specifically,
6.5 including a challenge to the accuracy and completeness of data under section 13.04.
6.6 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment
6.7 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
6.8 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
6.9 contested case proceeding under the provisions of chapter 14. Hearings requested under
6.10 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
6.11 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
6.12 only available when there is no juvenile court or adult criminal action pending. If such
6.13 action is filed in either court while an administrative review is pending, the administrative
6.14 review must be suspended until the judicial actions are completed. If the juvenile court
6.15 action or criminal charge is dismissed or the criminal action overturned, the matter may be
6.16 considered in an administrative hearing.

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

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

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

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

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

6.35 Sec. 5. Minnesota Statutes 2008, section 626.556, subdivision 10i, is amended to read:

7.1 Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative
7.2 reconsideration is not applicable in family assessments since no determination concerning
7.3 maltreatment is made. For investigations, except as provided under paragraph (e), an
7.4 individual or facility that the commissioner of human services, a local social service
7.5 agency, or the commissioner of education determines has maltreated a child, an interested
7.6 person acting on behalf of the child, regardless of the determination, who contests
7.7 the investigating agency's final determination regarding maltreatment, may request the
7.8 investigating agency to reconsider its final determination regarding maltreatment. The
7.9 request for reconsideration must be submitted in writing to the investigating agency within
7.10 15 calendar days after receipt of notice of the final determination regarding maltreatment
7.11 or, if the request is made by an interested person who is not entitled to notice, within
7.12 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the
7.13 request for reconsideration must be postmarked and sent to the investigating agency
7.14 within 15 calendar days of the individual's or facility's receipt of the final determination. If
7.15 the request for reconsideration is made by personal service, it must be received by the
7.16 investigating agency within 15 calendar days after the individual's or facility's receipt of the
7.17 final determination. Effective January 1, 2002, an individual who was determined to have
7.18 maltreated a child under this section and who was disqualified on the basis of serious or
7.19 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
7.20 of the maltreatment determination and the disqualification. The request for reconsideration
7.21 of the maltreatment determination and the disqualification must be submitted within 30
7.22 calendar days of the individual's receipt of the notice of disqualification under sections
7.23 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment
7.24 determination and the disqualification must be postmarked and sent to the investigating
7.25 agency within 30 calendar days of the individual's receipt of the maltreatment
7.26 determination and notice of disqualification. If the request for reconsideration is made by
7.27 personal service, it must be received by the investigating agency within 30 calendar days
7.28 after the individual's receipt of the notice of disqualification.

7.29 (b) Except as provided under paragraphs (e) and (f), if the investigating agency
7.30 denies the request or fails to act upon the request within 15 working days after receiving
7.31 the request for reconsideration, the person or facility entitled to a fair hearing under section
7.32 256.045 may submit to the commissioner of human services or the commissioner of
7.33 education a written request for a hearing under that section. Section 256.045 also governs
7.34 hearings requested to contest a final determination of the commissioner of education. For
7.35 reports involving maltreatment of a child in a facility, an interested person acting on behalf
7.36 of the child may request a review by the Child Maltreatment Review Panel under section

8.1 256.022 if the investigating agency denies the request or fails to act upon the request or
8.2 if the interested person contests a reconsidered determination. The investigating agency
8.3 shall notify persons who request reconsideration of their rights under this paragraph.
8.4 The request must be submitted in writing to the review panel and a copy sent to the
8.5 investigating agency within 30 calendar days of receipt of notice of a denial of a request
8.6 for reconsideration or of a reconsidered determination. The request must specifically
8.7 identify the aspects of the agency determination with which the person is dissatisfied.

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

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

8.17 (e) ~~Effective January 1, 2002,~~ If an individual was disqualified under sections
8.18 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was
8.19 serious or recurring, and the individual has requested reconsideration of the maltreatment
8.20 determination under paragraph (a) and requested reconsideration of the disqualification
8.21 under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and
8.22 reconsideration of the disqualification shall be consolidated into a single reconsideration.
8.23 If reconsideration of the maltreatment determination is denied or the disqualification is not
8.24 ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair
8.25 hearing under section 256.045. If an individual requests a fair hearing on the maltreatment
8.26 determination and the disqualification, the scope of the fair hearing shall include both the
8.27 maltreatment determination and the disqualification.

8.28 (f) ~~Effective January 1, 2002,~~ If a maltreatment determination or a disqualification
8.29 based on serious or recurring maltreatment is the basis for a denial of a license under
8.30 section 245A.05 or a licensing sanction under section 245A.07, the license holder has the
8.31 right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505
8.32 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the
8.33 contested case hearing shall include the maltreatment determination, disqualification,
8.34 and licensing sanction or denial of a license. In such cases, a fair hearing regarding
8.35 the maltreatment determination and disqualification shall not be conducted under
8.36 section 256.045. Except for family child care and child foster care, reconsideration of a

9.1 maltreatment determination as provided under this subdivision, and reconsideration of a
9.2 disqualification as provided under section 245C.22, shall also not be conducted when:

9.3 (1) a denial of a license under section 245A.05 or a licensing sanction under section
9.4 245A.07, is based on a determination that the license holder is responsible for maltreatment
9.5 or the disqualification of a license holder based on serious or recurring maltreatment;

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

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

9.10 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
9.11 determination or disqualification, but does not appeal the denial of a license or a licensing
9.12 sanction, reconsideration of the maltreatment determination shall be conducted under
9.13 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
9.14 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
9.15 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
9.16 626.557, subdivision 9d.

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

9.21 (g) For purposes of this subdivision, "interested person acting on behalf of the
9.22 child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult
9.23 stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been
9.24 determined to be the perpetrator of the maltreatment.

9.25 Sec. 6. Minnesota Statutes 2008, section 626.557, subdivision 9d, is amended to read:

9.26 Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided
9.27 under paragraph (e), any individual or facility which a lead agency determines has
9.28 maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on
9.29 behalf of the vulnerable adult, regardless of the lead agency's determination, who contests
9.30 the lead agency's final disposition of an allegation of maltreatment, may request the
9.31 lead agency to reconsider its final disposition. The request for reconsideration must be
9.32 submitted in writing to the lead agency within 15 calendar days after receipt of notice of
9.33 final disposition or, if the request is made by an interested person who is not entitled to
9.34 notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable
9.35 adult's legal guardian. If mailed, the request for reconsideration must be postmarked and

10.1 sent to the lead agency within 15 calendar days of the individual's or facility's receipt of
10.2 the final disposition. If the request for reconsideration is made by personal service, it must
10.3 be received by the lead agency within 15 calendar days of the individual's or facility's
10.4 receipt of the final disposition. An individual who was determined to have maltreated a
10.5 vulnerable adult under this section and who was disqualified on the basis of serious or
10.6 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
10.7 of the maltreatment determination and the disqualification. The request for reconsideration
10.8 of the maltreatment determination and the disqualification must be submitted in writing
10.9 within 30 calendar days of the individual's receipt of the notice of disqualification
10.10 under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of
10.11 the maltreatment determination and the disqualification must be postmarked and sent
10.12 to the lead agency within 30 calendar days of the individual's receipt of the notice of
10.13 disqualification. If the request for reconsideration is made by personal service, it must be
10.14 received by the lead agency within 30 calendar days after the individual's receipt of the
10.15 notice of disqualification.

10.16 (b) Except as provided under paragraphs (e) and (f), if the lead agency denies the
10.17 request or fails to act upon the request within 15 working days after receiving the request
10.18 for reconsideration, the person or facility entitled to a fair hearing under section 256.045,
10.19 may submit to the commissioner of human services a written request for a hearing
10.20 under that statute. The vulnerable adult, or an interested person acting on behalf of the
10.21 vulnerable adult, may request a review by the Vulnerable Adult Maltreatment Review
10.22 Panel under section 256.021 if the lead agency denies the request or fails to act upon the
10.23 request, or if the vulnerable adult or interested person contests a reconsidered disposition.
10.24 The lead agency shall notify persons who request reconsideration of their rights under this
10.25 paragraph. The request must be submitted in writing to the review panel and a copy sent
10.26 to the lead agency within 30 calendar days of receipt of notice of a denial of a request for
10.27 reconsideration or of a reconsidered disposition. The request must specifically identify the
10.28 aspects of the agency determination with which the person is dissatisfied.

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

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

11.1 (e) If an individual was disqualified under sections 245C.14 and 245C.15, on the
11.2 basis of a determination of maltreatment, which was serious or recurring, and the individual
11.3 has requested reconsideration of the maltreatment determination under paragraph (a) and
11.4 reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration
11.5 of the maltreatment determination and requested reconsideration of the disqualification
11.6 shall be consolidated into a single reconsideration. If reconsideration of the maltreatment
11.7 determination is denied ~~or if the disqualification is not set aside under sections 245C.21 to~~
11.8 ~~245C.27~~ and the individual remains disqualified following a reconsideration decision, the
11.9 individual may request a fair hearing under section 256.045. If an individual requests a
11.10 fair hearing on the maltreatment determination and the disqualification, the scope of the
11.11 fair hearing shall include both the maltreatment determination and the disqualification.

11.12 (f) If a maltreatment determination or a disqualification based on serious or recurring
11.13 maltreatment is the basis for a denial of a license under section 245A.05 or a licensing
11.14 sanction under section 245A.07, the license holder has the right to a contested case hearing
11.15 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided
11.16 for under section 245A.08, the scope of the contested case hearing must include the
11.17 maltreatment determination, disqualification, and licensing sanction or denial of a license.
11.18 In such cases, a fair hearing must not be conducted under section 256.045. Except for
11.19 family child care and child foster care, reconsideration of a maltreatment determination
11.20 under this subdivision, and reconsideration of a disqualification under section 245C.22,
11.21 must not be conducted when:

11.22 (1) a denial of a license under section 245A.05, or a licensing sanction under section
11.23 245A.07, is based on a determination that the license holder is responsible for maltreatment
11.24 or the disqualification of a license holder based on serious or recurring maltreatment;

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

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

11.29 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
11.30 determination or disqualification, but does not appeal the denial of a license or a licensing
11.31 sanction, reconsideration of the maltreatment determination shall be conducted under
11.32 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
11.33 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
11.34 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
11.35 626.557, subdivision 9d.

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

12.5 (g) Until August 1, 2002, an individual or facility that was determined by the
12.6 commissioner of human services or the commissioner of health to be responsible for
12.7 neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August
12.8 1, 2001, that believes that the finding of neglect does not meet an amended definition of
12.9 neglect may request a reconsideration of the determination of neglect. The commissioner
12.10 of human services or the commissioner of health shall mail a notice to the last known
12.11 address of individuals who are eligible to seek this reconsideration. The request for
12.12 reconsideration must state how the established findings no longer meet the elements of
12.13 the definition of neglect. The commissioner shall review the request for reconsideration
12.14 and make a determination within 15 calendar days. The commissioner's decision on this
12.15 reconsideration is the final agency action.

12.16 (1) For purposes of compliance with the data destruction schedule under subdivision
12.17 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as
12.18 a result of a reconsideration under this paragraph, the date of the original finding of a
12.19 substantiated maltreatment must be used to calculate the destruction date.

12.20 (2) For purposes of any background studies under chapter 245C, when a
12.21 determination of substantiated maltreatment has been changed as a result of a
12.22 reconsideration under this paragraph, any prior disqualification of the individual under
12.23 chapter 245C that was based on this determination of maltreatment shall be rescinded,
12.24 and for future background studies under chapter 245C the commissioner must not use the
12.25 previous determination of substantiated maltreatment as a basis for disqualification or as a
12.26 basis for referring the individual's maltreatment history to a health-related licensing board
12.27 under section 245C.31.

12.28 ARTICLE 2

12.29 HEALTH CARE

12.30 Section 1. Minnesota Statutes 2008, section 144.291, subdivision 2, is amended to read:

12.31 Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following
12.32 terms have the meanings given.

12.33 (a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

12.34 (b) "Health information exchange" means a legal arrangement between health care
12.35 providers and group purchasers to enable and oversee the business and legal issues

13.1 involved in the electronic exchange of health records between the entities for the delivery
13.2 of patient care.

13.3 (c) "Health record" means any information, whether oral or recorded in any form or
13.4 medium, that relates to the past, present, or future physical or mental health or condition of
13.5 a patient; the provision of health care to a patient; or the past, present, or future payment
13.6 for the provision of health care to a patient.

13.7 (d) "Identifying information" means the patient's name, address, date of birth,
13.8 gender, parent's or guardian's name regardless of the age of the patient, and other
13.9 nonclinical data which can be used to uniquely identify a patient.

13.10 (e) "Individually identifiable form" means a form in which the patient is or can be
13.11 identified as the subject of the health records.

13.12 (f) "Medical emergency" means medically necessary care which is immediately
13.13 needed to preserve life, prevent serious impairment to bodily functions, organs, or parts,
13.14 or prevent placing the physical or mental health of the patient in serious jeopardy.

13.15 (g) "Patient" means a natural person who has received health care services from a
13.16 provider for treatment or examination of a medical, psychiatric, or mental condition, the
13.17 surviving spouse and parents of a deceased patient, or a person the patient appoints in
13.18 writing as a representative, including a health care agent acting according to chapter 145C,
13.19 unless the authority of the agent has been limited by the principal in the principal's health
13.20 care directive. Except for minors who have received health care services under sections
13.21 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a
13.22 person acting as a parent or guardian in the absence of a parent or guardian.

13.23 (h) "Provider" means:

13.24 (1) any person who furnishes health care services and is regulated to furnish the
13.25 services under chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A,
13.26 151, 153, or 153A;

13.27 (2) a home care provider licensed under section 144A.46;

13.28 (3) a health care facility licensed under this chapter or chapter 144A;

13.29 (4) a physician assistant registered under chapter 147A; and

13.30 (5) an unlicensed mental health practitioner regulated under sections 148B.60 to
13.31 148B.71.

13.32 (i) "Record locator service" means an electronic index of patient identifying
13.33 information that directs providers in a health information exchange to the location of
13.34 patient health records held by providers and group purchasers.

13.35 (j) "Related health care entity" means an affiliate, as defined in section 144.6521,
13.36 subdivision 3, paragraph (b), of the provider releasing the health records, including, but

14.1 not limited to, affiliates of providers participating in a coordinated care delivery system
14.2 established under section 256D.031, subdivision 6.

14.3 Sec. 2. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
14.4 to read:

14.5 Subd. 30. **Review and evaluation of ongoing studies.** The commissioner
14.6 shall review all ongoing studies, reports, and program evaluations completed by the
14.7 Department of Human Services for state fiscal years 2006 through 2010. For each item,
14.8 the commissioner shall report the legislature's appropriation for that work, if any, and the
14.9 actual reported cost of the completed work by the Department of Human Services. The
14.10 commissioner shall make recommendations to the legislature about which studies, reports,
14.11 and program evaluations required by law on an ongoing basis are duplicative, unnecessary,
14.12 or obsolete. The commissioner shall repeat this review every five fiscal years.

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

14.14 **Subd. 3. Surcharge on HMOs and community integrated service networks.** (a)
14.15 Effective October 1, 1992, each health maintenance organization with a certificate of
14.16 authority issued by the commissioner of health under chapter 62D and each community
14.17 integrated service network licensed by the commissioner under chapter 62N shall pay to
14.18 the commissioner of human services a surcharge equal to six-tenths of one percent of the
14.19 total premium revenues of the health maintenance organization or community integrated
14.20 service network as reported to the commissioner of health according to the schedule in
14.21 subdivision 4.

14.22 (b) Effective June 1, 2010: (1) the surcharge under paragraph (a) is increased to 2.5
14.23 percent; and (2) each county-based purchasing plan authorized under section 256B.692
14.24 shall pay to the commissioner a surcharge equal to 2.5 percent of the total premium
14.25 revenues of the plan, as reported to the commissioner of health, according to the payment
14.26 schedule in subdivision 4.

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

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

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

15.1 (3) Medicare revenue, as a result of an arrangement between a health maintenance
15.2 organization or a community integrated service network and the Centers for Medicare
15.3 and Medicaid Services of the federal Department of Health and Human Services, for
15.4 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
15.5 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
15.6 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
15.7 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

15.21 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
15.22 corporation's surcharge shall be based on the revenues earned in the second previous
15.23 calendar year by all of the entities or corporations subject to the merger, consolidation,
15.24 or acquisition regardless of whether one of the entities or corporations does not retain a
15.25 certificate of authority under chapter 62D or a license under chapter 62N until the total
15.26 premium revenues of the surviving corporation include the total premium revenues of all
15.27 the merged entities as reported to the commissioner of health.

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

15.33 ~~(f)~~ (g) In the event a health maintenance organization or community integrated
15.34 service network converts its licensure to a different type of entity subject to liability
15.35 for the surcharge under this chapter, but survives in the same or substantially similar
15.36 form, the surviving entity remains liable for the surcharge regardless of whether one of

16.1 the entities or corporations does not retain a certificate of authority under chapter 62D
16.2 or a license under chapter 62N.

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

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

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

16.9 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
16.10 assistance program must not be submitted until the recipient is discharged. However,
16.11 the commissioner shall establish monthly interim payments for inpatient hospitals that
16.12 have individual patient lengths of stay over 30 days regardless of diagnostic category.
16.13 Except as provided in section 256.9693, medical assistance reimbursement for treatment
16.14 of mental illness shall be reimbursed based on diagnostic classifications. Individual
16.15 hospital payments established under this section and sections 256.9685, 256.9686, and
16.16 256.9695, in addition to third party and recipient liability, for discharges occurring during
16.17 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
16.18 inpatient services paid for the same period of time to the hospital. This payment limitation
16.19 shall be calculated separately for medical assistance and general assistance medical
16.20 care services. The limitation on general assistance medical care shall be effective for
16.21 admissions occurring on or after July 1, 1991. Services that have rates established under
16.22 subdivision 11 or 12, must be limited separately from other services. After consulting with
16.23 the affected hospitals, the commissioner may consider related hospitals one entity and
16.24 may merge the payment rates while maintaining separate provider numbers. The operating
16.25 and property base rates per admission or per day shall be derived from the best Medicare
16.26 and claims data available when rates are established. The commissioner shall determine
16.27 the best Medicare and claims data, taking into consideration variables of recency of the
16.28 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
16.29 The commissioner shall notify hospitals of payment rates by December 1 of the year
16.30 preceding the rate year. The rate setting data must reflect the admissions data used to
16.31 establish relative values. Base year changes from 1981 to the base year established for the
16.32 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
16.33 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
16.34 1. The commissioner may adjust base year cost, relative value, and case mix index data
16.35 to exclude the costs of services that have been discontinued by the October 1 of the year

17.1 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
17.2 that encompass portions of two or more rate years shall have payments established based
17.3 on payment rates in effect at the time of admission unless the date of admission preceded
17.4 the rate year in effect by six months or more. In this case, operating payment rates for
17.5 services rendered during the rate year in effect and established based on the date of
17.6 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

17.15 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
17.16 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
17.17 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
17.18 from the current statutory rates. Mental health services within diagnosis related groups
17.19 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
17.20 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
17.21 assistance does not include general assistance medical care. Payments made to managed
17.22 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
17.23 this reduction.

17.24 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
17.25 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
17.26 to hospitals for inpatient services before third-party liability and spenddown, is reduced
17.27 3.46 percent from the current statutory rates. Mental health services with diagnosis related
17.28 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
17.29 paragraph. Payments made to managed care plans shall be reduced for services provided
17.30 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

17.31 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
17.32 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
17.33 to hospitals for inpatient services before third-party liability and spenddown, is reduced
17.34 1.9 percent from the current statutory rates. Mental health services with diagnosis related
17.35 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this

18.1 paragraph. Payments made to managed care plans shall be reduced for services provided
18.2 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

18.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
18.4 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
18.5 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
18.6 from the current statutory rates. Mental health services with diagnosis related groups
18.7 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
18.8 Payments made to managed care plans shall be reduced for services provided on or after
18.9 July 1, 2010, to reflect this reduction.

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

18.16 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
18.17 payment for fee-for-service admissions occurring on or after July 1, 2011, through June 30,
18.18 2013, made to hospitals for inpatient services before third-party liability and spenddown,
18.19 is reduced 7.5 percent from the current statutory rates. Facilities defined under subdivision
18.20 16 are excluded from this paragraph. Payments made to managed care plans shall be
18.21 reduced for services provided on or after January 1, 2012, through December 31, 2013,
18.22 to reflect this reduction.

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

18.24 Subd. 21. **Mental health or chemical dependency admissions; rates.** (a)
18.25 Admissions under the general assistance medical care program occurring on or after
18.26 July 1, 1990, and admissions under medical assistance, excluding general assistance
18.27 medical care, occurring on or after July 1, 1990, and on or before September 30, 1992,
18.28 that are classified to a diagnostic category of mental health or chemical dependency
18.29 shall have rates established according to the methods of subdivision 14, except the per
18.30 day rate shall be multiplied by a factor of 2, provided that the total of the per day rates
18.31 shall not exceed the per admission rate. This methodology shall also apply when a hold
18.32 or commitment is ordered by the court for the days that inpatient hospital services are
18.33 medically necessary. Stays which are medically necessary for inpatient hospital services
18.34 and covered by medical assistance shall not be billable to any other governmental entity.

19.1 Medical necessity shall be determined under criteria established to meet the requirements
 19.2 of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

19.3 (b) Payment rates for fee-for-service medical assistance admissions occurring on
 19.4 or after July 1, 2011, through June 30, 2013, for diagnosis-related groups admissions
 19.5 related to children's mental health specified by the commissioner, shall be increased for
 19.6 these diagnosis-related groups at a percentage calculated to cost not more than a total
 19.7 of \$7,200,000 per fiscal year, including state and federal shares. For purposes of this
 19.8 paragraph, medical assistance does not include general assistance medical care. The
 19.9 commissioner shall adjust rates paid to a prepaid health plan under contract with the
 19.10 commissioner on a temporary basis to reflect payments provided in this paragraph, and
 19.11 prepaid health plans are required to increase rates to providers under contract on a
 19.12 temporary basis to reflect payments provided in this paragraph.

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

19.14 Sec. 6. Minnesota Statutes 2008, section 256B.04, subdivision 14, is amended to read:

19.15 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical,
 19.16 and feasible, the commissioner may utilize volume purchase through competitive bidding
 19.17 and negotiation under the provisions of chapter 16C, to provide items under the medical
 19.18 assistance program including but not limited to the following:

19.19 (1) eyeglasses;

19.20 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency
 19.21 situation on a short-term basis, until the vendor can obtain the necessary supply from
 19.22 the contract dealer;

19.23 (3) hearing aids and supplies; ~~and~~

19.24 (4) durable medical equipment, including but not limited to:

19.25 (i) hospital beds;

19.26 (ii) commodes;

19.27 (iii) glide-about chairs;

19.28 (iv) patient lift apparatus;

19.29 (v) wheelchairs and accessories;

19.30 (vi) oxygen administration equipment;

19.31 (vii) respiratory therapy equipment;

19.32 (viii) electronic diagnostic, therapeutic and life-support systems;

19.33 (5) nonemergency medical transportation level of need determinations, disbursement
 19.34 of public transportation passes and tokens, and volunteer and recipient mileage and
 19.35 parking reimbursements; ~~and~~

20.1 (6) drugs; and

20.2 (7) medical supplies.

20.3 (b) Rate changes under this chapter and chapters 256D and 256L do not affect
20.4 contract payments under this subdivision unless specifically identified.

20.5 (c) The commissioner may not utilize volume purchase through competitive bidding
20.6 and negotiation for special transportation services under the provisions of chapter 16C.

20.7 Sec. 7. Minnesota Statutes 2008, section 256B.055, is amended by adding a
20.8 subdivision to read:

20.9 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
20.10 who is:

20.11 (1) at least age 21 and under age 65;

20.12 (2) not pregnant;

20.13 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII
20.14 of the Social Security Act;

20.15 (4) not an adult in a family with children as defined in section 256L.01, subdivision
20.16 3a; and

20.17 (5) not described in another subdivision of this section.

20.18 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
20.19 approval, whichever is later.

20.20 Sec. 8. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

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

20.26 (b) To be eligible for medical assistance, families and children may have an income
20.27 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
20.28 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
20.29 1996, shall be increased by three percent.

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

20.32 (d) In computing income to determine eligibility of persons under paragraphs (a)
20.33 to (c) and (e) who are not residents of long-term care facilities, the commissioner shall
20.34 disregard increases in income as required by Public Law Numbers 94-566, section 503;

21.1 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration
21.2 unusual medical expense payments are considered income to the recipient.

21.3 (e) To be eligible for medical assistance, a person eligible under section 256B.055,
21.4 subdivision 15, may have gross countable income up to 75 percent of the federal poverty
21.5 guidelines for family size.

21.6 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
21.7 approval.

21.8 Sec. 9. Minnesota Statutes 2008, section 256B.0625, subdivision 8, is amended to read:

21.9 Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related
21.10 services, ~~including specialized maintenance therapy.~~ Authorization by the commissioner
21.11 is required to provide services to a recipient beyond any of the following onetime service
21.12 thresholds: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality
21.13 sessions; and (3) three evaluations or reevaluations. Services provided by a physical
21.14 therapy assistant shall be reimbursed at the same rate as services performed by a physical
21.15 therapist when the services of the physical therapy assistant are provided under the
21.16 direction of a physical therapist who is on the premises. Services provided by a physical
21.17 therapy assistant that are provided under the direction of a physical therapist who is not on
21.18 the premises shall be reimbursed at 65 percent of the physical therapist rate.

21.19 Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to
21.20 read:

21.21 Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy
21.22 and related services, ~~including specialized maintenance therapy.~~ Authorization by the
21.23 commissioner is required to provide services to a recipient beyond any of the following
21.24 onetime service thresholds: (1) 120 units of any combination of approved CPT codes;
21.25 and (2) two evaluations or reevaluations. Services provided by an occupational therapy
21.26 assistant shall be reimbursed at the same rate as services performed by an occupational
21.27 therapist when the services of the occupational therapy assistant are provided under the
21.28 direction of the occupational therapist who is on the premises. Services provided by an
21.29 occupational therapy assistant that are provided under the direction of an occupational
21.30 therapist who is not on the premises shall be reimbursed at 65 percent of the occupational
21.31 therapist rate.

21.32 Sec. 11. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to
21.33 read:

22.1 Subd. 8b. **Speech language pathology and audiology services.** Medical assistance
22.2 covers speech language pathology and related services, ~~including specialized maintenance~~
22.3 ~~therapy.~~ Authorization by the commissioner is required to provide services to a recipient
22.4 beyond any of the following onetime service thresholds: (1) 50 treatment sessions with
22.5 any combination of approved CPT codes; and (2) one evaluation. Medical assistance
22.6 covers audiology services and related services. Services provided by a person who has
22.7 been issued a temporary registration under section 148.5161 shall be reimbursed at the
22.8 same rate as services performed by a speech language pathologist or audiologist as long as
22.9 the requirements of section 148.5161, subdivision 3, are met.

22.10 Sec. 12. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
22.11 subdivision to read:

22.12 Subd. 8d. **Chiropractic services.** Payment for chiropractic services is limited to
22.13 one annual evaluation and 12 visits per year unless prior authorization of a greater number
22.14 of visits is obtained.

22.15 Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9,
22.16 is amended to read:

22.17 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

22.18 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
22.19 following services:

22.20 (1) comprehensive exams, limited to once every five years;

22.21 (2) periodic exams, limited to one per year;

22.22 (3) limited exams;

22.23 (4) bitewing x-rays, limited to one set per year;

22.24 (5) periapical x-rays;

22.25 (6) panoramic x-rays or full-mouth radiographs, limited to one every five years,

22.26 and only if provided in conjunction with a posterior extraction or scheduled outpatient

22.27 facility procedure, or as medically necessary for the diagnosis and follow-up of oral and

22.28 maxillofacial pathology and trauma. Panoramic x-rays may be taken once every two years

22.29 for patients who cannot cooperate for intraoral film due to a developmental disability or

22.30 medical condition that does not allow for intraoral film placement;

22.31 (7) prophylaxis, limited to one per year;

22.32 (8) application of fluoride varnish, limited to one per year;

22.33 (9) posterior fillings, all at the amalgam rate;

22.34 (10) anterior fillings;

- 23.1 (11) endodontics, limited to root canals on the anterior and premolars only, and
 23.2 molar root canal therapy as deemed medically necessary for patients that are at high risk
 23.3 of osteonecrosis from molar extractions;
- 23.4 (12) removable prostheses, each dental arch limited to one every six years; including:
 23.5 (i) relines of full dentures once every six years per dental arch;
 23.6 (ii) repair of acrylic bases of full dentures and acrylic partial dentures, limited to one
 23.7 per year; and
- 23.8 (iii) adding a maximum of two denture teeth and two wrought wire clasps per year to
 23.9 partial dentures per dental arch;
- 23.10 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of
 23.11 abscesses;
- 23.12 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~
- 23.13 (15) full-mouth ~~debridement~~ periodontal scaling and root planing, limited to one
 23.14 every five years; and
- 23.15 (16) moderate sedation, deep sedation, and general anesthesia, limited to when
 23.16 provided by an oral maxillofacial surgeon who is board-certified, or actively participating
 23.17 in the American Board of Oral and Maxillofacial Surgery certification process, when
 23.18 medically necessary to allow the surgical management of acute oral and maxillofacial
 23.19 pathology which cannot be accomplished safely with local anesthesia alone and would
 23.20 otherwise require operating room services.
- 23.21 (c) In addition to the services specified in paragraph (b), medical assistance
 23.22 covers the following services for adults, if provided in an outpatient hospital setting or
 23.23 freestanding ambulatory surgical center as part of outpatient dental surgery:
- 23.24 (1) periodontics, limited to periodontal scaling and root planing once every two
 23.25 years;
- 23.26 (2) general anesthesia; and
- 23.27 (3) full-mouth survey once every ~~five~~ two years.
- 23.28 (d) Medical assistance covers dental services for children that are medically
 23.29 necessary. The following guidelines apply:
- 23.30 (1) posterior fillings are paid at the amalgam rate;
- 23.31 (2) application of sealants once every five years per permanent molar; and
- 23.32 (3) application of fluoride varnish once every six months.

23.33 Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e,
 23.34 is amended to read:

24.1 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
24.2 shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee;
24.3 the maximum allowable cost set by the federal government or by the commissioner plus
24.4 the fixed dispensing fee; or the usual and customary price charged to the public. The
24.5 amount of payment basis must be reduced to reflect all discount amounts applied to the
24.6 charge by any provider/insurer agreement or contract for submitted charges to medical
24.7 assistance programs. The net submitted charge may not be greater than the patient liability
24.8 for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee
24.9 for intravenous solutions which must be compounded by the pharmacist shall be \$8 per
24.10 bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral
24.11 nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral
24.12 nutritional products dispensed in quantities greater than one liter. Actual acquisition cost
24.13 includes quantity and other special discounts except time and cash discounts. Effective
24.14 ~~July 1, 2009~~ July 1, 2010, the actual acquisition cost of a drug shall be estimated by the
24.15 commissioner, at average wholesale price minus ~~15~~ 12.5 percent or wholesale acquisition
24.16 cost plus 5.0 percent, whichever is lower. The actual acquisition cost of antihemophilic
24.17 factor drugs shall be estimated at the average wholesale price minus ~~30~~ 28.12 percent or
24.18 wholesale acquisition cost minus 13.76 percent, whichever is lower. Average wholesale
24.19 price is defined as the price for a drug product listed as the average wholesale price in the
24.20 commissioner's primary reference source. Wholesale acquisition cost is defined as the
24.21 manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the
24.22 United States, not including prompt pay or other discounts, rebates, or reductions in price,
24.23 for the most recent month for which information is available, as reported in wholesale price
24.24 guides or other publications of drug or biological pricing data. The maximum allowable
24.25 cost of a multisource drug may be set by the commissioner and it shall be comparable to,
24.26 but no higher than, the maximum amount paid by other third-party payors in this state who
24.27 have maximum allowable cost programs. Establishment of the amount of payment for
24.28 drugs shall not be subject to the requirements of the Administrative Procedure Act.

24.29 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
24.30 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
24.31 facilities when a unit dose blister card system, approved by the department, is used. Under
24.32 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
24.33 The National Drug Code (NDC) from the drug container used to fill the blister card must
24.34 be identified on the claim to the department. The unit dose blister card containing the
24.35 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
24.36 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider

25.1 will be required to credit the department for the actual acquisition cost of all unused
25.2 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
25.3 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
25.4 dispensed in a quantity that is less than a 30-day supply.

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

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

25.13 (e) The commissioner may negotiate lower reimbursement rates for specialty
25.14 pharmacy products than the rates specified in paragraph (a). The commissioner may
25.15 require individuals enrolled in the health care programs administered by the department
25.16 to obtain specialty pharmacy products from providers with whom the commissioner has
25.17 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
25.18 used by a small number of recipients or recipients with complex and chronic diseases
25.19 that require expensive and challenging drug regimens. Examples of these conditions
25.20 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
25.21 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
25.22 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
25.23 biotechnology drugs, high-cost therapies, and therapies that require complex care. The
25.24 commissioner shall consult with the formulary committee to develop a list of specialty
25.25 pharmacy products subject to this paragraph. In consulting with the formulary committee
25.26 in developing this list, the commissioner shall take into consideration the population
25.27 served by specialty pharmacy products, the current delivery system and standard of care in
25.28 the state, and access to care issues. The commissioner shall have the discretion to adjust
25.29 the reimbursement rate to prevent access to care issues.

25.30 **EFFECTIVE DATE.** This section is effective July 1, 2010, or upon federal
25.31 approval, whichever is later.

25.32 Sec. 15. Minnesota Statutes 2008, section 256B.0625, subdivision 18a, is amended to
25.33 read:

26.1 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
26.2 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
26.3 \$6.50 for lunch, or \$8 for dinner.

26.4 (b) Medical assistance reimbursement for lodging for persons traveling to receive
26.5 medical care may not exceed \$50 per day unless prior authorized by the local agency.

26.6 (c) Medical assistance direct mileage reimbursement to the eligible person or the
26.7 eligible person's driver may not exceed 20 cents per mile.

26.8 (d) Regardless of the number of employees that an enrolled health care provider
26.9 may have, medical assistance covers sign and oral language interpreter services when
26.10 provided by an enrolled health care provider during the course of providing a direct,
26.11 person-to-person covered health care service to an enrolled recipient with limited English
26.12 proficiency or who has a hearing loss and uses interpreting services. Coverage for
26.13 face-to-face oral language interpreter services shall be provided only if the oral language
26.14 interpreter used by the enrolled health care provider is listed in the registry or roster
26.15 established under section 144.058.

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

26.17 Sec. 16. Minnesota Statutes 2008, section 256B.0625, subdivision 31, is amended to
26.18 read:

26.19 Subd. 31. **Medical supplies and equipment.** Medical assistance covers medical
26.20 supplies and equipment. Separate payment outside of the facility's payment rate shall
26.21 be made for wheelchairs and wheelchair accessories for recipients who are residents
26.22 of intermediate care facilities for the developmentally disabled. Reimbursement for
26.23 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
26.24 conditions and limitations as coverage for recipients who do not reside in institutions. A
26.25 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
26.26 The commissioner may set reimbursement rates for specified categories of medical
26.27 supplies at levels below the Medicare payment rate.

26.28 Sec. 17. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
26.29 subdivision to read:

26.30 Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers
26.31 services provided in a birth center licensed under section 144.615 by a licensed health
26.32 professional if the service would otherwise be covered if provided in a hospital.

26.33 (b) Facility services provided by a birth center shall be paid at the lower of billed
26.34 charges or 70 percent of the statewide average for a facility payment rate made to a

27.1 hospital for an uncomplicated vaginal birth as determined using the most recent calendar
27.2 year for which complete claims data is available. If a recipient is transported from a birth
27.3 center to a hospital prior to the delivery, the payment for facility services to the birth center
27.4 shall be the lower of billed charges or 15 percent of the average facility payment made to a
27.5 hospital for the services provided for an uncomplicated vaginal delivery as determined
27.6 using the most recent calendar year for which complete claims data is available.

27.7 (c) Professional services provided by traditional midwives licensed under chapter
27.8 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a
27.9 physician performing the same services. If a recipient is transported from a birth center to
27.10 a hospital prior to the delivery, a licensed traditional midwife who does not perform the
27.11 delivery may not bill for any delivery services. Services are not covered if provided by an
27.12 unlicensed traditional midwife.

27.13 (d) The commissioner shall apply for any necessary waivers from the Centers for
27.14 Medicare and Medicaid Services to allow birth centers and birth center providers to be
27.15 reimbursed.

27.16 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
27.17 approval, whichever is later.

27.18 Sec. 18. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
27.19 read:

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

27.23 (1) \$3 per nonpreventive visit. For purposes of this subdivision, a visit means an
27.24 episode of service which is required because of a recipient's symptoms, diagnosis, or
27.25 established illness, and which is delivered in an ambulatory setting by a physician or
27.26 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
27.27 audiologist, optician, or optometrist;

27.28 (2) \$3 for eyeglasses;

27.29 (3) \$6 for nonemergency visits to a hospital-based emergency room; and

27.30 (4) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
27.31 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
27.32 shall apply to antipsychotic drugs when used for the treatment of mental illness.

27.33 (b) Except as provided in subdivision 2, the medical assistance benefit plan shall
27.34 include the following co-payments for all recipients, effective for services provided on
27.35 or after January 1, 2009:

28.1 (1) ~~\$6~~ \$3.50 for nonemergency visits to a hospital-based emergency room;
28.2 (2) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject
28.3 to a ~~\$7~~ \$12 per month maximum for prescription drug co-payments. No co-payments shall
28.4 apply to antipsychotic drugs when used for the treatment of mental illness; and

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

28.10 (c) Recipients of medical assistance are responsible for all co-payments in this
28.11 subdivision.

28.12 **EFFECTIVE DATE.** The amendment to paragraph (b), clause (1), related to the
28.13 co-payment for nonemergency visits is effective January 1, 2011, and the amendment
28.14 to paragraph (b), clause (2), related to the per month maximum for prescription drug
28.15 co-payments is effective July 1, 2010.

28.16 Sec. 19. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to
28.17 read:

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

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

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

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

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

28.30 Sec. 20. Minnesota Statutes 2008, section 256B.0644, as amended by Laws 2010,
28.31 chapter 200, article 1, section 6, is amended to read:

28.32 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
28.33 **PROGRAMS.**

29.1 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
29.2 health maintenance organization, as defined in chapter 62D, must participate as a provider
29.3 or contractor in the medical assistance program, general assistance medical care program,
29.4 and MinnesotaCare as a condition of participating as a provider in health insurance plans
29.5 and programs or contractor for state employees established under section 43A.18, the
29.6 public employees insurance program under section 43A.316, for health insurance plans
29.7 offered to local statutory or home rule charter city, county, and school district employees,
29.8 the workers' compensation system under section 176.135, and insurance plans provided
29.9 through the Minnesota Comprehensive Health Association under sections 62E.01 to
29.10 62E.19. The limitations on insurance plans offered to local government employees shall
29.11 not be applicable in geographic areas where provider participation is limited by managed
29.12 care contracts with the Department of Human Services.

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

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

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

29.20 (3) for dental service providers, at least ten percent of the provider's patients are
29.21 covered by medical assistance, general assistance medical care, and MinnesotaCare as
29.22 their primary source of coverage, or the provider accepts new medical assistance and
29.23 MinnesotaCare patients who are children with special health care needs. For purposes
29.24 of this section, "children with special health care needs" means children up to age 18
29.25 who: (i) require health and related services beyond that required by children generally;
29.26 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
29.27 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
29.28 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
29.29 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
29.30 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
29.31 commissioner after consultation with representatives of pediatric dental providers and
29.32 consumers.

29.33 (c) Patients seen on a volunteer basis by the provider at a location other than
29.34 the provider's usual place of practice may be considered in meeting the participation
29.35 requirement in this section. The commissioner shall establish participation requirements
29.36 for health maintenance organizations. The commissioner shall provide lists of participating

30.1 medical assistance providers on a quarterly basis to the commissioner of management and
 30.2 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
 30.3 of the commissioners shall develop and implement procedures to exclude as participating
 30.4 providers in the program or programs under their jurisdiction those providers who do
 30.5 not participate in the medical assistance program. The commissioner of management
 30.6 and budget shall implement this section through contracts with participating health and
 30.7 dental carriers.

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

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

30.16 **EFFECTIVE DATE.** The amendment striking the existing paragraph (d) is effective
 30.17 30 days after federal approval of the amendments in this article to Minnesota Statutes,
 30.18 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011,
 30.19 whichever is later. The amendment to the new paragraph (d) is effective June 1, 2010.

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

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

30.25 (b) Home care therapies must be:

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

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

30.30 (3) assessed by an appropriate therapist; and

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

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

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

31.3 **Sec. 22. [256B.0755] PAYMENT REFORM DEMONSTRATION PROJECT FOR**
31.4 **SPECIAL PATIENT POPULATIONS.**

31.5 Subdivision 1. **Demonstration project.** (a) The commissioner of human services,
31.6 in consultation with the commissioner of health, shall establish a payment reform
31.7 demonstration project implementing an alternative payment system for health care
31.8 providers serving an identified group of patients who are enrolled in a state health
31.9 care program, and are either high utilizers of high-cost health care services or have
31.10 characteristics that put them at high risk of becoming high utilizers. The purpose of the
31.11 demonstration project is to implement and evaluate methods of reducing hospitalizations,
31.12 emergency room use, high-cost medications and specialty services, admissions to nursing
31.13 facilities, or use of long-term home and community-based services, in order to reduce the
31.14 total cost of care and services for the patients.

31.15 (b) The commissioner shall give the highest priority to projects that will serve
31.16 patients who have chronic medical conditions or complex medical needs that are
31.17 complicated by a physical disability, serious mental illness, or serious socioeconomic
31.18 factors such as poverty, homelessness, or language or cultural barriers. The commissioner
31.19 shall also give the highest priority to providers or groups of providers who have the
31.20 highest concentrations of patients with these characteristics.

31.21 (c) The commissioner must implement this payment reform demonstration project
31.22 in a manner consistent with the payment reform initiative provided in sections 62U.02
31.23 to 62U.04.

31.24 (d) For purposes of this section, "state health care program" means the medical
31.25 assistance, MinnesotaCare, and general assistance medical care programs.

31.26 Subd. 2. **Participation.** (a) The commissioner shall request eligible providers or
31.27 groups of providers to submit a proposal to participate in the demonstration project by
31.28 January 1, 2011. The providers who are interested in participating shall negotiate with
31.29 the commissioner to determine:

31.30 (1) the identified group of patients who are to be enrolled in the program;

31.31 (2) the services that are to be included in the total cost of care calculation;

31.32 (3) the methodology for calculating the total cost of care, which may take into
31.33 consideration the impact on costs to other state or local government programs including,
31.34 but not limited to, social services and income maintenance programs;

31.35 (4) the time period to be covered under the bid;

32.1 (5) the implementation of a risk adjustment mechanism to adjust for factors that are
32.2 beyond the control of the provider including nonclinical factors that will affect the cost
32.3 or outcomes of treatment;

32.4 (6) the payment reforms and payment methods to be used under the project, which
32.5 may include but are not limited to adjustments in fee-for-service payments, payment of
32.6 care coordination fees, payments for start-up and implementation costs to be recovered or
32.7 repaid later in the project, payments adjusted based on a provider's proportion of patients
32.8 who are enrolled in state health care programs; payments adjusted for the clinical or
32.9 socioeconomic complexity of the patients served, payment incentives tied to use of
32.10 inpatient and emergency room services, and periodic settle-up adjustments;

32.11 (7) methods of sharing financial risk and benefit between the commissioner and
32.12 the provider or groups of providers, which may include but are not limited to stop-loss
32.13 arrangements to cover high-cost outlier cases or costs that are beyond the control of the
32.14 provider, and risk-sharing and benefit-sharing corridors; and

32.15 (8) performance and outcome benchmarks to be used to measure performance,
32.16 achievement of cost-savings targets, and quality of care provided.

32.17 (b) A provider or group of providers may submit a proposal for a demonstration
32.18 project in partnership with a health maintenance organization or county-based purchasing
32.19 plan for the purposes of sharing risk, claims processing, or administration of the project,
32.20 or to extend participation in the project to persons who are enrolled in prepaid health
32.21 care programs.

32.22 Subd. 3. **Total cost of care agreement.** Based on negotiations, the commissioner
32.23 must enter into an agreement with interested and eligible providers or groups of providers
32.24 to implement projects that are designed to reduce the total cost of care for the identified
32.25 patients. To the extent possible, the projects shall begin implementation on July 1, 2011,
32.26 or upon federal approval, whichever is later.

32.27 Subd. 4. **Eligibility.** To be eligible to participate, providers or groups of providers
32.28 must meet certification standards for health care homes established by the Department of
32.29 Health and the Department of Human Services under section 256B.0751.

32.30 Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers
32.31 and approvals necessary to implement this section and to obtain federal matching funds. To
32.32 the extent authorized by federal law, the commissioner may waive existing fee-for-service
32.33 payment rates, provider contract or performance requirements, consumer incentive
32.34 policies, or other requirements in statute or rule in order to allow the providers or groups
32.35 of providers to utilize alternative payment and financing methods that will appropriately
32.36 fund necessary and cost-effective primary care and care coordination services; establish

33.1 appropriate incentives for prevention, health promotion, and care coordination; and
33.2 mitigate financial harm to participating providers caused by the successful reduction in
33.3 preventable hospitalization, emergency room use, and other costly services.

33.4 Subd. 6. **Cost neutrality.** The total cost, including administrative costs, of this
33.5 demonstration project must not exceed the costs that would otherwise be incurred by
33.6 the state had services to the state health care program enrollees participating in the
33.7 demonstration project been provided, as applicable for the enrollee, under fee-for-service
33.8 or through managed care or county-based purchasing plans.

33.9 Sec. 23. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a,
33.10 is amended to read:

33.11 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
33.12 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
33.13 basis beginning January 1, 1996. Managed care contracts which were in effect on June
33.14 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
33.15 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
33.16 commissioner may issue separate contracts with requirements specific to services to
33.17 medical assistance recipients age 65 and older.

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

33.23 (c) Effective for services rendered on or after January 1, 2003, the commissioner
33.24 shall withhold five percent of managed care plan payments under this section and
33.25 county-based purchasing plan's payment rate under section 256B.692 for the prepaid
33.26 medical assistance and general assistance medical care programs pending completion of
33.27 performance targets. Each performance target must be quantifiable, objective, measurable,
33.28 and reasonably attainable, except in the case of a performance target based on a federal
33.29 or state law or rule. Criteria for assessment of each performance target must be outlined
33.30 in writing prior to the contract effective date. The managed care plan must demonstrate,
33.31 to the commissioner's satisfaction, that the data submitted regarding attainment of
33.32 the performance target is accurate. The commissioner shall periodically change the
33.33 administrative measures used as performance targets in order to improve plan performance
33.34 across a broader range of administrative services. The performance targets must include
33.35 measurement of plan efforts to contain spending on health care services and administrative

34.1 activities. The commissioner may adopt plan-specific performance targets that take into
34.2 account factors affecting only one plan, including characteristics of the plan's enrollee
34.3 population. The withheld funds must be returned no sooner than July of the following
34.4 year if performance targets in the contract are achieved. The commissioner may exclude
34.5 special demonstration projects under subdivision 23.

34.6 (d) Effective for services rendered on or after January 1, 2009, through December 31,
34.7 2009, the commissioner shall withhold three percent of managed care plan payments under
34.8 this section and county-based purchasing plan payments under section 256B.692 for the
34.9 prepaid medical assistance and general assistance medical care programs. The withheld
34.10 funds must be returned no sooner than July 1 and no later than July 31 of the following
34.11 year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

34.21 (f) Effective for services rendered on or after January 1, 2010, through December
34.22 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments
34.23 under this section and county-based purchasing plan payments under section 256B.692
34.24 for the prepaid medical assistance program. The withheld funds must be returned no
34.25 sooner than July 1 and no later than July 31 of the following year. The commissioner may
34.26 exclude special demonstration projects under subdivision 23.

34.27 (g) Effective for services rendered on or after January 1, 2011, through December
34.28 31, 2011, the commissioner shall withhold four percent of managed care plan payments
34.29 under this section and county-based purchasing plan payments under section 256B.692
34.30 for the prepaid medical assistance program. The withheld funds must be returned no
34.31 sooner than July 1 and no later than July 31 of the following year. The commissioner may
34.32 exclude special demonstration projects under subdivision 23.

34.33 (h) Effective for services rendered on or after January 1, 2012, through December
34.34 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
34.35 under this section and county-based purchasing plan payments under section 256B.692
34.36 for the prepaid medical assistance program. The withheld funds must be returned no

35.1 sooner than July 1 and no later than July 31 of the following year. The commissioner may
35.2 exclude special demonstration projects under subdivision 23.

35.3 (i) Effective for services rendered on or after January 1, 2013, through December 31,
35.4 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
35.5 this section and county-based purchasing plan payments under section 256B.692 for the
35.6 prepaid medical assistance program. The withheld funds must be returned no sooner than
35.7 July 1 and no later than July 31 of the following year. The commissioner may exclude
35.8 special demonstration projects under subdivision 23.

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

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

35.18 (l) Contracts between the commissioner and a prepaid health plan are exempt from
35.19 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
35.20 (a), and 7.

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

35.26 The withheld funds must be returned no sooner than July 1 and no later than July
35.27 31 of the following calendar year if the managed care plan or county-based purchasing
35.28 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
35.29 rate was achieved.

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

35.34 Sec. 24. Minnesota Statutes 2008, section 256B.69, is amended by adding a
35.35 subdivision to read:

36.1 Subd. 5k. **Payment rate modification.** For services rendered on or after July 1,
 36.2 2011, the total payment made to managed care and county-based purchasing plans under
 36.3 the medical assistance program and under MinnesotaCare for families with children shall
 36.4 be increased by 1.4 percent.

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

36.6 Sec. 25. Minnesota Statutes 2008, section 256B.69, is amended by adding a
 36.7 subdivision to read:

36.8 Subd. 5l. **Payment reduction.** For services rendered on or after January 1, 2011,
 36.9 the total payment made to managed care plans for providing covered services under
 36.10 the medical assistance and MinnesotaCare programs is reduced by one percent. This
 36.11 provision excludes payments for nursing home services, home and community-based
 36.12 waivers, home care services covered under section 256B.0651, subdivision 2, payments to
 36.13 demonstration projects for persons with disabilities, and mental health services added as
 36.14 covered benefits after December 31, 2007.

36.15 Sec. 26. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by
 36.16 Laws 2010, chapter 200, article 1, section 10, is amended to read:

36.17 Subd. 20. **Ombudsperson.** (a) The commissioner shall designate an ombudsperson
 36.18 to advocate for persons required to enroll in prepaid health plans under this section. The
 36.19 ombudsperson shall advocate for recipients enrolled in prepaid health plans through
 36.20 complaint and appeal procedures and ensure that necessary medical services are provided
 36.21 either by the prepaid health plan directly or by referral to appropriate social services. At
 36.22 the time of enrollment in a prepaid health plan, the local agency shall inform recipients
 36.23 about the ombudsperson program and their right to a resolution of a complaint by the
 36.24 prepaid health plan if they experience a problem with the plan or its providers.

36.25 ~~(b) The commissioner shall designate an ombudsperson to advocate for persons~~
 36.26 ~~enrolled in a care coordination delivery system under section 256D.031. The~~
 36.27 ~~ombudsperson shall advocate for recipients enrolled in a care coordination delivery~~
 36.28 ~~system through the state appeal process and assist enrollees in accessing necessary~~
 36.29 ~~medical services through the care coordination delivery systems directly or by referral to~~
 36.30 ~~appropriate services. At the time of enrollment in a care coordination delivery system, the~~
 36.31 ~~local agency shall inform recipients about the ombudsperson program.~~

37.1 **EFFECTIVE DATE.** This section is effective 30 days after federal approval of the
 37.2 amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and
 37.3 256B.056, subdivision 4, or January 1, 2011, whichever is later.

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

37.5 Subd. 27. **Information for persons with limited English-language proficiency.**
 37.6 Managed care contracts entered into under this section and ~~sections 256D.03, subdivision~~
 37.7 ~~4, paragraph (c), and section 256L.12~~ must require demonstration providers to provide
 37.8 language assistance to enrollees that ensures meaningful access to its programs and
 37.9 services according to Title VI of the Civil Rights Act and federal regulations adopted
 37.10 under that law or any guidance from the United States Department of Health and Human
 37.11 Services.

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

37.13 Sec. 28. Minnesota Statutes 2008, section 256B.692, subdivision 1, is amended to read:

37.14 Subdivision 1. **In general.** County boards or groups of county boards may elect
 37.15 to purchase or provide health care services on behalf of persons eligible for medical
 37.16 assistance ~~and general assistance medical care~~ who would otherwise be required to or may
 37.17 elect to participate in the prepaid medical assistance ~~or prepaid general assistance medical~~
 37.18 ~~care programs~~ according to ~~sections~~ section 256B.69 and 256D.03. Counties that elect to
 37.19 purchase or provide health care under this section must provide all services included in
 37.20 prepaid managed care programs according to ~~sections~~ section 256B.69, subdivisions 1
 37.21 to 22, ~~and 256D.03~~. County-based purchasing under this section is governed by section
 37.22 256B.69, unless otherwise provided for under this section.

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

37.24 Sec. 29. Minnesota Statutes 2008, section 256B.75, is amended to read:

37.25 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

37.26 (a) For outpatient hospital facility fee payments for services rendered on or after
 37.27 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
 37.28 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
 37.29 services for which there is a federal maximum allowable payment. Effective for services
 37.30 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
 37.31 facility fees and emergency room facility fees shall be increased by eight percent over the
 37.32 rates in effect on December 31, 1999, except for those services for which there is a federal

38.1 maximum allowable payment. Services for which there is a federal maximum allowable
38.2 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
38.3 allowable payment. Total aggregate payment for outpatient hospital facility fee services
38.4 shall not exceed the Medicare upper limit. If it is determined that a provision of this
38.5 section conflicts with existing or future requirements of the United States government with
38.6 respect to federal financial participation in medical assistance, the federal requirements
38.7 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
38.8 avoid reduced federal financial participation resulting from rates that are in excess of
38.9 the Medicare upper limitations.

38.10 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
38.11 ambulatory surgery hospital facility fee services for critical access hospitals designated
38.12 under section 144.1483, clause (10), shall be paid on a cost-based payment system that is
38.13 based on the cost-finding methods and allowable costs of the Medicare program.

38.14 (c) Effective for services provided on or after July 1, 2003, rates that are based
38.15 on the Medicare outpatient prospective payment system shall be replaced by a budget
38.16 neutral prospective payment system that is derived using medical assistance data. The
38.17 commissioner shall provide a proposal to the 2003 legislature to define and implement
38.18 this provision.

38.19 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
38.20 before third-party liability and spenddown, made to hospitals for outpatient hospital
38.21 facility services is reduced by .5 percent from the current statutory rate.

38.22 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
38.23 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
38.24 facility services before third-party liability and spenddown, is reduced five percent from
38.25 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
38.26 excluded from this paragraph.

38.27 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
38.28 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
38.29 hospital facility services before third-party liability and spenddown, is reduced three
38.30 percent from the current statutory rates. Mental health services and facilities defined under
38.31 section 256.969, subdivision 16, are excluded from this paragraph.

38.32 (g) Notwithstanding any contrary provision in this section, payment for all outpatient
38.33 and emergency services provided by any hospital that, prior to December 31, 2007, has
38.34 received payment to support the training of residents from an approved graduate medical
38.35 residency training program under United States Code, title 42, section 256e, must be paid
38.36 for the specified fiscal years as follows:

- 39.1 (1) 2014: 50 percent of costs;
39.2 (2) 2015: 60 percent of costs;
39.3 (3) 2016: 70 percent of costs;
39.4 (4) 2017: 80 percent of costs;
39.5 (5) 2018: 90 percent of costs; and
39.6 (6) 2019 and thereafter: 100 percent of costs.

39.7 Sec. 30. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is
39.8 amended to read:

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

39.12 (1) payment for level one Centers for Medicare and Medicaid Services' common
39.13 procedural coding system codes titled "office and other outpatient services," "preventive
39.14 medicine new and established patient," "delivery, antepartum, and postpartum care,"
39.15 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
39.16 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
39.17 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
39.18 30, 1992. If the rate on any procedure code within these categories is different than the
39.19 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
39.20 then the larger rate shall be paid;

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

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

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

39.32 (c) Effective for services rendered on or after July 1, 2009, payment rates for
39.33 physician and professional services shall be reduced by five percent over the rates in
39.34 effect on June 30, 2009. This reduction does not apply to office or other outpatient visits,
39.35 preventive medicine visits and family planning visits billed by physicians, advanced

40.1 practice nurses, or physician assistants in a family planning agency or in one of the
40.2 following primary care practices: general practice, general internal medicine, general
40.3 pediatrics, general geriatrics, and family medicine. This reduction does not apply to
40.4 federally qualified health centers, rural health centers, and Indian health services. This
40.5 reduction does not apply to physical therapy services, occupational therapy services,
40.6 and speech pathology and related services provided on or after July 1, 2010. Effective
40.7 October 1, 2009, payments made to managed care plans and county-based purchasing
40.8 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction
40.9 described in this paragraph.

40.10 (d) Effective for services rendered on or after July 1, 2010, payment rates for
40.11 physician and professional services shall be reduced by three percent over the rates in
40.12 effect on June 30, 2010. This reduction does not apply to those providers and entities
40.13 exempt from the reduction in paragraph (c). Effective October 1, 2010, payments made
40.14 to managed care plans and county-based purchasing plans under sections 256B.69,
40.15 256B.692, and 256L.12 shall reflect the payment reductions in this paragraph.

40.16 (e) Effective for services rendered on or after June 1, 2010, payment rates for
40.17 physician and professional services billed by physicians employed by and clinics that are
40.18 owned by a nonprofit health maintenance organization shall be increased by 15 percent.
40.19 Effective October 1, 2010, payments to managed care and county-based purchasing
40.20 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
40.21 described in this paragraph.

40.22 Sec. 31. Minnesota Statutes 2008, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

40.31 (c) Effective for services rendered on or after January 1, 2000, payment rates for
40.32 dental services shall be increased by three percent over the rates in effect on December
40.33 31, 1999.

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

41.4 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
41.5 2000, for managed care.

41.6 (f) Effective for dental services rendered on or after October 1, 2010, by a
41.7 state-operated dental clinic, payment shall be paid on a cost-based payment system that
41.8 is based on the cost-finding methods and allowable costs of the Medicare program. For
41.9 services performed by a state-operated dental clinic pursuant to a contract between the
41.10 clinic and a managed care plan or a county-based purchasing plan, a supplemental payment
41.11 shall be made to the clinic by the commissioner that is equal to the amount by which the
41.12 amount determined under this paragraph exceeds the amount of the payments provided
41.13 under the contract. Managed care plans and county-based purchasing plans participating
41.14 in medical assistance must provide to the commissioner any expenditure, cost, and
41.15 revenue information deemed necessary by the commissioner for purposes of obtaining
41.16 federal Medicaid matching funds for cost-based reimbursement for state-operated dental
41.17 clinics. Cost-based reimbursement shall be implemented in managed care contracts
41.18 beginning January 1, 2011.

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

41.24 Sec. 32. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

41.25 Subd. 4. **Critical access dental providers.** Effective for dental services rendered
41.26 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
41.27 and dental clinics deemed by the commissioner to be critical access dental providers.
41.28 For dental services rendered on or after July 1, 2007, the commissioner shall increase
41.29 reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to
41.30 the critical access dental provider. The commissioner shall pay the health plan companies
41.31 in amounts sufficient to reflect increased reimbursements to critical access dental providers
41.32 as approved by the commissioner. In determining which dentists and dental clinics shall
41.33 be deemed critical access dental providers, the commissioner shall review:

42.1 (1) the utilization rate in the service area in which the dentist or dental clinic operates
42.2 for dental services to patients covered by medical assistance, general assistance medical
42.3 care, or MinnesotaCare as their primary source of coverage;

42.4 (2) the level of services provided by the dentist or dental clinic to patients covered
42.5 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
42.6 source of coverage; ~~and~~. The commissioner shall pay critical access dental provider
42.7 payments to a dentist or dental clinic that meets any one of the following criteria:

42.8 (i) at least 40 percent of patient encounters are with patients who are uninsured or
42.9 covered by medical assistance, general assistance medical care, or MinnesotaCare;

42.10 (ii) the dental clinic or dental group is owned and operated by a nonprofit operation
42.11 under chapter 317A with more than 10,000 patient encounters per year with patients
42.12 who are uninsured or covered by medical assistance, general assistance medical care,
42.13 or MinnesotaCare;

42.14 (iii) the dental clinic is associated with an oral health or dental education program
42.15 operated by the University of Minnesota or an institution within the Minnesota State
42.16 Colleges and Universities system; or

42.17 (iv) the dental clinic is a state-operated dental clinic;

42.18 (3) whether the level of services provided by the dentist or dental clinic is critical to
42.19 maintaining adequate levels of patient access within ~~the~~ a geographic service area, and
42.20 to ensure that the maximum travel distance or travel time is the lesser of 60 miles or 60
42.21 minutes;

42.22 (4) whether the provider has completed the application for critical access dental
42.23 provider designation by the due date, and has provided correct information;

42.24 (5) whether the dentist or dental clinic meets the quality and continuity of care
42.25 criteria recommended by the dental services advisory committee and adopted by the
42.26 department; and

42.27 (6) whether the dentist or dental clinic serves people in all Minnesota health care
42.28 programs.

42.29 In the absence of a critical access dental provider in a service area, the commissioner may
42.30 designate a dentist or dental clinic as a critical access dental provider if the dentist or
42.31 dental clinic is willing to provide care to patients covered by medical assistance, general
42.32 assistance medical care, or MinnesotaCare at a level which significantly increases access
42.33 to dental care in the service area.

42.34 **EFFECTIVE DATE.** This section is effective January 1, 2011.

43.1 Sec. 33. Minnesota Statutes 2008, section 256B.76, is amended by adding a
43.2 subdivision to read:

43.3 Subd. 4a. **Designation and termination of critical access dental providers.** (a)
43.4 Notwithstanding the provisions in subdivision 4, the commissioner may review and not
43.5 designate an individual dentist or dental clinic as a critical access dental provider under
43.6 subdivision 4 or section 256L.11, subdivision 7, when the dentist or clinic:

43.7 (1) has been subject to a corrective or disciplinary action by the Board of Dentistry
43.8 related to fraud or direct patient care. Designation shall not be made until the provider is no
43.9 longer subject to a corrective or disciplinary action related to fraud or direct patient care; or

43.10 (2) has been subject, within the past three years, to a postinvestigation action by the
43.11 commissioner of human services or issuance of a warning as specified in Minnesota Rules,
43.12 parts 9505.2160 to 9505.2245. The provider shall not be considered for critical access
43.13 dental designation until the January following the year in which the action has ended.

43.14 (b) The commissioner may terminate a critical access designation of an individual
43.15 dentist or clinic if the dentist or clinic:

43.16 (1) becomes subject to a disciplinary or corrective action by the Board of Dentistry
43.17 related to fraud or direct patient care. The provider shall not be considered for critical
43.18 access designation until the January following the year in which the action has ended;

43.19 (2) becomes subject to a postinvestigation action by the commissioner of human
43.20 services or issuance of a warning as specified in Minnesota Rules, parts 9505.2160
43.21 to 9505.2245;

43.22 (3) does not meet the quality and continuity of care criteria that have been
43.23 recommended by the Dental Services Advisory Committee and adopted by the department;
43.24 or

43.25 (4) does not serve people in all Minnesota public health care programs.

43.26 (c) Any termination is effective on the date of notification of the:

43.27 (1) postinvestigative action;

43.28 (2) disciplinary or corrective action by the Minnesota Board of Dentistry; or

43.29 (3) determination of not meeting quality and continuity of care criteria.

43.30 The commissioner may review postinvestigative actions taken by a health plan
43.31 under contract to provide dental services to Minnesota health care program enrollees.

43.32 After an investigation conducted by the Department of Human Services surveillance unit,
43.33 the findings of the health plan may be incorporated to determine if a provider will be
43.34 designated or terminated from the program.

43.35 (d) A provider who has been terminated or not designated under this section may
43.36 appeal only through the contested hearing process as defined in section 14.02, subdivision

44.1 3, by filing with the commissioner a written request of appeal. The appeal request must
44.2 be received by the commissioner no later than 30 days after notification of termination
44.3 or nondesignation.

44.4 (e) The commissioner may make an exception to paragraphs (a) and (b) if an action
44.5 taken by the Board of Dentistry or the commissioner is the result of events not directly
44.6 related to patient care or that will not affect direct patient care to Minnesota health care
44.7 program enrollees.

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

44.9 Sec. 34. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

44.10 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

44.11 (a) Effective for services provided on or after July 1, 2009, total payments for
44.12 basic care services, shall be reduced by three percent, prior to third-party liability and
44.13 spenddown calculation. This reduction applies to physical therapy services, occupational
44.14 therapy services, and speech language pathology and related services provided on or after
44.15 July 1, 2010. Effective July 1, 2010, the commissioner shall classify physical therapy
44.16 services, occupational therapy services, and speech language pathology and related
44.17 services as basic care services. Payments made to managed care plans and county-based
44.18 purchasing plans shall be reduced for services provided on or after October 1, 2009,
44.19 to reflect this reduction.

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

44.24 Sec. 35. **[256B.767] MEDICARE PAYMENT LIMIT.**

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

44.31 Sec. 36. **[256B.768] FEE-FOR-SERVICE PAYMENT INCREASE.**

45.1 Effective for services rendered on or after January 1, 2011, the commissioner shall
45.2 increase fee-for-service payment rates by seven percent for physician and professional
45.3 services under section 256B.76, subdivision 1, and basic care services subject to the rate
45.4 reduction specified in section 256B.766.

45.5 Sec. 37. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as
45.6 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

45.7 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
45.8 the general assistance medical care program shall be administered according to section
45.9 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
45.10 which shall continue to be administered under this section and funded under section
45.11 256D.031, subdivision 9, beginning June 1, 2010.

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

45.14 (1) are covered under the medical assistance program as described in section
45.15 256B.0625, subdivisions 13 and 13d; and

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

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

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

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

45.26 Sec. 38. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

45.27 Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care
45.28 applicants and recipients must cooperate with the state and local agency to identify
45.29 potentially liable third-party payors and assist the state in obtaining third-party payments.
45.30 Cooperation includes identifying any third party who may be liable for care and services
45.31 provided under this chapter to the applicant, recipient, or any other family member for
45.32 whom application is made and providing relevant information to assist the state in pursuing
45.33 a potentially liable third party. ~~General assistance medical care applicants and recipients~~
45.34 ~~must cooperate by providing information about any group health plan in which they may~~

46.1 ~~be eligible to enroll. They must cooperate with the state and local agency in determining~~
 46.2 ~~if the plan is cost-effective. For purposes of this subdivision, coverage provided by the~~
 46.3 ~~Minnesota Comprehensive Health Association under chapter 62E shall not be considered~~
 46.4 ~~group health plan coverage or cost-effective by the state and local agency. If the plan is~~
 46.5 ~~determined cost-effective and the premium will be paid by the state or local agency or is~~
 46.6 ~~available at no cost to the person, they must enroll or remain enrolled in the group health~~
 46.7 ~~plan. Cost-effective insurance premiums approved for payment by the state agency and~~
 46.8 ~~paid by the local agency are eligible for reimbursement according to subdivision 6.~~

46.9 (b) Effective for all premiums due on or after June 30, 1997, general assistance
 46.10 medical care does not cover premiums that a recipient is required to pay under a qualified
 46.11 or Medicare supplement plan issued by the Minnesota Comprehensive Health Association.
 46.12 General assistance medical care shall continue to cover premiums for recipients who are
 46.13 covered under a plan issued by the Minnesota Comprehensive Health Association on June
 46.14 30, 1997, for a period of six months following receipt of the notice of termination or
 46.15 until December 31, 1997, whichever is later.

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

46.17 Sec. 39. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

46.18 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for
 46.19 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
 46.20 each state revenue and expenditure forecast, the commissioner must make an assessment
 46.21 of the expected expenditures for the covered services for the remainder of the current
 46.22 biennium and for the following biennium. The estimated expenditure, including the
 46.23 reserve, shall be compared to an estimate of the revenues that will be available in the health
 46.24 care access fund. Based on this comparison, and after consulting with the chairs of the
 46.25 house of representatives Ways and Means Committee and the senate Finance Committee,
 46.26 and the Legislative Commission on Health Care Access, the commissioner shall, as
 46.27 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures
 46.28 remain within the limits of available revenues for the remainder of the current biennium
 46.29 and for the following biennium. The commissioner shall not hire additional staff using
 46.30 appropriations from the health care access fund until the commissioner of management
 46.31 and budget makes a determination that the adjustments implemented under paragraph (b)
 46.32 are sufficient to allow MinnesotaCare expenditures to remain within the limits of available
 46.33 revenues for the remainder of the current biennium and for the following biennium.

46.34 (b) The adjustments the commissioner shall use must be implemented in this order,
 46.35 but shall not be implemented before July 1, 2014: first, stop enrollment of single adults

47.1 and households without children; and second, upon 45 days' notice, stop coverage of
 47.2 single adults and households without children already enrolled in the MinnesotaCare
 47.3 program; ~~third, upon 90 days' notice, decrease the premium subsidy amounts by ten~~
 47.4 ~~percent for families with gross annual income above 200 percent of the federal poverty~~
 47.5 ~~guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten~~
 47.6 ~~percent for families with gross annual income at or below 200 percent; and fifth, require~~
 47.7 ~~applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare~~
 47.8 ~~program.~~ If these measures are insufficient to limit the expenditures to the estimated
 47.9 amount of revenue, the commissioner shall ~~further limit enrollment or decrease premium~~
 47.10 ~~subsidies~~ notify the chairs of the house of representatives Ways and Means Committee and
 47.11 the senate Finance Committee, and the Legislative Commission on Health Care Access,
 47.12 and present recommendations to the chairs and commission for limiting expenditures to
 47.13 the estimated amount of revenue.

47.14 **EFFECTIVE DATE.** This section is effective upon federal approval of the
 47.15 amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and
 47.16 256B.056, subdivision 4.

47.17 Sec. 40. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

47.18 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
 47.19 inpatient hospital services, including inpatient hospital mental health services and inpatient
 47.20 hospital and residential chemical dependency treatment, subject to those limitations
 47.21 necessary to coordinate the provision of these services with eligibility under the medical
 47.22 assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under
 47.23 section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and
 47.24 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or
 47.25 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not
 47.26 pregnant, is subject to an annual limit of \$10,000, unless supplemental hospital coverage
 47.27 has been purchased under subdivision 3c.

47.28 (b) Admissions for inpatient hospital services paid for under section 256L.11,
 47.29 subdivision 3, must be certified as medically necessary in accordance with Minnesota
 47.30 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

47.31 (1) all admissions must be certified, except those authorized under rules established
 47.32 under section 254A.03, subdivision 3, or approved under Medicare; and

47.33 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
 47.34 for admissions for which certification is requested more than 30 days after the day of

48.1 admission. The hospital may not seek payment from the enrollee for the amount of the
48.2 payment reduction under this clause.

48.3 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
48.4 approval, whichever is later. The commissioner of human services shall notify the revisor
48.5 of statutes when federal approval is obtained.

48.6 Sec. 41. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision
48.7 to read:

48.8 Subd. 3c. **Supplemental hospital coverage.** (a) The commissioner shall offer all
48.9 MinnesotaCare applicants, and all enrollees during the open enrollment periods specified
48.10 in paragraph (b), the opportunity to purchase at full cost, supplemental hospital coverage
48.11 to cover inpatient hospital expenses in excess of the inpatient hospital annual limit
48.12 established under subdivision 3. Premiums for this coverage may vary only for age and
48.13 shall be collected by the commissioner using the procedures established for the sliding
48.14 scale premium determined under section 256L.15.

48.15 (b) The commissioner shall notify all persons submitting applications of the option to
48.16 purchase this coverage at the time of application. The commissioner shall provide persons
48.17 enrolled in MinnesotaCare on the effective date of this subdivision with the opportunity to
48.18 purchase this supplemental coverage during an initial open enrollment period. Following
48.19 this initial open enrollment period, the commissioner shall provide all enrollees with the
48.20 opportunity to purchase this supplemental coverage during an annual open enrollment
48.21 period during the month of November with coverage to take effect the following January 1.

48.22 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
48.23 approval, whichever is later. The commissioner of human services shall notify the revisor
48.24 of statutes when federal approval is obtained.

48.25 Sec. 42. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is
48.26 amended to read:

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

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

48.32 (2) \$3 per prescription for adult enrollees;

48.33 (3) \$25 for eyeglasses for adult enrollees;

49.1 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
49.2 episode of service which is required because of a recipient's symptoms, diagnosis, or
49.3 established illness, and which is delivered in an ambulatory setting by a physician or
49.4 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
49.5 audiologist, optician, or optometrist; and

49.6 (5) \$6 for nonemergency visits to a hospital-based emergency room for services
49.7 provided through December 31, 2010, and \$3.50 effective January 1, 2011.

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

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

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

49.12 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal
49.13 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,
49.14 and who are not pregnant shall be financially responsible for the coinsurance amount, if
49.15 applicable, and if supplemental coverage has not been purchased under subdivision 3c,
49.16 amounts which exceed the \$10,000 inpatient hospital benefit limit.

49.17 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
49.18 or changes from one prepaid health plan to another during a calendar year, any charges
49.19 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket
49.20 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
49.21 prior to enrollment, or prior to the change in health plans, shall be disregarded.

49.22 (g) MinnesotaCare reimbursement to fee-for-service providers and payments to
49.23 managed care plans shall not be increased as a result of the reduction of the co-payments
49.24 in paragraph (a), clause (5), effective January 1, 2011.

49.25 **EFFECTIVE DATE.** The amendment to paragraph (e) is effective January 1, 2011,
49.26 or upon federal approval, whichever is later.

49.27 Sec. 43. Minnesota Statutes 2008, section 256L.04, subdivision 7, is amended to read:

49.28 Subd. 7. **Single adults and households with no children.** ~~(a) The definition of~~
49.29 ~~eligible persons includes all individuals and households with no children who have gross~~
49.30 ~~family incomes that are equal to or less than 200 percent of the federal poverty guidelines.~~

49.31 ~~(b) Effective July 1, 2009,~~ The definition of eligible persons includes all individuals
49.32 and households with no children who have gross family incomes that are above 75 percent
49.33 and equal to or less than 250 percent of the federal poverty guidelines.

50.1 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon
50.2 implementation of medical assistance for adults without children under Minnesota Statutes,
50.3 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, whichever is later.

50.4 Sec. 44. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
50.5 to read:

50.6 Subd. 6. **Disclosure statement for inpatient hospital limit.** The commissioner
50.7 shall develop, and include with MinnesotaCare application and renewal materials, a
50.8 disclosure statement that contains the following or similar language: "For adults without
50.9 children, and for parents and relative caretakers with family gross income that exceeds
50.10 215 percent of the federal poverty guidelines, who are not pregnant, coverage of inpatient
50.11 hospital services under MinnesotaCare is subject to an annual limit of \$10,000. Enrollees
50.12 subject to the limit may be responsible for inpatient hospital costs that exceed the \$10,000
50.13 annual limit."

50.14 Sec. 45. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

50.15 Subdivision 1. **General requirements.** (a) Children enrolled in the original
50.16 children's health plan as of September 30, 1992, children who enrolled in the
50.17 MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,
50.18 article 4, section 17, and children who have family gross incomes that are equal to or
50.19 less than 150 percent of the federal poverty guidelines are eligible without meeting
50.20 the requirements of subdivision 2 and the four-month requirement in subdivision 3, as
50.21 long as they maintain continuous coverage in the MinnesotaCare program or medical
50.22 assistance. Children who apply for MinnesotaCare on or after the implementation date
50.23 of the employer-subsidized health coverage program as described in Laws 1998, chapter
50.24 407, article 5, section 45, who have family gross incomes that are equal to or less than 150
50.25 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to
50.26 be eligible for MinnesotaCare.

50.27 (b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose
50.28 income increases above 275 percent of the federal poverty guidelines, are no longer
50.29 eligible for the program and shall be disenrolled by the commissioner.

50.30 (c) ~~Beginning January 1, 2008,~~ Individuals enrolled in MinnesotaCare under section
50.31 256L.04, subdivision 7, whose income ~~decreases to 75 percent of the federal poverty~~
50.32 ~~guidelines or less, or increases above 200 percent of the federal poverty guidelines or~~
50.33 ~~250 percent of the federal poverty guidelines on or after July 1, 2009,~~ are no longer
50.34 eligible for the program and shall be disenrolled by the commissioner. For persons

51.1 disenrolled under this subdivision due to income above the income limits, MinnesotaCare
 51.2 coverage terminates the last day of the calendar month following the month in which the
 51.3 commissioner determines that the income of a family or individual exceeds program
 51.4 income limits. Persons disenrolled under this subdivision due to income at or above 75
 51.5 percent of the federal poverty guidelines shall have eligibility redetermined for medical
 51.6 assistance under section 256B.055, subdivision 15.

51.7 ~~(b)~~ (d) Notwithstanding paragraph (a), children may remain enrolled in
 51.8 MinnesotaCare if ten percent of their gross individual or gross family income as defined in
 51.9 section 256L.01, subdivision 4, is less than the annual premium for a policy with a \$500
 51.10 deductible available through the Minnesota Comprehensive Health Association. Children
 51.11 who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month
 51.12 notice period from the date that ineligibility is determined before disenrollment. The
 51.13 premium for children remaining eligible under this clause shall be the maximum premium
 51.14 determined under section 256L.15, subdivision 2, paragraph (b).

51.15 ~~(c)~~ (e) Notwithstanding paragraphs (a) and ~~(b)~~ (d), parents are not eligible for
 51.16 MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period
 51.17 of eligibility.

51.18 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon
 51.19 implementation of medical assistance for adults without children under Minnesota Statutes,
 51.20 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, whichever is later.

51.21 Sec. 46. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision
 51.22 to read:

51.23 **Subd. 9. Firefighters; volunteer ambulance attendants.** (a) For purposes of this
 51.24 subdivision, "qualified individual" means:

51.25 (1) a volunteer firefighter with a department as defined in section 299N.01,
 51.26 subdivision 2, who has passed the probationary period; and

51.27 (2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

51.28 (b) A qualified individual who documents to the satisfaction of the commissioner
 51.29 status as a qualified individual by completing and submitting a one-page form developed
 51.30 by the commissioner is eligible for MinnesotaCare without meeting other eligibility
 51.31 requirements of this chapter, but must pay premiums equal to the average expected
 51.32 capitation rate for adults with no children paid under section 256L.12. Individuals eligible
 51.33 under this subdivision shall receive coverage for the benefit set provided to adults with no
 51.34 children.

52.1 **EFFECTIVE DATE.** This section is effective April 1, 2011.

52.2 Sec. 47. Minnesota Statutes 2009 Supplement, section 256L.11, subdivision 1, is
52.3 amended to read:

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

52.7 (b) Effective for services provided on or after July 1, 2009, total payments for basic
52.8 care services shall be reduced by three percent, in accordance with section 256B.766.

52.9 Payments made to managed care and county-based purchasing plans shall be reduced for
52.10 services provided on or after October 1, 2009, to reflect this reduction.

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

52.16 (d) Effective for services provided on or after July 1, 2010, payment rates for
52.17 physician and professional services shall be reduced as described under section 256B.76,
52.18 subdivision 1, paragraph (d). Payments made to managed care plans and county-based
52.19 purchasing plans shall be reduced for services provided on or after October 1, 2010,
52.20 to reflect this reduction.

52.21 Sec. 48. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

52.22 Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who
52.23 become eligible for medical assistance ~~or general assistance medical care~~ will remain in
52.24 the same managed care plan if the managed care plan has a contract for that population.
52.25 ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for
52.26 general assistance medical care pursuant to section 256D.03, subdivision 3, within six
52.27 months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant
52.28 to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care
52.29 plan if the managed care plan has a contract for that population. Managed care plans must
52.30 participate in the MinnesotaCare ~~and general assistance medical care programs~~ program
52.31 under a contract with the Department of Human Services in service areas where they
52.32 participate in the medical assistance program.

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

53.1 Sec. 49. Minnesota Statutes 2008, section 256L.12, subdivision 6, is amended to read:

53.2 Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all
53.3 co-payments in sections 256L.03, subdivision 5, and 256L.035, and shall pay co-payments
53.4 to the managed care plan or to its participating providers. The enrollee is also responsible
53.5 for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit,
53.6 unless supplemental hospital coverage has been purchased under subdivision 3c.

53.7 **EFFECTIVE DATE.** This section is effective July 1, 2011, or upon federal
53.8 approval, whichever is later. The commissioner of human services shall notify the revisor
53.9 of statutes when federal approval is obtained.

53.10 Sec. 50. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

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

53.22 (c) For services rendered on or after January 1, 2004, the commissioner shall
53.23 withhold five percent of managed care plan payments under this section pending
53.24 completion of performance targets. Each performance target must be quantifiable,
53.25 objective, measurable, and reasonably attainable, except in the case of a performance target
53.26 based on a federal or state law or rule. Criteria for assessment of each performance target
53.27 must be outlined in writing prior to the contract effective date. The managed care plan
53.28 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
53.29 attainment of the performance target is accurate. The commissioner shall periodically
53.30 change the administrative measures used as performance targets in order to improve plan
53.31 performance across a broader range of administrative services. The performance targets
53.32 must include measurement of plan efforts to contain spending on health care services and
53.33 administrative activities. The commissioner may adopt plan-specific performance targets
53.34 that take into account factors affecting only one plan, such as characteristics of the plan's
53.35 enrollee population. The withheld funds must be returned no sooner than July 1 and no

54.1 later than July 31 of the following calendar year if performance targets in the contract are
 54.2 achieved. ~~A managed care plan or a county-based purchasing plan under section 256B.692~~
 54.3 ~~may include as admitted assets under section 62D.044 any amount withheld under this~~
 54.4 ~~paragraph that is reasonably expected to be returned.~~

54.5 (d) For services rendered on or after January 1, 2011, the commissioner shall
 54.6 withhold an additional three percent of managed care plan payments under this section.
 54.7 The withheld funds must be returned no sooner than July 1, and no later than July 31 of
 54.8 the following calendar year. The return of the withhold under this paragraph is not subject
 54.9 to the requirements of paragraph (b) or (c).

54.10 (e) A managed care plan or a county-based purchasing plan under section 256B.692
 54.11 may include as admitted assets under section 62D.044 any amount withheld under this
 54.12 section.

54.13 Sec. 51. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:

54.14 Subdivision 1. **Medical assistance coverage.** The commissioner of human services
 54.15 shall establish a demonstration project to provide additional medical assistance coverage
 54.16 for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth
 54.17 who are burdened by health disparities associated with the cumulative health impact
 54.18 of toxic environmental exposures. Under this demonstration project, the additional
 54.19 medical assistance coverage for this population must include, but is not limited to, home
 54.20 environmental assessments for triggers of asthma, in-home asthma education on the proper
 54.21 medical management of asthma by a certified asthma educator or public health nurse with
 54.22 asthma management training limited to two visits per child. Coverage also includes the
 54.23 following durable medical equipment: high efficiency particulate air (HEPA) cleaners,
 54.24 HEPA vacuum cleaners, allergy bed and pillow encasements, high filtration filters for
 54.25 forced air gas furnaces, and dehumidifiers with medical tubing to connect the appliance to
 54.26 a floor drain, if the listed item is medically ~~necessary~~ useful to reduce asthma symptoms.
 54.27 Provision of these items of durable medical equipment must be preceded by a home
 54.28 environmental assessment for triggers of asthma and in-home asthma education on the
 54.29 proper medical management of asthma by a Certified Asthma Educator or public health
 54.30 nurse with asthma management training.

54.31 Sec. 52. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

54.32 Subd. 5. **Expiration.** This section, with the exception of subdivision 4, expires
 54.33 ~~December 31, 2010~~ August 31, 2011. Subdivision 4 expires February 28, 2012.

55.1 Sec. 53. Laws 2010, chapter 200, article 1, section 12, subdivision 6, is amended to
55.2 read:

55.3 Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the
55.4 commissioner shall contract with hospitals or groups of hospitals that qualify under
55.5 paragraph (b) and agree to deliver services according to this subdivision. Contracting
55.6 hospitals shall develop and implement a coordinated care delivery system to provide health
55.7 care services to individuals who are eligible for general assistance medical care under this
55.8 section and who either choose to receive services through the coordinated care delivery
55.9 system or who are enrolled by the commissioner under paragraph (c). A contracting
55.10 hospital may negotiate a limit to the number of general assistance medical care enrollees it
55.11 serves, but must comply with the emergency care requirements of United States Code, title
55.12 42, 1395dd (EMTALA). The health care services provided by the system must include:
55.13 (1) the services described in subdivision 4 with the exception of outpatient prescription
55.14 drug coverage but shall include drugs administered in a clinic or other outpatient setting;
55.15 or (2) a set of comprehensive and medically necessary health services that the recipients
55.16 might reasonably require to be maintained in good health and that has been approved by
55.17 the commissioner, including at a minimum, but not limited to, emergency care, medical
55.18 transportation services, inpatient hospital and physician care, outpatient health services,
55.19 preventive health services, mental health services, and prescription drugs administered
55.20 in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered
55.21 on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded
55.22 under subdivision 9. A hospital establishing a coordinated care delivery system under this
55.23 subdivision must ensure that the requirements of this subdivision are met.

55.24 (b) A hospital or group of hospitals may contract with the commissioner to develop
55.25 and implement a coordinated care delivery system as follows:

55.26 (1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during
55.27 calendar year 2008, it received fee-for-service payments for services to general assistance
55.28 medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater
55.29 than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to
55.30 provide geographic access or to ensure that at least 80 percent of enrollees have access to
55.31 a coordinated care delivery system; and

55.32 (2) effective December 1, 2010, a Minnesota hospital not qualified under clause
55.33 (1) may contract with the commissioner under this subdivision if it agrees to satisfy the
55.34 requirements of this subdivision.

56.1 ~~Participation by hospitals shall become effective quarterly on June 1, September 1,~~
56.2 ~~December 1, or March 1. Hospital participation is effective for a period of 12 months and~~
56.3 ~~may be renewed for successive 12-month periods.~~

56.4 Coordinated care delivery system contracts are in effect from June 1, 2010, to
56.5 December 31, 2010, or to the effective date of the expansion of medical assistance
56.6 coverage to include adults without children, whichever is later.

56.7 (c) Applicants and recipients may enroll in any available coordinated care delivery
56.8 system statewide. If more than one coordinated care delivery system is available, the
56.9 applicant or recipient shall be allowed to choose among the systems that provide services
56.10 within 25 miles of the individual's community of residence. The commissioner may assign
56.11 an applicant or recipient to a coordinated care delivery system that provides services
56.12 within 25 miles of the individual's community of residence, if no choice is made by the
56.13 applicant or recipient. The commissioner shall consider a recipient's zip code, city of
56.14 residence, county of residence, or distance from a participating coordinated care delivery
56.15 system when determining default assignment. An applicant or recipient may decline
56.16 enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care
56.17 delivery system, the recipient must agree to receive all nonemergency services through the
56.18 coordinated care delivery system. Enrollment in a coordinated care delivery system is
56.19 for six months and may be renewed for additional six-month periods, except that initial
56.20 enrollment is for six months or until the end of a recipient's period of general assistance
56.21 medical care eligibility, whichever occurs first. A recipient who continues to meet the
56.22 eligibility requirements of this section is not eligible to enroll in MinnesotaCare during
56.23 a period of enrollment in a coordinated care delivery system. From June 1, 2010, to
56.24 November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery
56.25 system may seek services from a hospital eligible for reimbursement under the temporary
56.26 uncompensated care pool established under subdivision 8. After November 30, 2010,
56.27 services are available only through a coordinated care delivery system.

56.28 (d) A hospital must provide access to cost-effective outpatient services available
56.29 in its service area. The hospital may contract and coordinate with providers and clinics
56.30 for the delivery of services and shall contract with federally qualified health centers and
56.31 essential community providers as defined under section 62Q.19, subdivision 1, paragraph
56.32 (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a
56.33 hospital to provide services through the coordinated care delivery system, the provider
56.34 may not refuse to provide services to any recipient enrolled in the system, and payment for
56.35 services shall be negotiated with the hospital and paid by the hospital from the system's
56.36 allocation under subdivision 7.

57.1 (e) A coordinated care delivery system must:

57.2 (1) provide the covered services required under paragraph (a) to recipients enrolled
57.3 in the coordinated care delivery system, and comply with the requirements of subdivision
57.4 4, paragraphs (b) to (g);

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

57.7 (3) in cooperation with counties, coordinate the delivery of health care services with
57.8 existing homeless prevention, supportive housing, and rent subsidy programs and funding
57.9 administered by the Minnesota Housing Finance Agency under chapter 462A; and

57.10 (4) adopt innovative and cost-effective methods of care delivery and coordination,
57.11 which may include the use of allied health professionals, telemedicine, patient educators,
57.12 care coordinators, and community health workers.

57.13 (f) The hospital may require a recipient to designate a primary care provider or
57.14 a primary care clinic. The hospital may limit the delivery of services to a network of
57.15 providers who have contracted with the hospital to deliver services in accordance with
57.16 this subdivision, and require a recipient to seek services only within this network. The
57.17 hospital may also require a referral to a provider before the service is eligible for payment.
57.18 A coordinated care delivery system is not required to provide payment to a provider who
57.19 is not employed by or under contract with the system for services provided to a recipient
57.20 enrolled in the system; ~~except in cases of an emergency. For purposes of this section,~~
57.21 ~~emergency services are defined in accordance with Code of Federal Regulations, title~~
57.22 ~~42, section 438.114 (a).~~

57.23 (g) A recipient enrolled in a coordinated care delivery system has the right to appeal
57.24 to the commissioner according to section 256.045.

57.25 (h) The state shall not be liable for the payment of any cost or obligation incurred
57.26 by the coordinated care delivery system.

57.27 (i) The hospital must provide the commissioner with data necessary for assessing
57.28 enrollment, quality of care, cost, and utilization of services. Each hospital must provide,
57.29 on a quarterly basis on a form prescribed by the commissioner for each recipient served by
57.30 the coordinated care delivery system, the services provided, the cost of services provided,
57.31 and the actual payment amount for the services provided and any other information the
57.32 commissioner deems necessary to claim federal Medicaid match. The commissioner must
57.33 provide this data to the legislature on a quarterly basis.

57.34 (j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2,
57.35 paragraph (b), do not apply to general assistance medical care provided under this section.

58.1 (k) If a recipient is transferred from a hospital that is not participating in a
58.2 coordinated care delivery system to a hospital participating in a coordinated care delivery
58.3 system, in order to receive a higher level of care, the transferring hospital remains eligible
58.4 to receive any available funding through the temporary uncompensated care pool for the
58.5 care initially provided at that hospital. The hospital participating in the coordinated care
58.6 delivery system shall be responsible only for care provided at that hospital, and is not
58.7 financially liable for the initial care provided by the transferring hospital.

58.8 Sec. 54. Laws 2010, chapter 200, article 1, section 12, subdivision 7, is amended to
58.9 read:

58.10 **Subd. 7. Payments; rate setting for the hospital coordinated care delivery**
58.11 **system.** (a) Effective for general assistance medical care services, with the exception
58.12 of outpatient prescription drug coverage, provided on or after June 1, 2010, through a
58.13 coordinated care delivery system, the commissioner shall allocate the annual appropriation
58.14 for the coordinated care delivery system to hospitals participating under subdivision
58.15 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1,
58.16 2010. The payment shall be allocated among all hospitals qualified to participate on the
58.17 allocation date. Each hospital or group of hospitals shall receive a pro rata share of the
58.18 allocation based on the hospital's or group of hospitals' calendar year 2008 payments for
58.19 general assistance medical care services, adjusted for any limits on the number of general
58.20 assistance medical care enrollees accepted by a hospital, provided that, for the purposes of
58.21 this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint
58.22 Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be
58.23 weighted at 110 percent of the actual amount. The commissioner may prospectively
58.24 reallocate payments to participating hospitals on a biannual basis to ensure that final
58.25 allocations reflect actual coordinated care delivery system enrollment. The 2008 base year
58.26 shall be updated by one calendar year each June 1, beginning June 1, 2011.

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

58.31 ~~(b)~~ (c) In order to be reimbursed under this section, nonhospital providers of health
58.32 care services shall contract with one or more hospitals described in paragraph (a) to
58.33 provide services to general assistance medical care recipients through the coordinated care
58.34 delivery system established by the hospital. The hospital shall reimburse bills submitted

59.1 by nonhospital providers participating under this paragraph at a rate negotiated between
59.2 the hospital and the nonhospital provider.

59.3 ~~(e)~~ (d) The commissioner shall apply for federal matching funds under section
59.4 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

59.5 ~~(d)~~ (e) Outpatient prescription drug coverage is provided in accordance with section
59.6 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

59.7 Sec. 55. Laws 2010, chapter 200, article 1, section 12, subdivision 8, is amended to
59.8 read:

59.9 Subd. 8. **Temporary uncompensated care pool.** (a) The commissioner shall
59.10 establish a temporary uncompensated care pool, effective June 1, 2010. Payments from
59.11 the pool must be distributed, within the limits of the available appropriation, to hospitals
59.12 that are not part of a coordinated care delivery system established under subdivision
59.13 6. Payments from the pool must also be distributed, within the limits of the available
59.14 appropriation, to ambulance services licensed under chapter 144E that respond to a request
59.15 for an emergency ambulance call or interfacility transfer for a general assistance medical
59.16 care enrollee, if the call or transfer originates from a location more than 25 miles from the
59.17 health care facility that receives the enrollee.

59.18 (b) Hospitals seeking reimbursement from this pool must submit an invoice to
59.19 the commissioner in a form prescribed by the commissioner for payment for services
59.20 provided to an applicant or recipient not enrolled in a coordinated care delivery system. A
59.21 payment amount, as calculated under current law, must be determined, but not paid, for
59.22 each admission of or service provided to a general assistance medical care recipient on or
59.23 after June 1, 2010, to ~~November 30~~ December 31, 2010.

59.24 (c) The aggregated payment amounts for each hospital must be calculated as a
59.25 percentage of the total calculated amount for all hospitals.

59.26 (d) Distributions from the uncompensated care pool for each hospital must be
59.27 determined by multiplying the factor in paragraph (c) by the amount of money in the
59.28 uncompensated care pool that is available for the six-month period.

59.29 (e) The commissioner shall apply for federal matching funds under section
59.30 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

59.31 (f) Outpatient prescription drugs are not eligible for payment under this subdivision.

59.32 Sec. 56. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to
59.33 read:

60.1 **EFFECTIVE DATE.** This section is effective for services rendered on or after April
60.2 1, 2010, except that subdivision 3, paragraph (e), regarding MinnesotaCare eligibility, and
60.3 subdivision 4 are effective June 1, 2010.

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

60.5 Sec. 57. Laws 2010, chapter 200, article 1, section 13, subdivision 1b, is amended to
60.6 read:

60.7 Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September
60.8 1, 2006, county agencies shall enroll single adults and households with no children
60.9 formerly enrolled in general assistance medical care in MinnesotaCare according to
60.10 Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies
60.11 shall perform all duties necessary to administer the MinnesotaCare program ongoing for
60.12 these enrollees, including the redetermination of MinnesotaCare eligibility at renewal,
60.13 through January 1, 2011, or implementation of medical assistance for adults without
60.14 children under section 256B.055, subdivision 15, whichever is later.

60.15 **EFFECTIVE DATE.** This section is effective January 1, 2011.

60.16 Sec. 58. Laws 2010, chapter 200, article 1, section 16, is amended to read:

60.17 Sec. 16. Minnesota Statutes 2008, section 256L.05, subdivision 3c, is amended to
60.18 read:

60.19 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
60.20 date of coverage shall be the first day of the month following termination from medical
60.21 assistance for families and individuals who are eligible for MinnesotaCare and who
60.22 submitted a written request for retroactive MinnesotaCare coverage with a completed
60.23 application within 30 days of the mailing of notification of termination from medical
60.24 assistance. The applicant must provide all required verifications within 30 days of the
60.25 written request for verification. For retroactive coverage, premiums must be paid in full
60.26 for any retroactive month, current month, and next month within 30 days of the premium
60.27 billing. General assistance medical care recipients may qualify for retroactive coverage
60.28 under this subdivision at six-month renewal.

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

60.30 Sec. 59. Laws 2010, chapter 200, article 1, section 21, is amended to read:

60.31 Sec. 21. **REPEALER.**

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

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

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

61.7 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
61.8 3, are repealed effective for federal fiscal year 2010.

61.9 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
61.10 4; and 256L.17, subdivision 7, are repealed January 1, 2011.

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

61.12 Sec. 60. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

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

61.14 Appropriations by Fund

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

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

61.21 **Special Revenue Fund Transfers.**

61.22 (1) The commissioner shall transfer the
61.23 following amounts from special revenue
61.24 fund balances to the general fund by June
61.25 30 of each respective fiscal year: \$410,000
61.26 for fiscal year 2010, and \$412,000 for fiscal
61.27 year 2011.

61.28 (2) Actual transfers made under clause (1)
61.29 must be separately identified and reported as
61.30 part of the quarterly reporting of transfers
61.31 to the chairs of the relevant senate budget
61.32 division and house of representatives finance
61.33 division.

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

62.2 Sec. 61. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

62.3 Subd. 8. **Transfers**

62.4 The commissioner must transfer \$29,538,000
62.5 in fiscal year 2010 and \$18,462,000 in fiscal
62.6 year 2011 from the health care access fund to
62.7 the general fund. This is a onetime transfer.

62.8 The commissioner must transfer \$4,800,000
62.9 from the consolidated chemical dependency
62.10 treatment fund to the general fund by June
62.11 30, 2010.

62.12 **Compulsive Gambling ~~Special Revenue~~**

62.13 **Administration.** The lottery prize fund
62.14 appropriation for compulsive gambling
62.15 administration is reduced by \$6,000 for fiscal
62.16 year 2010 and \$4,000 for fiscal year 2011
62.17 ~~must be transferred from the lottery prize~~
62.18 ~~fund appropriation for compulsive gambling~~
62.19 ~~administration to the general fund by June~~
62.20 ~~30 of each respective fiscal year. These are~~
62.21 onetime reductions.

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

62.23 Sec. 62. **EARLY EXPANSION.**

62.24 All costs related to implementation of Minnesota Statutes, sections 256B.055,
62.25 subdivision 15, and 256B.056, subdivision 4, paragraph (e), shall be paid from the health
62.26 care access fund.

62.27 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
62.28 approval.

62.29 Sec. 63. **FISCAL AND ACTUARIAL ANALYSIS.**

62.30 The commissioner of human services shall offer a request for proposal and accept
62.31 bids for the completion of a complete fiscal and actuarial analysis of 2010 House File 135

63.1 and 2010 Senate File 118. The commissioner shall report this analysis to the chairs of the
63.2 health and human services finance and policy divisions in the house of representatives and
63.3 senate no later than December 15, 2010.

63.4 Sec. 64. **REPEALER; TRANSFER.**

63.5 (a) Laws 2010, chapter 200, article 1, section 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8,
63.6 and 9, are repealed.

63.7 (b) Laws 2010, chapter 200, article 1, sections 18; and 19, are repealed.

63.8 (c) Minnesota Statutes 2008, section 256D.03, subdivisions 3a, 3b, 5, 6, 7, and 8,
63.9 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, are repealed.

63.10 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective 30 days after federal
63.11 approval of the amendments in this article to Minnesota Statutes, sections 256B.055,
63.12 subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later,
63.13 and all remaining unspent appropriations for the program established by Laws 2010,
63.14 chapter 200, are transferred to the health care access fund. Paragraph (c) is effective
63.15 30 days after federal approval of the amendments in this article to Minnesota Statutes,
63.16 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011,
63.17 whichever is later.

63.18 **ARTICLE 3**

63.19 **CONTINUING CARE**

63.20 Section 1. Minnesota Statutes 2009 Supplement, section 252.27, subdivision 2a,
63.21 is amended to read:

63.22 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
63.23 child, including a child determined eligible for medical assistance without consideration of
63.24 parental income, must contribute to the cost of services used by making monthly payments
63.25 on a sliding scale based on income, unless the child is married or has been married,
63.26 parental rights have been terminated, or the child's adoption is subsidized according to
63.27 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
63.28 is a partial or full payment for medical services provided for diagnostic, therapeutic,
63.29 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
63.30 defined in United States Code, title 26, section 213, needed by the child with a chronic
63.31 illness or disability.

64.1 (b) For households with adjusted gross income equal to or greater than 100 percent
64.2 of federal poverty guidelines, the parental contribution shall be computed by applying the
64.3 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

64.4 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
64.5 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
64.6 contribution is \$4 per month;

64.7 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
64.8 poverty guidelines and less than or equal to 545 percent of federal poverty guidelines,
64.9 the parental contribution shall be determined using a sliding fee scale established by the
64.10 commissioner of human services which begins at one percent of adjusted gross income
64.11 at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted
64.12 gross income for those with adjusted gross income up to 545 percent of federal poverty
64.13 guidelines; and

64.14 (3) if the adjusted gross income is greater than 545 percent of federal poverty
64.15 guidelines ~~and less than 675 percent of federal poverty guidelines~~, the parental
64.16 contribution shall be ~~7.5~~ 12.5 percent of adjusted gross income;

64.17 ~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal~~
64.18 ~~poverty guidelines and less than 975 percent of federal poverty guidelines, the parental~~
64.19 ~~contribution shall be determined using a sliding fee scale established by the commissioner~~
64.20 ~~of human services which begins at 7.5 percent of adjusted gross income at 675 percent of~~
64.21 ~~federal poverty guidelines and increases to ten percent of adjusted gross income for those~~
64.22 ~~with adjusted gross income up to 975 percent of federal poverty guidelines; and~~

64.23 ~~(5) if the adjusted gross income is equal to or greater than 975 percent of federal~~
64.24 ~~poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross~~
64.25 ~~income.~~

64.26 If the child lives with the parent, the annual adjusted gross income is reduced by
64.27 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
64.28 specified in section 256B.35, the parent is responsible for the personal needs allowance
64.29 specified under that section in addition to the parental contribution determined under this
64.30 section. The parental contribution is reduced by any amount required to be paid directly to
64.31 the child pursuant to a court order, but only if actually paid.

64.32 (c) The household size to be used in determining the amount of contribution under
64.33 paragraph (b) includes natural and adoptive parents and their dependents, including the
64.34 child receiving services. Adjustments in the contribution amount due to annual changes
64.35 in the federal poverty guidelines shall be implemented on the first day of July following
64.36 publication of the changes.

65.1 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
65.2 natural or adoptive parents determined according to the previous year's federal tax form,
65.3 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
65.4 have been used to purchase a home shall not be counted as income.

65.5 (e) The contribution shall be explained in writing to the parents at the time eligibility
65.6 for services is being determined. The contribution shall be made on a monthly basis
65.7 effective with the first month in which the child receives services. Annually upon
65.8 redetermination or at termination of eligibility, if the contribution exceeded the cost of
65.9 services provided, the local agency or the state shall reimburse that excess amount to
65.10 the parents, either by direct reimbursement if the parent is no longer required to pay a
65.11 contribution, or by a reduction in or waiver of parental fees until the excess amount is
65.12 exhausted. All reimbursements must include a notice that the amount reimbursed may be
65.13 taxable income if the parent paid for the parent's fees through an employer's health care
65.14 flexible spending account under the Internal Revenue Code, section 125, and that the
65.15 parent is responsible for paying the taxes owed on the amount reimbursed.

65.16 (f) The monthly contribution amount must be reviewed at least every 12 months;
65.17 when there is a change in household size; and when there is a loss of or gain in income
65.18 from one month to another in excess of ten percent. The local agency shall mail a written
65.19 notice 30 days in advance of the effective date of a change in the contribution amount.
65.20 A decrease in the contribution amount is effective in the month that the parent verifies a
65.21 reduction in income or change in household size.

65.22 (g) Parents of a minor child who do not live with each other shall each pay the
65.23 contribution required under paragraph (a). An amount equal to the annual court-ordered
65.24 child support payment actually paid on behalf of the child receiving services shall be
65.25 deducted from the adjusted gross income of the parent making the payment prior to
65.26 calculating the parental contribution under paragraph (b).

65.27 (h) The contribution under paragraph (b) shall be increased by an additional five
65.28 percent if the local agency determines that insurance coverage is available but not
65.29 obtained for the child. For purposes of this section, "available" means the insurance is a
65.30 benefit of employment for a family member at an annual cost of no more than five percent
65.31 of the family's annual income. For purposes of this section, "insurance" means health
65.32 and accident insurance coverage, enrollment in a nonprofit health service plan, health
65.33 maintenance organization, self-insured plan, or preferred provider organization.

65.34 Parents who have more than one child receiving services shall not be required
65.35 to pay more than the amount for the child with the highest expenditures. There shall
65.36 be no resource contribution from the parents. The parent shall not be required to pay

66.1 a contribution in excess of the cost of the services provided to the child, not counting
 66.2 payments made to school districts for education-related services. Notice of an increase in
 66.3 fee payment must be given at least 30 days before the increased fee is due.

66.4 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if,
 66.5 in the 12 months prior to July 1:

66.6 (1) the parent applied for insurance for the child;

66.7 (2) the insurer denied insurance;

66.8 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
 66.9 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
 66.10 commerce, or litigated the complaint or appeal; and

66.11 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

66.12 For purposes of this section, "insurance" has the meaning given in paragraph (h).

66.13 A parent who has requested a reduction in the contribution amount under this
 66.14 paragraph shall submit proof in the form and manner prescribed by the commissioner or
 66.15 county agency, including, but not limited to, the insurer's denial of insurance, the written
 66.16 letter or complaint of the parents, court documents, and the written response of the insurer
 66.17 approving insurance. The determinations of the commissioner or county agency under this
 66.18 paragraph are not rules subject to chapter 14.

66.19 **Sec. 2. [256.4825] REPORT REGARDING PROGRAMS AND SERVICES FOR**
 66.20 **PEOPLE WITH DISABILITIES.**

66.21 The Minnesota State Council on Disability, the Minnesota Consortium for Citizens
 66.22 with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of
 66.23 each year, beginning in 2012, to the chairs and ranking minority members of the legislative
 66.24 committees with jurisdiction over programs serving people with disabilities as provided in
 66.25 this section. The report must describe the existing state policies and goals for programs
 66.26 serving people with disabilities including, but not limited to, programs for employment,
 66.27 transportation, housing, education, quality assurance, consumer direction, physical and
 66.28 programmatic access, and health. The report must provide data and measurements to
 66.29 assess the extent to which the policies and goals are being met. The commissioner of
 66.30 human services and the commissioners of other state agencies administering programs for
 66.31 people with disabilities shall cooperate with the Minnesota State Council on Disability,
 66.32 the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and
 66.33 provide those organizations with existing published information and reports that will assist
 66.34 in the preparation of the report.

67.1 Sec. 3. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

67.2 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
67.3 for a person who is employed and who:

67.4 (1) but for excess earnings or assets, meets the definition of disabled under the
67.5 supplemental security income program;

67.6 (2) is at least 16 but less than 65 years of age;

67.7 (3) meets the asset limits in paragraph (c); and

67.8 (4) ~~effective November 1, 2003~~, pays a premium and other obligations under
67.9 paragraph (e).

67.10 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
67.11 determinations.

67.12 (b) After the month of enrollment, a person enrolled in medical assistance under
67.13 this subdivision who:

67.14 (1) is temporarily unable to work and without receipt of earned income due to a
67.15 medical condition, as verified by a physician, may retain eligibility for up to four calendar
67.16 months; or

67.17 (2) effective January 1, 2004, loses employment for reasons not attributable to the
67.18 enrollee, may retain eligibility for up to four consecutive months after the month of job
67.19 loss. To receive a four-month extension, enrollees must verify the medical condition or
67.20 provide notification of job loss. All other eligibility requirements must be met and the
67.21 enrollee must pay all calculated premium costs for continued eligibility.

67.22 (c) For purposes of determining eligibility under this subdivision, a person's assets
67.23 must not exceed \$20,000, excluding:

67.24 (1) all assets excluded under section 256B.056;

67.25 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
67.26 Keogh plans, and pension plans; and

67.27 (3) medical expense accounts set up through the person's employer.

67.28 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a \$65
67.29 earned income disregard. To be eligible, a person applying for medical assistance under
67.30 this subdivision must have earned income above the disregard level.

67.31 (2) Effective January 1, 2004, to be considered earned income, Medicare, Social
67.32 Security, and applicable state and federal income taxes must be withheld. To be eligible,
67.33 a person must document earned income tax withholding.

67.34 (e)(1) A person whose earned and unearned income is equal to or greater than 100
67.35 percent of federal poverty guidelines for the applicable family size must pay a premium
67.36 to be eligible for medical assistance under this subdivision. The premium shall be based

68.1 on the person's gross earned and unearned income and the applicable family size using a
68.2 sliding fee scale established by the commissioner, which begins at one percent of income
68.3 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
68.4 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual
68.5 adjustments in the premium schedule based upon changes in the federal poverty guidelines
68.6 shall be effective for premiums due in July of each year.

68.7 (2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for
68.8 medical assistance under this subdivision. An enrollee shall pay the greater of a ~~\$35~~ \$50
68.9 premium or the premium calculated in clause (1).

68.10 (3) Effective November 1, 2003, all enrollees who receive unearned income must
68.11 pay ~~one-half of one~~ 2.5 percent of unearned income in addition to the premium amount.

68.12 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
68.13 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
68.14 commissioner must reimburse the enrollee for Medicare Part B premiums under section
68.15 256B.0625, subdivision 15, paragraph (a).

68.16 (5) Increases in benefits under title II of the Social Security Act shall not be counted
68.17 as income for purposes of this subdivision until July 1 of each year.

68.18 (f) A person's eligibility and premium shall be determined by the local county
68.19 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
68.20 the commissioner.

68.21 (g) Any required premium shall be determined at application and redetermined at
68.22 the enrollee's six-month income review or when a change in income or household size is
68.23 reported. Enrollees must report any change in income or household size within ten days
68.24 of when the change occurs. A decreased premium resulting from a reported change in
68.25 income or household size shall be effective the first day of the next available billing month
68.26 after the change is reported. Except for changes occurring from annual cost-of-living
68.27 increases, a change resulting in an increased premium shall not affect the premium amount
68.28 until the next six-month review.

68.29 (h) Premium payment is due upon notification from the commissioner of the
68.30 premium amount required. Premiums may be paid in installments at the discretion of
68.31 the commissioner.

68.32 (i) Nonpayment of the premium shall result in denial or termination of medical
68.33 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
68.34 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
68.35 D, are met. Except when an installment agreement is accepted by the commissioner,
68.36 all persons disenrolled for nonpayment of a premium must pay any past due premiums

69.1 as well as current premiums due prior to being reenrolled. Nonpayment shall include
69.2 payment with a returned, refused, or dishonored instrument. The commissioner may
69.3 require a guaranteed form of payment as the only means to replace a returned, refused,
69.4 or dishonored instrument.

69.5 (j) The commissioner shall notify enrollees annually beginning at least 24 months
69.6 before the person's 65th birthday of the medical assistance eligibility rules affecting
69.7 income, assets, and treatment of a spouse's income and assets that will be applied upon
69.8 reaching age 65.

69.9 **EFFECTIVE DATE.** The amendments to paragraph (e) are effective July 1, 2011.
69.10 The amendments to all other paragraphs in this section are effective January 1, 2011.

69.11 Sec. 4. Minnesota Statutes 2009 Supplement, section 256B.0915, subdivision 3a,
69.12 is amended to read:

69.13 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
69.14 waived services to an individual elderly waiver client except for individuals described
69.15 in paragraph (b) shall be the weighted average monthly nursing facility rate of the case
69.16 mix resident class to which the elderly waiver client would be assigned under Minnesota
69.17 Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance
69.18 as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in
69.19 which the resident assessment system as described in section 256B.438 for nursing home
69.20 rate determination is implemented. Effective on the first day of the state fiscal year in
69.21 which the resident assessment system as described in section 256B.438 for nursing home
69.22 rate determination is implemented and the first day of each subsequent state fiscal year, the
69.23 monthly limit for the cost of waived services to an individual elderly waiver client shall
69.24 be the rate of the case mix resident class to which the waiver client would be assigned
69.25 under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the
69.26 previous state fiscal year, adjusted by ~~the greater of any legislatively adopted home and~~
69.27 ~~community-based services percentage rate increase or the average statewide percentage~~
69.28 ~~increase in nursing facility payment rates~~ adjustment.

69.29 (b) The monthly limit for the cost of waived services to an individual elderly
69.30 waiver client assigned to a case mix classification A under paragraph (a) with (1) no
69.31 dependencies in activities of daily living, (2) only one dependency in bathing, dressing,
69.32 grooming, or walking, or (3) a dependency score of less than three if eating is the only
69.33 dependency, shall be the lower of the case mix classification amount for case mix A as
69.34 determined under paragraph (a) or the case mix classification amount for case mix A
69.35 effective on October 1, 2008, per month for all new participants enrolled in the program

70.1 on or after July 1, 2009. This monthly limit shall be applied to all other participants who
70.2 meet this criteria at reassessment.

70.3 (c) If extended medical supplies and equipment or environmental modifications are
70.4 or will be purchased for an elderly waiver client, the costs may be prorated for up to
70.5 12 consecutive months beginning with the month of purchase. If the monthly cost of a
70.6 recipient's waived services exceeds the monthly limit established in paragraph (a) or
70.7 (b), the annual cost of all waived services shall be determined. In this event, the annual
70.8 cost of all waived services shall not exceed 12 times the monthly limit of waived
70.9 services as described in paragraph (a) or (b).

70.10 Sec. 5. Minnesota Statutes 2008, section 256B.0915, subdivision 3b, is amended to
70.11 read:

70.12 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing**
70.13 **facility.** (a) For a person who is a nursing facility resident at the time of requesting a
70.14 determination of eligibility for elderly waived services, a monthly conversion limit for
70.15 the cost of elderly waived services may be requested. The monthly conversion limit for
70.16 the cost of elderly waiver services shall be the resident class assigned under Minnesota
70.17 Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where
70.18 the resident currently resides until July 1 of the state fiscal year in which the resident
70.19 assessment system as described in section 256B.438 for nursing home rate determination
70.20 is implemented. Effective on July 1 of the state fiscal year in which the resident
70.21 assessment system as described in section 256B.438 for nursing home rate determination
70.22 is implemented, the monthly conversion limit for the cost of elderly waiver services shall
70.23 be the per diem nursing facility rate as determined by the resident assessment system as
70.24 described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the
70.25 resident currently resides, but in effect on June 30, 2010, and adjusted annually by any
70.26 legislatively adopted percentage change in the elderly waiver services rates. That per
70.27 diem shall be multiplied by 365 and, divided by 12, less and reduced by the recipient's
70.28 maintenance needs allowance as described in subdivision 1d. The initially approved
70.29 conversion rate ~~may~~ must be adjusted by ~~the greater of~~ any subsequent legislatively
70.30 adopted home and community-based services percentage rate ~~increase or the average~~
70.31 ~~statewide percentage increase in nursing facility payment rates~~ adjustment. The limit
70.32 under this subdivision only applies to persons discharged from a nursing facility after a
70.33 minimum 30-day stay and found eligible for waived services on or after July 1, 1997.
70.34 For conversions from the nursing home to the elderly waiver with consumer directed
70.35 community support services, the conversion rate limit is equal to the nursing facility rate

71.1 reduced by a percentage equal to the percentage difference between the consumer directed
71.2 services budget limit that would be assigned according to the federally approved waiver
71.3 plan and the corresponding community case mix cap, but not to exceed 50 percent.

71.4 (b) The following costs must be included in determining the total monthly costs
71.5 for the waiver client:

71.6 (1) cost of all waived services, including ~~extended medical~~ specialized supplies
71.7 and equipment and environmental ~~modifications and~~ accessibility adaptations; and

71.8 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
71.9 by medical assistance.

71.10 Sec. 6. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is
71.11 amended to read:

71.12 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
71.13 commissioner may implement demonstration projects to create alternative integrated
71.14 delivery systems for acute and long-term care services to elderly persons and persons
71.15 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
71.16 coordination, improve access to quality services, and mitigate future cost increases.
71.17 The commissioner may seek federal authority to combine Medicare and Medicaid
71.18 capitation payments for the purpose of such demonstrations and may contract with
71.19 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
71.20 services shall be administered according to the terms and conditions of the federal contract
71.21 and demonstration provisions. For the purpose of administering medical assistance funds,
71.22 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
71.23 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
71.24 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
71.25 items B and C, which do not apply to persons enrolling in demonstrations under this
71.26 section. An initial open enrollment period may be provided. Persons who disenroll from
71.27 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
71.28 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
71.29 the health plan's participation is subsequently terminated for any reason, the person shall
71.30 be provided an opportunity to select a new health plan and shall have the right to change
71.31 health plans within the first 60 days of enrollment in the second health plan. Persons
71.32 required to participate in health plans under this section who fail to make a choice of
71.33 health plan shall not be randomly assigned to health plans under these demonstrations.
71.34 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
71.35 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,

72.1 the commissioner may contract with managed care organizations, including counties, to
72.2 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
72.3 disabled persons only. For persons with a primary diagnosis of developmental disability,
72.4 serious and persistent mental illness, or serious emotional disturbance, the commissioner
72.5 must ensure that the county authority has approved the demonstration and contracting
72.6 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
72.7 commissioner shall not implement any demonstration project under this subdivision for
72.8 persons with a primary diagnosis of developmental disabilities, serious and persistent
72.9 mental illness, or serious emotional disturbance, without approval of the county board of
72.10 the county in which the demonstration is being implemented.

72.11 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
72.12 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
72.13 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
72.14 under this section projects for persons with developmental disabilities. The commissioner
72.15 may capitate payments for ICF/MR services, waived services for developmental
72.16 disabilities, including case management services, day training and habilitation and
72.17 alternative active treatment services, and other services as approved by the state and by the
72.18 federal government. Case management and active treatment must be individualized and
72.19 developed in accordance with a person-centered plan. Costs under these projects may not
72.20 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
72.21 and until four years after the pilot project implementation date, subcontractor participation
72.22 in the long-term care developmental disability pilot is limited to a nonprofit long-term
72.23 care system providing ICF/MR services, home and community-based waiver services,
72.24 and in-home services to no more than 120 consumers with developmental disabilities in
72.25 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
72.26 prior to expansion of the developmental disability pilot project. This paragraph expires
72.27 four years after the implementation date of the pilot project.

72.28 (c) Before implementation of a demonstration project for disabled persons, the
72.29 commissioner must provide information to appropriate committees of the house of
72.30 representatives and senate and must involve representatives of affected disability groups
72.31 in the design of the demonstration projects.

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

73.1 (e) The commissioner, in consultation with the commissioners of commerce and
73.2 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
73.3 according to federal laws and regulations governing that program and state laws or rules
73.4 applicable to participating providers. ~~The process for approval of these programs shall~~
73.5 ~~begin only after the commissioner receives grant money in an amount sufficient to cover~~
73.6 ~~the state share of the administrative and actuarial costs to implement the programs during~~
73.7 ~~state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an~~
73.8 ~~account in the special revenue fund and are appropriated to the commissioner to be used~~
73.9 ~~solely for the purpose of PACE administrative and actuarial costs.~~ A PACE provider is
73.10 not required to be licensed or certified as a health plan company as defined in section
73.11 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
73.12 and found to be eligible for services under the elderly waiver or community alternatives
73.13 for disabled individuals or who are already eligible for Medicaid but meet level of
73.14 care criteria for receipt of waiver services may choose to enroll in the PACE program.
73.15 Medicare and Medicaid services will be provided according to this subdivision and
73.16 federal Medicare and Medicaid requirements governing PACE providers and programs.
73.17 PACE enrollees will receive Medicaid home and community-based services through the
73.18 PACE provider as an alternative to services for which they would otherwise be eligible
73.19 through home and community-based waiver programs and Medicaid State Plan Services.
73.20 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
73.21 costs that would have been incurred under fee-for-service or other relevant managed care
73.22 programs operated by the state.

73.23 (f) The commissioner shall seek federal approval to expand the Minnesota disability
73.24 health options (MnDHO) program established under this subdivision in stages, first to
73.25 regional population centers outside the seven-county metro area and then to all areas of
73.26 the state. Until July 1, 2009, expansion for MnDHO projects that include home and
73.27 community-based services is limited to the two projects and service areas in effect on
73.28 March 1, 2006. Enrollment in integrated MnDHO programs that include home and
73.29 community-based services shall remain voluntary. Costs for home and community-based
73.30 services included under MnDHO must not exceed costs that would have been incurred
73.31 under the fee-for-service program. Notwithstanding whether expansion occurs under
73.32 this paragraph, in determining MnDHO payment rates and risk adjustment methods ~~for~~
73.33 ~~contract years starting in 2012~~, the commissioner must consider the methods used to
73.34 determine county allocations for home and community-based program participants. If
73.35 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
73.36 for home and community-based services, the commissioner shall achieve the reduction

74.1 by maintaining the base rate for contract ~~years~~ year 2010 ~~and 2011~~ for services provided
 74.2 under the community alternatives for disabled individuals waiver at the same level as for
 74.3 contract year 2009. The commissioner may apply other reductions to MnDHO rates to
 74.4 implement decreases in provider payment rates required by state law. Effective December
 74.5 31, 2010, enrollment and operation of the MnDHO program in effect during calendar year
 74.6 2010 must close. The commissioner may reopen the program provided all applicable
 74.7 conditions of this section are met. In developing program specifications for expansion
 74.8 of integrated programs, the commissioner shall involve and consult the state-level
 74.9 stakeholder group established in subdivision 28, paragraph (d), including consultation on
 74.10 whether and how to include home and community-based waiver programs. Plans for
 74.11 ~~further expansion~~ of MnDHO projects shall be presented to the chairs of the house of
 74.12 representatives and senate committees with jurisdiction over health and human services
 74.13 policy and finance ~~by February 1, 2007~~ prior to any further implementation or expansion.

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

74.18 Sec. 7. Laws 2009, chapter 79, article 8, section 51, the effective date, is amended to
 74.19 read:

74.20 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2011.

74.21 Sec. 8. **CASE MANAGEMENT REFORM.**

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

74.24 (1) define the administrative and the service functions of case management and make
 74.25 changes to improve the funding for administrative functions;

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

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

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

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

75.7 **Sec. 9. COMMISSIONER TO SEEK FEDERAL MATCH.**

75.8 (a) The commissioner of human services shall seek federal financial participation
 75.9 for eligible activity related to fiscal years 2010 and 2011 grants to Advocating Change
 75.10 Together to establish a statewide self-advocacy network for persons with developmental
 75.11 disabilities and for eligible activities under any future grants to the organization.

75.12 (b) The commissioner shall report to the chairs of the senate Health and Human
 75.13 Services Budget Division and the house of representatives Health Care and Human
 75.14 Services Finance Division by December 15, 2010, with the results of the application for
 75.15 federal matching funds.

75.16 **Sec. 10. ICF/MR RATE INCREASE.**

75.17 The daily rate at an intermediate care facility for the developmentally disabled
 75.18 located in Clearwater County and classified as a Class A facility with 15 beds shall be
 75.19 increased from \$112.73 to \$138.23 beginning July 1, 2010.

75.20 **ARTICLE 4**

75.21 **CHILDREN AND FAMILY SERVICES**

75.22 Section 1. Minnesota Statutes 2008, section 119B.025, subdivision 1, is amended to
 75.23 read:

75.24 Subdivision 1. **Factors which must be verified.** (a) The county shall verify the
 75.25 following at all initial child care applications using the universal application:

75.26 (1) identity of adults;

75.27 (2) presence of the minor child in the home, if questionable;

75.28 (3) relationship of minor child to the parent, stepparent, legal guardian, eligible
 75.29 relative caretaker, or the spouses of any of the foregoing;

75.30 (4) age;

75.31 (5) immigration status, if related to eligibility;

75.32 (6) Social Security number, if given;

76.1 (7) income;

76.2 (8) spousal support and child support payments made to persons outside the
76.3 household;

76.4 (9) residence; and

76.5 (10) inconsistent information, if related to eligibility.

76.6 (b) If a family did not use the universal application or child care addendum to apply
76.7 for child care assistance, the family must complete the universal application or child care
76.8 addendum at its next eligibility redetermination and the county must verify the factors
76.9 listed in paragraph (a) as part of that redetermination. Once a family has completed a
76.10 universal application or child care addendum, the county shall use the redetermination
76.11 form described in paragraph (c) for that family's subsequent redeterminations. Eligibility
76.12 must be redetermined at least every six months. For a family where at least one parent is
76.13 under the age of 21, does not have a high school or general equivalency diploma, and is a
76.14 student in a school district or another similar program that provides or arranges for child
76.15 care, as well as parenting, social services, career and employment supports, and academic
76.16 support to achieve high school graduation, the redetermination of eligibility shall be
76.17 deferred beyond six months, but not to exceed 12 months, to the end of the student's
76.18 school year. If a family reports a change in an eligibility factor before the family's next
76.19 regularly scheduled redetermination, the county must recalculate eligibility without
76.20 requiring verification of any eligibility factor that did not change.

76.21 (c) The commissioner shall develop a redetermination form to redetermine eligibility
76.22 and a change report form to report changes that minimize paperwork for the county and
76.23 the participant.

76.24 **EFFECTIVE DATE.** This section is effective October 15, 2010.

76.25 Sec. 2. Minnesota Statutes 2008, section 119B.09, subdivision 4, is amended to read:

76.26 Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant
76.27 family is the current monthly income of the family multiplied by 12 or the income for
76.28 the 12-month period immediately preceding the date of application, or income calculated
76.29 by the method which provides the most accurate assessment of income available to the
76.30 family. Self-employment income must be calculated based on gross receipts less operating
76.31 expenses. Income must be recalculated when the family's income changes, but no less
76.32 often than every six months. For a family where at least one parent is under the age
76.33 of 21, does not have a high school or general equivalency diploma, and is a student in
76.34 a school district or another similar program that provides or arranges for child care,
76.35 as well as parenting, social services, career and employment supports, and academic

77.1 support to achieve high school graduation, income must be recalculated when the family's
 77.2 income changes, but otherwise shall be deferred beyond six months, but not to exceed 12
 77.3 months, to the end of the student's school year. Income must be verified with documentary
 77.4 evidence. If the applicant does not have sufficient evidence of income, verification must
 77.5 be obtained from the source of the income.

77.6 **EFFECTIVE DATE.** This section is effective October 15, 2010.

77.7 Sec. 3. Minnesota Statutes 2008, section 119B.11, subdivision 1, is amended to read:

77.8 Subdivision 1. **County contributions required.** (a) In addition to payments from
 77.9 basic sliding fee child care program participants, each county shall contribute from county
 77.10 tax or other sources a ~~fixed local match~~ maintenance of effort equal to its calendar year
 77.11 1996 required county contribution reduced by the administrative funding loss that would
 77.12 have occurred in state fiscal year 1996 under section 119B.15, except the maintenance of
 77.13 effort for a county must be equal to at least 1.1 percent of the county's basic sliding fee
 77.14 direct services allocation for the previous calendar year and no greater than six percent
 77.15 of the county's basic sliding fee direct services allocation for the previous calendar year.
 77.16 The commissioner shall recover funds from the county as necessary to bring county
 77.17 expenditures into compliance with this subdivision. The commissioner may accept county
 77.18 contributions, including contributions above the ~~fixed local match~~ county maintenance of
 77.19 effort, in order to make state payments.

77.20 (b) The commissioner may accept payments from counties to:

77.21 (1) fulfill the county contribution as required under subdivision 1;

77.22 (2) pay for services authorized under this chapter beyond those paid for with federal
 77.23 or state funds or with the required county contributions; or

77.24 (3) pay for child care services in addition to those authorized under this chapter, as
 77.25 authorized under other federal, state, or local statutes or regulations.

77.26 (c) The county payments must be deposited in an account in the special revenue
 77.27 fund. Money in this account is appropriated to the commissioner for child care assistance
 77.28 under this chapter and other applicable statutes and regulations and is in addition to other
 77.29 state and federal appropriations.

77.30 **EFFECTIVE DATE.** This section is effective January 1, 2011.

77.31 Sec. 4. Minnesota Statutes 2008, section 256D.0515, is amended to read:

77.32 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

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

78.3 ~~(1) their gross income meets the federal Food Stamp requirements under United~~
78.4 ~~States Code, title 7, section 2014(c); and is equal to or less than 165 percent of the federal~~
78.5 ~~poverty guidelines for the same family size.~~

78.6 ~~(2) they have financial resources, excluding vehicles, of less than \$7,000.~~

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

78.8 Sec. 5. Minnesota Statutes 2008, section 256I.05, is amended by adding a subdivision
78.9 to read:

78.10 Subd. 1n. **Supplemental rate; Mahnomen County.** Notwithstanding the
78.11 provisions of this section, beginning July 1, 2009, a county agency shall negotiate a
78.12 supplemental service rate in addition to the rate specified in subdivision 1, not to exceed
78.13 \$753 per month or the existing rate, including any legislative authorized inflationary
78.14 adjustments, for a group residential provider located in Mahnomen County that operates
78.15 a 28-bed facility providing 24-hour care to individuals who are homeless, disabled,
78.16 chemically dependent, mentally ill, or chronically homeless.

78.17 Sec. 6. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

78.18 Subd. 3. **Other property limitations.** To be eligible for MFIP, the equity value of
78.19 all nonexcluded real and personal property of the assistance unit must not exceed \$2,000
78.20 for applicants and \$5,000 for ongoing participants. The value of assets in clauses (1) to
78.21 (19) must be excluded when determining the equity value of real and personal property:

78.22 (1) a licensed vehicle up to a loan value of less than or equal to ~~\$15,000~~ \$7,500. ~~If the~~
78.23 ~~assistance unit owns more than one licensed vehicle, the county agency shall determine the~~
78.24 ~~loan value of all additional vehicles and exclude the combined loan value of less than or~~
78.25 ~~equal to \$7,500.~~ The county agency shall apply any excess loan value as if it were equity
78.26 value to the asset limit described in this section; If the assistance unit owns more than
78.27 one licensed vehicle, the county agency shall determine the vehicle with the highest loan
78.28 value and count only the loan value over \$7,500, excluding: (i) the value of one vehicle
78.29 per physically disabled person when the vehicle is needed to transport the disabled unit
78.30 member; this exclusion does not apply to mentally disabled people; (ii) the value of special
78.31 equipment for a disabled member of the assistance unit; and (iii) any vehicle used for
78.32 long-distance travel, other than daily commuting, for the employment of a unit member.

78.33 The county agency shall count the loan value of all other vehicles and apply this
78.34 amount as if it were equity value to the asset limit described in this section. To establish the

79.1 loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide,
79.2 Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook,
79.3 or when the applicant or participant disputes the loan value listed in the guidebook as
79.4 unreasonable given the condition of the particular vehicle, the county agency may require
79.5 the applicant or participant document the loan value by securing a written statement from
79.6 a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer
79.7 would pay to purchase the vehicle. The county agency shall reimburse the applicant or
79.8 participant for the cost of a written statement that documents a lower loan value;

79.9 (2) the value of life insurance policies for members of the assistance unit;

79.10 (3) one burial plot per member of an assistance unit;

79.11 (4) the value of personal property needed to produce earned income, including
79.12 tools, implements, farm animals, inventory, business loans, business checking and
79.13 savings accounts used at least annually and used exclusively for the operation of a
79.14 self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use
79.15 is to produce income and if the vehicles are essential for the self-employment business;

79.16 (5) the value of personal property not otherwise specified which is commonly
79.17 used by household members in day-to-day living such as clothing, necessary household
79.18 furniture, equipment, and other basic maintenance items essential for daily living;

79.19 (6) the value of real and personal property owned by a recipient of Supplemental
79.20 Security Income or Minnesota supplemental aid;

79.21 (7) the value of corrective payments, but only for the month in which the payment
79.22 is received and for the following month;

79.23 (8) a mobile home or other vehicle used by an applicant or participant as the
79.24 applicant's or participant's home;

79.25 (9) money in a separate escrow account that is needed to pay real estate taxes or
79.26 insurance and that is used for this purpose;

79.27 (10) money held in escrow to cover employee FICA, employee tax withholding,
79.28 sales tax withholding, employee worker compensation, business insurance, property rental,
79.29 property taxes, and other costs that are paid at least annually, but less often than monthly;

79.30 (11) monthly assistance payments for the current month's or short-term emergency
79.31 needs under section 256J.626, subdivision 2;

79.32 (12) the value of school loans, grants, or scholarships for the period they are
79.33 intended to cover;

79.34 (13) payments listed in section 256J.21, subdivision 2, clause (9), which are held
79.35 in escrow for a period not to exceed three months to replace or repair personal or real
79.36 property;

- 80.1 (14) income received in a budget month through the end of the payment month;
- 80.2 (15) savings from earned income of a minor child or a minor parent that are set aside
80.3 in a separate account designated specifically for future education or employment costs;
- 80.4 (16) the federal earned income credit, Minnesota working family credit, state and
80.5 federal income tax refunds, state homeowners and renters credits under chapter 290A,
80.6 property tax rebates and other federal or state tax rebates in the month received and the
80.7 following month;
- 80.8 (17) payments excluded under federal law as long as those payments are held in a
80.9 separate account from any nonexcluded funds;
- 80.10 (18) the assets of children ineligible to receive MFIP benefits because foster care or
80.11 adoption assistance payments are made on their behalf; and
- 80.12 (19) the assets of persons whose income is excluded under section 256J.21,
80.13 subdivision 2, clause (43).

80.14 **EFFECTIVE DATE.** This section is effective March 1, 2011.

80.15 Sec. 7. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

80.16 Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income
80.17 disregard to ensure that most participants do not lose eligibility for MFIP until their
80.18 income reaches at least ~~115~~ 110 percent of the federal poverty guidelines in effect ~~in~~
80.19 ~~October of each fiscal year~~ at the time of the adjustment. The adjustment to the disregard
80.20 shall be based on a household size of three, and the resulting earned income disregard
80.21 percentage must be applied to all household sizes. The adjustment under this subdivision
80.22 must be implemented ~~at the same time as the October food stamp or~~ whenever there is a
80.23 ~~food support cost-of-living~~ adjustment is reflected in the food portion of MFIP transitional
80.24 standard as required under subdivision 5a.

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

80.26 Sec. 8. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

80.27 Subd. 3a. **Rental subsidies; unearned income.** (a) ~~Effective July 1, 2003,~~ The
80.28 county agency shall count ~~\$50~~ \$100 of the value of public and assisted rental subsidies
80.29 provided through the Department of Housing and Urban Development (HUD) as unearned
80.30 income to the cash portion of the MFIP grant. The full amount of the subsidy must be
80.31 counted as unearned income when the subsidy is less than ~~\$50~~ \$100. The income from
80.32 this subsidy shall be budgeted according to section 256J.34.

81.1 (b) The provisions of this subdivision shall not apply to an MFIP assistance unit
81.2 which includes a participant who is:

81.3 (1) age 60 or older;

81.4 (2) a caregiver who is suffering from an illness, injury, or incapacity that has been
81.5 certified by a qualified professional when the illness, injury, or incapacity is expected
81.6 to continue for more than 30 days and prevents the person from obtaining or retaining
81.7 employment; or

81.8 (3) a caregiver whose presence in the home is required due to the illness or
81.9 incapacity of another member in the assistance unit, a relative in the household, or a foster
81.10 child in the household when the illness or incapacity and the need for the participant's
81.11 presence in the home has been certified by a qualified professional and is expected to
81.12 continue for more than 30 days.

81.13 (c) The provisions of this subdivision shall not apply to an MFIP assistance unit
81.14 where the parental caregiver is an SSI recipient.

81.15 (d) Prior to implementing this provision, the commissioner must identify the MFIP
81.16 participants subject to this provision and provide written notice to these participants at
81.17 least 30 days before the first grant reduction. The notice must inform the participant of the
81.18 basis for the potential grant reduction, the exceptions to the provision, if any, and inform
81.19 the participant of the steps necessary to claim an exception. A person who is found not to
81.20 meet one of the exceptions to the provision must be notified and informed of the right to a
81.21 fair hearing under section 256J.40. The notice must also inform the participant that the
81.22 participant may be eligible for a rent reduction resulting from a reduction in the MFIP
81.23 grant and encourage the participant to contact the local housing authority.

81.24 **EFFECTIVE DATE.** This section is effective February 1, 2011.

81.25 Sec. 9. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is
81.26 amended to read:

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

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

81.34 (2) a person who:

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

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

82.11 (3) a person who is determined by a qualified professional to be learning disabled,
82.12 and the condition severely limits the person's ability to obtain or maintain suitable
82.13 employment. For purposes of the initial approval of a learning disability extension, the
82.14 determination must have been made or confirmed within the previous 12 months. In the
82.15 case of a non-English-speaking person: (i) the determination must be made by a qualified
82.16 professional with experience conducting culturally appropriate assessments, whenever
82.17 possible; and (ii) these reports must include a statement of confidence in the results. If a
82.18 rehabilitation plan for a participant extended as learning disabled is developed or approved
82.19 by the county agency, the plan must be incorporated into the employment plan. However,
82.20 a rehabilitation plan does not replace the requirement to develop and comply with an
82.21 employment plan under section 256J.521; or

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

82.24 (b) For purposes of this ~~section~~ chapter, "severely limits the person's ability to obtain
82.25 or maintain suitable employment" means:

82.26 (1) that a qualified professional has determined that the person's condition prevents
82.27 the person from working 20 or more hours per week; or

82.28 (2) for a person who meets the requirements of paragraph (a), clause (2), item (ii), or
82.29 clause (3), a qualified professional has determined the person's condition:

82.30 (i) significantly restricts the range of employment that the person is able to perform;

82.31 or

82.32 (ii) significantly interferes with the person's ability to obtain or maintain suitable
82.33 employment for 20 or more hours per week.

82.34 Sec. 10. **QUALITY RATING SYSTEM TRAINING, COACHING,**
82.35 **CONSULTATION, AND SUPPORTS.**

83.1 The commissioner of human services shall direct \$500,000 in federal child care
 83.2 development funds used for grants under Minnesota Statutes, section 119B.21, in fiscal
 83.3 year 2011 for the purpose of providing statewide child care provider training, coaching,
 83.4 consultation, and supports to prepare for the voluntary Minnesota quality rating system.
 83.5 This is a onetime appropriation. In addition, to the extent that private funds are made
 83.6 available, the commissioner shall designate those funds for this purpose.

83.7 **Sec. 11. CHILD CARE ASSISTANCE REDETERMINATION OF ELIGIBILITY**
 83.8 **AND INFORMATION VERIFICATION.**

83.9 The commissioner of human services shall use existing resources to implement
 83.10 the changes in this act related to child care assistance redetermination of eligibility and
 83.11 information verification under Minnesota Statutes, sections 119B.025, subdivision 1, and
 83.12 119B.09, subdivision 4.

83.13 **ARTICLE 5**

83.14 **MISCELLANEOUS**

83.15 **Section 1. [62A.3075] CANCER CHEMOTHERAPY TREATMENT**
 83.16 **COVERAGE.**

83.17 (a) A health plan company that provides coverage under a health plan for cancer
 83.18 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
 83.19 amount for a prescribed, orally administered anticancer medication that is used to kill or
 83.20 slow the growth of cancerous cells than what the health plan requires for an intravenously
 83.21 administered or injected cancer medication that is provided, regardless of formulation or
 83.22 benefit category determination by the health plan company.

83.23 (b) A health plan company must not achieve compliance with this section
 83.24 by imposing an increase in co-payment, deductible, or coinsurance amount for an
 83.25 intravenously administered or injected cancer chemotherapy agent covered under the
 83.26 health plan.

83.27 (c) Nothing in this section shall be interpreted to prohibit a health plan company
 83.28 from requiring prior authorization or imposing other appropriate utilization controls in
 83.29 approving coverage for any chemotherapy.

83.30 (d) A plan offered by the commissioner of management and budget under section
 83.31 43A.23 is deemed to be at parity and in compliance with this section.

83.32 **EFFECTIVE DATE.** Paragraphs (a) and (c) are effective August 1, 2010, and apply
 83.33 to health plans providing coverage to a Minnesota resident offered, issued, sold, renewed,

84.1 or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after
84.2 that date. Paragraph (b) is effective the day following final enactment.

84.3 **Sec. 2. [62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

84.4 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
84.5 paragraphs (b) to (e) have the meanings given.

84.6 (b) "Autism spectrum disorder" means the following conditions as determined by
84.7 criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of
84.8 Mental Disorders of the American Psychiatric Association:

84.9 (1) autism or autistic disorder;

84.10 (2) Asperger's syndrome; or

84.11 (3) pervasive developmental disorder - not otherwise specified.

84.12 (c) "Board-certified behavior analyst" means an individual certified by the Behavior
84.13 Analyst Certification Board as a board-certified behavior analyst.

84.14 (d) "Evidence-based," for purposes of this section only, is as described in subdivision
84.15 2, paragraph (c), clause (2).

84.16 (e) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

84.17 (f) "Manualized approach" means a self-contained volume, text, or set of
84.18 instructional media, which may include videos or compact discs, that codifies in
84.19 reasonable detail the procedures for implementing treatment.

84.20 (g) "Medical necessity" or "medically necessary care" has the meaning given in
84.21 section 62Q.53, subdivision 2.

84.22 (h) "Mental health professional" has the meaning given in section 245.4871,
84.23 subdivision 27, clauses (1) to (6).

84.24 (i) "Qualified mental health behavioral aide" means a mental health behavioral aide
84.25 as defined in section 256B.0943, subdivision 7.

84.26 (j) "Qualified mental health practitioner" means a mental health practitioner as
84.27 defined in section 245.4871, subdivision 26.

84.28 (k) "Statistically superior outcomes" means a research study in which the probability
84.29 that the results would be obtained under the null hypothesis is less than five percent.

84.30 Subd. 2. **Coverage required.** (a) For coverage requirements to apply, an individual
84.31 must have a diagnosis of autism spectrum disorder made through an evaluation of the
84.32 patient, completed within the six months prior to the start of treatment, which includes
84.33 all of the following:

84.34 (1) a complete medical and psychological evaluation performed by a licensed
84.35 physician and psychologist using empirically validated tools or tests that incorporate

85.1 measures for intellectual functioning, language development, adaptive skills, and
85.2 behavioral problems, which must include:

85.3 (i) a developmental history of the child, focusing on developmental milestones
85.4 and delays;

85.5 (ii) a family history, including whether there are other family members with an
85.6 autism spectrum disorder, developmental disability, fragile X syndrome, or tuberous
85.7 sclerosis;

85.8 (iii) a medical history, including signs of deterioration, seizure activity, brain injury,
85.9 and head circumference;

85.10 (iv) a physical examination completed within the past 12 months;

85.11 (v) an evaluation for intellectual functioning;

85.12 (vi) a lead screening for those children with a developmental disability; and

85.13 (vii) other evaluations and testing as indicated by the medical evaluation, which
85.14 may include neuropsychological testing, occupational therapy, physical therapy, family
85.15 functioning, genetic testing, imaging laboratory tests, and electrophysiological testing;

85.16 (2) a communication assessment conducted by a speech pathologist; and

85.17 (3) a comprehensive hearing test conducted by an audiologist with experience in
85.18 testing very young children.

85.19 (b) A health plan must provide coverage for the diagnosis, evaluation, assessment,
85.20 and medically necessary care of autism spectrum disorders that is evidence-based,
85.21 including but not limited to:

85.22 (1) neurodevelopmental and behavioral health treatments, instruction, and
85.23 management;

85.24 (2) applied behavior analysis and intensive early intervention services, including
85.25 service package models such as intensive early intervention behavior therapy services
85.26 and Lovaas therapy;

85.27 (3) speech therapy;

85.28 (4) occupational therapy;

85.29 (5) physical therapy; and

85.30 (6) prescription medications.

85.31 (c) Coverage required under this section shall include treatment that is in accordance
85.32 with:

85.33 (1) an individualized treatment plan prescribed by the insured's treating physician or
85.34 mental health professional as defined in this section; and

85.35 (2) medically and scientifically accepted evidence that meets the criteria of a
85.36 peer-reviewed, published study that is one of the following:

86.1 (i) a randomized study with adequate statistical power, including a sample size of
86.2 30 or more for each group, that shows statistically superior outcomes to a pill placebo
86.3 group, psychological placebo group, another treatment group, or a wait list control group,
86.4 or that is equivalent to another evidence-based treatment that meets the above standard
86.5 for the specified problem area; or

86.6 (ii) a series of at least three single-case design experiments with clear specification
86.7 of the subjects and with clear specification of the treatment approach that:

86.8 (A) use robust experimental designs;

86.9 (B) show statistically superior outcomes to pill placebo, psychological placebo,
86.10 or another treatment group; and

86.11 (C) either use a manualized approach or are conducted by at least two independent
86.12 investigators or teams; or

86.13 (3) where evidence meeting the standards of this subdivision does not exist for
86.14 the treatment of a diagnosed condition or for an individual matching the demographic
86.15 characteristics for which the evidence is valid, practice guidelines based on consensus
86.16 of Minnesota health care professionals knowledgeable in the treatment of individuals
86.17 with autism spectrum disorders.

86.18 (d) Early intensive behavior therapies that meet the criteria set forth in paragraphs
86.19 (b) and (c) must also meet the following best practices standards:

86.20 (1) the services must be prescribed by a mental health professional as an appropriate
86.21 treatment option for the individual child;

86.22 (2) regular reporting of services provided and the child's progress must be submitted
86.23 to the prescribing mental health professional;

86.24 (3) care must include appropriate parent or legal guardian education and
86.25 involvement;

86.26 (4) the medically prescribed treatment and frequency of services should be
86.27 coordinated between the school and provider for all children up to age 21; and

86.28 (5) services must be provided by a mental health professional or, as appropriate, a
86.29 board-certified behavior analyst, a qualified mental health practitioner, or a qualified
86.30 mental health behavioral aide.

86.31 (e) Providers under this section must work with the commissioner in implementing
86.32 evidence-based practices and, specifically for children under age 21, the Minnesota
86.33 Evidence-Based Practice Database of research-informed practice elements and specific
86.34 constituent practices.

87.1 (f) A health plan company may not refuse to renew or reissue, or otherwise terminate
87.2 or restrict coverage of an individual solely because the individual is diagnosed with an
87.3 autism spectrum disorder.

87.4 (g) A health plan company may request an updated treatment plan only once every
87.5 six months, unless the health plan company and the treating physician or mental health
87.6 professional agree that a more frequent review is necessary due to emerging circumstances.

87.7 **Subd. 3. Supervision, delegation of duties, and observation of qualified mental**
87.8 **health practitioner, board-certified behavior analyst, or mental health behavioral**
87.9 **aide.** A mental health professional who uses the services of a qualified mental health
87.10 practitioner, board-certified behavior analyst, or qualified mental health behavioral aide for
87.11 the purpose of assisting in the provision of services to patients who have autism spectrum
87.12 disorder is responsible for functions performed by these service providers. The qualified
87.13 mental health professional must maintain clinical supervision of services they provide
87.14 and accept full responsibility for their actions. The services provided must be medically
87.15 necessary and identified in the child's individual treatment plan. Service providers must
87.16 document their activities in written progress notes that reflect implementation of the
87.17 individual treatment plan.

87.18 **Subd. 4. State health care programs.** This section does not affect benefits
87.19 available under the medical assistance, MinnesotaCare, and general assistance medical
87.20 care programs, and the state employee group insurance plan offered under sections
87.21 43A.22 to 43A.30. These programs and the state employee group insurance plan must
87.22 maintain current levels of coverage, and section 256B.0644 shall continue to apply.
87.23 The commissioner shall monitor these services and report to the chairs of the house
87.24 of representatives and senate standing committees that have jurisdiction over health
87.25 and human services by February 1, 2011, whether there are gaps in the level of service
87.26 provided by these programs and the state employee group insurance plan, and the level of
87.27 service provided by private health plans following enactment of this section.

87.28 **Subd. 5. No effect on other law.** Nothing in this section limits in any way the
87.29 coverage required under sections 62Q.47 and 62Q.53.

87.30 **EFFECTIVE DATE.** This section is effective August 1, 2010, and applies to
87.31 coverage offered, issued, sold, renewed, or continued as defined in Minnesota Statutes,
87.32 section 60A.02, subdivision 2a, on or after that date.

87.33 Sec. 3. Minnesota Statutes 2008, section 62J.38, is amended to read:

87.34 **62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.**

88.1 (a) The commissioner shall require group purchasers to submit detailed data on total
88.2 health care spending for each calendar year. Group purchasers shall submit data for the
88.3 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the
88.4 preceding calendar year.

88.5 (b) The commissioner shall require each group purchaser to submit data on revenue,
88.6 expenses, and member months, as applicable. Revenue data must distinguish between
88.7 premium revenue and revenue from other sources and must also include information
88.8 on the amount of revenue in reserves and changes in reserves. Expenditure data must
88.9 distinguish between costs incurred for patient care and administrative costs, including
88.10 amounts paid to contractors, subcontractors, and other entities for the purpose of managing
88.11 provider utilization or distributing provider payments. Patient care and administrative
88.12 costs must include only expenses incurred on behalf of health plan members and must
88.13 not include the cost of providing health care services for nonmembers at facilities owned
88.14 by the group purchaser or affiliate. Expenditure data must be provided separately
88.15 for the following categories and for other categories required by the commissioner:
88.16 physician services, dental services, other professional services, inpatient hospital services,
88.17 outpatient hospital services, emergency, pharmacy services and other nondurable medical
88.18 goods, mental health, and chemical dependency services, other expenditures, subscriber
88.19 liability, and administrative costs. Administrative costs must include costs for marketing;
88.20 advertising; overhead; salaries and benefits of central office staff who do not provide
88.21 direct patient care; underwriting; lobbying; claims processing; provider contracting and
88.22 credentialing; detection and prevention of payment for fraudulent or unjustified requests
88.23 for reimbursement or services; clinical quality assurance and other types of medical care
88.24 quality improvement efforts; concurrent or prospective utilization review as defined in
88.25 section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the
88.26 assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or
88.27 any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation
88.28 agreement with a hospital, clinic, or other health care provider. Capital costs and costs
88.29 incurred must be recorded according to standard accounting principles. The reports of
88.30 this data must also separately identify expenses for local, state, and federal taxes, fees,
88.31 and assessments. The commissioner may require each group purchaser to submit any
88.32 other data, including data in unaggregated form, for the purposes of developing spending
88.33 estimates, setting spending limits, and monitoring actual spending and costs. In addition to
88.34 reporting administrative costs incurred to acquire a hospital, clinic, or health care facility,
88.35 or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture,
88.36 integration, or affiliation agreement with a hospital, clinic, or other health care provider;

89.1 reports submitted under this section also must include the payments made during the
 89.2 calendar year for these purposes. The commissioner shall make public, by group purchaser
 89.3 data collected under this paragraph in accordance with section 62J.321, subdivision 5.
 89.4 Workers' compensation insurance plans and automobile insurance plans are exempt from
 89.5 complying with this paragraph as it relates to the submission of administrative costs.

89.6 (c) The commissioner may collect information on:

89.7 (1) premiums, benefit levels, managed care procedures, and other features of health
 89.8 plan companies;

89.9 (2) prices, provider experience, and other information for services less commonly
 89.10 covered by insurance or for which patients commonly face significant out-of-pocket
 89.11 expenses; and

89.12 (3) information on health care services not provided through health plan companies,
 89.13 including information on prices, costs, expenditures, and utilization.

89.14 (d) All group purchasers shall provide the required data using a uniform format and
 89.15 uniform definitions, as prescribed by the commissioner.

89.16 Sec. 4. **[62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.**

89.17 (a) Private duty nursing services, as provided under section 256B.0625, subdivision
 89.18 7, with the exception of section 256B.0654, subdivision 4, shall be provided by a
 89.19 health plan company for persons who require private duty nursing services and who
 89.20 are concurrently covered by a health plan, as defined in section 62Q.01, and enrolled in
 89.21 medical assistance under chapter 256B.

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

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

89.32 Sec. 5. Minnesota Statutes 2008, section 62Q.76, subdivision 1, is amended to read:

89.33 Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to ~~62Q.79~~ 62Q.791,
 89.34 the terms ~~defined in this section~~ contract, health care provider, dental plan, dental

90.1 organization, dentist, and enrollee have the meanings given them in sections 62Q.733
90.2 and 62Q.76.

90.3 **Sec. 6. [62Q.791] CONTRACTS WITH DENTAL CARE PROVIDERS.**

90.4 (a) Notwithstanding any other provision of law, no contract of any dental
90.5 organization licensed under chapter 62C for provision of dental care services may:

90.6 (1) require, directly or indirectly, that a dentist or health care provider provide dental
90.7 care services to its enrollees at a fee set by the dental organization, unless the services
90.8 provided are covered dental care services for enrollees under the dental plan or contract; or

90.9 (2) prohibit, directly or indirectly, the dentist or health care provider from offering or
90.10 providing dental care services that are not covered dental care services under the dental
90.11 plan or contract, on terms and conditions acceptable to the enrollee and the dentist or
90.12 health care provider. For purposes of this section, "covered dental care services" means
90.13 dental care services that are expressly covered under the dental plan or contract, including
90.14 dental care services that are subject to contractual limitations such as deductibles,
90.15 co-payments, annual maximums, and waiting periods.

90.16 (b) When making payment or otherwise adjudicating any claim for dental care
90.17 services provided to an enrollee, a dental organization or dental plan must clearly identify
90.18 on an explanation of benefits form or other form of claim resolution the amount, if any,
90.19 that is the enrollee's responsibility to pay to the enrollee's dentist or health care provider.

90.20 (c) This section does not apply to any contract for the provision of dental care
90.21 services under any public program sponsored or funded by the state or federal government.

90.22 **EFFECTIVE DATE.** This section is effective August 1, 2010.

90.23 **Sec. 7. [245.6971] ADVISORY GROUP ON STATE-OPERATED SERVICES**
90.24 **REDESIGN.**

90.25 Subdivision 1. **Establishment.** The Advisory Group on State-Operated Services
90.26 Redesign is established to make recommendations to the commissioner of human services
90.27 and the legislature on the continuum of services needed to provide individuals with
90.28 complex conditions including mental illness and developmental disabilities access to
90.29 quality care and the appropriate level of care across the state to promote wellness, reduce
90.30 cost, and improve efficiency.

90.31 Subd. 2. **Duties.** The Advisory Group on State-Operated Services Redesign shall
90.32 make recommendations to the commissioner and the legislature no later than December
90.33 15, 2010, on the following:

- 91.1 (1) transformation needed to improve service delivery and provide a continuum of
91.2 care, such as transition of current facilities, closure of current facilities, or the development
91.3 of new models of care;
- 91.4 (2) gaps and barriers to accessing quality care, system inefficiencies, and cost
91.5 pressures;
- 91.6 (3) services that are best provided by the state and those that are best provided
91.7 in the community;
- 91.8 (4) an implementation plan to achieve integrated service delivery across the public,
91.9 private, and nonprofit sectors;
- 91.10 (5) an implementation plan to ensure that individuals with complex chemical and
91.11 mental health needs receive the appropriate level of care to achieve recovery and wellness;
91.12 and
- 91.13 (6) financing mechanisms that include all possible revenue sources to maximize
91.14 federal funding and promote cost efficiencies and sustainability.
- 91.15 Subd. 3. **Membership.** The advisory group shall be composed of the following,
91.16 who will serve at the pleasure of their appointing authority:
- 91.17 (1) the commissioner of human services or the commissioner's designee, and two
91.18 additional representatives from the department;
- 91.19 (2) two legislators appointed by the speaker of the house, one from the minority
91.20 and one from the majority;
- 91.21 (3) two legislators appointed by the senate rules committee, one from the minority
91.22 and one from the majority;
- 91.23 (4) one representative appointed by AFSCME Council 5;
- 91.24 (5) one representative appointed by the ombudsman for mental health and
91.25 developmental disabilities;
- 91.26 (6) one representative appointed by the Minnesota Association of Professional
91.27 Employees;
- 91.28 (7) one representative appointed by the Minnesota Hospital Association;
- 91.29 (8) one representative appointed by the Minnesota Nurses Association;
- 91.30 (9) one representative appointed by NAMI-MN;
- 91.31 (10) one representative appointed by the Mental Health Association of Minnesota;
- 91.32 (11) one representative appointed by the Minnesota Association Of Community
91.33 Mental Health Programs;
- 91.34 (12) one representative appointed by the Minnesota Dental Association;
- 91.35 (13) three clients or client family members representing different populations
91.36 receiving services from state-operated services, who are appointed by the commissioner;

92.1 (14) one representative appointed by the chair of the state-operated services
 92.2 governing board; and

92.3 (15) one representative appointed by the Minnesota Disability Law Center.

92.4 Subd. 4. **Administration.** The commissioner shall convene the first meeting of the
 92.5 advisory group and shall provide administrative support and staff.

92.6 Subd. 5. **Recommendations.** The advisory group must report its recommendations
 92.7 to the commissioner and to the legislature no later than December 15, 2010.

92.8 Subd. 6. **Expiration.** This section expires January 31, 2011.

92.9 **Sec. 8. [245.6972] LEGISLATIVE APPROVAL REQUIRED.**

92.10 The commissioner of human services shall not redesign or move state-operated
 92.11 services programs without specific legislative approval. The commissioner may proceed
 92.12 with redesign at the Mankato Crisis Center and the closure of the Community Behavioral
 92.13 Health Hospital in Cold Spring.

92.14 **Sec. 9. Minnesota Statutes 2009 Supplement, section 252.025, subdivision 7, is**
 92.15 **amended to read:**

92.16 **Subd. 7. **Minnesota extended treatment options.**** The commissioner shall develop
 92.17 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have
 92.18 developmental disabilities and exhibit severe behaviors which present a risk to public
 92.19 safety. This program is statewide and must provide specialized residential services in
 92.20 Cambridge and an array of community-based services with sufficient levels of care and a
 92.21 sufficient number of specialists to ensure that individuals referred to the program receive
 92.22 the appropriate care. The number of beds at the Cambridge facility may be reorganized
 92.23 into two 16-bed facilities, one for individuals with developmental disabilities and one for
 92.24 individuals with developmental disabilities and a co-occurring mental illness. Remaining
 92.25 beds shall be converted into community-based transitional intensive treatment foster
 92.26 homes in the Cambridge area and staffed by state employees. The individuals working
 92.27 in the community-based services under this section are state employees supervised by
 92.28 the commissioner of human services. No layoffs shall occur as a result of restructuring
 92.29 under this section.

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

92.31 **Sec. 10. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:**

92.32 **Subd. 2. **American Indian.**** For purposes of services provided under section
 92.33 ~~254B.09, subdivision 7~~ 254B.09, subdivision 8, "American Indian" means a person who is

93.1 a member of an Indian tribe, and the commissioner shall use the definitions of "Indian"
 93.2 and "Indian tribe" and "Indian organization" provided in Public Law 93-638. For purposes
 93.3 of services provided under section ~~254B.09, subdivision 4~~ 254B.09, subdivision 6,
 93.4 "American Indian" means a resident of federally recognized tribal lands who is recognized
 93.5 as an Indian person by the federally recognized tribal governing body.

93.6 Sec. 11. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

93.7 Subdivision 1. **Chemical dependency treatment allocation.** The chemical
 93.8 dependency ~~funds appropriated for allocation~~ treatment appropriation shall be placed in
 93.9 a special revenue account. The commissioner shall annually transfer funds from the
 93.10 chemical dependency fund to pay for operation of the drug and alcohol abuse normative
 93.11 evaluation system and to pay for all costs incurred by adding two positions for licensing
 93.12 of chemical dependency treatment and rehabilitation programs located in hospitals for
 93.13 which funds are not otherwise appropriated. ~~Six percent of the remaining money must~~
 93.14 ~~be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The~~
 93.15 ~~commissioner shall annually divide the money available in the chemical dependency~~
 93.16 ~~fund that is not held in reserve by counties from a previous allocation, or allocated to~~
 93.17 ~~the American Indian chemical dependency tribal account. Six percent of the remaining~~
 93.18 ~~money must be reserved for the nonreservation American Indian chemical dependency~~
 93.19 ~~allocation for treatment of American Indians by eligible vendors under section 254B.05;~~
 93.20 ~~subdivision 1. The remainder of the money must be allocated among the counties~~
 93.21 ~~according to the following formula, using state demographer data and other data sources~~
 93.22 ~~determined by the commissioner:~~ in the special revenue account must be used according
 93.23 to the requirements in this chapter.

93.24 ~~(a) For purposes of this formula, American Indians and children under age 14 are~~
 93.25 ~~subtracted from the population of each county to determine the restricted population:~~

93.26 ~~(b) The amount of chemical dependency fund expenditures for entitled persons for~~
 93.27 ~~services not covered by prepaid plans governed by section 256B.69 in the previous year is~~
 93.28 ~~divided by the amount of chemical dependency fund expenditures for entitled persons for~~
 93.29 ~~all services to determine the proportion of exempt service expenditures for each county:~~

93.30 ~~(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt~~
 93.31 ~~service expenditures to determine the adjusted prepaid plan months of eligibility for~~
 93.32 ~~each county:~~

93.33 ~~(d) The adjusted prepaid plan months of eligibility is added to the number of~~
 93.34 ~~restricted population fee for service months of eligibility for the Minnesota family~~

94.1 ~~investment program, general assistance, and medical assistance and divided by the county~~
 94.2 ~~restricted population to determine county per capita months of covered service eligibility.~~

94.3 ~~(e) The number of adjusted prepaid plan months of eligibility for the state is added~~
 94.4 ~~to the number of fee for service months of eligibility for the Minnesota family investment~~
 94.5 ~~program, general assistance, and medical assistance for the state restricted population and~~
 94.6 ~~divided by the state restricted population to determine state per capita months of covered~~
 94.7 ~~service eligibility.~~

94.8 ~~(f) The county per capita months of covered service eligibility is divided by the~~
 94.9 ~~state per capita months of covered service eligibility to determine the county welfare~~
 94.10 ~~caseload factor.~~

94.11 ~~(g) The median married couple income for the most recent three-year period~~
 94.12 ~~available for the state is divided by the median married couple income for the same period~~
 94.13 ~~for each county to determine the income factor for each county.~~

94.14 ~~(h) The county restricted population is multiplied by the sum of the county welfare~~
 94.15 ~~caseload factor and the county income factor to determine the adjusted population.~~

94.16 ~~(i) \$15,000 shall be allocated to each county.~~

94.17 ~~(j) The remaining funds shall be allocated proportional to the county adjusted~~
 94.18 ~~population.~~

94.19 Sec. 12. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

94.20 Subd. 5. **Administrative adjustment.** The commissioner may make payments to
 94.21 local agencies from money allocated under this section to support administrative activities
 94.22 under sections 254B.03 and 254B.04. The administrative payment must not exceed
 94.23 the lesser of (1) five percent of the first \$50,000, four percent of the next \$50,000, and
 94.24 three percent of the remaining payments for services from the ~~allocation~~ special revenue
 94.25 account according to subdivision 1; or (2) the local agency administrative payment for
 94.26 the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in
 94.27 the appropriation for this chapter.

94.28 Sec. 13. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

94.29 Subd. 4. **Division of costs.** Except for services provided by a county under
 94.30 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
 94.31 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for
 94.32 ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services
 94.33 provided to persons eligible for medical assistance under chapter 256B and general
 94.34 assistance medical care under chapter 256D. Counties may use the indigent hospitalization

95.1 levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent
 95.2 of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost
 95.3 of payment and collections, must be distributed to the county that paid for a portion of
 95.4 the treatment under this section. ~~If all funds allocated according to section 254B.02 are~~
 95.5 ~~exhausted by a county and the county has met or exceeded the base level of expenditures~~
 95.6 ~~under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the~~
 95.7 ~~costs paid by the state under this section. The commissioner may refuse to pay state funds~~
 95.8 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~
 95.9 ~~financially responsible for the persons has exhausted its allocation.~~

95.10 Sec. 14. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

95.11 Subd. 4. **Regional treatment centers.** Regional treatment center chemical
 95.12 dependency treatment units are eligible vendors. The commissioner may expand the
 95.13 capacity of chemical dependency treatment units beyond the capacity funded by direct
 95.14 legislative appropriation to serve individuals who are referred for treatment by counties
 95.15 and whose treatment will be paid for ~~with a county's allocation under section 254B.02 by~~
 95.16 funding under this chapter or other funding sources. Notwithstanding the provisions of
 95.17 sections 254B.03 to 254B.041, payment for any person committed at county request to
 95.18 a regional treatment center under chapter 253B for chemical dependency treatment and
 95.19 determined to be ineligible under the chemical dependency consolidated treatment fund,
 95.20 shall become the responsibility of the county.

95.21 Sec. 15. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

95.22 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal
 95.23 financial participation collections to ~~the reserve fund under section 254B.02, subdivision 3~~
 95.24 a special revenue account. The commissioner shall ~~retain 85~~ allocate 83.86 percent of
 95.25 patient payments and third-party payments to the special revenue account and ~~allocate~~
 95.26 ~~the collections to the treatment allocation for the county that is financially responsible~~
 95.27 ~~for the person. Fifteen 16.14~~ percent of patient and third-party payments must be paid
 95.28 to the county financially responsible for the patient. ~~Collections for patient payment and~~
 95.29 ~~third-party payment for services provided under section 254B.09 shall be allocated to the~~
 95.30 ~~allocation of the tribal unit which placed the person. Collections of federal financial~~
 95.31 ~~participation for services provided under section 254B.09 shall be allocated to the tribal~~
 95.32 ~~reserve account under section 254B.09, subdivision 5.~~

95.33 Sec. 16. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

96.1 Subd. 8. **Payments to improve services to American Indians.** The commissioner
96.2 may set rates for chemical dependency services to American Indians according to the
96.3 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.
96.4 These rates shall supersede rates set in county purchase of service agreements when
96.5 payments are made on behalf of clients eligible according to Public Law 94-437.

96.6 Sec. 17. **[254B.13] PILOT PROJECTS; CHEMICAL HEALTH CARE.**

96.7 Subdivision 1. Authorization for pilot projects. The commissioner of human
96.8 services may approve and implement pilot projects developed under the planning process
96.9 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
96.10 enhance coordination of the delivery of chemical health services required under section
96.11 254B.03.

96.12 Subd. 2. Program design and implementation. (a) The commissioner of
96.13 human services and counties participating in the pilot projects shall continue to work in
96.14 partnership to refine and implement the pilot projects initiated under Laws 2009, chapter
96.15 79, article 7, section 26.

96.16 (b) The commissioner and counties participating in the pilot projects shall
96.17 complete the planning phase by June 30, 2010, and, if approved by the commissioner for
96.18 implementation, enter into agreements governing the operation of the pilot projects with
96.19 implementation scheduled no earlier than July 1, 2010.

96.20 Subd. 3. Program evaluation. The commissioner of human services shall evaluate
96.21 pilot projects under this section and report the results of the evaluation to the legislative
96.22 committees with jurisdiction over chemical health by June 30, 2013. Evaluation of the
96.23 pilot projects must be based on outcome evaluation criteria negotiated with the projects
96.24 prior to implementation.

96.25 Subd. 4. Notice of project discontinuation. Each county's participation in the
96.26 pilot project may be discontinued for any reason by the county or the commissioner of
96.27 human services after 30 days' written notice to the other party. Any unspent funds held
96.28 for the exiting county's pro rata share in the special revenue fund under the authority
96.29 in subdivision 5, paragraph (c), shall be transferred to the general fund following
96.30 discontinuation of the pilot project.

96.31 Subd. 5. Duties of commissioner. (a) Notwithstanding any other provisions in
96.32 this chapter, the commissioner may authorize pilot projects to use chemical dependency
96.33 treatment funds to pay for services:

96.34 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
96.35 (a); and

97.1 (2) by vendors in addition to those authorized under section 254B.05 when not
 97.2 providing chemical dependency treatment services.

97.3 (b) State expenditures for chemical dependency services and any other services
 97.4 provided by or through the pilot projects must not be greater than chemical dependency
 97.5 treatment fund expenditures expected in the absence of the pilot projects. The
 97.6 commissioner may restructure the schedule of payments between the state and participating
 97.7 counties under the local agency share and division of cost provisions under section
 97.8 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the pilot projects.

97.9 (c) To the extent that state fiscal year expenditures within a pilot project region are
 97.10 less than expected in the absence of the pilot projects, the commissioner may deposit
 97.11 these unexpended funds in the special revenue fund and make these funds available for
 97.12 expenditure by the pilot counties the following year. To the extent that treatment and pilot
 97.13 project ancillary services expenditures within the pilot project exceed the amount expected
 97.14 in the absence of the pilot projects, the pilot counties are responsible for the portion of
 97.15 nontreatment expenditures in excess of otherwise expected expenditures.

97.16 (d) The commissioner may waive administrative rule requirements which are
 97.17 incompatible with the implementation of the pilot project.

97.18 (e) The commissioner shall not approve or enter into any agreement related to pilot
 97.19 projects authorized under this section which puts current or future federal funding at risk.

97.20 Subd. 6. **Duties of county board.** The county board, or other county entity that is
 97.21 approved to administer a pilot project, shall:

97.22 (1) administer the pilot project in a manner consistent with the objectives described
 97.23 in subdivision 2 and the planning process in subdivision 5;

97.24 (2) ensure that no one is denied chemical dependency treatment services for which
 97.25 they would otherwise be eligible under section 254A.03, subdivision 3; and

97.26 (3) provide the commissioner of human services with timely and pertinent
 97.27 information as negotiated in agreements governing operation of the pilot projects.

97.28 Sec. 18. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
 97.29 to read:

97.30 Subd. 30. **Office of Health Care Inspector General.** (a) The commissioner shall
 97.31 create within the Department of Human Services an Office of Health Care Inspector
 97.32 General to enhance antifraud activities and to protect the integrity of the state health care
 97.33 programs, as well as the health and welfare of the beneficiaries of those programs. The
 97.34 Office of Health Care Inspector General must periodically report to the commissioner and

98.1 to the legislature program and management problems and recommendations to correct
98.2 them.

98.3 (b) The duties of the Office of Health Care Inspector General include, but are not
98.4 limited to:

98.5 (1) promoting economy, efficiency, and effectiveness through the elimination of
98.6 waste, fraud, and abuse;

98.7 (2) conducting and supervising audits, investigations, inspections, and evaluations
98.8 relating to the state health care programs under chapters 256B, 256D, and 256L;

98.9 (3) identifying weaknesses giving rise to opportunities for fraud and abuse in the
98.10 state health care programs and operations and making recommendations to prevent their
98.11 recurrence;

98.12 (4) leading and coordinating activities to prevent and detect fraud and abuse in the
98.13 state health care programs and operations;

98.14 (5) detecting wrongdoers and abusers of the state health care programs and
98.15 beneficiaries so appropriate remedies may be brought;

98.16 (6) keeping the commissioner and the legislature fully and currently informed about
98.17 problems and deficiencies in the administration of the state health care programs and
98.18 operations and about the need for and progress of corrective action;

98.19 (7) operating a toll-free hotline to permit individuals to call in suspected fraud,
98.20 waste, or abuse, referring the calls for appropriate action by the agency, and analyzing the
98.21 calls to identify trends and patterns of fraud and abuse needing attention;

98.22 (8) developing and reviewing legislative, regulatory, and program proposals to
98.23 reduce vulnerabilities to fraud, waste, and mismanagement; and

98.24 (9) recommending changes in program policies, regulations, and laws to improve
98.25 efficiency and effectiveness, and to prevent fraud, waste, abuse, and mismanagement.

98.26 (c) Beginning July 1, 2011, the commissioner, in consultation with the Office of
98.27 Health Care Inspector General, shall annually report to the legislature and the governor
98.28 new results from the two ongoing federal Medicaid audits. The commissioner shall report

98.29 (1) the most recent Medicaid Integrity Program (MIP) audit results, with any corrective
98.30 actions needed, and (2) certify the rate of errors determined for the state health care

98.31 programs under chapters 256B, 256D, and 256L, as determined from the most recent

98.32 Payment Error Rate Measurement (PERM) audit results for Minnesota. When the PERM

98.33 audit rate for Minnesota is greater than the national rate for the year or the MIP audit

98.34 determines the need for corrective action, the commissioner shall present a plan to the

98.35 legislature and the governor for the corrective actions and reduction of the error rate

98.36 in the next calendar year.

99.1 Sec. 19. Laws 2009, chapter 79, article 3, section 18, is amended to read:

99.2 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
 99.3 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
 99.4 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

99.5 ~~In consultation with community partners, the commissioner of human services~~ The
 99.6 Advisory Group on State-Operated Services Redesign shall ~~develop~~ recommend an array
 99.7 of community-based services to transform the current services now provided to patients
 99.8 at the Anoka-Metro Regional Treatment Center. The community-based services may
 99.9 be provided in facilities with 16 or fewer beds, and must provide the appropriate level
 99.10 of care for the patients being admitted to the facilities. The planning for this transition
 99.11 must be completed by October 1, ~~2009~~ 2010, with an initial report to the committee chairs
 99.12 of health and human services by November 30, ~~2009~~ 2010, and a semiannual report on
 99.13 progress until the transition is completed. ~~The commissioner of human services shall~~
 99.14 ~~solicit interest from stakeholders and potential community partners.~~ The individuals
 99.15 working in the community-based services facilities under this section are state employees
 99.16 supervised by the commissioner of human services. No layoffs shall occur as a result of
 99.17 restructuring under this section.

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

99.19 Sec. 20. **NONSUBMISSION OF HEALTH CARE CLAIM BY**
 99.20 **CLEARINGHOUSE; SIGNIFICANT DISRUPTION.**

99.21 (a) A situation shall be considered a significant disruption to normal operations that
 99.22 materially affects the provider's or facility's ability to conduct business in a normal manner
 99.23 and to submit claims on a timely basis under Minnesota Statutes, section 62Q.75, if:

99.24 (1) a clearinghouse loses, or otherwise does not submit, a health care claim as
 99.25 required by Minnesota Statutes, section 62J.536; and

99.26 (2) the provider or facility can substantiate that it submitted a complete claim to the
 99.27 clearinghouse within provisions stated in contract or six months of the date of service,
 99.28 whichever is less.

99.29 (b) This section expires January 1, 2012.

99.30 Sec. 21. **REPORT ON HUMAN SERVICES FISCAL NOTES.**

99.31 The commissioner of management and budget shall issue a report to the legislature
 99.32 no later than November 15, 2010, making recommendations for improving the preparation
 99.33 and delivery of fiscal notes under Minnesota Statutes, section 3.98, relating to human
 99.34 services. The report shall consider: (1) the establishment of an independent fiscal

100.1 note office in the human services department and (2) transferring the responsibility for
 100.2 preparing human services fiscal notes to the legislature. The report must include detailed
 100.3 information regarding the financial costs, staff resources, training, access to information,
 100.4 and data protection issues relative to the preparation of human services fiscal notes. The
 100.5 report shall describe methods and procedures used by other states to insure independence
 100.6 and accuracy of fiscal estimates on legislative proposals for changes in human services.

100.7 Sec. 22. **REPEALER.**

100.8 Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09,
 100.9 subdivisions 4, 5, and 7, and Laws 2009, chapter 79, article 7, section 26, subdivision
 100.10 3, are repealed.

100.11 Sec. 23. **EFFECTIVE DATE.**

100.12 Sections 10 to 14 and 22 are effective for claims paid on or after July 1, 2010.

100.13 **ARTICLE 6**

100.14 **DEPARTMENT OF HEALTH**

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

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

100.18 (a) Every health maintenance organization must directly allocate administrative expenses
 100.19 to specific lines of business or products when such information is available. Remaining
 100.20 expenses that cannot be directly allocated must be allocated based on other methods, as
 100.21 recommended by the Advisory Group on Administrative Expenses. Health maintenance
 100.22 organizations must submit this information, including administrative expenses for dental
 100.23 services, using the reporting template provided by the commissioner of health.

100.24 (b) Every health maintenance organization must allocate investment income based
 100.25 on cumulative net income over time by business line or product and must submit this
 100.26 information, including investment income for dental services, using the reporting template
 100.27 provided by the commissioner of health.

100.28 **EFFECTIVE DATE.** This section is effective January 1, 2012.

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

100.30 Subdivision 1. Establishment. The Advisory Group on Administrative Expenses
 100.31 is established to make recommendations on the development of consistent guidelines

101.1 and reporting requirements, including development of a reporting template, for health
101.2 maintenance organizations and county-based purchasers that participate in publicly
101.3 funded programs.

101.4 Subd. 2. **Membership.** The membership of the advisory group shall be comprised
101.5 of the following, who serve at the pleasure of their appointing authority:

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

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

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

101.9 (4) representatives of health maintenance organizations and county-based purchasers
101.10 appointed by the commissioner of health.

101.11 Subd. 3. **Administration.** The commissioner of health shall convene the first
101.12 meeting of the advisory group by September 1, 2010, and shall provide administrative
101.13 support and staff. The commissioner of health may contract with a consultant to provide
101.14 professional assistance and expertise to the advisory group.

101.15 Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses
101.16 must report its recommendations, including any proposed legislation necessary to
101.17 implement the recommendations, to the commissioner of health and to the chairs and
101.18 ranking minority members of the legislative committees and divisions with jurisdiction
101.19 over health policy and finance by July 1, 2011.

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

101.22 Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is
101.23 amended to read:

101.24 Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an
101.25 electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH
101.26 Act to meet the standards and implementation specifications adopted under section 3004
101.27 as applicable.

101.28 (b) "Commissioner" means the commissioner of health.

101.29 (c) "Pharmaceutical electronic data intermediary" means any entity that provides
101.30 the infrastructure to connect computer systems or other electronic devices utilized
101.31 by prescribing practitioners with those used by pharmacies, health plans, third-party
101.32 administrators, and pharmacy benefit managers in order to facilitate the secure
101.33 transmission of electronic prescriptions, refill authorization requests, communications,
101.34 and other prescription-related information between such entities.

102.1 (d) "HITECH Act" means the Health Information Technology for Economic and
102.2 Clinical Health Act in division A, title XIII and division B, title IV of the American
102.3 Recovery and Reinvestment Act of 2009, including federal regulations adopted under
102.4 that act.

102.5 (e) "Interoperable electronic health record" means an electronic health record that
102.6 securely exchanges health information with another electronic health record system that
102.7 meets requirements specified in subdivision 3, and national requirements for certification
102.8 under the HITECH Act.

102.9 (f) "Qualified electronic health record" means an electronic record of health-related
102.10 information on an individual that includes patient demographic and clinical health
102.11 information and has the capacity to:

102.12 (1) provide clinical decision support;

102.13 (2) support physician order entry;

102.14 (3) capture and query information relevant to health care quality; and

102.15 (4) exchange electronic health information with, and integrate such information
102.16 from, other sources.

102.17 Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is
102.18 amended to read:

102.19 Subd. 3. **Interoperable electronic health record requirements.** To meet the
102.20 requirements of subdivision 1, hospitals and health care providers must meet the following
102.21 criteria when implementing an interoperable electronic health records system within their
102.22 hospital system or clinical practice setting.

102.23 (a) The electronic health record must be a qualified electronic health record.

102.24 (b) The electronic health record must be certified by the Office of the National
102.25 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and
102.26 health care providers ~~only~~ if a certified electronic health record product for the provider's
102.27 particular practice setting is available. This criterion shall be considered met if a hospital
102.28 or health care provider is using an electronic health records system that has been certified
102.29 within the last three years, even if a more current version of the system has been certified
102.30 within the three-year period.

102.31 (c) The electronic health record must meet the standards established according to
102.32 section 3004 of the HITECH Act as applicable.

102.33 (d) The electronic health record must have the ability to generate information on
102.34 clinical quality measures and other measures reported under sections 4101, 4102, and
102.35 4201 of the HITECH Act.

103.1 (e) The electronic health record system must be connected to a state-certified
 103.2 health information organization either directly or through a connection facilitated by a
 103.3 state-certified health data intermediary as defined in section 62J.498.

103.4 ~~(e)~~ (f) A health care provider who is a prescriber or dispenser of legend drugs must
 103.5 have an electronic health record system that meets the requirements of section 62J.497.

103.6 Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a
 103.7 subdivision to read:

103.8 Subd. 6. **State agency information system.** Development of a state agency
 103.9 information system necessary to implement this section is subject to the authority of the
 103.10 Office of Enterprise Technology in chapter 16E, including, but not limited to:

103.11 (1) evaluation and approval of the system as specified in section 16E.03, subdivisions
 103.12 3 and 4;

103.13 (2) review of the system to ensure compliance with security policies, guidelines, and
 103.14 standards as specified in section 16E.03, subdivision 7; and

103.15 (3) assurance that the system complies with accessibility standards developed under
 103.16 section 16E.03, subdivision 9.

103.17 Sec. 6. **[62J.498] HEALTH INFORMATION EXCHANGE.**

103.18 Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to
 103.19 62J.4982:

103.20 (a) "Clinical transaction" means any meaningful use transaction that is not covered
 103.21 by section 62J.536.

103.22 (b) "Commissioner" means the commissioner of health.

103.23 (c) "Direct health information exchange" means the electronic transmission of
 103.24 health-related information through a direct connection between the electronic health
 103.25 record systems of health care providers without the use of a health data intermediary.

103.26 (d) "Health care provider" or "provider" means a health care provider or provider as
 103.27 defined in section 62J.03, subdivision 8.

103.28 (e) "Health data intermediary" means an entity that provides the infrastructure to
 103.29 connect computer systems or other electronic devices used by health care providers,
 103.30 laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit
 103.31 managers to facilitate the secure transmission of health information, including
 103.32 pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not
 103.33 include health care providers engaged in a direct health information exchange.

104.1 (f) "Health information exchange" means the electronic transmission of
104.2 health-related information between organizations according to nationally recognized
104.3 standards.

104.4 (g) "Health information exchange service provider" means a health data intermediary
104.5 or health information organization that has been issued a certificate of authority by the
104.6 commissioner under section 62J.4981.

104.7 (h) "Health information organization" means an organization that oversees, governs,
104.8 and facilitates the exchange of health-related information among organizations according
104.9 to nationally recognized standards.

104.10 (i) "HITECH Act" means the Health Information Technology for Economic and
104.11 Clinical Health Act as defined in section 62J.495.

104.12 (j) "Major participating entity" means:

104.13 (1) a participating entity that receives compensation for services that is greater
104.14 than 30 percent of the health information organization's gross annual revenues from the
104.15 health information exchange service provider;

104.16 (2) a participating entity providing administrative, financial, or management services
104.17 to the health information organization, if the total payment for all services provided by the
104.18 participating entity exceeds three percent of the gross revenue of the health information
104.19 organization; and

104.20 (3) a participating entity that nominates or appoints 30 percent or more of the board
104.21 of directors of the health information organization.

104.22 (k) "Meaningful use" means use of certified electronic health record technology that
104.23 includes e-prescribing, and is connected in a manner that provides for the electronic
104.24 exchange of health information and used for the submission of clinical quality measures
104.25 as established by the Center for Medicare and Medicaid Services and the Minnesota
104.26 Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH
104.27 Act.

104.28 (l) "Meaningful use transaction" means an electronic transaction that a health care
104.29 provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare
104.30 penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

104.31 (m) "Participating entity" means any of the following persons, health care providers,
104.32 companies, or other organizations with which a health information organization or health
104.33 data intermediary has contracts or other agreements for the provision of health information
104.34 exchange service providers:

- 105.1 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home
105.2 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise
105.3 licensed under the laws of this state or registered with the commissioner;
- 105.4 (2) a health care provider, and any other health care professional otherwise licensed
105.5 under the laws of this state or registered with the commissioner;
- 105.6 (3) a group, professional corporation, or other organization that provides the
105.7 services of individuals or entities identified in clause (2), including but not limited to a
105.8 medical clinic, a medical group, a home health care agency, an urgent care center, and
105.9 an emergent care center;
- 105.10 (4) a health plan as defined in section 62A.011, subdivision 3; and
- 105.11 (5) a state agency as defined in section 13.02, subdivision 17.
- 105.12 (n) "Reciprocal agreement" means an arrangement in which two or more health
105.13 information exchange service providers agree to share in-kind services and resources to
105.14 allow for the pass-through of meaningful use transactions.
- 105.15 (o) "State-certified health data intermediary" means a health data intermediary that:
- 105.16 (1) provides a subset of the meaningful use transaction capabilities necessary for
105.17 hospitals and providers to achieve meaningful use of electronic health records;
- 105.18 (2) is not exclusively engaged in the exchange of meaningful use transactions
105.19 covered by section 62J.536; and
- 105.20 (3) has been issued a certificate of authority to operate in Minnesota.
- 105.21 (p) "State-certified health information organization" means a nonprofit health
105.22 information organization that provides transaction capabilities necessary to fully support
105.23 clinical transactions required for meaningful use of electronic health records that has been
105.24 issued a certificate of authority to operate in Minnesota.
- 105.25 **Subd. 2. Health information exchange oversight.** (a) The commissioner shall
105.26 protect the public interest on matters pertaining to health information exchange. The
105.27 commissioner shall:
- 105.28 (1) review and act on applications from health data intermediaries and health
105.29 information organizations for certificates of authority to operate in Minnesota;
- 105.30 (2) provide ongoing monitoring to ensure compliance with criteria established under
105.31 sections 62J.498 to 62J.4982;
- 105.32 (3) respond to public complaints related to health information exchange services;
- 105.33 (4) take enforcement actions as necessary, including the imposition of fines,
105.34 suspension, or revocation of certificates of authority as outlined in section 62J.4982;
- 105.35 (5) provide a biannual report on the status of health information exchange services
105.36 that includes but is not limited to:

- 106.1 (i) recommendations on actions necessary to ensure that health information exchange
106.2 services are adequate to meet the needs of Minnesota citizens and providers statewide;
- 106.3 (ii) recommendations on enforcement actions to ensure that health information
106.4 exchange service providers act in the public interest without causing disruption in health
106.5 information exchange services;
- 106.6 (iii) recommendations on updates to criteria for obtaining certificates of authority
106.7 under this section; and
- 106.8 (iv) recommendations on standard operating procedures for health information
106.9 exchange, including but not limited to the management of consumer preferences; and
106.10 (6) other duties necessary to protect the public interest.
- 106.11 (b) As part of the application review process for certification under paragraph (a),
106.12 prior to issuing a certificate of authority, the commissioner shall:
- 106.13 (1) hold public hearings that provide an adequate opportunity for participating
106.14 entities and consumers to provide feedback and recommendations on the application under
106.15 consideration. The commissioner shall make all portions of the application classified
106.16 as public data available to the public at least ten days in advance of the hearing. The
106.17 applicant shall participate in the hearing by presenting an application overview and
106.18 responding to questions from interested parties;
- 106.19 (2) make available all feedback and recommendations from the hearing available to
106.20 the public prior to issuing a certificate of authority; and
- 106.21 (3) consult with hospitals, physicians, and other professionals eligible to receive
106.22 meaningful use incentive payments or are subject to penalties as established in the
106.23 HITECH Act, and their respective statewide associations, prior to issuing a certificate of
106.24 authority.
- 106.25 (c)(1) When the commissioner is actively considering a suspension or revocation of
106.26 a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory
106.27 data that are collected, created, or maintained related to the suspension or revocation
106.28 are classified as confidential data on individuals and as protected nonpublic data in the
106.29 case of data not on individuals.
- 106.30 (2) The commissioner may disclose data classified as protected nonpublic or
106.31 confidential under this paragraph if disclosing the data will protect the health or safety of
106.32 patients.
- 106.33 (d) After the commissioner makes a final determination regarding a suspension or
106.34 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,
106.35 conclusions of law, and the specification of the final disciplinary action, are classified
106.36 as public data.

107.1 Sec. 7. **[62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
107.2 **INFORMATION EXCHANGE SERVICES.**

107.3 Subdivision 1. Authority to require organizations to apply. The commissioner
107.4 shall require an entity providing health information exchange services to apply for a
107.5 certificate of authority under this section. An applicant may continue to operate until
107.6 the commissioner acts on the application. If the application is denied, the applicant is
107.7 considered a health information organization whose certificate of authority has been
107.8 revoked under section 62J.4982, subdivision 2, paragraph (d).

107.9 Subd. 2. Certificate of authority for health data intermediaries. (a) A health
107.10 data intermediary that provides health information exchange services for the transmission
107.11 of one or more clinical transactions necessary for hospitals, providers, or eligible
107.12 professionals to achieve meaningful use must be registered with the state and comply with
107.13 requirements established in this section.

107.14 (b) Notwithstanding any law to the contrary, any corporation organized to do so
107.15 may apply to the commissioner for a certificate of authority to establish and operate as
107.16 a health data intermediary in compliance with this section. No person shall establish or
107.17 operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers
107.18 to purchase or receive advance or periodic consideration in conjunction with a health
107.19 data intermediary contract unless the organization has a certificate of authority or has an
107.20 application under active consideration under this section.

107.21 (c) In issuing the certificate of authority, the commissioner shall determine whether
107.22 the applicant for the certificate of authority has demonstrated that the applicant meets
107.23 the following minimum criteria:

107.24 (1) can interoperate with at least one state-certified health information organization;

107.25 (2) can provide an option for Minnesota entities to connect to their services through
107.26 at least one state-certified health information organization;

107.27 (3) has a record locator service as defined in section 144.291, subdivision 2,
107.28 paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8,
107.29 when conducting meaningful use transactions; and

107.30 (4) holds reciprocal agreements with at least one state-certified health information
107.31 organization to enable access to record locator services to find patient data, and for the
107.32 transmission and receipt of meaningful use transactions consistent with the format and
107.33 content required by national standards established by Centers for Medicare and Medicaid
107.34 Services. Reciprocal agreements must meet the requirements established in subdivision 5.

107.35 Subd. 3. Certificate of authority for health information organizations.

107.36 (a) A health information organization that provides all electronic capabilities for the

108.1 transmission of clinical transactions necessary for meaningful use of electronic health
108.2 records must obtain a certificate of authority from the commissioner and demonstrate
108.3 compliance with the criteria in paragraph (c).

108.4 (b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do
108.5 so may apply for a certificate of authority to establish and operate a health information
108.6 organization under this section. No person shall establish or operate a health information
108.7 organization in this state, or sell or offer to sell, or solicit offers to purchase or receive
108.8 advance or periodic consideration in conjunction with a health information organization
108.9 or health information contract unless the organization has a certificate of authority under
108.10 this section.

108.11 (c) In issuing the certificate of authority, the commissioner shall determine whether
108.12 the applicant for the certificate of authority has demonstrated that the applicant meets
108.13 the following minimum criteria:

108.14 (1) the entity is a legally established, nonprofit organization;

108.15 (2) has appropriate insurance, including liability insurance, for the operation of the
108.16 health information organization is in place and sufficient to protect the interest of the
108.17 public and participating entities;

108.18 (3) has strategic and operational plans that clearly address how the organization will
108.19 expand technical capacity of the health information organization to support providers in
108.20 achieving meaningful use of electronic health records over time;

108.21 (4) the entity addresses the parameters to be used with participating entities and
108.22 other health information organizations for meaningful use transactions, compliance with
108.23 Minnesota law, and interstate health information exchange in trust agreements;

108.24 (5) the entity's board of directors is comprised of members that broadly represent the
108.25 health information organization's participating entities and consumers;

108.26 (6) the entity maintains a professional staff responsible to the board of directors with
108.27 the capacity to ensure accountability to the organization's mission;

108.28 (7) the entity is compliant with criteria established under the Health Information
108.29 Exchange Accreditation Program of the Electronic Healthcare Network Accreditation
108.30 Commission (EHNAC) or equivalent criteria established by the commissioner;

108.31 (8) the entity maintains a record locator service as defined in section 144.291,
108.32 subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293,
108.33 subdivision 8, when conducting meaningful use transactions;

108.34 (9) the organization demonstrates interoperability with all other state-certified health
108.35 information organizations using nationally recognized standards;

- 109.1 (10) the organization demonstrates compliance with all privacy and security
109.2 requirements required by state and federal law; and
- 109.3 (11) the organization uses financial policies and procedures consistent with generally
109.4 accepted accounting principles and has an independent audit of the organization's
109.5 financials on an annual basis.
- 109.6 (d) Health information organizations that have obtained a certificate of authority
109.7 must:
- 109.8 (1) meet the requirements established for connecting to the Nationwide Health
109.9 Information Network (NHIN) within the federally mandated timeline or within a time
109.10 frame established by the commissioner and published in the State Register. If the state
109.11 timeline for implementation varies from the federal timeline, the State Register notice
109.12 shall include an explanation for the variation;
- 109.13 (2) annually submit strategic and operational plans for review by the commissioner
109.14 that address:
- 109.15 (i) increasing adoption rates to include a sufficient number of participating entities to
109.16 achieve financial sustainability; and
- 109.17 (ii) progress in achieving objectives included in previously submitted strategic
109.18 and operational plans across the following domains: business and technical operations,
109.19 technical infrastructure, legal and policy issues, finance, and organizational governance;
- 109.20 (3) develop and maintain a business plan that addresses:
- 109.21 (i) plans for ensuring the necessary capacity to support meaningful use transactions;
109.22 (ii) approach for attaining financial sustainability, including public and private
109.23 financing strategies, and rate structures;
- 109.24 (iii) rates of adoption, utilization, and transaction volume, and mechanisms to
109.25 support health information exchange; and
- 109.26 (iv) an explanation of methods employed to address the needs of community clinics,
109.27 critical access hospitals, and free clinics in accessing health information exchange services;
- 109.28 (4) annually submit a rate plan outlining fee structures for health information
109.29 exchange services for approval by the commissioner. The commissioner shall approve the
109.30 rate plan if it:
- 109.31 (i) distributes costs equitably among users of health information services;
109.32 (ii) provides predictable costs for participating entities;
109.33 (iii) covers all costs associated with conducting the full range of meaningful use
109.34 clinical transactions, including access to health information retrieved through other
109.35 state-certified health information exchange service providers; and

110.1 (iv) provides for a predictable revenue stream for the health information organization
110.2 and generates sufficient resources to maintain operating costs and develop technical
110.3 infrastructure necessary to serve the public interest;

110.4 (5) enter into reciprocal agreements with all other state-certified health information
110.5 organizations to enable access to record locator services to find patient data, and
110.6 transmission and receipt of meaningful use transactions consistent with the format and
110.7 content required by national standards established by Centers for Medicare and Medicaid
110.8 Services. Reciprocal agreements must meet the requirements in subdivision 5; and

110.9 (6) comply with additional requirements for the certification or recertification of
110.10 health information organizations that may be established by the commissioner.

110.11 **Subd. 4. Application for certificate of authority for health information exchange**
110.12 **service providers.** (a) Each application for a certificate of authority shall be in a form
110.13 prescribed by the commissioner and verified by an officer or authorized representative of
110.14 the applicant. Each application shall include the following:

110.15 (1) a copy of the basic organizational document, if any, of the applicant and of
110.16 each major participating entity, such as the articles of incorporation, or other applicable
110.17 documents, and all amendments to it;

110.18 (2) a list of the names, addresses, and official positions of the following:

110.19 (i) all members of the board of directors and the principal officers and, if applicable,
110.20 shareholders of the applicant organization; and

110.21 (ii) all members of the board of directors and the principal officers of each major
110.22 participating entity and, if applicable, each shareholder beneficially owning more than ten
110.23 percent of any voting stock of the major participating entity;

110.24 (3) the name and address of each participating entity and the agreed-upon duration
110.25 of each contract or agreement if applicable;

110.26 (4) a copy of each standard agreement or contract intended to bind the participating
110.27 entities and the health information organization. Contractual provisions shall be consistent
110.28 with the purposes of this section in regard to the services to be performed under the
110.29 standard agreement or contract, the manner in which payment for services is determined,
110.30 the nature and extent of responsibilities to be retained by the health information
110.31 organization, and contractual termination provisions;

110.32 (5) a copy of each contract intended to bind major participating entities and the
110.33 health information organization. Contract information filed with the commissioner under
110.34 this section shall be nonpublic as defined in section 13.02, subdivision 9;

110.35 (6) a statement generally describing the health information organization, its health
110.36 information exchange contracts, facilities, and personnel, including a statement describing

- 111.1 the manner in which the applicant proposes to provide participants with comprehensive
111.2 health information exchange services;
- 111.3 (7) financial statements showing the applicant's assets, liabilities, and sources
111.4 of financial support, including a copy of the applicant's most recent certified financial
111.5 statement;
- 111.6 (8) strategic and operational plans that specifically address how the organization
111.7 will expand technical capacity of the health information organization to support providers
111.8 in achieving meaningful use of electronic health records over time, a description of
111.9 the proposed method of marketing the services, a schedule of proposed charges, and a
111.10 financial plan that includes a three-year projection of the expenses and income and other
111.11 sources of future capital;
- 111.12 (9) a statement reasonably describing the geographic area or areas to be served and
111.13 the type or types of participants to be served;
- 111.14 (10) a description of the complaint procedures to be used as required under this
111.15 section;
- 111.16 (11) a description of the mechanism by which participating entities will have an
111.17 opportunity to participate in matters of policy and operation;
- 111.18 (12) a copy of any pertinent agreements between the health information organization
111.19 and insurers, including liability insurers, demonstrating coverage is in place;
- 111.20 (13) a copy of the conflict of interest policy that applies to all members of the board
111.21 of directors and the principal officers of the health information organization; and
- 111.22 (14) other information as the commissioner may reasonably require to be provided.
- 111.23 (b) Thirty days after the receipt of the application for a certificate of authority,
111.24 the commissioner shall determine whether or not the application submitted meets the
111.25 requirements for completion in paragraph (a), and notify the applicant of any further
111.26 information required for the application to be processed.
- 111.27 (c) Ninety days after the receipt of a complete application for a certificate of
111.28 authority, the commissioner shall issue a certificate of authority to the applicant if the
111.29 commissioner determines that the applicant meets the minimum criteria requirements
111.30 of subdivision 2 for health data intermediaries or subdivision 3 for health information
111.31 organizations. If the commissioner determines that the applicant is not qualified, the
111.32 commissioner shall notify the applicant and specify the reasons for disqualification.
- 111.33 (d) Upon being granted a certificate of authority to operate as a health information
111.34 organization, the organization must operate in compliance with the provisions of this
111.35 section. Noncompliance may result in the imposition of a fine or the suspension or
111.36 revocation of the certificate of authority according to section 62J.4982.

112.1 Subd. 5. Reciprocal agreements between health information exchange entities.

112.2 (a) Reciprocal agreements between two health information organizations or between a
112.3 health information organization and a health data intermediary must include a fair and
112.4 equitable model for charges between the entities that:

112.5 (1) does not impede the secure transmission of transactions necessary to achieve
112.6 meaningful use;

112.7 (2) does not charge a fee for the exchange of meaningful use transactions transmitted
112.8 according to nationally recognized standards where no additional value-added service
112.9 is rendered to the sending or receiving health information organization or health data
112.10 intermediary either directly or on behalf of the client;

112.11 (3) is consistent with fair market value and proportionately reflects the value-added
112.12 services accessed as a result of the agreement; and

112.13 (4) prevents health care stakeholders from being charged multiple times for the
112.14 same service.

112.15 (b) Reciprocal agreements must include comparable quality of service standards that
112.16 ensure equitable levels of services.

112.17 (c) Reciprocal agreements are subject to review and approval by the commissioner.

112.18 (d) Nothing in this section precludes a state-certified health information organization
112.19 or state-certified health data intermediary from entering into contractual agreements for
112.20 the provision of value-added services beyond meaningful use.

112.21 (e) The commissioner of human services or health, when providing access to data or
112.22 services through a certified health information organization, must offer the same data or
112.23 services directly through any certified health information organization at the same pricing,
112.24 if the health information organization pays for all connection costs to the state data or
112.25 service. For all external connectivity to the respective agencies through existing or future
112.26 information exchange implementations, the respective agency shall establish the required
112.27 connectivity methods as well as protocol standards to be utilized.

112.28 Subd. 6. State participation in health information exchange. A state agency
112.29 that connects to a health information exchange service provider for the purpose of
112.30 exchanging meaningful use transactions must ensure that the contracted health information
112.31 exchange service provider has reciprocal agreements in place as required by this section.
112.32 The reciprocal agreements must provide equal access to information supplied by the
112.33 agency and necessary for meaningful use by the participating entities of the other health
112.34 information service providers.

112.35 Sec. 8. [62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.

113.1 Subdivision 1. Penalties and enforcement. (a) The commissioner may, for any
113.2 violation of statute or rule applicable to a health information exchange service provider,
113.3 levy an administrative penalty in an amount up to \$25,000 for each violation. In
113.4 determining the level of an administrative penalty, the commissioner shall consider the
113.5 following factors:

113.6 (1) the number of participating entities affected by the violation;
113.7 (2) the effect of the violation on participating entities' access to health information
113.8 exchange services;

113.9 (3) if only one participating entity is affected, the effect of the violation on the
113.10 patients of that entity;

113.11 (4) whether the violation is an isolated incident or part of a pattern of violations;
113.12 (5) the economic benefits derived by the health information organization or a health
113.13 data intermediary by virtue of the violation;

113.14 (6) whether the violation hindered or facilitated an individual's ability to obtain
113.15 health care;

113.16 (7) whether the violation was intentional;
113.17 (8) whether the violation was beyond the direct control of the health information
113.18 exchange service provider;

113.19 (9) any history of prior compliance with the provisions of this section, including
113.20 violations;

113.21 (10) whether and to what extent the health information exchange service provider
113.22 attempted to correct previous violations;

113.23 (11) how the health information exchange service provider responded to technical
113.24 assistance from the commissioner provided in the context of a compliance effort; and
113.25 (12) the financial condition of the health information exchange service provider
113.26 including, but not limited to, whether the health information exchange service provider
113.27 had financial difficulties that affected its ability to comply or whether the imposition of an
113.28 administrative monetary penalty would jeopardize the ability of the health information
113.29 exchange service provider to continue to deliver health information exchange services.

113.30 Reasonable notice in writing shall be given to the health information exchange
113.31 service provider of the intent to levy the penalty and the reasons for them. A health
113.32 information exchange service provider may have 15 days within which to contest whether
113.33 the finding of facts constitute a violation of this section and section 62J.4981, according to
113.34 the contested case and judicial review provisions of sections 14.57 to 14.69.

113.35 (b) If the commissioner has reason to believe that a violation of this section or
113.36 section 62J.4981 has occurred or is likely, the commissioner may confer with the persons

114.1 involved before commencing action under subdivision 2. The commissioner may notify
114.2 the health information exchange service provider and the representatives, or other persons
114.3 who appear to be involved in the suspected violation, to arrange a voluntary conference
114.4 with the alleged violators or their authorized representatives. The purpose of the
114.5 conference is to attempt to learn the facts about the suspected violation and if it appears
114.6 that a violation has occurred or is threatened, to find a way to correct or prevent it. The
114.7 conference is not governed by any formal procedural requirements and may be conducted
114.8 as the commissioner considers appropriate.

114.9 (c) The commissioner may issue an order directing a health information exchange
114.10 service provider or a representative of a health information exchange service provider to
114.11 cease and desist from engaging in any act or practice in violation of this section and
114.12 section 62J.4981.

114.13 (d) Within 20 days after service of the order to cease and desist, a health information
114.14 exchange service provider may contest whether the finding of facts constitutes a violation
114.15 of this section and section 62J.4981 according to the contested case and judicial review
114.16 provisions of sections 14.57 to 14.69.

114.17 (e) In the event of noncompliance with a cease and desist order issued under this
114.18 subdivision, the commissioner may institute a proceeding to obtain injunctive relief or
114.19 other appropriate relief in Ramsey County District Court.

114.20 Subd. 2. **Suspension or revocation of certificates of authority.** (a) The
114.21 commissioner may suspend or revoke a certificate of authority issued to a health
114.22 data intermediary or health information organization under section 62J.4981 if the
114.23 commissioner finds that:

114.24 (1) the health information exchange service provider is operating significantly
114.25 in contravention of its basic organizational document, or in a manner contrary to that
114.26 described in and reasonably inferred from any other information submitted under section
114.27 62J.4981, unless amendments to the submissions have been filed with and approved by
114.28 the commissioner;

114.29 (2) the health information exchange service provider is unable to fulfill its
114.30 obligations to furnish comprehensive health information exchange services as required
114.31 under its health information exchange contract;

114.32 (3) the health information exchange service provider is no longer financially solvent
114.33 or may not reasonably be expected to meet its obligations to participating entities;

114.34 (4) the health information exchange service provider has failed to implement the
114.35 complaint system in a manner designed to reasonably resolve valid complaints;

115.1 (5) the health information exchange service provider, or any person acting with its
115.2 sanction, has advertised or merchandised its services in an untrue, misleading, deceptive,
115.3 or unfair manner;

115.4 (6) the continued operation of the health information exchange service provider
115.5 would be hazardous to its participating entities or the patients served by the participating
115.6 entities; or

115.7 (7) the health information exchange service provider has otherwise failed to
115.8 substantially comply with section 62J.4981 or with any other statute or administrative
115.9 rule applicable to health information exchange service providers, or has submitted false
115.10 information in any report required under sections 62J.498 to 62J.4982.

115.11 (b) A certificate of authority shall be suspended or revoked only after meeting the
115.12 requirements of subdivision 3.

115.13 (c) If the certificate of authority of a health information exchange service provider is
115.14 suspended, the health information exchange service provider shall not, during the period
115.15 of suspension, enroll any additional participating entities, and shall not engage in any
115.16 advertising or solicitation.

115.17 (d) If the certificate of authority of a health information exchange service provider is
115.18 revoked, the organization shall proceed, immediately following the effective date of the
115.19 order of revocation, to wind up its affairs and shall conduct no further business except as
115.20 necessary to the orderly conclusion of the affairs of the organization. The organization
115.21 shall engage in no further advertising or solicitation. The commissioner may, by written
115.22 order, permit further operation of the organization as the commissioner finds to be in the
115.23 best interest of participating entities, to the end that participating entities will be given the
115.24 greatest practical opportunity to access continuing health information exchange services.

115.25 **Subd. 3. Denial, suspension, and revocation; administrative procedures.** (a)
115.26 When the commissioner has cause to believe that grounds for the denial, suspension,
115.27 or revocation of a certificate of authority exists, the commissioner shall notify the
115.28 health information exchange service provider in writing stating the grounds for denial,
115.29 suspension, or revocation and setting a time within 20 days for a hearing on the matter.

115.30 (b) After a hearing before the commissioner at which the health information
115.31 exchange service provider may respond to the grounds for denial, suspension, or
115.32 revocation, or upon the failure of the health information exchange service provider to
115.33 appear at the hearing, the commissioner shall take action as deemed necessary and shall
115.34 issue written findings that shall be mailed to the health information exchange service
115.35 provider.

116.1 (c) If suspension, revocation, or an administrative penalty is proposed according
116.2 to this section, the commissioner must deliver, or send by certified mail with return
116.3 receipt requested, to the health information exchange service provider written notice of
116.4 the commissioner's intent to impose a penalty. This notice of proposed determination
116.5 must include:

116.6 (1) a reference to the statutory basis for the penalty;

116.7 (2) a description of the findings of fact regarding the violations with respect to
116.8 which the penalty is proposed;

116.9 (3) the nature and amount of the proposed penalty;

116.10 (4) any circumstances described in subdivision 1, paragraph (a), that were considered
116.11 in determining the amount of the proposed penalty;

116.12 (5) instructions for responding to the notice, including a statement of the health
116.13 information exchange service provider's right to a contested case proceeding and a
116.14 statement that failure to request a contested case proceeding within 30 calendar days
116.15 permits the imposition of the proposed penalty; and

116.16 (6) the address to which the contested case proceeding request must be sent.

116.17 Subd. 4. **Coordination.** (a) To the extent possible when implementing sections
116.18 62J.498 to 62J.4982, the commissioner shall seek the advice of the Minnesota e-Health
116.19 Advisory Committee, in the review and update of criteria for the certification and
116.20 recertification of health information exchange service providers.

116.21 (b) By January 1, 2011, the commissioner shall report to the governor and the
116.22 chairs of the senate and house of representatives committees having jurisdiction over
116.23 health information policy issues on the status of the health information exchange in
116.24 Minnesota and provide recommendations on further action necessary to facilitate the
116.25 secure electronic movement of health information among health providers that will enable
116.26 Minnesota providers and hospitals to meet meaningful use exchange requirements.

116.27 Subd. 5. **Fees and monetary penalties.** (a) Every health information exchange
116.28 service provider subject to this section and section 62J.4981 shall be assessed fees as
116.29 follows:

116.30 (1) filing an application for certificate of authority to operate as a health information
116.31 organization, \$10,500;

116.32 (2) filing an application for certificate of authority to operate as a health data
116.33 intermediary, \$7,000;

116.34 (3) annual health information organization certificate fee, \$14,000;

116.35 (4) annual health data intermediary certificate fee, \$7,000; and

116.36 (5) fees for other filings, as specified by rule.

117.1 (b) Administrative monetary penalties imposed under this subdivision shall be
117.2 deposited into a revolving fund and are appropriated to the commissioner for the purposes
117.3 of sections 62J.498 to 62J.4982.

117.4 Sec. 9. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

117.5 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
117.6 community providers. The criteria for essential community provider designation shall be
117.7 the following:

117.8 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
117.9 with medical care for uninsured persons and high-risk and special needs populations,
117.10 underserved, and other special needs populations; and

117.11 (2) a commitment to serve low-income and underserved populations by meeting the
117.12 following requirements:

117.13 (i) has nonprofit status in accordance with chapter 317A;

117.14 (ii) has tax exempt status in accordance with the Internal Revenue Service Code,
117.15 section 501(c)(3);

117.16 (iii) charges for services on a sliding fee schedule based on current poverty income
117.17 guidelines; and

117.18 (iv) does not restrict access or services because of a client's financial limitation;

117.19 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
117.20 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
117.21 government, an Indian health service unit, or a community health board as defined in
117.22 chapter 145A;

117.23 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
117.24 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
117.25 conditions; ~~or~~

117.26 (5) a sole community hospital. For these rural hospitals, the essential community
117.27 provider designation applies to all health services provided, including both inpatient and
117.28 outpatient services. For purposes of this section, "sole community hospital" means a
117.29 rural hospital that:

117.30 (i) is eligible to be classified as a sole community hospital according to Code
117.31 of Federal Regulations, title 42, section 412.92, or is located in a community with a
117.32 population of less than 5,000 and located more than 25 miles from a like hospital currently
117.33 providing acute short-term services;

118.1 (ii) has experienced net operating income losses in two of the previous three
118.2 most recent consecutive hospital fiscal years for which audited financial information is
118.3 available; and

118.4 (iii) consists of 40 or fewer licensed beds; or
118.5 (6) a birth center licensed under section 144.615.

118.6 (b) Prior to designation, the commissioner shall publish the names of all applicants
118.7 in the State Register. The public shall have 30 days from the date of publication to submit
118.8 written comments to the commissioner on the application. No designation shall be made
118.9 by the commissioner until the 30-day period has expired.

118.10 (c) The commissioner may designate an eligible provider as an essential community
118.11 provider for all the services offered by that provider or for specific services designated by
118.12 the commissioner.

118.13 (d) For the purpose of this subdivision, supportive and stabilizing services include at
118.14 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

118.15 Sec. 10. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

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

118.25 (b) In addition to any fee prescribed under subdivision 1, there shall be a
118.26 nonrefundable surcharge of \$10 for each certified birth record. The local or state registrar
118.27 shall forward this amount to the commissioner of finance for deposit in the general fund
118.28 for the Minnesota Birth Defects Information System established under section 144.2215.
118.29 This surcharge shall not be charged under those circumstances in which no fee for a
118.30 certified birth record is permitted under subdivision 1, paragraph (a).

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

118.32 Sec. 11. Minnesota Statutes 2008, section 144.293, subdivision 4, is amended to read:

119.1 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is
119.2 valid for one year or for a ~~lesser~~ period specified in the consent or for a different period
119.3 provided by law.

119.4 Sec. 12. **[144.615] BIRTH CENTERS.**

119.5 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
119.6 have the meanings given them.

119.7 (b) "Birth center" means a facility licensed for the primary purpose of performing
119.8 low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are
119.9 planned to occur away from the mother's usual residence following a low-risk pregnancy.

119.10 (c) "CABC" means the Commission for the Accreditation of Birth Centers.

119.11 (d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as
119.12 determined by documentation of adequate prenatal care and the anticipation of a normal
119.13 uncomplicated labor and birth, as defined by reasonable and generally accepted criteria
119.14 adopted by professional groups for maternal, fetal, and neonatal health care.

119.15 Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be
119.16 established, operated, or maintained in the state without first obtaining a license from the
119.17 commissioner of health according to this section.

119.18 (b) A license issued under this section is not transferable or assignable and is subject
119.19 to suspension or revocation at any time for failure to comply with this section.

119.20 (c) A birth center licensed under this section shall not assert, represent, offer,
119.21 provide, or imply that the center is or may render care or services other than the services it
119.22 is permitted to render within the scope of the license or the accreditation issued.

119.23 (d) The license must be conspicuously posted in an area where patients are admitted.

119.24 Subd. 3. **Temporary license.** For new birth centers planning to begin operations
119.25 after January 1, 2011, the commissioner may issue a temporary license to the birth center
119.26 that is valid for a period of six months from the date of issuance. The birth center must
119.27 submit to the commissioner an application and applicable fee for licensure as required
119.28 under subdivision 4. The application must include the information required in subdivision
119.29 4, clauses (1) to (3) and (5) to (7), and documentation that the birth center has submitted
119.30 an application for accreditation to the CABC. Upon receipt of accreditation from the
119.31 CABC, the birth center must submit to the commissioner the information required in
119.32 subdivision 4, clause (4), and the applicable fee under subdivision 8. The commissioner
119.33 shall issue a new license.

120.1 Subd. 4. **Application.** An application for a license to operate a birth center and the
120.2 applicable fee under subdivision 8 must be submitted to the commissioner on a form
120.3 provided by the commissioner and must contain:

120.4 (1) the name of the applicant;

120.5 (2) the site location of the birth center;

120.6 (3) the name of the person in charge of the center;

120.7 (4) documentation that the accreditation described under subdivision 6 has been
120.8 issued, including the effective date and the expiration date of the accreditation, and the
120.9 date of the last site visit by the CABC;

120.10 (5) the number of patients the birth center is capable of serving at a given time;

120.11 (6) the names and license numbers, if applicable, of the health care professionals
120.12 on staff at the birth center; and

120.13 (7) any other information the commissioner deems necessary.

120.14 Subd. 5. **Suspension, revocation, and refusal to renew.** The commissioner may
120.15 refuse to grant or renew, or may suspend or revoke, a license on any of the grounds
120.16 described under section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or
120.17 upon the loss of accreditation by the CABC. The applicant or licensee is entitled to notice
120.18 and a hearing as described under section 144.55, subdivision 7, and a new license may be
120.19 issued after proper inspection of the birth center has been conducted.

120.20 Subd. 6. **Standards for licensure.** (a) To be eligible for licensure under this
120.21 section, a birth center must be accredited by the CABC or must obtain accreditation
120.22 within six months of the date of the application for licensure. If the birth center loses its
120.23 accreditation, the birth center must immediately notify the commissioner.

120.24 (b) The center must have procedures in place specifying criteria by which risk status
120.25 will be established and applied to each woman at admission and during labor.

120.26 (c) Upon request, the birth center shall provide the commissioner of health with any
120.27 material submitted by the birth center to the CABC as part of the accreditation process,
120.28 including the accreditation application, the self-evaluation report, the accreditation
120.29 decision letter from the CABC, and any reports from the CABC following a site visit.

120.30 Subd. 7. **Limitations of services.** (a) The following limitations apply to the services
120.31 performed at a birth center:

120.32 (1) surgical procedures must be limited to those normally accomplished during an
120.33 uncomplicated birth, including episiotomy and repair;

120.34 (2) no abortions may be administered; and

120.35 (3) no general or regional anesthesia may be administered.

121.1 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth
121.2 center if the administration of the anesthetic is performed within the scope of practice of a
121.3 health care professional.

121.4 Subd. 8. **Fees.** (a) The biennial license fee for a birth center is \$365.

121.5 (b) The temporary license fee is \$365.

121.6 (c) Fees shall be collected and deposited according to section 144.122.

121.7 Subd. 9. **Renewal.** (a) Except as provided in paragraph (b), a license issued under
121.8 this section expires two years from the date of issue.

121.9 (b) A temporary license issued under subdivision 3 expires six months from the date
121.10 of issue, and may be renewed for one additional six-month period.

121.11 (c) An application for renewal shall be submitted at least 60 days prior to expiration
121.12 of the license on forms prescribed by the commissioner of health.

121.13 Subd. 10. **Records.** All health records maintained on each client by a birth center
121.14 are subject to sections 144.292 to 144.298.

121.15 Subd. 11. **Report.** (a) The commissioner of health, in consultation with the
121.16 commissioner of human services and representatives of the licensed birth centers,
121.17 the American College of Obstetricians and Gynecologists, the American Academy
121.18 of Pediatrics, the Minnesota Hospital Association, and the Minnesota Ambulance
121.19 Association, shall evaluate the quality of care and outcomes for services provided in
121.20 licensed birth centers, including, but not limited to, the utilization of services provided at a
121.21 birth center, the outcomes of care provided to both mothers and newborns, and the numbers
121.22 of transfers to other health care facilities that are required and the reasons for the transfers.
121.23 The commissioner shall work with the birth centers to establish a process to gather and
121.24 analyze the data within protocols that protect the confidentiality of patient identification.

121.25 (b) The commissioner of health shall report the findings of the evaluation to the
121.26 legislature by January 15, 2014.

121.27 Sec. 13. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:

121.28 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person
121.29 who is admitted to an acute care inpatient facility for a continuous period longer than
121.30 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental
121.31 health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20,
121.32 "patient" also means a person who receives health care services at an outpatient surgical
121.33 center or at a birth center licensed under section 144.615. "Patient" also means a minor
121.34 who is admitted to a residential program as defined in section 253C.01. For purposes of
121.35 subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving

122.1 mental health treatment on an outpatient basis or in a community support program or other
122.2 community-based program. "Resident" means a person who is admitted to a nonacute care
122.3 facility including extended care facilities, nursing homes, and boarding care homes for
122.4 care required because of prolonged mental or physical illness or disability, recovery from
122.5 injury or disease, or advancing age. For purposes of all subdivisions except subdivisions
122.6 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board
122.7 and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised
122.8 living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates
122.9 a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

122.10 Sec. 14. Minnesota Statutes 2008, section 144.9504, is amended by adding a
122.11 subdivision to read:

122.12 Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner
122.13 must revise clinical and case management guidelines to include recommendations
122.14 for protective health actions and follow-up services when a child's blood lead level
122.15 exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be
122.16 implemented to the extent possible using available resources.

122.17 (b) In revising the clinical and case management guidelines for blood lead levels
122.18 greater than five micrograms of lead per deciliter of blood under this subdivision,
122.19 the commissioner of health must consult with a statewide organization representing
122.20 physicians, the public health department of Minneapolis and other public health
122.21 departments, and a nonprofit organization with expertise in lead abatement.

122.22 Sec. 15. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

122.23 Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility
122.24 which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a
122.25 facility or that part of a facility which is required to be licensed under any law of this state
122.26 which provides for the licensure of nursing homes.

122.27 Sec. 16. Minnesota Statutes 2008, section 144E.37, is amended to read:

122.28 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

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

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

123.2 Sec. 17. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
123.3 **REDUCTION; REPORTING REQUIREMENTS.**

123.4 (a) Minnesota health plans and county-based purchasing plans may complete an
123.5 inventory of existing data collection and reporting requirements for health plans and
123.6 county-based purchasing plans and submit to the commissioners of health and human
123.7 services a list of data, documentation, and reports that:

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

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

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

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

123.15 (b) The report to the commissioners may also identify the percentage of health
123.16 plan and county-based purchasing plan administrative time and expense attributed to
123.17 fulfilling reporting requirements and include recommendations regarding ways to reduce
123.18 duplicative reporting requirements.

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

123.25 Sec. 18. **APPLICATION PROCESS FOR HEALTH INFORMATION**
123.26 **EXCHANGE.**

123.27 To the extent that the commissioner of health applies for additional federal funding
123.28 to support the commissioner's responsibilities of developing and maintaining state level
123.29 health information exchange under section 3013 of the HITECH Act, the commissioner of
123.30 health shall ensure that applications are made through an open process that provides health
123.31 information exchange service providers equal opportunity to receive funding.

123.32 Sec. 19. **TRANSFER.**

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

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

124.6 Sec. 20. **REVISOR'S INSTRUCTION.**

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

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

124.11 **ARTICLE 7**

124.12 **HEALTH CARE REFORM**

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

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

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

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

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

124.24 Subd. 2. **Timing of this section.** This section applies beginning as of the date the
124.25 temporary federal qualified high risk health pool created under the federal law begins
124.26 to provide coverage in this state.

124.27 Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive
124.28 health association on its member insurers must comply with the maintenance of effort
124.29 requirement contained in paragraph (b), clause (3), of the federal law, to the extent that
124.30 requirement applies to assessments made by the association.

124.31 Subd. 4. **Coordination with state health care programs.** The commissioner of
124.32 human services, in consultation with the commissioner of commerce and the Minnesota
124.33 Comprehensive Health Association, shall coordinate enrollment between medical

125.1 assistance, MinnesotaCare, the federal qualified high-risk pool, and the Minnesota
125.2 Comprehensive Health Association, to ensure that:

125.3 (1) applicants for coverage through the federal qualified high-risk pool, or through
125.4 the Minnesota Comprehensive Health Association to the extent the association is enrolling
125.5 new members, are referred to the medical assistance or MinnesotaCare programs if they
125.6 are determined to be potentially eligible for coverage through those programs; and

125.7 (2) applicants for coverage under medical assistance or MinnesotaCare who are
125.8 determined not to be eligible for those programs are provided information about coverage
125.9 through the federal qualified high-risk pool and the Minnesota Comprehensive Health
125.10 Association.

125.11 Sec. 2. Minnesota Statutes 2008, section 62J.07, subdivision 2, is amended to read:

125.12 Subd. 2. **Membership.** The Legislative Commission on Health Care Access
125.13 consists of ~~five~~ seven members of the senate appointed under the rules of the senate and
125.14 ~~five~~ seven members of the house of representatives appointed under the rules of the house
125.15 of representatives. The Legislative Commission on Health Care Access must include ~~three~~
125.16 five members of the majority party and two members of the minority party in each house.

125.17 Sec. 3. Minnesota Statutes 2008, section 62J.07, is amended by adding a subdivision to
125.18 read:

125.19 Subd. 5. **Federal health care reform.** (a) The Legislative Commission on
125.20 Health Care Access shall analyze options and make recommendations regarding the
125.21 implementation of provisions of the Patient Protection and Affordable Health Care Act,
125.22 Public Law 111-148, and the health care reform provisions in the Health Care and
125.23 Education Reconciliation Act of 2010, Public Law 111-152, including:

125.24 (1) development of accountable care organizations;

125.25 (2) health insurance reform, including options related to coverage, purchasing,
125.26 exchange development, and coverage for high-risk individuals; and

125.27 (3) other provisions that will require changes in state law.

125.28 (b) Before finalizing and submitting federal applications for pilot projects authorized
125.29 under federal health care reform, the governor and state agencies shall seek review and
125.30 advice from the commission.

125.31 (c) The commission may create and make appointments to work groups to assist the
125.32 commission in its work. Work group members may include legislators, representatives
125.33 of businesses and nonprofit agencies impacted by federal health care reform, academic
125.34 experts, and consumer representatives.

126.1 Sec. 4. Minnesota Statutes 2008, section 62U.05, is amended to read:

126.2 **62U.05 PROVIDER PRICING FOR BASKETS OF CARE; ACCOUNTABLE**
126.3 **CARE ORGANIZATIONS.**

126.4 Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner
126.5 of health shall establish uniform definitions for baskets of care beginning with a minimum
126.6 of seven baskets of care. In selecting health conditions for which baskets of care should
126.7 be defined, the commissioner shall consider coronary artery and heart disease, diabetes,
126.8 asthma, and depression. In selecting health conditions, the commissioner shall also
126.9 consider the prevalence of the health conditions, the cost of treating the health conditions,
126.10 and the potential for innovations to reduce cost and improve quality.

126.11 (b) The commissioner shall convene one or more work groups to assist in
126.12 establishing these definitions. Each work group shall include members appointed by
126.13 statewide associations representing relevant health care providers and health plan
126.14 companies, and organizations that work to improve health care quality in Minnesota.

126.15 (c) To the extent possible, the baskets of care must incorporate a patient-directed,
126.16 decision-making support model.

126.17 (d) By January 1, 2012, the commissioner shall establish uniform definitions for the
126.18 total cost of providing all necessary services to a patient through an accountable care
126.19 organization meeting the standards specified in section 3022 of the Patient Protection
126.20 and Affordable Care Act, Public Law 111-148, and shall develop a standard method
126.21 and format for accountable care organizations to use for submitting package prices for
126.22 the total cost of care. This method must be published in the State Register and must be
126.23 made available to all providers.

126.24 Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may
126.25 establish package prices for the baskets of care defined under subdivision 1. Beginning
126.26 July 1, 2012, accountable care organizations may establish package prices for the total
126.27 cost of care defined under subdivision 1.

126.28 (b) Beginning January 1, 2010, no health care provider or group of providers that
126.29 has established a package price for a basket of care under this section, and beginning
126.30 July 1, 2012, no accountable care organization that has established a package price for
126.31 the total cost of care under this section, shall vary the payment amount that the provider
126.32 or organization accepts as full payment for a health care service based upon the identity of
126.33 the payer, upon a contractual relationship with a payer, upon the identity of the patient,
126.34 or upon whether the patient has coverage through a group purchaser. This paragraph
126.35 applies only to health care services provided to Minnesota residents or to non-Minnesota
126.36 residents who obtain health insurance through a Minnesota employer. This paragraph does

127.1 not apply to services paid for by Medicare, state public health care programs through
127.2 fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile
127.3 insurance. This paragraph does not affect the right of a provider to provide charity care
127.4 or care for a reduced price due to financial hardship of the patient or due to the patient
127.5 being a relative or friend of the provider.

127.6 Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall
127.7 establish quality measurements for the defined baskets of care by December 31, 2009.
127.8 The commissioner shall establish quality measures for the total cost of care for services
127.9 delivered through an accountable care organization by June 30, 2012. The commissioner
127.10 may contract with an organization that works to improve health care quality to make
127.11 recommendations about the use of existing measures or establishing new measures where
127.12 no measures currently exist.

127.13 (b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall
127.14 publish comparative price and quality information on the baskets of care in a manner
127.15 that is easily accessible and understandable to the public, as this information becomes
127.16 available. Beginning January 1, 2013, the commissioner or the commissioner's designee
127.17 shall publish comparative price and quality information on the total cost of care for
127.18 services delivered through an accountable care organization in a manner that is easily
127.19 accessible and understandable to the public, as this information becomes available.

127.20 Sec. 5. Minnesota Statutes 2008, section 256B.0754, is amended by adding a
127.21 subdivision to read:

127.22 Subd. 3. **Accountable care organizations.** By July 1, 2012, the commissioner of
127.23 human services shall deliver services to enrollees in state health care programs through
127.24 accountable care organizations, and shall provide incentive payments to accountable care
127.25 organizations that meet or exceed annual quality and performance targets. Accountable
127.26 care organizations and incentive payments must meet the standards specified in the Patient
127.27 Protection and Affordable Care Act, Public Law 111-148. Prescription drug coverage
127.28 must not be provided through accountable care organizations and must instead be provided
127.29 through a delivery method that qualifies for federal prescription drug rebates.

127.30 Sec. 6. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

127.31 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
127.32 medical assistance coverage of health home services for eligible individuals with chronic
127.33 conditions who select a designated provider, a team of health care professionals, or a
127.34 health team as the individual's health home.

128.1 (b) The commissioner shall implement this section in compliance with the
128.2 requirements of the state option to provide health homes for enrollees with chronic
128.3 conditions, as provided under the Patient Protection and Affordable Care Act, Public
128.4 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
128.5 provided in that act.

128.6 Subd. 2. **Eligible individual.** An individual is eligible for health home services
128.7 under this section if the individual is eligible for medical assistance under this chapter
128.8 and has at least:

128.9 (1) two chronic conditions;

128.10 (2) one chronic condition and is at risk of having a second chronic condition; or

128.11 (3) one serious and persistent mental health condition.

128.12 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
128.13 timely high-quality services that are provided by a health home. These services include:

128.14 (1) comprehensive care management;

128.15 (2) care coordination and health promotion;

128.16 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
128.17 to other settings;

128.18 (4) patient and family support, including authorized representatives;

128.19 (5) referral to community and social support services, if relevant; and

128.20 (6) use of health information technology to link services, as feasible and appropriate.

128.21 (b) The commissioner shall maximize the number and type of services

128.22 included in this subdivision to the extent permissible under federal law, including

128.23 physician, outpatient, mental health treatment, and rehabilitation services necessary for

128.24 comprehensive transitional care following hospitalization.

128.25 Subd. 4. **Health teams.** The commissioner shall establish health teams to support

128.26 the patient-centered health home and provide the services described in subdivision 3 to

128.27 individuals eligible under subdivision 2. The commissioner shall apply for grants or

128.28 contracts as provided under section 3502 of the Patient Protection and Affordable Care

128.29 Act to establish health teams and provide capitated payments to primary care providers.

128.30 For purposes of this section, "health teams" means community-based, interdisciplinary,

128.31 inter-professional teams of health care providers that support primary care practices.

128.32 These providers may include medical specialists, nurses, advanced practice registered

128.33 nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers,

128.34 doctors of chiropractic, licensed complementary and alternative medicine practitioners,

128.35 and physician's assistants.

129.1 Subd. 5. **Payments.** The commissioner shall make payments to each health home
129.2 and each health team for the provision of health home services to each eligible individual
129.3 with chronic conditions that selects the health home as a provider.

129.4 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
129.5 the requirements and payment methods for health homes and health teams developed
129.6 under this section are consistent with the requirements and payment methods for health
129.7 care homes established under sections 256B.0751 and 256B.0753. The commissioner may
129.8 modify requirements and payment methods under sections 256B.0751 and 256B.0753 in
129.9 order to be consistent with federal health home requirements and payment methods.

129.10 Subd. 7. **State plan amendment.** The commissioner shall submit a state plan
129.11 amendment to implement this section to the federal Centers for Medicare and Medicaid
129.12 Services by January 1, 2011.

129.13 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
129.14 approval, whichever is later.

129.15 Sec. 7. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS**
129.16 **AND GRANTS.**

129.17 (a) The commissioner of human services shall seek to participate in the following
129.18 demonstration projects, or apply for the following grants, as described in the federal
129.19 Patient Protection and Affordable Care Act, Public Law 111-148:

129.20 (1) the demonstration project to evaluate integrated care around a hospitalization,
129.21 Public Law 111-148, section 2704;

129.22 (2) the Medicaid global payment system demonstration project, Public Law 111-148,
129.23 section 2705;

129.24 (3) the pediatric accountable care organization demonstration project, Public Law
129.25 111-148, section 2706;

129.26 (4) the Medicaid emergency psychiatric demonstration project, Public Law 111-148,
129.27 section 2707; and

129.28 (5) grants to provide incentives for prevention of chronic diseases in Medicaid,
129.29 Public Law 111-148, section 4108.

129.30 (b) The commissioner of human services shall report to the chairs and ranking
129.31 minority members of the house of representatives and senate committees or divisions with
129.32 jurisdiction over health care policy and finance on the status of the demonstration project
129.33 and grant applications. If the state is accepted as a demonstration project participant, or is
129.34 awarded a grant, the commissioner shall notify the chairs and ranking minority members

130.1 of those committees or divisions of any legislative changes necessary to implement the
130.2 demonstration projects or grants.

130.3 Sec. 8. **HEALTH CARE REFORM TASK FORCE.**

130.4 Subdivision 1. **Task force.** (a) The governor shall convene a Health Care
130.5 Reform Task Force to advise and assist the governor and the legislature regarding state
130.6 implementation of federal health care reform legislation. For purposes of this section,
130.7 "federal health care reform legislation" means the Patient Protection and Affordable Care
130.8 Act, Public Law 111-148, and the health care reform provisions in the Health Care and
130.9 Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:

130.10 (1) two legislators from the house of representatives appointed by the speaker and
130.11 two legislators from the senate appointed by the Subcommittee on Committees of the
130.12 Committee on Rules and Administration;

130.13 (2) two representatives appointed by the governor to represent the governor and
130.14 state agencies;

130.15 (3) three persons appointed by the governor who have demonstrated leadership in
130.16 health care organizations, health plan companies, or health care trade or professional
130.17 associations;

130.18 (4) three persons appointed by the governor who have demonstrated leadership in
130.19 employer and group purchaser activities related to health system improvement of whom
130.20 two must be from a labor organization and one from the business community; and

130.21 (5) five persons appointed by the governor who have demonstrated expertise in the
130.22 areas of health care financing, access, and quality.

130.23 The governor is exempt from the requirements of the open appointments process
130.24 for purposes of appointing task force members. Members shall be appointed for one-year
130.25 terms and may be reappointed.

130.26 (b) The Department of Health, Department of Human Services, and Department of
130.27 Commerce shall provide staff support to the task force. The task force may accept outside
130.28 resources to help support its efforts.

130.29 (c) Task force members must be appointed by July 1, 2010. The task force must hold
130.30 its first meeting by July 15, 2010.

130.31 Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and
130.32 present to the legislature and the governor a preliminary report and recommendations on
130.33 state implementation of federal health care reform legislation. The report must include
130.34 recommendations for state law and program changes necessary to comply with the federal
130.35 health care reform legislation, and also recommendations for implementing provisions of

131.1 the federal legislation that are optional for states. In developing recommendations, the task
 131.2 force shall consider the extent to which an approach maximizes federal funding to the state.

131.3 (b) The task force, in consultation with the governor and the legislature, shall also
 131.4 establish timelines and criteria for future reports on state implementation of the federal
 131.5 health care reform legislation.

131.6 **Sec. 9. AMERICAN HEALTH BENEFIT EXCHANGE; PLANNING**
 131.7 **PROVISIONS.**

131.8 Subdivision 1. **Federal planning grants.** The commissioners of commerce, health,
 131.9 and human services shall jointly or separately apply to the federal secretary of health and
 131.10 human services for one or more planning and establishment grants, including renewal
 131.11 grants, authorized under section 1311 of the Patient Protection and Affordable Care Act,
 131.12 Public Law 111-148, including any future amendments of that provision, relating to state
 131.13 creation of American Health Benefit Exchanges.

131.14 Subd. 2. **Consideration of early creation and operation of exchange.** (a) The
 131.15 commissioners referenced in subdivision 1 shall analyze the advantages and disadvantages
 131.16 to the state of planning to have a state health insurance exchange, similar to an American
 131.17 Health Benefit Exchange referenced in subdivision 1, begin prior to the federal deadline
 131.18 of January 1, 2014.

131.19 (b) The commissioners shall provide a written report to the legislature on the results
 131.20 of the analysis required under paragraph (a) no later than December 15, 2010. The written
 131.21 report must comply with Minnesota Statutes, sections 3.195 and 3.197.

131.22 **Sec. 10. STATE FISCAL IMPACT OF FEDERAL REFORM.**

131.23 The commissioner of human services, in consultation with the commissioners of
 131.24 health and commerce, must report to the legislature by January 1, 2011, the additional costs
 131.25 and savings to the state in fiscal years 2011 through 2015 imposed under implementation
 131.26 of the Federal Patient Protection and Affordable Care Act.

131.27 **ARTICLE 8**

131.28 **PUBLIC HEALTH**

131.29 **Section 1. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is**
 131.30 **amended to read:**

131.31 **Subd. 3. **Establishment fees; definitions.** (a) The following fees are required**
 131.32 **for food and beverage service establishments, youth camps, hotels, motels, lodging**
 131.33 **establishments, public pools, and resorts licensed under this chapter. Food and beverage**

132.1 service establishments must pay the highest applicable fee under paragraph (d), clause
132.2 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
132.3 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
132.4 licensed under this chapter for the same calendar year is one-half of the appropriate annual
132.5 license fee, plus any penalty that may be required. The license fee for operators opening
132.6 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
132.7 that may be required.

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

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

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

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

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

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

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

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

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

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

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

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

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

132.35 (iv) is a boarding establishment; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

134.15	Service Area	Type	Fee
134.16	Food	limited food menu	\$275
134.17		small establishment	\$400
134.18		medium establishment	\$450
134.19		large food establishment	\$500
134.20		additional food service	\$150
134.21	Transient food service	food cart	\$250
134.22		seasonal permanent food stand	\$250
134.23		seasonal temporary food stand	\$250
134.24		mobile food unit	\$350
134.25	Alcohol	beer or wine table service	\$150
134.26		alcohol service from bar	\$250
134.27	Lodging	less than 25 rooms	\$375
134.28		25 to less than 100 rooms	\$400
134.29		100 rooms or more	\$500
134.30		less than five cabins	\$350
134.31		five to less than ten cabins	\$400
134.32		ten cabins or more	\$450

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

134.37	Service Area	Type	Fee
134.38	Food	limited food menu	\$250
134.39		small establishment	\$300

135.1		medium establishment	\$350
135.2		large food establishment	\$400
135.3		additional food service	\$150
135.4	Transient food service	food cart	\$250
135.5		seasonal permanent food stand	\$250
135.6		seasonal temporary food stand	\$250
135.7		mobile food unit	\$250
135.8	Alcohol	beer or wine table service	\$150
135.9		alcohol service from bar	\$250
135.10	Lodging	less than 25 rooms	\$250
135.11		25 to less than 100 rooms	\$300
135.12		100 rooms or more	\$450
135.13		less than five cabins	\$250
135.14		five to less than ten cabins	\$350
135.15		ten cabins or more	\$400

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

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

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

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

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

135.22 (i) A youth camp which pays fees under paragraph (d) is not required to pay fees
135.23 under paragraph (h).

135.24 Sec. 2. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is
135.25 amended to read:

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

135.27 The following fees are required for manufactured home parks and recreational camping
135.28 areas licensed under this chapter. Recreational camping areas and manufactured home
135.29 parks shall pay the highest applicable base fee under paragraph ~~(e)~~ (b). The license fee
135.30 for new operators of a manufactured home park or recreational camping area previously
135.31 licensed under this chapter for the same calendar year is one-half of the appropriate annual
135.32 license fee, plus any penalty that may be required. The license fee for operators opening
135.33 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
135.34 that may be required.

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

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

136.1 (2) a recreational camping area with:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

136.29 **Sec. 3. FOOD SUPPORT FOR CHILDREN WITH SEVERE ALLERGIES.**

136.30 The commissioner of human services must seek a federal waiver from the federal
 136.31 Department of Agriculture, Food and Nutrition Service, for the supplemental nutrition
 136.32 assistance program, to increase the income eligibility requirements to 375 percent of the
 136.33 federal poverty guidelines, in order to cover nutritional food products required to treat
 136.34 or manage severe food allergies, including allergies to wheat and gluten, for infants and
 136.35 children who have been diagnosed with life-threatening severe food allergies.

137.1 **ARTICLE 9**

137.2 **HUMAN SERVICES FORECAST ADJUSTMENTS**

137.3 Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
 137.4 **SERVICES FORECAST ADJUSTMENT.**

137.5 The dollar amounts shown are added to or if shown in parentheses, are subtracted
 137.6 from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009,
 137.7 chapter 173, article 2, from the general fund or any fund named to the Department of
 137.8 Human Services for the purposes specified in this article, to be available for the fiscal
 137.9 year indicated for each purpose. The figure "2010" used in this article means that the
 137.10 appropriation or appropriations listed are available for the fiscal year ending June 30,
 137.11 2010. The figure "2011" used in this article means that the appropriation or appropriations
 137.12 listed are available for the fiscal year ending June 30, 2011.

	<u>2010</u>	<u>2011</u>
137.13		
137.14 <u>General</u>	\$ (109,876,000)	\$ (28,344,000)
137.15 <u>Health Care Access</u>	99,654,000	276,500,000
137.16 <u>Federal TANF</u>	(9,830,000)	15,133,000
137.17 <u>Total</u>	\$ (20,052,000)	\$ 263,289,000

137.18 Sec. 2. **COMMISSIONER OF HUMAN**
 137.19 **SERVICES**

137.20 <u>Subdivision 1. Total Appropriation</u>	\$ (20,052,000)	\$ 263,289,000
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137.21 Appropriations by Fund

	<u>2010</u>	<u>2011</u>
137.22		
137.23 <u>General</u>	(109,876,000)	(28,344,000)
137.24 <u>Health Care Access</u>	99,654,000	276,500,000
137.25 <u>Federal TANF</u>	(9,830,000)	15,133,000

137.26 Subd. 2. Revenue and Pass-Through

137.27 <u>Federal TANF</u>	390,000	(251,000)
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137.28 Subd. 3. Children and Economic Assistance
 137.29 **Grants**

137.30 <u>General Fund</u>	4,489,000	(4,140,000)
137.31 <u>Federal TANF</u>	(10,220,000)	15,384,000

137.32 The amounts that may be spent from this

137.33 appropriation are as follows:

137.34 **(a) MFIP Grants**

138.1	<u>General Fund</u>	<u>7,916,000</u>	<u>(14,481,000)</u>	
138.2	<u>TANF Fund</u>	<u>(10,220,000)</u>	<u>15,384,000</u>	
138.3	<u>(b) MFIP Child Care Assistance Grants</u>			<u>(7,832,000)</u>
				<u>2,579,000</u>
138.4	<u>(c) General Assistance Grants</u>			<u>875,000</u>
				<u>1,339,000</u>
138.5	<u>(d) Minnesota Supplemental Aid Grants</u>			<u>2,454,000</u>
				<u>3,843,000</u>
138.6	<u>(e) Group Residential Housing Grants</u>			<u>1,076,000</u>
				<u>2,580,000</u>
138.7	<u>Subd. 4. Basic Health Care Grants</u>			
138.8	<u>General Fund</u>	<u>(62,770,000)</u>	<u>29,192,000</u>	
138.9	<u>TANF Fund</u>	<u>99,654,000</u>	<u>276,500,000</u>	
138.10	<u>The amounts that may be spent from this</u>			
138.11	<u>appropriation are as follows:</u>			
138.12	<u>(a) MinnesotaCare Grants</u>			
138.13	<u>Health Care Access</u>			
138.14	<u>Fund</u>	<u>99,654,000</u>	<u>276,500,000</u>	
138.15	<u>(b) Medical Assistance Basic Health Care –</u>			
138.16	<u>Families and Children</u>			<u>1,165,000</u>
				<u>24,146,000</u>
138.17	<u>(c) Medical Assistance Basic Health Care –</u>			
138.18	<u>Elderly and Disabled</u>			<u>(63,935,000)</u>
				<u>5,046,000</u>
138.19	<u>Subd. 5. Continuing Care Grants</u>			<u>(51,595,000)</u>
				<u>(53,396,000)</u>
138.20	<u>The amounts that may be spent from this</u>			
138.21	<u>appropriation are as follows:</u>			
138.22	<u>(a) Medical Assistance Long-Term Care</u>			
138.23	<u>Facilities</u>			<u>(3,774,000)</u>
				<u>(8,275,000)</u>
138.24	<u>(b) Medical Assistance Long-Term Care</u>			
138.25	<u>Waivers</u>			<u>(27,710,000)</u>
				<u>(22,452,000)</u>
138.26	<u>(c) Chemical Dependency Entitlement Grants</u>			<u>(20,111,000)</u>
				<u>(22,669,000)</u>

138.27 **Sec. 3. EFFECTIVE DATE.**138.28 Sections 1 and 2 are effective the day following final enactment.138.29 **ARTICLE 10**138.30 **HUMAN SERVICES CONTINGENT APPROPRIATIONS**138.31 **Section 1. SUMMARY OF HUMAN SERVICES APPROPRIATIONS.**

140.1	<u>(a) MinnesotaCare Grants</u>	<u>-0-</u>	<u>686,000</u>
140.2	<u>This appropriation is from the health care</u>		
140.3	<u>access fund.</u>		
140.4	<u>(b) Medical Assistance Basic Health Care</u>		
140.5	<u>Grants - Families and Children</u>	<u>-0-</u>	<u>6,297,000</u>
140.6	<u>(c) Medical Assistance Basic Health Care</u>		
140.7	<u>Grants - Elderly and Disabled</u>	<u>-0-</u>	<u>3,697,000</u>
140.8	<u>Subd. 3. Continuing Care Grants</u>		
140.9	<u>(a) Medical Assistance - Long-Term Care</u>		
140.10	<u>Facilities Grants</u>	<u>-0-</u>	<u>2,486,000</u>
140.11	<u>(b) Medical Assistance Grants - Long-Term</u>		
140.12	<u>Care Waivers and Home Care Grants</u>	<u>-0-</u>	<u>547,000</u>
140.13	<u>(c) Chemical Dependency Entitlement Grants</u>	<u>-0-</u>	<u>356,000</u>

140.14 Sec. 4. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision
140.15 to read:

140.16 Subd. 4a. Division of costs for medical assistance services. Notwithstanding
140.17 subdivision 4, for chemical dependency services provided on or after October 1, 2008, and
140.18 reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

140.19 Sec. 5. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to
140.20 read:

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

140.26 **EFFECTIVE DATE.** This section is effective retroactive from March 23, 2010.

140.27 Sec. 6. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 1a,
140.28 is amended to read:

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

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

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

- 141.1 (2) providing recommendations on cost-effective community services that are
141.2 available to the individual;
- 141.3 (3) development of an individual's person-centered community support plan;
- 141.4 (4) providing information regarding eligibility for Minnesota health care programs;
- 141.5 (5) face-to-face long-term care consultation assessments, which may be completed
141.6 in a hospital, nursing facility, intermediate care facility for persons with developmental
141.7 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
141.8 residence;
- 141.9 (6) federally mandated screening to determine the need for a institutional level of
141.10 care under section 256B.0911, ~~subdivision 4, paragraph (a)~~ subdivision 4a;
- 141.11 (7) determination of home and community-based waiver service eligibility including
141.12 level of care determination for individuals who need an institutional level of care as
141.13 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including
141.14 state plan home care services identified in section 256B.0625, subdivisions 6, 7, and
141.15 19, paragraphs (a) and (c), based on assessment and support plan development with
141.16 appropriate referrals;
- 141.17 (8) providing recommendations for nursing facility placement when there are no
141.18 cost-effective community services available; and
- 141.19 (9) assistance to transition people back to community settings after facility
141.20 admission.
- 141.21 (b) "Long-term care options counseling" means the services provided by the linkage
141.22 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
141.23 telephone assistance and follow up once a long-term care consultation assessment has
141.24 been completed.
- 141.25 (c) "Minnesota health care programs" means the medical assistance program under
141.26 chapter 256B and the alternative care program under section 256B.0913.
- 141.27 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
141.28 plans administering long-term care consultation assessment and support planning services.

141.29 Sec. 7. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

141.30 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall
141.31 be responsible for a monthly transfer payment of \$1,500,000, due before noon on the
141.32 15th of each month and the University of Minnesota shall be responsible for a monthly
141.33 transfer payment of \$500,000 due before noon on the 15th of each month, beginning July
141.34 15, 1995. These sums shall be part of the designated governmental unit's portion of the
141.35 nonfederal share of medical assistance costs.

142.1 (b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall
142.2 be \$2,066,000 each month.

142.3 (c) Beginning July 1, 2001, the commissioner shall increase annual capitation
142.4 payments to the metropolitan health plan under section 256B.69 for the prepaid medical
142.5 assistance program by approximately ~~\$3,400,000, plus any available federal matching~~
142.6 ~~funds, \$6,800,000~~ to recognize higher than average medical education costs.

142.7 (d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a)
142.8 and (b) shall be reduced to \$566,000, and the University of Minnesota's payment under
142.9 paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010,
142.10 Hennepin County's payment under paragraphs (a) and (b) shall be \$434,688. Effective
142.11 January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be
142.12 \$566,000.

142.13 (e) Notwithstanding paragraph (d), upon federal enactment of an extension to June
142.14 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally
142.15 provided under Public Law 111-5, for the six-month period from January 1, 2011, to June
142.16 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be \$434,688.

142.17 Sec. 8. Minnesota Statutes 2008, section 256L.15, subdivision 1, is amended to read:

142.18 Subdivision 1. **Premium determination.** (a) Families with children and individuals
142.19 shall pay a premium determined according to subdivision 2.

142.20 (b) Pregnant women and children under age two are exempt from the provisions
142.21 of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment
142.22 for failure to pay premiums. For pregnant women, this exemption continues until the
142.23 first day of the month following the 60th day postpartum. Women who remain enrolled
142.24 during pregnancy or the postpartum period, despite nonpayment of premiums, shall be
142.25 disenrolled on the first of the month following the 60th day postpartum for the penalty
142.26 period that otherwise applies under section 256L.06, unless they begin paying premiums.

142.27 (c) Members of the military and their families who meet the eligibility criteria
142.28 for MinnesotaCare upon eligibility approval made within 24 months following the end
142.29 of the member's tour of active duty shall have their premiums paid by the commissioner.
142.30 The effective date of coverage for an individual or family who meets the criteria of this
142.31 paragraph shall be the first day of the month following the month in which eligibility is
142.32 approved. This exemption applies for 12 months. This paragraph expires June 30, 2010.
142.33 If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this
142.34 provision will expire on the date when it is no longer subject to section 5001 of Public Law
142.35 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

143.1 Sec. 9. Laws 2005, First Special Session chapter 4, article 8, section 66, as amended by
143.2 Laws 2009, chapter 173, article 3, section 24, the effective date, is amended to read:

143.3 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2009, ~~and upon federal~~
143.4 approval and on the date when it is no longer subject to the maintenance of effort
143.5 requirements of section 5001 of Public Law 111-5. The commissioner of human services
143.6 shall notify the revisor of statutes of that date. Paragraph (e) is effective September 1,
143.7 2006.

143.8 Sec. 10. Laws 2009, chapter 79, article 5, section 17, the effective date, is amended to
143.9 read:

143.10 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
143.11 approval, ~~whichever is later~~ and on the date when it is no longer subject to the maintenance
143.12 of effort requirements of section 5001 of Public Law 111-5. The commissioner of human
143.13 services shall notify the revisor of statutes of that date.

143.14 Sec. 11. Laws 2009, chapter 79, article 5, section 18, the effective date, is amended to
143.15 read:

143.16 **EFFECTIVE DATE.** This section is effective ~~January 1, 2011~~ upon federal
143.17 approval and on the date when it is no longer subject to the maintenance of effort
143.18 requirements of section 5001 of Public Law 111-5. The commissioner of human services
143.19 shall notify the revisor of statutes when federal approval is obtained.

143.20 Sec. 12. Laws 2009, chapter 79, article 5, section 22, the effective date, is amended to
143.21 read:

143.22 **EFFECTIVE DATE.** This section is effective for periods of ineligibility established
143.23 on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.
143.24 If it is in violation of that section, then it shall be effective on the date when it is no longer
143.25 subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The
143.26 commissioner of human services shall notify the revisor of statutes of that date.

143.27 Sec. 13. Laws 2009, chapter 79, article 8, section 2, the effective date, is amended to
143.28 read:

143.29 **EFFECTIVE DATE.** The section is effective ~~January~~ July 1, 2011.

144.1 Sec. 14. Laws 2009, chapter 173, article 1, section 17, the effective date, is amended to
144.2 read:

144.3 **EFFECTIVE DATE.** This section is effective for pooled trust accounts established
144.4 on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.
144.5 If it is in violation of that section, then it shall be effective on the date when it is no longer
144.6 subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The
144.7 commissioner of human services shall notify the revisor of statutes of that date.

144.8 **ARTICLE 11**

144.9 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

144.10 Section 1. **SUMMARY OF APPROPRIATIONS.**

144.11 The amounts shown in this section summarize direct appropriations, by fund, made
144.12 in this article.

144.13		<u>2010</u>		<u>2011</u>		<u>Total</u>
144.14	<u>General</u>	\$ (10,071,000)	\$	(92,097,000)	\$	(102,168,000)
144.15	<u>State Government Special</u>					
144.16	<u>Revenue</u>	2,002,000		(275,000)		1,727,000
144.17	<u>Health Care Access</u>	(1,094,000)		71,245,000		70,151,000
144.18	<u>Federal TANF</u>	20,500,000		11,500,000		32,000,000
144.19	<u>Total</u>	\$ 11,337,000	\$	(9,627,000)	\$	1,710,000

144.20 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

144.21 The sums shown in the columns marked "Appropriations" are added to or, if shown
144.22 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,
144.23 as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes
144.24 specified in this article. The appropriations are from the general fund and are available
144.25 for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in
144.26 this article mean that the addition to or subtraction from the appropriation listed under
144.27 them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively.
144.28 Supplemental appropriations and reductions to appropriations for the fiscal year ending
144.29 June 30, 2010, are effective the day following final enactment unless a different effective
144.30 date is explicit.

144.31	<u>APPROPRIATIONS</u>
144.32	<u>Available for the Year</u>
144.33	<u>Ending June 30</u>
144.34	<u>2010</u> <u>2011</u>

146.1 and Early Childhood Finance and Policy
 146.2 Division by December 1 of each fiscal
 146.3 year. Notwithstanding any provision to the
 146.4 contrary, this rider expires June 30, 2013.

146.5 The appropriation reductions for each
 146.6 purpose are shown in the following
 146.7 subdivisions.

146.8 **SNAP Enhanced Administrative Funding.**
 146.9 The funds available for administration
 146.10 of the Supplemental Nutrition Assistance
 146.11 Program under the Department of Defense
 146.12 Appropriations Act of 2010, Public
 146.13 Law 111-118, are appropriated to the
 146.14 commissioner to pay the actual costs
 146.15 of providing for increased eligibility
 146.16 determinations, caseload-related cost, timely
 146.17 application processing, and quality control.
 146.18 Of these funds, 20 percent shall be allocated
 146.19 to the commissioner and 80 percent shall
 146.20 be allocated to counties. The commissioner
 146.21 shall allocate the county portion based
 146.22 on recent caseload. Reimbursement shall
 146.23 be based on actual costs reported by
 146.24 counties through existing processes. Tribal
 146.25 reimbursement must be made from the state
 146.26 portion, based on a caseload factor equivalent
 146.27 to that of a county.

146.28 **Subd. 2. Agency Management; Financial**
 146.29 **Operations**

146.30 This appropriation reduction is from the state
 146.31 government special revenue fund.

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

146.34 **TANF Funding for the Working Family**
 146.35 **Tax Credit.** In addition to the amounts

(8,000)

(16,000)

20,672,00021,402,000

147.1 specified in Minnesota Statutes, section
147.2 290.0671, subdivision 6, \$18,722,000
147.3 of TANF funds in fiscal year 2010 and
147.4 \$18,957,000 of TANF funds in fiscal year
147.5 2011 are appropriated to the commissioner
147.6 of human services to reimburse the general
147.7 fund for the cost of the working family tax
147.8 credit for eligible families, with respect to
147.9 the amounts appropriated for fiscal year
147.10 2010, the commissioner shall reimburse
147.11 the general fund by June 30, 2010, with
147.12 respect to the funds appropriated for fiscal
147.13 year 2011, beginning January 1, 2011, the
147.14 commissioner shall reimburse the general
147.15 fund on a monthly basis according to a
147.16 schedule based on the pattern of working
147.17 family credit expenditures through June 30,
147.18 2011. This rider is effective upon enactment.

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

147.21 **(a) MFIP and Diversionary Work Program**
147.22 **Grants** -0- (2,024,000)

147.23 This appropriation reduction is from the
147.24 federal TANF fund.

147.25 **(b) Support Services Grants** -0- (7,646,000)

147.26 **Supported Work.** The fiscal year 2011
147.27 TANF appropriation to the commissioner
147.28 of human services for supported work for
147.29 MFIP recipients is reduced by \$4,000,000.
147.30 This reduction is onetime. \$4,000,000 of
147.31 the amounts earned in the TANF emergency
147.32 fund (TEF) subsidized employment
147.33 category under the American Recovery and
147.34 Reinvestment Act (ARRA) of 2009, Public
147.35 Law 111-5, are available for reimbursement

148.1	<u>in the working family credit in fiscal year</u>		
148.2	<u>2011.</u>		
148.3	<u>Base Adjustment.</u> <u>The federal TANF base</u>		
148.4	<u>shall be increased by \$2,642,000 for fiscal</u>		
148.5	<u>years 2012 and 2013.</u>		
148.6	<u>(c) MFIP Child Care Assistance Grants</u>	<u>-0-</u>	<u>(38,000)</u>
148.7	<u>(d) Basic Sliding Fee Child Care Assistance</u>		
148.8	<u>Grants</u>	<u>-0-</u>	<u>(7,500,000)</u>
148.9	<u>This appropriation reduces the fiscal</u>		
148.10	<u>year 2011 general fund appropriation by</u>		
148.11	<u>\$7,500,000 and carries over and expends, in</u>		
148.12	<u>fiscal year 2011, \$7,500,000 of the TANF</u>		
148.13	<u>funds transferred in fiscal year 2010, which</u>		
148.14	<u>reflect the child care and development</u>		
148.15	<u>fund unexpended balance for the basic</u>		
148.16	<u>sliding fee child care assistance program</u>		
148.17	<u>under Minnesota Statutes, section 119B.03.</u>		
148.18	<u>The commissioner shall ensure that all</u>		
148.19	<u>the funds are expended according to the</u>		
148.20	<u>federal child care and development fund</u>		
148.21	<u>regulations relating to TANF transfers. This</u>		
148.22	<u>appropriation is onetime.</u>		
148.23	<u>(e) Children and Community Services Grants</u>	<u>-0-</u>	<u>(5,900,000)</u>
148.24	<u>Children and Community Services Grant</u>		
148.25	<u>Reduction.</u> <u>The fiscal year 2011 general fund</u>		
148.26	<u>appropriation to the commissioner of human</u>		
148.27	<u>services for the children and community</u>		
148.28	<u>services grants under Minnesota Statutes,</u>		
148.29	<u>section 256M.40, is reduced by \$5,900,000.</u>		
148.30	<u>The ongoing reduction must be \$9,900,000</u>		
148.31	<u>in each of fiscal years 2012 and 2013.</u>		
148.32	<u>(f) Children's Mental Health Grants</u>	<u>-0-</u>	<u>(5,980,000)</u>

149.1	<u>(1) The general fund appropriation for</u>		
149.2	<u>children's capacity school-based services is</u>		
149.3	<u>reduced by \$4,777,000 for fiscal year 2011.</u>		
149.4	<u>(2) The general fund appropriation for</u>		
149.5	<u>children's mental health targeted case</u>		
149.6	<u>management grants is reduced by \$1,210,000</u>		
149.7	<u>for fiscal year 2011.</u>		
149.8	<u>Base adjustment.</u> The general fund base		
149.9	<u>is increased by \$2,048,000 in each of fiscal</u>		
149.10	<u>years 2012 and 2013.</u>		
149.11	<u>(g) Other Children and Economic Assistance</u>		
149.12	<u>Grants</u>	<u>290,000</u>	<u>63,000</u>
149.13	<u>Subd. 5. Children and Economic Assistance</u>		
149.14	<u>Management</u>		
149.15	<u>(a) Children and Economic Assistance</u>		
149.16	<u>Administration</u>	<u>-0-</u>	<u>-0-</u>
149.17	<u>The TANF fund base shall be reduced by</u>		
149.18	<u>\$700,000 in fiscal years 2012 and 2013.</u>		
149.19	<u>(b) Children and Economic Assistance</u>		
149.20	<u>Operations</u>	<u>(1,580,000)</u>	<u>(1,613,000)</u>
149.21	<u>The federal TANF fund appropriation is</u>		
149.22	<u>reduced by \$172,000 in fiscal year 2010 and</u>		
149.23	<u>\$176,000 in fiscal year 2011.</u>		
149.24	<u>The general fund appropriation is reduced</u>		
149.25	<u>by \$1,408,000 in fiscal year 2010 and by</u>		
149.26	<u>\$1,534,000 in fiscal year 2011. The general</u>		
149.27	<u>fund base is reduced by \$26,000 in each of</u>		
149.28	<u>fiscal years 2012 and 2013.</u>		
149.29	<u>\$74,000 in fiscal year 2011 is appropriated</u>		
149.30	<u>from the health care access fund. This</u>		
149.31	<u>appropriation is onetime.</u>		
149.32	<u>Subd. 6. Basic Health Care Grants</u>		
149.33	<u>(a) MinnesotaCare Grants</u>	<u>-0-</u>	<u>(68,763,000)</u>

150.1 This appropriation reduction is from the
150.2 health care access fund.

150.3 **(b) Medical Assistance Basic Health Care**
150.4 **Grants - Families and Children** -0- (7,101,000)

150.5 **(c) Medical Assistance Basic Health Care**
150.6 **Grants - Elderly and Disabled** -0- (9,167,000)

150.7 **MnDHO Transition.** \$250,000 is
150.8 appropriated from the general fund in fiscal
150.9 year 2011 to the commissioner of human
150.10 services to be made available to county
150.11 agencies to assist in the proactive transition
150.12 of the approximately 1,290 current MnDHO
150.13 members to the fee-for-service Medicaid
150.14 program or another managed care option by
150.15 January 1, 2011. County agencies shall work
150.16 with the Department of Human Services,
150.17 health plans, and MnDHO members and
150.18 their legal representatives to develop and
150.19 implement transition plans that include:

150.20 (1) identification of service needs of MnDHO
150.21 members based on the current assessment or
150.22 through the completion of a new assessment;

150.23 (2) identification of services currently
150.24 provided to MnDHO members and which
150.25 of those services will continue to be
150.26 reimbursable through fee-for-service or
150.27 another managed care option under the
150.28 Medicaid state plan or a Title XIX home and
150.29 community-based waiver program;

150.30 (3) identification of service providers who do
150.31 not have a contract with the county or who
150.32 are currently reimbursed at a different rate
150.33 than the county-contracted rate; and

150.34 (4) development of an individual service
150.35 plan that is within allowable home and

151.1	<u>community-based service waiver funding</u>		
151.2	<u>limits.</u>		
151.3	<u>(d) General Assistance Medical Care Grants</u>	<u>-0-</u>	<u>(52,614,000)</u>
151.4	<u>Funding Reduction; Coordinated Care</u>		
151.5	<u>Delivery Systems.</u> The appropriation for		
151.6	<u>payments to coordinated care delivery</u>		
151.7	<u>systems in Laws 2010, chapter 200, article</u>		
151.8	<u>2, section 2, subdivision 4, paragraph (d), is</u>		
151.9	<u>reduced by \$20,000,000 in fiscal year 2011.</u>		
151.10	<u>(e) Medical Assistance; Adults Without</u>		
151.11	<u>Children</u>	<u>-0-</u>	<u>142,768,000</u>
151.12	<u>Of this appropriation, \$142,768,000 is from</u>		
151.13	<u>the health care access fund.</u>		
151.14	<u>(f) Other Health Care Grants</u>	<u>-0-</u>	<u>(1,831,000)</u>
151.15	<u>Of this appropriation, the general fund is</u>		
151.16	<u>increased by \$19,000 and the health care</u>		
151.17	<u>access fund appropriation is reduced by</u>		
151.18	<u>\$1,850,000. This appropriation is onetime.</u>		
151.19	<u>COBRA Carryforward.</u> Unexpended		
151.20	<u>funds appropriated in fiscal year 2010 for</u>		
151.21	<u>COBRA grants under Laws 2009, chapter</u>		
151.22	<u>79, article 5, section 78, do not cancel and</u>		
151.23	<u>are available to the commissioner of human</u>		
151.24	<u>services for fiscal year 2011 COBRA grant</u>		
151.25	<u>expenditures. Up to \$110,000 of the fiscal</u>		
151.26	<u>year 2011 appropriation for COBRA grants</u>		
151.27	<u>provided in Laws 2009, chapter 79, article</u>		
151.28	<u>13, section 3, subdivision 6, may be used</u>		
151.29	<u>by the commissioner of human services for</u>		
151.30	<u>costs related to administration of the COBRA</u>		
151.31	<u>grants.</u>		
151.32	<u>Transfer.</u> The commissioner shall transfer		
151.33	<u>\$19,000 to the commissioner of commerce</u>		

152.1 for regulation of Minnesota Statutes, section
 152.2 62A.3075.

152.3 **Subd. 7. Health Care Management**

152.4 **(a) Health Care Administration** (2,998,000) (4,468,000)

152.5 For fiscal year 2011 the health care access
 152.6 fund appropriation is increased by \$250,000
 152.7 and the general fund appropriation is reduced
 152.8 by \$4,633,000.

152.9 **PACE Implementation Funding.** For fiscal
 152.10 year 2011, \$145,000 is appropriated from
 152.11 the general fund to the commissioner of
 152.12 human services to complete the actuarial and
 152.13 administrative work necessary to begin the
 152.14 operation of PACE under Minnesota Statutes,
 152.15 section 256B.69, subdivision 23, paragraph
 152.16 (e). Base level funding for this activity shall
 152.17 be \$130,000 in fiscal year 2012 and \$0 in
 152.18 fiscal year 2013.

152.19 **Minnesota Senior Health Options**

152.20 **Reimbursement.** Effective July 1, 2011,
 152.21 federal administrative reimbursement
 152.22 resulting from the Minnesota senior
 152.23 health options project is appropriated
 152.24 to the commissioner for this activity.
 152.25 Notwithstanding any contrary provision, this
 152.26 provision expires June 30, 2013.

152.27 **Health Care Inspector General.** \$120,000
 152.28 from the general fund in fiscal year 2011
 152.29 is for the Office of Health Care Inspector
 152.30 General, established under Minnesota
 152.31 Statutes, section 256.01, subdivision 30.

152.32 **Fiscal and Actuarial Analysis.** \$250,000
 152.33 from the general fund is for the fiscal and
 152.34 actuarial analysis of 2010 House File No.

153.1 135 and 2010 Senate File No. 118. This
 153.2 appropriation is onetime.

153.3 **Utilization Review.** Effective July 1,
 153.4 2011, federal administrative reimbursement
 153.5 resulting from prior authorization and
 153.6 inpatient admission certification by a
 153.7 professional review organization shall be
 153.8 dedicated to, and is appropriated to, the
 153.9 commissioner for these activities. A portion
 153.10 of these funds must be used for activities to
 153.11 decrease unnecessary pharmaceutical costs
 153.12 in medical assistance. Notwithstanding any
 153.13 contrary provision, this provision expires
 153.14 June 30, 2013.

153.15 **Base Adjustment.** The health care access
 153.16 fund base is reduced by \$50,000 in each of
 153.17 fiscal years 2012 and 2013.

153.18 The general fund base is reduced by \$516,000
 153.19 in each of fiscal years 2012 and 2013.

153.20 **(b) Health Care Operations**

153.21	<u>Appropriations by Fund</u>		
153.22	<u>General</u>	<u>-0-</u>	<u>44,000</u>
153.23	<u>Health Care Access</u>	<u>(1,094,000)</u>	<u>(1,234,000)</u>

153.24 **Base Adjustment.** The health care access
 153.25 fund base for health care operations is
 153.26 reduced by \$1,272,000 in fiscal year 2012
 153.27 and \$1,337,000 in fiscal year 2013. The
 153.28 general fund appropriation is onetime.

153.29 **Subd. 8. Continuing Care Grants**

153.30 **(a) Aging and Adult Services Grants** -0- (154,000)

153.31 This reduction is onetime and must not be
 153.32 applied to the base.

153.33 **Community Service Development**

153.34 **Reduction.** The appropriation in Laws

154.1 2009, chapter 79, article 13, section 3,
 154.2 subdivision 8, paragraph (a), for community
 154.3 service development grants, as amended by
 154.4 Laws 2009, chapter 173, article 2, section
 154.5 1, subdivision 8, paragraph (a), is reduced
 154.6 by \$154,000 in fiscal year 2011. The
 154.7 appropriation base is reduced by \$139,000
 154.8 for fiscal year 2012 and \$0 for fiscal year
 154.9 2013. Notwithstanding any law or rule to
 154.10 the contrary, this provision expires June 30,
 154.11 2012.

154.12 **(b) Medical Assistance Long-Term Care**
 154.13 **Facilities Grants**

-0-

683,000

154.14 **Clearwater County; ICF/MR Payment**

154.15 **Rate.** \$84,000 is appropriated in fiscal
 154.16 year 2011 from the general fund to the
 154.17 commissioner of human services for the
 154.18 purposes of the Clearwater County facility
 154.19 ICF/MR rate increase in article 3. This
 154.20 appropriation is onetime.

154.21 **Kandiyohi County; ICF/MR Payment**

154.22 **Rate.** \$36,000 is appropriated from the
 154.23 general fund in fiscal year 2011 and \$4,000
 154.24 in fiscal year 2012 to increase payment rates
 154.25 for an ICF/MR licensed for six beds and
 154.26 located in Kandiyohi County to serve persons
 154.27 with high behavioral needs. The payment
 154.28 rate increase shall be effective for services
 154.29 provided from July 1, 2010, through June 30,
 154.30 2011. These appropriations are onetime.

154.31 **Crisis Center Services.** Of this

154.32 appropriation, \$400,000 in fiscal year
 154.33 2011 is to a community collaborative to
 154.34 continue crisis center services provided in
 154.35 the Mankato area.

155.1 **Group Residential Housing; Mahnomen**
 155.2 **County.** \$48,000 is appropriated from
 155.3 the general fund in fiscal year 2011 to the
 155.4 commissioner of human services for the
 155.5 purposes of Minnesota Statutes, section
 155.6 256I.05, subdivision 1n. This appropriation
 155.7 is onetime.

155.8 **(c) Medical Assistance Long-Term Care**
 155.9 **Waivers and Home Care Grants** -0- (2,747,000)

155.10 **Manage Growth in Traumatic Brain**
 155.11 **Injury and Community Alternatives for**
 155.12 **Disabled Individuals' Waivers.** During
 155.13 the fiscal year beginning July 1, 2010, the
 155.14 commissioner shall allocate money for home
 155.15 and community-based waiver programs
 155.16 under Minnesota Statutes, section 256B.49,
 155.17 to ensure a reduction in state spending that is
 155.18 equivalent to limiting the caseload growth
 155.19 of the traumatic brain injury waiver to six
 155.20 allocations per month and the community
 155.21 alternatives for disabled individuals waiver
 155.22 to 60 allocations per month. The limits do not
 155.23 apply: (1) when there is an approved plan for
 155.24 nursing facility bed closures for individuals
 155.25 under age 65 who require relocation due to
 155.26 the bed closure; (2) to fiscal year 2009 waiver
 155.27 allocations delayed due to unallotment; or (3)
 155.28 to transfers authorized by the commissioner
 155.29 from the personal care assistance program
 155.30 of individuals having a home care rating of
 155.31 CS, MT, or HL. Priorities for the allocation
 155.32 of funds must be for individuals anticipated
 155.33 to be discharged from institutional settings or
 155.34 who are at imminent risk of a placement in
 155.35 an institutional setting.

156.1 **Manage Growth in the Developmental**

156.2 **Disability (DD) Waiver.** The commissioner
 156.3 shall manage the growth in the developmental
 156.4 disability waiver by limiting the allocations
 156.5 included in the November 2010 forecast to
 156.6 six additional diversion allocations each
 156.7 month for the calendar year that begins on
 156.8 January 1, 2011. Additional allocations must
 156.9 be made available for transfers authorized
 156.10 by the commissioner from the personal care
 156.11 assistance program of individuals having a
 156.12 home care rating of CS, MT, or HL. This
 156.13 provision is effective through December 31,
 156.14 2011.

156.15 **(d) Adult Mental Health Grants**

(3,500,000)

(9,903,000)

156.16 **Compulsive Gambling Special Revenue**

156.17 **Account.** \$149,000 for fiscal year 2010
 156.18 and \$27,000 for fiscal year 2011 from
 156.19 the compulsive gambling special revenue
 156.20 account established under Minnesota
 156.21 Statutes, section 245.982, must be transferred
 156.22 and deposited into the general fund by June
 156.23 30 of each respective fiscal year.

156.24 **Compulsive Gambling Lottery Prize Fund**

156.25 **Appropriation.** The lottery prize fund
 156.26 appropriation for compulsive gambling, is
 156.27 reduced by \$80,000 in fiscal year 2010 and
 156.28 \$79,000 in fiscal year 2011. This is a onetime
 156.29 reduction.

156.30 **Adult Mental Health.** (1) The general

156.31 fund appropriation for adult mental health
 156.32 evidence-based practices, including but not
 156.33 limited to, assertive community treatment
 156.34 and integrated dual diagnosis treatment

- 157.1 services, is reduced by \$750,000 for fiscal
 157.2 year 2011. This reduction is onetime.
- 157.3 (2) The general fund appropriation for
 157.4 mental health grants to increase availability
 157.5 of culturally specific adult mental health
 157.6 services is reduced by \$300,000 for fiscal
 157.7 year 2011. This reduction is onetime.
- 157.8 (3) The general fund appropriation for
 157.9 grants to community hospitals to provide
 157.10 alternatives to residential treatment center
 157.11 mental health programs is reduced by
 157.12 \$2,653,000 for fiscal year 2011. This
 157.13 reduction is onetime.
- 157.14 (4) The general fund appropriation for grants
 157.15 to counties for adult mental health services is
 157.16 reduced by \$6,200,000 for fiscal year 2011,
 157.17 and \$6,000,000 in each of fiscal years 2012
 157.18 and 2013.
- 157.19 (5) Of the fiscal year 2010 general fund
 157.20 appropriation for grants to counties for
 157.21 housing with support services for adults
 157.22 with serious and persistent mental illness,
 157.23 \$3,300,000 is canceled and returned to the
 157.24 general fund.
- 157.25 (6) Of the fiscal year 2010 general
 157.26 fund appropriation for additional crisis
 157.27 intervention team training for law
 157.28 enforcement, \$200,000 is canceled and
 157.29 returned to the general fund.
- 157.30 **Base adjustment.** The general fund base
 157.31 is increased by \$3,903,000 in each of fiscal
 157.32 years 2012 and 2013.
- 157.33 **(e) Chemical Dependency Entitlement Grants** -0- (3,986,000)

158.1	<u>(f) Chemical Dependency Nonentitlement</u>		
158.2	<u>Grants</u>	<u>(389,000)</u>	<u>-0-</u>
158.3	<u>Chemical Health.</u> Of the fiscal year 2010		
158.4	<u>general fund appropriation to Mother's First</u>		
158.5	<u>and the Native American Program, \$389,000</u>		
158.6	<u>is canceled and returned to the general fund.</u>		
158.7	<u>(g) Other Continuing Care Grants</u>	<u>-0-</u>	<u>100,000</u>
158.8	<u>Region 10 Quality Assurance Commission.</u>		
158.9	<u>\$100,000 is appropriated from the general</u>		
158.10	<u>fund in fiscal year 2011 to the commissioner</u>		
158.11	<u>of human services for the purposes</u>		
158.12	<u>of the Region 10 Quality Assurance</u>		
158.13	<u>Commission under Minnesota Statutes,</u>		
158.14	<u>section 256B.0951. This appropriation is</u>		
158.15	<u>onetime.</u>		
158.16	<u>Subd. 9. Continuing Care Management</u>	<u>-0-</u>	<u>111,000</u>
158.17	<u>PACE Implementation Funding.</u> For fiscal		
158.18	<u>year 2011, \$111,000 is appropriated from</u>		
158.19	<u>the general fund to the commissioner of</u>		
158.20	<u>human services to complete the actuarial</u>		
158.21	<u>and administrative work necessary to begin</u>		
158.22	<u>the operation of PACE under Minnesota</u>		
158.23	<u>Statutes, section 256B.69, subdivision 23,</u>		
158.24	<u>paragraph (e). Base level funding for this</u>		
158.25	<u>activity shall be \$101,000 in fiscal year 2012</u>		
158.26	<u>and \$0 in fiscal year 2013. For fiscal year</u>		
158.27	<u>2013 and beyond, the commissioner must</u>		
158.28	<u>work with stakeholders to develop financing</u>		
158.29	<u>mechanisms to complete the actuarial</u>		
158.30	<u>and administrative costs of PACE. The</u>		
158.31	<u>commissioner shall inform the chairs and</u>		
158.32	<u>ranking minority members of the legislative</u>		
158.33	<u>committee with jurisdiction over health care</u>		
158.34	<u>funding by January 15, 2011, on progress to</u>		
158.35	<u>develop financing mechanisms.</u>		

159.1 Subd. 10. State-Operated Services159.2 Obsolete Laundry Depreciation Account.

159.3 \$669,000, or the balance, whichever is
 159.4 greater, must be transferred from the
 159.5 state-operated services laundry depreciation
 159.6 account in the special revenue fund and
 159.7 deposited into the general fund by June 30,
 159.8 2010.

159.9 State-Operated Services. Of this
 159.10 appropriation, \$12,854,000 in fiscal year
 159.11 2011 is for the commissioner to maintain
 159.12 dental clinics, the METO program, and other
 159.13 residential adult mental health services.

159.14 Subd. 11. Adult Mental Health Services-0-12,854,000

159.15 This appropriation is onetime and does not
 159.16 affect the agency's base.

159.17 Subd. 12. Contingent Appropriations
 159.18 Reductions

159.19 Upon enactment of the extension of
 159.20 the enhanced federal medical assistance
 159.21 percentage (FMAP) under Public Law 111-5
 159.22 to June 30, 2011, that is contained in the
 159.23 president's budget for federal fiscal year 2011
 159.24 or contained in House Resolution 2847, the
 159.25 federal "Jobs for Main Street Act of 2010," or
 159.26 subsequent federal legislation, the reductions
 159.27 identified in each clause shall be made to
 159.28 the specified general fund appropriations
 159.29 for fiscal year 2011. These contingent
 159.30 reductions, if implemented, are in addition
 159.31 to the reductions specified in subdivision 6,
 159.32 paragraphs (a), (b), and (c), and subdivision
 159.33 8, paragraphs (c) and (d), respectively.

159.34 (1) MinnesotaCare Grants-0-(9,200,000)

160.1	<u>(2) Medical Assistance Basic Health Care Grants</u>		
160.2	<u>- Families and Children</u>	<u>-0-</u>	<u>(109,662,500)</u>
160.3	<u>(3) Medical Assistance Basic Health Care Grants</u>		
160.4	<u>- Elderly and Disabled</u>	<u>-0-</u>	<u>(110,437,500)</u>
160.5	<u>(4) Medical Assistance Long-Term Care Facilities</u>		
160.6	<u>Grants</u>	<u>-0-</u>	<u>(51,925,000)</u>
160.7	<u>(5) Medical Assistance Long-Term Care Waivers</u>		
160.8	<u>and Home Care Grants</u>	<u>-0-</u>	<u>(115,475,000)</u>

160.9 **Sec. 4. COMMISSIONER OF HEALTH**

160.10		<u>APPROPRIATIONS</u>	
160.11		<u>Available for the Year</u>	
160.12		<u>Ending June 30</u>	
160.13		<u>2010</u>	<u>2011</u>

160.14	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>(2,992,000)</u>	<u>\$</u>	<u>5,224,000</u>
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160.15	<u>Appropriations by Fund</u>		
160.16		<u>2010</u>	<u>2011</u>
160.17	<u>General</u>	<u>(2,392,000)</u>	<u>5,283,000</u>
160.18	<u>State Government</u>		
160.19	<u>Special Revenue</u>	<u>(600,000)</u>	<u>(259,000)</u>
160.20	<u>Health Care Access</u>		
160.21	<u>Fund</u>	<u>-0-</u>	<u>200,000</u>

160.22	<u>Subd. 2. Community and Family Health</u>	<u>(221,000)</u>	<u>(121,000)</u>
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160.23 **Statewide Health Improvement Program.**

160.24 \$8,500,000 from the health care access
 160.25 fund in fiscal year 2012 and \$8,500,000 in
 160.26 fiscal year 2013 is for the statewide health
 160.27 improvement program under Minnesota
 160.28 Statutes, section 145.986. These additions
 160.29 are onetime.

160.30 **Base adjustment.** The general fund base is
 160.31 reduced by \$132,000 in each of fiscal years
 160.32 2012 and 2013.

160.33 **Subd. 3. Policy, Quality, and Compliance**

160.34	<u>Appropriations by Fund</u>		
160.35		<u>2010</u>	<u>2011</u>
160.36	<u>General</u>	<u>(1,797,000)</u>	<u>5,209,000</u>

161.1	<u>State Government</u>		
161.2	<u>Special Revenue</u>	<u>(600,000)</u>	<u>(268,000)</u>
161.3	<u>Health Care Access</u>		
161.4	<u>Fund</u>	<u>-0-</u>	<u>200,000</u>

161.5 Of this appropriation, \$74,000 in fiscal
 161.6 year 2011 is to restore unallotments for the
 161.7 Office of Unlicensed Complementary and
 161.8 Alternative Health Care Practice.

161.9 **Health Care Reform.** Funds appropriated
 161.10 in Laws 2008, chapter 358, article 5, section
 161.11 4, subdivision 3, for health reform activities
 161.12 to implement Laws 2008, chapter 358,
 161.13 article 4, are available until expended.
 161.14 Notwithstanding any contrary provision in
 161.15 this article, this provision shall not expire.

161.16 **Health Care Reform Task Force.** \$200,000
 161.17 from the general fund is for expenses related
 161.18 to the Health Care Reform Task Force
 161.19 established under article 7, section 8.

161.20 **Autism Coverage Study.** \$50,000 in
 161.21 fiscal year 2011 is appropriated to the
 161.22 commissioner of health to monitor the gaps
 161.23 in the level of service provided by state
 161.24 health programs, the state employee group
 161.25 insurance plan, and private health plans for
 161.26 autism spectrum disorder. This appropriation
 161.27 is onetime.

161.28 **Rural Hospital Capital Improvement**
 161.29 **Grants.** Of the general fund reductions in
 161.30 fiscal year 2010, \$1,755,000 is for the rural
 161.31 hospital capital improvement grant program.

161.32 **Health Information Exchange Oversight.**
 161.33 Of the state government special revenue fund
 161.34 appropriations, \$104,000 in fiscal year 2011

162.1 is for the duties required under Minnesota
162.2 Statutes, sections 62J.498 to 62J.4982.

162.3 **Birth Centers.** Of the state government
162.4 special revenue fund appropriations, \$9,000
162.5 is for licensing birth centers under Minnesota
162.6 Statutes, section 144.651. Base funding shall
162.7 be \$7,000 in fiscal year 2012 and \$7,000 in
162.8 fiscal year 2013.

162.9 **Advisory Group on Administrative**
162.10 **Expenses.** Of the general fund appropriation,
162.11 \$40,000 in fiscal year 2011 is for the advisory
162.12 group established under Minnesota Statutes,
162.13 section 62D.31.

162.14 **Community Clinic Grants.** Of this
162.15 appropriation, \$2,500,000 in fiscal
162.16 year 2011 is for the commissioner to
162.17 provide community clinic grants under
162.18 Minnesota Statutes, section 145.9268. This
162.19 appropriation is onetime. In awarding grants
162.20 using this funding, the commissioner shall
162.21 give priority to proposals that seek to serve
162.22 medically underserved areas of the state that
162.23 are not served by a coordinated care delivery
162.24 system established under Minnesota Statutes,
162.25 section 256D.031, subdivision 6.

162.26 **Federally Qualified Health Center**
162.27 **Subsidies.** Of this appropriation, \$2,500,000
162.28 in fiscal year 2011 is for the commissioner to
162.29 increase subsidies to federally qualified health
162.30 centers provided under Minnesota Statutes,
162.31 section 145.9269. This appropriation is
162.32 onetime. In awarding subsidies using this
162.33 funding, the commissioner shall give priority
162.34 to federally qualified health centers that serve
162.35 medically underserved areas of the state that

163.1 are not served by a coordinated care delivery
 163.2 system established under Minnesota Statutes,
 163.3 section 256D.031, subdivision 6.

163.4 **Base Level Adjustment.** The general
 163.5 fund base is reduced by \$5,134,000 in each
 163.6 of fiscal years 2012 and 2013. The state
 163.7 government special revenue fund base is
 163.8 increased by \$365,000 in each of fiscal years
 163.9 2012 and 2013.

163.10 **Subd. 4. Health Protection** (374,000) 295,000

163.11 **Lead Base Grant Program.** Of the general
 163.12 fund reduction, \$25,000 in fiscal year 2010
 163.13 and fiscal year 2011 is for the elimination
 163.14 of state funding for the temporary lead-safe
 163.15 housing base grant program.

163.16 **Birth Defects Information System.** Of
 163.17 the general fund appropriation, \$500,000 in
 163.18 fiscal year 2011 is for the Minnesota Birth
 163.19 Defects Information System established
 163.20 under Minnesota Statutes, section 144.2215.

163.21 **Base Adjustment.** The general fund base is
 163.22 reduced by \$99,000 in each of fiscal years
 163.23 2012 and 2013.

163.24 **Subd. 5. Administrative Support Services** -0- (91,000)

163.25 **Sec. 5. HEALTH-RELATED BOARDS**

163.26 **Subdivision 1. Total Appropriation** \$ 2,610,000 \$ -0-

163.27 In fiscal year 2010, \$591,000 shall be
 163.28 transferred from the state government special
 163.29 revenue fund to the general fund. In fiscal
 163.30 year 2011, \$442,000 shall be transferred from
 163.31 the state government special revenue fund
 163.32 to the general fund. These transfers are in
 163.33 addition to those made in Laws 2009, chapter

164.1	<u>79, article 13, section 5, as amended by Laws</u>		
164.2	<u>2009, chapter 173, article 2, section 3.</u>		
164.3	<u>The transfers in this section are onetime in</u>		
164.4	<u>the fiscal year 2010-2011 biennium.</u>		
164.5	<u>Subd. 2. Board of Nursing Home</u>		
164.6	<u>Administrators</u>	<u>2,610,000</u>	<u>-0-</u>
164.7	<u>Administrative Services Unit; Transfer.</u>		
164.8	<u>This appropriation is from the state</u>		
164.9	<u>government special revenue fund in fiscal</u>		
164.10	<u>year 2010 to the administrative services</u>		
164.11	<u>unit. Upon request for a transfer from a</u>		
164.12	<u>health-related board, the administrative</u>		
164.13	<u>services unit is authorized to transfer</u>		
164.14	<u>money from this appropriation to the board</u>		
164.15	<u>with the approval of the commissioner of</u>		
164.16	<u>management and budget. This appropriation</u>		
164.17	<u>does not cancel. Any unencumbered and</u>		
164.18	<u>unspent balances remain available for these</u>		
164.19	<u>expenditures in subsequent fiscal years. The</u>		
164.20	<u>administrative services unit must report to</u>		
164.21	<u>the legislature a detailed spending report</u>		
164.22	<u>by September 1, 2011, on the uses of these</u>		
164.23	<u>appropriated funds.</u>		
164.24	<u>Sec. 6. EMERGENCY MEDICAL SERVICES</u>		
164.25	<u>BOARD</u>	<u>361,000</u>	<u>(133,000)</u>
164.26	<u>This appropriation must be applied to</u>		
164.27	<u>emergency medical services grant programs.</u>		
164.28	<u>Reductions from the general fund must be</u>		
164.29	<u>applied to the board's operating budget and</u>		
164.30	<u>must not be applied to grant programs.</u>		
164.31	<u>Longevity Award and Incentive Program</u>	<u>(19,000)</u>	<u>(19,000)</u>
164.32	<u>Emergency Medical Services Relief</u>		
164.33	<u>Transfer. \$10,000 in fiscal year 2010</u>		
164.34	<u>and \$24,000 in fiscal year 2011 shall be</u>		
164.35	<u>transferred to the general fund from the</u>		

165.1 portion of the emergency medical services
 165.2 relief account in the special revenue fund
 165.3 otherwise designated for distribution by
 165.4 the Emergency Medical Services Board
 165.5 under Minnesota Statutes, section 169.686,
 165.6 subdivision 3. These transfers are onetime in
 165.7 the 2010-2011 biennium.

165.8 **Sec. 7. OMBUDSMAN FOR MENTAL**
 165.9 **HEALTH AND DEVELOPMENTAL**
 165.10 **DISABILITIES**

\$ (31,000) \$ (50,000)

165.11 **Sec. 8. OMBUDSPERSON FOR FAMILIES**

\$ (4,000) \$ (8,000)

165.12 **Sec. 9. MINNESOTA MANAGEMENT AND**
 165.13 **BUDGET**

\$ -0- \$ 50,000

165.14 **Fiscal Note Report. \$50,000 in fiscal year**
 165.15 **2012 is to the commissioner of Minnesota**
 165.16 **Management and Budget from the general**
 165.17 **fund for the completion of the human**
 165.18 **services fiscal note report in article 5.**

165.19 Sec. 10. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

165.20 Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds
 165.21 appropriated for this program, the administrative services unit must purchase medical
 165.22 professional liability insurance, if available, for a health care provider who is registered in
 165.23 accordance with subdivision 4 and who is not otherwise covered by a medical professional
 165.24 liability insurance policy or self-insured plan either personally or through another facility
 165.25 or employer. The administrative services unit is authorized to prorate payments or
 165.26 otherwise limit the number of participants in the program if the costs of the insurance for
 165.27 eligible providers exceed the funds appropriated for the program.

165.28 (b) Coverage purchased under this subdivision must be limited to the provision of
 165.29 health care services performed by the provider for which the provider does not receive
 165.30 direct monetary compensation.

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

166.1 Sec. 11. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by
 166.2 Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

166.3 Subdivision 1. **Total Appropriation** **\$ 5,225,451,000 \$ 6,002,864,000**

166.4 Appropriations by Fund

166.5		2010	2011
166.6	General	4,375,689,000	5,209,765,000
166.7	State Government		
166.8	Special Revenue	565,000	565,000
166.9	Health Care Access	450,662,000	527,411,000
166.10	Federal TANF	286,770,000	263,458,000
166.11	Lottery Prize	1,665,000	1,665,000
166.12	Federal Fund	110,000,000	0

166.13 **Receipts for Systems Projects.**

166.14 Appropriations and federal receipts for
 166.15 information systems projects for MAXIS,
 166.16 PRISM, MMIS, and SSIS must be deposited
 166.17 in the state system account authorized in
 166.18 Minnesota Statutes, section 256.014. Money
 166.19 appropriated for computer projects approved
 166.20 by the Minnesota Office of Enterprise
 166.21 Technology, funded by the legislature, and
 166.22 approved by the commissioner of finance,
 166.23 may be transferred from one project to
 166.24 another and from development to operations
 166.25 as the commissioner of human services
 166.26 considers necessary, except that any transfers
 166.27 to one project that exceed \$1,000,000 or
 166.28 multiple transfers to one project that exceed
 166.29 \$1,000,000 in total require the express
 166.30 approval of the legislature. The preceding
 166.31 requirement for legislative approval does not
 166.32 apply to transfers made to establish a project's
 166.33 initial operating budget each year; instead,
 166.34 the requirements of section 11, subdivision
 166.35 2, of this article apply to those transfers. Any
 166.36 unexpended balance in the appropriation
 166.37 for these projects does not cancel but is

167.1 available for ongoing development and
167.2 operations. Any computer project with a
167.3 total cost exceeding \$1,000,000, including,
167.4 but not limited to, a replacement for the
167.5 proposed HealthMatch system, shall not be
167.6 commenced without the express approval of
167.7 the legislature.

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

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

167.18 **TANF Maintenance of Effort.**

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

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

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

168.1 (3) state and county MFIP administrative
168.2 costs under Minnesota Statutes, chapters
168.3 256J and 256K;

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

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

168.14 (6) qualifying working family credit
168.15 expenditures under Minnesota Statutes,
168.16 section 290.0671-; and

168.17 (7) qualifying Minnesota education credit
168.18 expenditures under Minnesota Statutes,
168.19 section 290.0674.

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

168.29 (c) For fiscal years beginning with state
168.30 fiscal year 2003, the commissioner shall
168.31 ensure that the maintenance of effort used
168.32 by the commissioner of finance for the
168.33 February and November forecasts required
168.34 under Minnesota Statutes, section 16A.103,
168.35 contains expenditures under paragraph (a),

169.1 clause (1), equal to at least 16 percent of
169.2 the total required under Code of Federal
169.3 Regulations, title 45, section 263.1.

169.4 (d) For the federal fiscal years beginning on
169.5 or after October 1, 2007, the commissioner
169.6 may not claim an amount of TANF/MOE in
169.7 excess of the 75 percent standard in Code
169.8 of Federal Regulations, title 45, section
169.9 263.1(a)(2), except:

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

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

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

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

169.34 (e) Minnesota Statutes, section 256.011,
169.35 subdivision 3, which requires that federal

170.1 grants or aids secured or obtained under that
170.2 subdivision be used to reduce any direct
170.3 appropriations provided by law, do not apply
170.4 if the grants or aids are federal TANF funds.

170.5 (f) Notwithstanding any contrary provision
170.6 in this article, this provision expires June 30,
170.7 2013.

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

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

170.18 (1) fiscal year 2010, ~~\$50,973,000~~
170.19 \$50,897,000;

170.20 (2) fiscal year 2011, ~~\$53,793,000~~
170.21 \$54,243,000;

170.22 (3) fiscal year 2012, ~~\$23,516,000~~
170.23 \$23,345,000; and

170.24 (4) fiscal year 2013, ~~\$16,808,000~~
170.25 \$16,585,000.

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

170.28 **Food Stamps Employment and Training.**

170.29 (a) The commissioner shall apply for and
170.30 claim the maximum allowable federal
170.31 matching funds under United States Code,
170.32 title 7, section 2025, paragraph (h), for
170.33 state expenditures made on behalf of family
170.34 stabilization services participants voluntarily

171.1 engaged in food stamp employment and
171.2 training activities, where appropriate.

171.3 (b) Notwithstanding Minnesota Statutes,
171.4 sections 256D.051, subdivisions 1a, 6b,
171.5 and 6c, and 256J.626, federal food stamps
171.6 employment and training funds received
171.7 as reimbursement of MFIP consolidated
171.8 fund grant expenditures for diversionary
171.9 work program participants and child
171.10 care assistance program expenditures for
171.11 two-parent families must be deposited in the
171.12 general fund. The amount of funds must be
171.13 limited to \$3,350,000 in fiscal year 2010
171.14 and \$4,440,000 in fiscal years 2011 through
171.15 2013, contingent on approval by the federal
171.16 Food and Nutrition Service.

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

171.23 **ARRA Food Support Administration.**

171.24 The funds available for food support
171.25 administration under the American Recovery
171.26 and Reinvestment Act (ARRA) of 2009
171.27 are appropriated to the commissioner
171.28 to pay actual costs of implementing the
171.29 food support benefit increases, increased
171.30 eligibility determinations, and outreach. Of
171.31 these funds, 20 percent shall be allocated
171.32 to the commissioner and 80 percent shall
171.33 be allocated to counties. The commissioner
171.34 shall allocate the county portion based on
171.35 caseload. Reimbursement shall be based on

172.1 actual costs reported by counties through
 172.2 existing processes. Tribal reimbursement
 172.3 must be made from the state portion based
 172.4 on a caseload factor equivalent to that of a
 172.5 county.

172.6 **ARRA Food Support Benefit Increases.**

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

172.13 **Emergency Fund for the TANF Program.**

172.14 TANF Emergency Contingency funds
 172.15 available under the American Recovery
 172.16 and Reinvestment Act of 2009 (Public Law
 172.17 111-5) are appropriated to the commissioner.
 172.18 The commissioner must request TANF
 172.19 Emergency Contingency funds from the
 172.20 Secretary of the Department of Health
 172.21 and Human Services to the extent the
 172.22 commissioner meets or expects to meet the
 172.23 requirements of section 403(c) of the Social
 172.24 Security Act. The commissioner must seek
 172.25 to maximize such grants. The funds received
 172.26 must be used as appropriated. Each county
 172.27 must maintain the county's current level of
 172.28 emergency assistance funding under the
 172.29 MFIP consolidated fund and use the funds
 172.30 under this paragraph to supplement existing
 172.31 emergency assistance funding levels.

172.32 Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by
 172.33 Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

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

	68,337,000	70,505,000
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173.1 This appropriation is from the federal TANF
173.2 fund.

173.3 **TANF Transfer to Federal Child Care**

173.4 **and Development Fund.** The following
173.5 TANF fund amounts are appropriated to the
173.6 commissioner for the purposes of MFIP and
173.7 transition year child care under Minnesota
173.8 Statutes, section 119B.05:

173.9 (1) fiscal year 2010, ~~\$6,531,000~~ \$862,000;

173.10 (2) fiscal year 2011, ~~\$10,241,000~~ \$978,000;

173.11 (3) fiscal year 2012, ~~\$10,826,000~~ \$0; and

173.12 (4) fiscal year 2013, ~~\$4,046,000~~ \$0.

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

173.20 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
173.21 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

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

173.27 Appropriations by Fund			
173.28	General	63,205,000	89,033,000
173.29	Federal TANF	100,818,000	84,538,000

173.30 **(b) Support Services Grants**

173.31 Appropriations by Fund			
173.32	General	8,715,000	12,498,000
173.33	Federal TANF	116,557,000	107,457,000

174.1 **MFIP Consolidated Fund.** The MFIP
174.2 consolidated fund TANF appropriation is
174.3 reduced by \$1,854,000 in fiscal year 2010
174.4 and fiscal year 2011.

174.5 Notwithstanding Minnesota Statutes, section
174.6 256J.626, subdivision 8, paragraph (b), the
174.7 commissioner shall reduce proportionately
174.8 the reimbursement to counties for
174.9 administrative expenses.

174.10 **Subsidized Employment Funding Through**
174.11 **ARRA.** The commissioner is authorized to
174.12 apply for TANF emergency fund grants for
174.13 subsidized employment activities. Growth
174.14 in expenditures for subsidized employment
174.15 within the supported work program and the
174.16 MFIP consolidated fund over the amount
174.17 expended in the calendar quarters in the
174.18 TANF emergency fund base year shall be
174.19 used to leverage the TANF emergency fund
174.20 grants for subsidized employment and to
174.21 fund supported work. The commissioner
174.22 shall develop procedures to maximize
174.23 reimbursement of these expenditures over the
174.24 TANF emergency fund base year quarters,
174.25 and may contract directly with employers
174.26 and providers to maximize these TANF
174.27 emergency fund grants.

174.28 **Supported Work.** Of the TANF
174.29 appropriation, \$4,700,000 in fiscal year 2010
174.30 and \$4,700,000 in fiscal year 2011 are to the
174.31 commissioner for supported work for MFIP
174.32 recipients and is available until expended.
174.33 Supported work includes paid transitional
174.34 work experience and a continuum of
174.35 employment assistance, including outreach

175.1 and recruitment, program orientation
175.2 and intake, testing and assessment, job
175.3 development and marketing, preworksite
175.4 training, supported worksite experience,
175.5 job coaching, and postplacement follow-up,
175.6 in addition to extensive case management
175.7 and referral services. This is a onetime
175.8 appropriation.

175.9 **Base Adjustment.** The general fund base
175.10 is reduced by \$3,783,000 in each of fiscal
175.11 years 2012 and 2013. The TANF fund base
175.12 is increased by \$5,004,000 in each of fiscal
175.13 years 2012 and 2013.

175.14 **Integrated Services Program Funding.**

175.15 The TANF appropriation for integrated
175.16 services program funding is \$1,250,000 in
175.17 fiscal year 2010 and \$0 in fiscal year 2011
175.18 and the base for fiscal years 2012 and 2013
175.19 is \$0.

175.20 **TANF Emergency Fund; Nonrecurrent**

175.21 **Short-Term Benefits.** (1) TANF emergency
175.22 contingency fund grants received due to
175.23 increases in expenditures for nonrecurrent
175.24 short-term benefits must be used to offset the
175.25 increase in these expenditures for counties
175.26 under the MFIP consolidated fund, under
175.27 Minnesota Statutes, section 256J.626,
175.28 and the diversionary work program. The
175.29 commissioner shall develop procedures
175.30 to maximize reimbursement of these
175.31 expenditures over the TANF emergency fund
175.32 base year quarters. Growth in expenditures
175.33 for the diversionary work program over the
175.34 amount expended in the calendar quarters in

176.1 the TANF emergency fund base year shall be
176.2 used to leverage these funds.

176.3 (2) To the extent that the commissioner
176.4 can claim eligible tax credit growth as
176.5 nonrecurrent short-term benefits, the
176.6 commissioner shall use those funds to
176.7 leverage the increased expenditures in clause
176.8 (1).

176.9 (3) TANF emergency funds for nonrecurrent
176.10 short-term benefits received in excess of the
176.11 amounts necessary for clauses (1) and (2)
176.12 shall be used to reimburse the general fund
176.13 for the costs of eligible tax credits in fiscal
176.14 year 2011. The amount of such funds shall
176.15 not exceed \$28,000,000.

176.16 (c) MFIP Child Care Assistance Grants	61,171,000	65,214,000
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176.17 **Acceleration of ARRA Child Care and**
176.18 **Development Fund Expenditure.** The
176.19 commissioner must liquidate all child care
176.20 and development money available under
176.21 the American Recovery and Reinvestment
176.22 Act (ARRA) of 2009, Public Law 111-5,
176.23 by September 30, 2010. In order to expend
176.24 those funds by September 30, 2010, the
176.25 commissioner may redesignate and expend
176.26 the ARRA child care and development funds
176.27 appropriated in fiscal year 2011 for purposes
176.28 under this section for related purposes that
176.29 will allow liquidation by September 30,
176.30 2010. Child care and development funds
176.31 otherwise available to the commissioner
176.32 for those related purposes shall be used to
176.33 fund the purposes from which the ARRA
176.34 child care and development funds had been
176.35 redesignated.

177.1 **School Readiness Service Agreements.**

177.2 \$400,000 in fiscal year 2010 and \$400,000

177.3 in fiscal year 2011 are from the federal

177.4 TANF fund to the commissioner of human

177.5 services consistent with federal regulations

177.6 for the purpose of school readiness service

177.7 agreements under Minnesota Statutes,

177.8 section 119B.231. This is a onetime

177.9 appropriation. Any unexpended balance the

177.10 first year is available in the second year.

177.11 **(d) Basic Sliding Fee Child Care Assistance**177.12 **Grants**

40,100,000

45,092,000

177.13 **School Readiness Service Agreements.**

177.14 \$257,000 in fiscal year 2010 and \$257,000

177.15 in fiscal year 2011 are from the general

177.16 fund for the purpose of school readiness

177.17 service agreements under Minnesota

177.18 Statutes, section 119B.231. This is a onetime

177.19 appropriation. Any unexpended balance the

177.20 first year is available in the second year.

177.21 **Child Care Development Fund**177.22 **Unexpended Balance.** In addition to

177.23 the amount provided in this section, the

177.24 commissioner shall expend \$5,244,000 in

177.25 fiscal year 2010 from the federal child care

177.26 development fund unexpended balance

177.27 for basic sliding fee child care under

177.28 Minnesota Statutes, section 119B.03. The

177.29 commissioner shall ensure that all child

177.30 care and development funds are expended

177.31 according to the federal child care and

177.32 development fund regulations.

177.33 **Basic Sliding Fee.** \$4,000,000 in fiscal year

177.34 2010 and \$4,000,000 in fiscal year 2011 are

177.35 from the federal child care development

177.36 funds received from the American Recovery

178.1 and Reinvestment Act of 2009, Public
178.2 Law 111-5, to the commissioner of human
178.3 services consistent with federal regulations
178.4 for the purpose of basic sliding fee child care
178.5 assistance under Minnesota Statutes, section
178.6 119B.03. This is a onetime appropriation.
178.7 Any unexpended balance the first year is
178.8 available in the second year.

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

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

178.29 (b) Up to three-fourths of the funds shall
178.30 be allocated in proportion to the average
178.31 of each county's most recent six months of
178.32 reported waiting list as defined in Minnesota
178.33 Statutes, section 119B.03, subdivision 2, and
178.34 the reinstatement list of those families whose
178.35 assistance was terminated with the approval

179.1 of the commissioner under Minnesota Rules,
 179.2 part 3400.0183, subpart 1. Funds in excess
 179.3 of the amount necessary to serve all families
 179.4 in this category shall be allocated according
 179.5 to paragraph (d).

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

179.12 (d) Funds in excess of the amount necessary
 179.13 to serve all families in paragraphs (a) and
 179.14 (b) shall be allocated in proportion to each
 179.15 county's total expenditures for the basic
 179.16 sliding fee child care program reported
 179.17 during the most recent fiscal year completed
 179.18 at the time of the notice of allocation. To
 179.19 the extent that funds are available, and
 179.20 notwithstanding Minnesota Statutes, section
 179.21 119B.03, subdivision 8, for the period
 179.22 January 1, 2011, to December 31, 2011, each
 179.23 county's guaranteed floor must be equal to its
 179.24 original calendar year 2010 allocation.

179.25 **Base Adjustment.** The general fund base is
 179.26 decreased by \$257,000 in each of fiscal years
 179.27 2012 and 2013.

179.28 (e) Child Care Development Grants	1,487,000	1,487,000
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179.29 **Family, friends, and neighbor grants.**
 179.30 \$375,000 in fiscal year 2010 and \$375,000
 179.31 in fiscal year 2011 are from the child
 179.32 care development fund required targeted
 179.33 quality funds for quality expansion and
 179.34 infant/toddler from the American Recovery
 179.35 and Reinvestment Act of 2009, Public

180.1 Law 111-5, to the commissioner of human
180.2 services for family, friends, and neighbor
180.3 grants under Minnesota Statutes, section
180.4 119B.232. This appropriation may be used
180.5 on programs receiving family, friends, and
180.6 neighbor grant funds as of June 30, 2009,
180.7 or on new programs or projects. This is a
180.8 onetime appropriation. Any unexpended
180.9 balance the first year is available in the
180.10 second year.

180.11 **Voluntary quality rating system training,**
180.12 **coaching, consultation, and supports.**
180.13 \$633,000 in fiscal year 2010 and \$633,000
180.14 in fiscal year 2011 are from the federal child
180.15 care development fund required targeted
180.16 quality funds for quality expansion and
180.17 infant/toddler from the American Recovery
180.18 and Reinvestment Act of 2009, Public
180.19 Law 111-5, to the commissioner of human
180.20 services consistent with federal regulations
180.21 for the purpose of providing grants to provide
180.22 statewide child-care provider training,
180.23 coaching, consultation, and supports to
180.24 prepare for the voluntary Minnesota quality
180.25 rating system rating tool. This is a onetime
180.26 appropriation. Any unexpended balance the
180.27 first year is available in the second year.

180.28 **Voluntary quality rating system.** \$184,000
180.29 in fiscal year 2010 and \$1,200,000 in fiscal
180.30 year 2011 are from the federal child care
180.31 development fund required targeted funds for
180.32 quality expansion and infant/toddler from the
180.33 American Recovery and Reinvestment Act of
180.34 2009, Public Law 111-5, to the commissioner
180.35 of human services consistent with federal
180.36 regulations for the purpose of implementing

181.1 the voluntary Parent Aware quality star
 181.2 rating system pilot in coordination with the
 181.3 Minnesota Early Learning Foundation. The
 181.4 appropriation for the first year is to complete
 181.5 and promote the voluntary Parent Aware
 181.6 quality rating system pilot program through
 181.7 June 30, 2010, and the appropriation for
 181.8 the second year is to continue the voluntary
 181.9 Minnesota quality rating system pilot
 181.10 through June 30, 2011. This is a onetime
 181.11 appropriation. Any unexpended balance the
 181.12 first year is available in the second year.

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

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

181.15	Appropriations by Fund		
181.16	General	48,333,000	50,498,000
181.17	Federal TANF	340,000	240,000

181.18 **Base Adjustment.** The general fund base is
 181.19 decreased by \$5,371,000 in fiscal year 2012
 181.20 and decreased \$5,371,000 in fiscal year 2013.

181.21 **Privatized Adoption Grants.** Federal
 181.22 reimbursement for privatized adoption grant
 181.23 and foster care recruitment grant expenditures
 181.24 is appropriated to the commissioner for
 181.25 adoption grants and foster care and adoption
 181.26 administrative purposes.

181.27 **Adoption Assistance Incentive Grants.**
 181.28 Federal funds available during fiscal year
 181.29 2010 and fiscal year 2011 for the adoption
 181.30 incentive grants are appropriated to the
 181.31 commissioner for postadoption services
 181.32 including parent support groups.

181.33 **Adoption Assistance and Relative Custody**
 181.34 **Assistance.** The commissioner may transfer
 181.35 unencumbered appropriation balances for

182.1	adoption assistance and relative custody		
182.2	assistance between fiscal years and between		
182.3	programs.		
182.4	(h) Children and Community Services Grants	67,663,000	67,542,000
182.5	Targeted Case Management Temporary		
182.6	Funding Adjustment. The commissioner		
182.7	shall recover from each county and tribe		
182.8	receiving a targeted case management		
182.9	temporary funding payment in fiscal year		
182.10	2008 an amount equal to that payment. The		
182.11	commissioner shall recover one-half of the		
182.12	funds by February 1, 2010, and the remainder		
182.13	by February 1, 2011. At the commissioner's		
182.14	discretion and at the request of a county		
182.15	or tribe, the commissioner may revise		
182.16	the payment schedule, but full payment		
182.17	must not be delayed beyond May 1, 2011.		
182.18	The commissioner may use the recovery		
182.19	procedure under Minnesota Statutes, section		
182.20	256.017, to recover the funds. Recovered		
182.21	funds must be deposited into the general		
182.22	fund.		
182.23	(i) General Assistance Grants	48,215,000	48,608,000
182.24	General Assistance Standard. The		
182.25	commissioner shall set the monthly standard		
182.26	of assistance for general assistance units		
182.27	consisting of an adult recipient who is		
182.28	childless and unmarried or living apart		
182.29	from parents or a legal guardian at \$203.		
182.30	The commissioner may reduce this amount		
182.31	according to Laws 1997, chapter 85, article		
182.32	3, section 54.		
182.33	Emergency General Assistance. The		
182.34	amount appropriated for emergency general		
182.35	assistance funds is limited to no more		

183.1 than \$7,889,812 in fiscal year 2010 and
 183.2 \$7,889,812 in fiscal year 2011. Funds
 183.3 to counties must be allocated by the
 183.4 commissioner using the allocation method
 183.5 specified in Minnesota Statutes, section
 183.6 256D.06.

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

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

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

183.18 **Group Residential Housing Costs**
 183.19 **Refinanced.** (a) Effective July 1, 2011, the
 183.20 commissioner shall increase the home and
 183.21 community-based service rates and county
 183.22 allocations provided to programs for persons
 183.23 with disabilities established under section
 183.24 1915(c) of the Social Security Act to the
 183.25 extent that these programs will be paying
 183.26 for the costs above the rate established
 183.27 in Minnesota Statutes, section 256I.05,
 183.28 subdivision 1.

183.29 (b) For persons receiving services under
 183.30 Minnesota Statutes, section 245A.02, who
 183.31 reside in licensed adult foster care beds
 183.32 for which a difficulty of care payment
 183.33 was being made under Minnesota Statutes,
 183.34 section 256I.05, subdivision 1c, paragraph
 183.35 (b), counties may request an exception to

184.1 the individual's service authorization not to
 184.2 exceed the difference between the client's
 184.3 monthly service expenditures plus the
 184.4 amount of the difficulty of care payment.

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

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

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

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

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

184.28 **ARRA Homeless Youth Funds.** To the
 184.29 extent permitted under federal law, the
 184.30 commissioner shall designate \$2,500,000
 184.31 of the Homeless Prevention and Rapid
 184.32 Re-Housing Program funds provided under
 184.33 the American Recovery and Reinvestment
 184.34 Act of 2009, Public Law 111-5, for agencies

185.1 providing homelessness prevention and rapid
185.2 rehousing services to youth.

185.3 **Supportive Housing Services.** \$1,500,000
185.4 each year is for supportive services under
185.5 Minnesota Statutes, section 256K.26. This is
185.6 a onetime appropriation.

185.7 **Community Action Grants.** Community
185.8 action grants are reduced one time by
185.9 \$1,794,000 each year. This reduction is due
185.10 to the availability of federal funds under the
185.11 American Recovery and Reinvestment Act.

185.12 **Base Adjustment.** The general fund base
185.13 is increased by ~~\$773,000~~ \$903,000 in fiscal
185.14 year 2012 and ~~\$773,000~~ \$413,000 in fiscal
185.15 year 2013.

185.16 **Federal ARRA Funds for Existing**
185.17 **Programs.** ~~(a)~~ (1) Federal funds received by
185.18 the commissioner for the emergency food
185.19 and shelter program from the American
185.20 Recovery and Reinvestment Act of 2009,
185.21 Public Law 111-5, but not previously
185.22 approved by the legislature are appropriated
185.23 to the commissioner for the purposes of the
185.24 grant program.

185.25 ~~(b)~~ (2) Federal funds received by the
185.26 commissioner for the emergency shelter
185.27 grant program including the Homelessness
185.28 Prevention and Rapid Re-Housing
185.29 Program from the American Recovery and
185.30 Reinvestment Act of 2009, Public Law
185.31 111-5, are appropriated to the commissioner
185.32 for the purposes of the grant programs.

185.33 ~~(c)~~ (3) Federal funds received by the
185.34 commissioner for the emergency food
185.35 assistance program from the American

186.1 Recovery and Reinvestment Act of 2009,
186.2 Public Law 111-5, are appropriated to the
186.3 commissioner for the purposes of the grant
186.4 program.

186.5 ~~(d)~~ (4) Federal funds received by the
186.6 commissioner for senior congregate meals
186.7 and senior home-delivered meals from the
186.8 American Recovery and Reinvestment Act
186.9 of 2009, Public Law 111-5, are appropriated
186.10 to the commissioner for the Minnesota Board
186.11 on Aging, for purposes of the grant programs.

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

186.19 **Long-Term Homeless Supportive**
186.20 **Service Fund Appropriation.** To the
186.21 extent permitted under federal law, the
186.22 commissioner shall designate \$3,000,000
186.23 of the Homelessness Prevention and Rapid
186.24 Re-Housing Program funds provided under
186.25 the American Recovery and Reinvestment
186.26 Act of 2009, Public Law, 111-5, to the
186.27 long-term homeless service fund under
186.28 Minnesota Statutes, section 256K.26. This
186.29 appropriation shall become available by July
186.30 1, 2009. This paragraph is effective the day
186.31 following final enactment.

186.32 Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
186.33 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

186.34 Subd. 8. **Continuing Care Grants**

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

187.3 (a) Aging and Adult Services Grants	13,499,000	15,805,000
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187.4 **Base Adjustment.** The general fund base is
187.5 increased by \$5,751,000 in fiscal year 2012
187.6 and \$6,705,000 in fiscal year 2013.

187.7 **Information and Assistance**

187.8 **Reimbursement.** Federal administrative
187.9 reimbursement obtained from information
187.10 and assistance services provided by the
187.11 Senior LinkAge or Disability Linkage lines
187.12 to people who are identified as eligible for
187.13 medical assistance shall be appropriated to
187.14 the commissioner for this activity.

187.15 **Community Service Development Grant**

187.16 **Reduction.** Funding for community service
187.17 development grants must be reduced by
187.18 \$260,000 for fiscal year 2010; \$284,000 in
187.19 fiscal year 2011; \$43,000 in fiscal year 2012;
187.20 and \$43,000 in fiscal year 2013. Base level
187.21 funding shall be restored in fiscal year 2014.

187.22 **Community Service Development Grant**

187.23 **Community Initiative.** Funding for
187.24 community service development grants shall
187.25 be used to offset the cost of aging support
187.26 grants. Base level funding shall be restored
187.27 in fiscal year 2014.

187.28 **Senior Nutrition Use of Federal Funds.**

187.29 For fiscal year 2010, general fund grants
187.30 for home-delivered meals and congregate
187.31 dining shall be reduced by \$500,000. The
187.32 commissioner must replace these general
187.33 fund reductions with equal amounts from
187.34 federal funding for senior nutrition from the

188.1	American Recovery and Reinvestment Act		
188.2	of 2009.		
188.3	(b) Alternative Care Grants	50,234,000	48,576,000
188.4	Base Adjustment. The general fund base is		
188.5	decreased by \$3,598,000 in fiscal year 2012		
188.6	and \$3,470,000 in fiscal year 2013.		
188.7	Alternative Care Transfer. Any money		
188.8	allocated to the alternative care program that		
188.9	is not spent for the purposes indicated does		
188.10	not cancel but must be transferred to the		
188.11	medical assistance account.		
188.12	(c) Medical Assistance Grants; Long-Term		
188.13	Care Facilities.	367,444,000	419,749,000
188.14	(d) Medical Assistance Long-Term Care		
188.15	Waivers and Home Care Grants	853,567,000	1,039,517,000
188.16	Manage Growth in TBI and CADI		
188.17	Waivers. During the fiscal years beginning		
188.18	on July 1, 2009, and July 1, 2010, the		
188.19	commissioner shall allocate money for home		
188.20	and community-based waiver programs		
188.21	under Minnesota Statutes, section 256B.49,		
188.22	to ensure a reduction in state spending that is		
188.23	equivalent to limiting the caseload growth of		
188.24	the TBI waiver to 12.5 allocations per month		
188.25	each year of the biennium and the CADI		
188.26	waiver to 95 allocations per month each year		
188.27	of the biennium. Limits do not apply: (1)		
188.28	when there is an approved plan for nursing		
188.29	facility bed closures for individuals under		
188.30	age 65 who require relocation due to the		
188.31	bed closure; (2) to fiscal year 2009 waiver		
188.32	allocations delayed due to unallotment; or (3)		
188.33	to transfers authorized by the commissioner		
188.34	from the personal care assistance program		
188.35	of individuals having a home care rating		

189.1 of "CS," "MT," or "HL." Priorities for the
189.2 allocation of funds must be for individuals
189.3 anticipated to be discharged from institutional
189.4 settings or who are at imminent risk of a
189.5 placement in an institutional setting.

189.6 **Manage Growth in ~~DD~~ Developmental**
189.7 **Disability Waiver**. The commissioner
189.8 shall manage the growth in the DD waiver
189.9 by limiting the allocations included in the
189.10 February 2009 forecast to 15 additional
189.11 diversion allocations each month for the
189.12 calendar years that begin on January 1, 2010,
189.13 and January 1, 2011. Additional allocations
189.14 must be made available for transfers
189.15 authorized by the commissioner from the
189.16 personal care program of individuals having
189.17 a home care rating of "CS," "MT," or "HL."

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

189.26 **Alternatives to Personal Care Assistance**
189.27 **Services**. Base level funding of \$3,237,000
189.28 in fiscal year 2012 and \$4,856,000 in
189.29 fiscal year 2013 is to implement alternative
189.30 services to personal care assistance services
189.31 for persons with mental health and other
189.32 behavioral challenges who can benefit
189.33 from other services that more appropriately
189.34 meet their needs and assist them in living
189.35 independently in the community. These

190.1 services may include, but not be limited to, a
 190.2 1915(i) state plan option.

190.3 **(e) Mental Health Grants**

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

190.8 **Funding Usage.** Up to 75 percent of a fiscal
 190.9 year's appropriation for adult mental health
 190.10 grants may be used to fund allocations in that
 190.11 portion of the fiscal year ending December
 190.12 31.

190.13	(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
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190.14	(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000
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190.15 **Payments for Substance Abuse Treatment.**

190.16 For ~~services provided~~ placements beginning
 190.17 during fiscal years 2010 and 2011,
 190.18 county-negotiated rates and provider claims
 190.19 to the consolidated chemical dependency
 190.20 fund must not exceed the lesser of: (1) rates
 190.21 charged for these services on January 1,
 190.22 2009; or (2) 160 percent of the average rate
 190.23 on January 1, 2009, for each group of vendors
 190.24 with similar attributes. For services provided
 190.25 during fiscal year 2011, all payment rates
 190.26 are reduced by five percent from the rates in
 190.27 effect on June 1, 2010. For services provided
 190.28 in fiscal years 2012 and 2013, the statewide
 190.29 average rates aggregate payment under the
 190.30 new rate methodology to be developed under
 190.31 Minnesota Statutes, section 254B.12, must
 190.32 not exceed the ~~average rates charged for~~
 190.33 ~~these services on January 1, 2009, plus a~~
 190.34 ~~state share increase of \$3,787,000 for fiscal~~
 190.35 ~~year 2012 and \$5,023,000 for fiscal year~~

191.1 ~~2013~~ projected aggregate payment under
 191.2 the rates in effect for fiscal year 2010 minus
 191.3 1.25 percent. Notwithstanding any provision
 191.4 to the contrary in this article, this provision
 191.5 expires on June 30, 2013.

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

191.12 **County CD Share of MA Costs for**
 191.13 **ARRA Compliance.** Notwithstanding the
 191.14 provisions of Minnesota Statutes, chapter
 191.15 254B, for chemical dependency services
 191.16 provided during the period October 1, 2008,
 191.17 to December 31, 2010, and reimbursed by
 191.18 medical assistance at the enhanced federal
 191.19 matching rate provided under the American
 191.20 Recovery and Reinvestment Act of 2009, the
 191.21 county share is 30 percent of the nonfederal
 191.22 share. This provision is effective the day
 191.23 following final enactment.

191.24	(h) Chemical Dependency Nonentitlement		
191.25	Grants	1,729,000	1,729,000

191.26	(i) Other Continuing Care Grants	19,201,000	17,528,000
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191.27 **Base Adjustment.** The general fund base is
 191.28 increased by \$2,639,000 in fiscal year 2012
 191.29 and increased by \$3,854,000 in fiscal year
 191.30 2013.

191.31 **Technology Grants.** \$650,000 in fiscal
 191.32 year 2010 and \$1,000,000 in fiscal year
 191.33 2011 are for technology grants, case
 191.34 consultation, evaluation, and consumer
 191.35 information grants related to developing and

192.1 supporting alternatives to shift-staff foster
192.2 care residential service models.

192.3 **Other Continuing Care Grants; HIV**

192.4 **Grants.** Money appropriated for the HIV
192.5 drug and insurance grant program in fiscal
192.6 year 2010 may be used in either year of the
192.7 biennium.

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

192.12 Sec. 15. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by
192.13 Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

192.14 Subd. 8. **Board of Nursing Home**

192.15 **Administrators**

1,211,000

1,023,000

192.16 **Administrative Services Unit - Operating**

192.17 **Costs.** Of this appropriation, \$524,000

192.18 in fiscal year 2010 and \$526,000 in

192.19 fiscal year 2011 are for operating costs

192.20 of the administrative services unit. The

192.21 administrative services unit may receive

192.22 and expend reimbursements for services

192.23 performed by other agencies.

192.24 **Administrative Services Unit - Retirement**

192.25 **Costs.** Of this appropriation in fiscal year

192.26 2010, \$201,000 is for onetime retirement

192.27 costs in the health-related boards. This

192.28 funding may be transferred to the health

192.29 boards incurring those costs for their

192.30 payment. These funds are available either

192.31 year of the biennium.

192.32 **Administrative Services Unit - Volunteer**

192.33 **Health Care Provider Program.** Of this

192.34 appropriation, \$79,000 in fiscal year 2010

193.1 and \$89,000 in fiscal year 2011 are to pay
193.2 for medical professional liability coverage
193.3 required under Minnesota Statutes, section
193.4 214.40.

193.5 **Administrative Services Unit - Contested**
193.6 **Cases and Other Legal Proceedings.** Of
193.7 this appropriation, \$200,000 in fiscal year
193.8 2010 and \$200,000 in fiscal year 2011 are
193.9 for costs of contested case hearings and other
193.10 unanticipated costs of legal proceedings
193.11 involving health-related boards funded
193.12 under this section and for unforeseen
193.13 expenditures of an urgent nature. Upon
193.14 certification of a health-related board to the
193.15 administrative services unit that the costs
193.16 will be incurred and that there is insufficient
193.17 money available to pay for the costs out of
193.18 money currently available to that board, the
193.19 administrative services unit is authorized
193.20 to transfer money from this appropriation
193.21 to the board for payment of those costs
193.22 with the approval of the commissioner of
193.23 finance. This appropriation does not cancel.
193.24 Any unencumbered and unspent balances
193.25 remain available for these expenditures in
193.26 subsequent fiscal years. The boards receiving
193.27 funds under this section shall include these
193.28 amounts when setting fees to cover their
193.29 costs.

193.30 Sec. 16. **CANCELLATIONS.**

193.31 The remaining balance from Laws 2008, chapter 358, article 5, section 4, subdivision
193.32 3, appropriation for Section 125 employer incentives, is canceled.

193.33 Sec. 17. **TRANSFERS.**

194.1 The commissioner of management and budget shall transfer from the general fund to
194.2 the health care access fund \$38,475,000 in fiscal year 2011, \$14,758,000 in fiscal year
194.3 2012, and \$35,058,000 in fiscal year 2013.

194.4 **EFFECTIVE DATE.** This section is effective upon federal approval of the
194.5 amendments to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056,
194.6 subdivision 4.

194.7 Sec. 18. **EXPIRATION OF UNCODIFIED LANGUAGE.**

194.8 All uncodified language contained in this article expires on June 30, 2011, unless a
194.9 different expiration date is explicit.

194.10 Sec. 19. **EFFECTIVE DATE.**

194.11 The provisions in this article are effective July 1, 2010, unless a different effective
194.12 date is explicit.

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subd. 2. **County adjustment; maximum allocation.** The commissioner shall determine the state money used by each county in fiscal year 1986, using all state data sources. If available records do not provide specific chemical dependency expenditures for every county, the commissioner shall determine the amount of state money using estimates based on available data. In state fiscal year 1988, a county must not be allocated more than 150 percent of the state money spent by or on behalf of the county in fiscal year 1986 for chemical dependency treatment services eligible for payment under section 254B.05 but not including expenditures made for persons eligible for placement under section 254B.09, subdivision 6. The allocation maximums must be increased by 25 percent each year. After fiscal year 1992, there must be no allocation maximum. The commissioner shall reallocate the excess over the maximum to counties allocated less than the fiscal year 1986 state money, using the following process:

(a) The allocation is divided by 1986 state expenditures to determine percentage of prior expenditure, and counties are ranked by percentage of prior expenditure less expenditures for persons eligible for placement under section 254B.09, subdivision 6.

(b) The allocation of the lowest ranked county is raised to the same percentage of prior expenditure as the second lowest ranked county. The allocation of these two counties is then raised to the percentage of prior expenditures of the third lowest ranked county.

(c) The operations under paragraph (b) are repeated with each county by ranking until the money in excess of the allocation maximum has been allocated.

Subd. 3. **Reserve account.** The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, at the end of each biennium, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Subd. 4. **Allocation spending limits.** Money allocated according to subdivision 1 and section 254B.09, subdivision 4, is available for payments for up to two years. The commissioner shall deduct payments from the most recent year allocation in which money is available. Allocations under this section that are not used within two years must be reallocated to the reserve account for payments under subdivision 3. Allocations under section 254B.09, subdivision 4, that are not used within two years must be reallocated for payments under section 254B.09, subdivision 5.

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subd. 4. **Tribal allocation.** Eighty-five percent of the American Indian chemical dependency tribal account must be allocated to the federally recognized American Indian tribal governing bodies that have entered into an agreement under subdivision 2 as follows: \$10,000 must be allocated to each governing body and the remainder must be allocated in direct proportion to the population of the reservation according to the most recently available estimates from the federal Bureau of Indian Affairs. When a tribal governing body has not entered into an agreement with the commissioner under subdivision 2, the county may use funds allocated to the reservation to pay for chemical dependency services for a current resident of the county and of the reservation.

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Subd. 5. **Tribal reserve account.** The commissioner shall reserve 15 percent of the American Indian chemical dependency tribal account. The reserve must be allocated to those tribal units that have used all money allocated under subdivision 4 according to agreements made under subdivision 2 and to counties submitting invoices for American Indians under subdivision 1 when all money allocated under subdivision 4 has been used. An American Indian tribal governing body or a county submitting invoices under subdivision 1 may receive not more than 30 percent of the reserve account in a year. The commissioner may refuse to make reserve payments for persons not eligible under section 254B.04, subdivision 1, if the tribal governing body responsible for treatment placement has exhausted its allocation. Money must be allocated as invoices are received.

Subd. 7. **Nonreservation Indian account.** The nonreservation American Indian chemical dependency allocation must be held in reserve by the commissioner in an account for treatment of Indians not residing on lands of a reservation receiving money under subdivision 4. This money must be used to pay for services certified by county invoice to have been provided to an American Indian eligible recipient. Money allocated under this subdivision may be used for payments on behalf of American Indian county residents only if, in addition to other placement standards, the county certifies that the placement was appropriate to the cultural orientation of the client. Any funds for treatment of nonreservation Indians remaining at the end of a fiscal year shall be reallocated under section 254B.02.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of \$1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

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(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

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

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

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

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

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial

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months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

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

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

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

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 5. **Certain county agencies to pay state for county share.** The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a

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pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. Duties of the commissioner. The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. Private insurance policies. (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

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(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Laws 2009, chapter 79, article 7, section 26, subdivision 3

Sec. 26. STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT PROJECT.

Subd. 3. **Report.** The Department of Human Services shall evaluate the efficacy and feasibility of the pilot projects and report the results of that evaluation to the legislative committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot projects may occur only if the department's report finds the pilot projects effective.

Laws 2010, chapter 200, article 1, section 12 Subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9,

Sec. 12. [256D.031] GENERAL ASSISTANCE MEDICAL CARE.

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of \$1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

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

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

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human

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Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

Subd. 4. General assistance medical care; services. (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare-certified rehabilitation agencies;
- (4) prescription drugs;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations;
- (7) hearing aids;
- (8) prosthetic devices, if not covered by veterans benefits;
- (9) laboratory and x-ray services;
- (10) physicians' services;
- (11) medical transportation except special transportation;
- (12) chiropractic services as covered under the medical assistance program;
- (13) podiatric services;
- (14) dental services;
- (15) mental health services covered under chapter 256B;
- (16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for

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inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

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

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

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) \$25 for nonemergency visits to a hospital-based emergency room; and

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

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

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 5. Payment rates and contract modification; April 1, 2010, to May 31, 2010. (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater than 1.3 percent of net

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patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

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

(3) in cooperation with counties, coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A; and

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

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner

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deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system.

(a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

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

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

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

Subd. 8. Temporary uncompensated care pool. (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to November 30, 2010.

(c) The aggregated payment amounts for each hospital must be calculated as a percentage of the total calculated amount for all hospitals.

(d) Distributions from the uncompensated care pool for each hospital must be determined by multiplying the factor in paragraph (c) by the amount of money in the uncompensated care pool that is available for the six-month period.

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

(f) Outpatient prescription drugs are not eligible for payment under this subdivision.

Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

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Sec. 18. DRUG REBATE PROGRAM.

The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph (cc), and 256D.03.

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

Laws 2010, chapter 200, article 1, section 19

Sec. 19. TRANSITIONAL MINNESOTACARE PHASEOUT.

For any applicant or recipient who meets the requirements of Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), before April 1, 2010, and who is not exempt under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (f), the commissioner of human services shall continue the process of enrolling the recipient in MinnesotaCare as required under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), and, upon the completion of enrollment, the recipient shall receive services under MinnesotaCare in accordance with Minnesota Statutes, section 256L.03. County agencies shall continue to perform all duties necessary to administer the MinnesotaCare program ongoing for individuals enrolled in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), including the redetermination of MinnesotaCare eligibility at renewal.

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

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