1.1 A bill for an act

1.2 relating to state government; state health care programs; continuing care;
1.3 children and family services; health care reform; Department of Health;
1.4 public health; health plans; increasing fees and surcharges; requiring reports;
1.5 making supplemental and contingent appropriations and reductions for the
1.6 Departments of Health and Human Services and other health-related boards
1.7 and councils; amending Minnesota Statutes 2008, sections 62D.08, by adding
1.8 a subdivision; 62J.692, subdivision 4; 62Q.19, subdivision 1; 144.05, by
1.9 adding a subdivision; 144.226, subdivision 3; 144.293, subdivision 4; 144.651,
1.10 subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5;
1.11 144D.03, subdivision 2, by adding a subdivision; 144D.04, subdivision 2;
1.12 144E.37; 144G.06; 152.126, as amended; 214.40, subdivision 7; 246.18, by
1.13 adding a subdivision; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5;
1.14 254B.03, subdivision 4; 254B.05, subdivision 4; 254B.06, subdivision 2;
1.15 254B.09, subdivision 8; 256.9657, subdivisions 2, 3, 3a; 256.969, subdivisions
1.16 21, 26, by adding a subdivision; 256B.055, by adding a subdivision; 256B.056,
1.17 subdivisions 3, 4; 256B.057, subdivision 9; 256B.0625, subdivisions 8, 8a, 8b,
1.18 18a, 22, 31, by adding subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644,
1.19 as amended; 256B.0915, by adding a subdivision; 256B.19, subdivision 1c;
1.20 256B.5012, by adding a subdivision; 256B.69, subdivisions 20, as amended,
1.21 27, by adding a subdivision; 256B.692, subdivision 1; 256B.76, subdivisions
1.22 2, 4; 256D.03, subdivision 3b; 256D.0515; 256I.05, by adding a subdivision;
1.23 256J.24, subdivision 6; 256L.07, by adding a subdivision; 256L.11, subdivision
1.24 6; 256L.12, subdivisions 5, 9, by adding a subdivision; 256L.15, subdivision
1.25 1; 517.08, subdivision 1c, as amended; Minnesota Statutes 2009 Supplement,
1.26 sections 157.16, subdivision 3; 252.27, subdivision 2a; 256.969, subdivisions 2b,
1.27 3a; 256.975, subdivision 7; 256B.0625, subdivision 13h; 256B.0653, subdivision
1.28 5; 256B.0659, subdivision 11; 256B.0911, subdivisions 1a, 3c; 256B.441,
1.29 subdivision 55; 256B.69, subdivisions 5a, 23; 256B.76, subdivision 1; 256B.766;
1.30 256D.03, subdivision 3, as amended; 256J.425, subdivision 3; 256L.03,
1.31 subdivision 5; 327.15, subdivision 3; 517.08, subdivision 1b; Laws 2005, First
1.32 Special Session chapter 4, article 8, section 66, as amended; Laws 2009, chapter
1.33 79, article 3, section 18; article 5, sections 17; 18; 22; 75, subdivision 1; 78,
1.34 subdivision 5; article 8, sections 2; 51; 84; article 13, sections 3, subdivisions
1.35 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5, subdivision 8,
1.36 as amended; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter
1.37 200, article 1, sections 12; 16; 21; article 2, section 2, subdivisions 1, 5, 8;
1.38 proposing coding for new law in Minnesota Statutes, chapters 62D; 62E; 62Q;
1.39 137; 144; 144D; 246; 254B; 256; 256B; repealing Minnesota Statutes 2008,

2.1 sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03,
2.2 subdivisions 3, 3a, 5, 6, 7, 8; Minnesota Statutes 2009 Supplement, section
2.3 256J.621; Laws 2010, chapter 200, article 1, sections 12; 18; 19.

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

2.5 ARTICLE 1

2.6 HEALTH CARE

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

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

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

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

2.18 (d) Effective October 1, 2011, the surcharge under paragraph (c) is reduced to
2.19 2.30 percent.

2.20 (e) Notwithstanding the Medicare cost finding and allowable cost principles, the
2.21 hospital surcharge is not an allowable cost for purposes of rate setting under sections
2.22 256.9685 to 256.9695.

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

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

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

2.33 (b) Effective October 1, 2010, in addition to the surcharge under paragraph (a), each
2.34 health maintenance organization shall pay to the commissioner a surcharge equal to 0.85

3.1 percent of total premium revenues and each county-based purchasing plan authorized
3.2 under section 256B.692 shall pay to the commissioner a surcharge equal to 1.45 percent
3.3 of the total premium revenues of the plan, as reported to the commissioner of health,
3.4 according to the payment schedule in subdivision 4. Notwithstanding section 256.9656,
3.5 money collected under this paragraph shall be deposited in the health care access fund
3.6 established in section 16A.724.

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

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

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

3.15 (3) Medicare revenue, as a result of an arrangement between a health maintenance
3.16 organization or a community integrated service network and the Centers for Medicare
3.17 and Medicaid Services of the federal Department of Health and Human Services, for
3.18 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
3.19 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
3.20 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
3.21 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

3.35 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
3.36 corporation's surcharge shall be based on the revenues earned in the second previous

4.1 calendar year by all of the entities or corporations subject to the merger, consolidation,
4.2 or acquisition regardless of whether one of the entities or corporations does not retain a
4.3 certificate of authority under chapter 62D or a license under chapter 62N until the total
4.4 premium revenues of the surviving corporation include the total premium revenues of all
4.5 the merged entities as reported to the commissioner of health.

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

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

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

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

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

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

5.1 its most recent Medicare cost report ending on or before September 1, 2008, with the
5.2 provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010.
5.3 For subsequent rate setting periods in which the base years are updated, a Minnesota
5.4 long-term hospital's base year shall remain within the same period as other hospitals.
5.5 Effective ~~April 1, 2012~~ January 1, 2013, rates shall be rebased at full value. The base year
5.6 operating payment rate per admission is standardized by the case mix index and adjusted
5.7 by the hospital cost index, relative values, and disproportionate population adjustment.
5.8 The cost and charge data used to establish operating rates shall only reflect inpatient
5.9 services covered by medical assistance and shall not include property cost information
5.10 and costs recognized in outlier payments.

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

5.12 Sec. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is
5.13 amended to read:
5.14 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
5.15 assistance program must not be submitted until the recipient is discharged. However,
5.16 the commissioner shall establish monthly interim payments for inpatient hospitals that
5.17 have individual patient lengths of stay over 30 days regardless of diagnostic category.
5.18 Except as provided in section 256.9693, medical assistance reimbursement for treatment
5.19 of mental illness shall be reimbursed based on diagnostic classifications. Individual
5.20 hospital payments established under this section and sections 256.9685, 256.9686, and
5.21 256.9695, in addition to third party and recipient liability, for discharges occurring during
5.22 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
5.23 inpatient services paid for the same period of time to the hospital. This payment limitation
5.24 shall be calculated separately for medical assistance and general assistance medical
5.25 care services. The limitation on general assistance medical care shall be effective for
5.26 admissions occurring on or after July 1, 1991. Services that have rates established under
5.27 subdivision 11 or 12, must be limited separately from other services. After consulting with
5.28 the affected hospitals, the commissioner may consider related hospitals one entity and
5.29 may merge the payment rates while maintaining separate provider numbers. The operating
5.30 and property base rates per admission or per day shall be derived from the best Medicare
5.31 and claims data available when rates are established. The commissioner shall determine
5.32 the best Medicare and claims data, taking into consideration variables of recency of the
5.33 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
5.34 The commissioner shall notify hospitals of payment rates by December 1 of the year
5.35 preceding the rate year. The rate setting data must reflect the admissions data used to

6.1 establish relative values. Base year changes from 1981 to the base year established for the
6.2 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
6.3 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
6.4 1. The commissioner may adjust base year cost, relative value, and case mix index data
6.5 to exclude the costs of services that have been discontinued by the October 1 of the year
6.6 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
6.7 that encompass portions of two or more rate years shall have payments established based
6.8 on payment rates in effect at the time of admission unless the date of admission preceded
6.9 the rate year in effect by six months or more. In this case, operating payment rates for
6.10 services rendered during the rate year in effect and established based on the date of
6.11 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

6.20 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
6.21 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
6.22 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
6.23 from the current statutory rates. Mental health services within diagnosis related groups
6.24 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
6.25 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
6.26 assistance does not include general assistance medical care. Payments made to managed
6.27 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
6.28 this reduction.

6.29 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
6.30 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
6.31 to hospitals for inpatient services before third-party liability and spenddown, is reduced
6.32 3.46 percent from the current statutory rates. Mental health services with diagnosis related
6.33 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
6.34 paragraph. Payments made to managed care plans shall be reduced for services provided
6.35 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

7.1 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
7.2 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
7.3 to hospitals for inpatient services before third-party liability and spenddown, is reduced
7.4 1.9 percent from the current statutory rates. Mental health services with diagnosis related
7.5 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
7.6 paragraph. Payments made to managed care plans shall be reduced for services provided
7.7 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

7.8 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
7.9 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
7.10 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
7.11 from the current statutory rates. Mental health services with diagnosis related groups
7.12 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
7.13 Payments made to managed care plans shall be reduced for services provided on or after
7.14 July 1, 2010, to reflect this reduction.

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

7.21 (i) In order to offset the ratable reductions provided for in this subdivision, the total
7.22 payment rate for medical assistance fee-for-service admissions occurring on or after July
7.23 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before
7.24 third-party liability and spenddown, shall be increased by five percent from the current
7.25 statutory rates. Effective July 1, 2011, the rate increase under this paragraph shall be
7.26 reduced to 1.96 percent. For purposes of this paragraph, medical assistance does not
7.27 include general assistance medical care. The commissioner shall not adjust rates paid to a
7.28 prepaid health plan under contract with the commissioner to reflect payments provided
7.29 in this paragraph. The commissioner may utilize a settlement process to adjust rates in
7.30 excess of the Medicare upper limits on payments.

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

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

7.33 Subd. 21. **Mental health or chemical dependency admissions; rates.** (a)
7.34 Admissions under the general assistance medical care program occurring on or after
7.35 July 1, 1990, and admissions under medical assistance, excluding general assistance

8.1 medical care, occurring on or after July 1, 1990, and on or before September 30, 1992,
8.2 that are classified to a diagnostic category of mental health or chemical dependency
8.3 shall have rates established according to the methods of subdivision 14, except the per
8.4 day rate shall be multiplied by a factor of 2, provided that the total of the per day rates
8.5 shall not exceed the per admission rate. This methodology shall also apply when a hold
8.6 or commitment is ordered by the court for the days that inpatient hospital services are
8.7 medically necessary. Stays which are medically necessary for inpatient hospital services
8.8 and covered by medical assistance shall not be billable to any other governmental entity.
8.9 Medical necessity shall be determined under criteria established to meet the requirements
8.10 of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).
8.11 (b) In order to ensure adequate access for the provision of mental health services
8.12 and to encourage broader delivery of these services outside the nonstate governmental
8.13 hospital setting, payment rates for medical assistance admissions occurring on or after
8.14 July 1, 2010, at a Minnesota private, not-for-profit hospital above the 75th percentile of all
8.15 Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521
8.16 to 523 admissions paid by medical assistance for admissions occurring in calendar year
8.17 2007, shall be increased for these diagnosis-related groups at a percentage calculated to
8.18 cost not more than $10,000,000 each fiscal year, including state and federal shares. For
8.19 purposes of this paragraph, medical assistance does not include general assistance medical
8.20 care. The commissioner shall not adjust rates paid to a prepaid health plan under contract
8.21 with the commissioner to reflect payments provided in this paragraph. The commissioner
8.22 may utilize a settlement process to adjust rates in excess of the Medicare upper limits
8.23 on payments.

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

8.25 Sec. 6. Minnesota Statutes 2008, section 256.969, subdivision 26, is amended to read:
8.26 Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For
8.27 admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service
8.28 inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals
8.29 located outside of the seven-county metropolitan area at the higher of:
8.30 (1) the hospital's current payment rate for the diagnostic category to which the
8.31 diagnosis-related group belongs, exclusive of disproportionate population adjustments
8.32 received under subdivision 9 and hospital payment adjustments received under subdivision
8.33 23; or
8.34 (2) 90 percent of the average payment rate for that diagnostic category for hospitals
8.35 located within the seven-county metropolitan area, exclusive of disproportionate

9.1 population adjustments received under subdivision 9 and hospital payment adjustments
9.2 received under subdivisions 20 and 23.

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

9.5 (1) 370 cesarean section with complicating diagnosis;

9.6 (2) 371 cesarean section without complicating diagnosis;

9.7 (3) 372 vaginal delivery with complicating diagnosis;

9.8 (4) 373 vaginal delivery without complicating diagnosis;

9.9 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;

9.10 (6) 388 full-term neonates with other problems;

9.11 (7) 390 prematurity without major problems;

9.12 (8) 391 normal newborn;

9.13 (9) 385 neonate, died or transferred to another acute care facility;

9.14 (10) 425 acute adjustment reaction and psychosocial dysfunction;

9.15 (11) 430 psychoses;

9.16 (12) 431 childhood mental disorders; and

9.17 (13) 164-167 appendectomy.

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

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

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

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

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

10.1 (2) for a hospital with total admissions reimbursed by government payers equal to
10.2 or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital
10.3 services shall be increased for each admission by $250 multiplied by 349.6 percent; and
10.4 (3) for a hospital with total admissions reimbursed by government payers of less
10.5 than 40 percent, payment rates for inpatient hospital services shall be increased for each
10.6 admission by $250 multiplied by 262.2 percent.
10.7 (b) For medical assistance admissions occurring on or after April 1, 2011, the
10.8 commissioner shall increase rates at Minnesota private, not-for-profit hospitals as follows:
10.9 (1) for a hospital with total admissions reimbursed by government payers equal to or
10.10 greater than 50 percent, payment rates for inpatient hospital services shall be increased for
10.11 each admission by $250 multiplied by 145 percent;
10.12 (2) for a hospital with total admissions reimbursed by government payers equal to
10.13 or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital
10.14 services shall be increased for each admission by $250 multiplied by 116 percent; and
10.15 (3) for a hospital with total admissions reimbursed by government payers of less
10.16 than 40 percent, payment rates for inpatient hospital services shall be increased for each
10.17 admission by $250 multiplied by 87 percent.
10.18 (c) For purposes of paragraphs (a) and (b), "government payers" means Medicare,
10.19 medical assistance, MinnesotaCare, and general assistance medical care.
10.20 (d) For medical assistance admissions occurring on or after July 1, 2010, to March
10.21 31, 2011, the commissioner shall increase rates for inpatient hospital services at Minnesota
10.22 hospitals by $850 for each admission. For medical assistance admissions occurring on
10.23 or after April 1, 2011, the payment under this paragraph shall be reduced to $320 per
10.24 admission.
10.25 (e) For purposes of this subdivision, medical assistance does not include general
10.26 assistance medical care. The commissioner shall not adjust rates paid to a prepaid
10.27 health plan under contract with the commissioner to reflect payments provided in this
10.28 subdivision. The commissioner may utilize a settlement process to adjust rates in excess
10.29 of the Medicare upper limits on payments.

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

10.31 Sec. 8. Minnesota Statutes 2008, section 256B.055, is amended by adding a
10.32 subdivision to read:
10.33 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
10.34 who is:
10.35 (1) at least age 21 and under age 65;

11.1 (2) not pregnant;

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

11.4 (4) not an adult in a family with children as defined in section 256L.01, subdivision
11.5 3a; and

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

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

11.8 Sec. 9. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

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

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

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

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

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

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

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

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services~~, including specialized maintenance therapy~~. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. Services provided by a physical therapy assistant shall be reimbursed at the same rate as

13.1 services performed by a physical therapist when the services of the physical therapy
13.2 assistant are provided under the direction of a physical therapist who is on the premises.
13.3 Services provided by a physical therapy assistant that are provided under the direction
13.4 of a physical therapist who is not on the premises shall be reimbursed at 65 percent of
13.5 the physical therapist rate.

13.6 **EFFECTIVE DATE.** This section is effective July 1, 2010, for services provided
13.7 through fee-for-service, and January 1, 2011, for services provided through managed care.

13.8 Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 8a, is amended to
13.9 read:

13.10 Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy
13.11 and related services~~, including specialized maintenance therapy~~. Authorization by the
13.12 commissioner is required to provide medically necessary services to a recipient beyond
13.13 any of the following onetime service thresholds, or a lower threshold where one has been
13.14 established by the commissioner for a specified service: (1) 120 units of any combination
13.15 of approved CPT codes; and (2) two evaluations or reevaluations. Services provided by an
13.16 occupational therapy assistant shall be reimbursed at the same rate as services performed
13.17 by an occupational therapist when the services of the occupational therapy assistant are
13.18 provided under the direction of the occupational therapist who is on the premises. Services
13.19 provided by an occupational therapy assistant that are provided under the direction of an
13.20 occupational therapist who is not on the premises shall be reimbursed at 65 percent of
13.21 the occupational therapist rate.

13.22 **EFFECTIVE DATE.** This section is effective July 1, 2010, for services provided
13.23 through fee-for-service, and January 1, 2011, for services provided through managed care.

13.24 Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to
13.25 read:

13.26 Subd. 8b. **Speech language pathology and audiology services.** Medical assistance
13.27 covers speech language pathology and related services~~, including specialized maintenance~~
13.28 ~~therapy~~. Authorization by the commissioner is required to provide medically necessary
13.29 services to a recipient beyond any of the following onetime service thresholds, or a
13.30 lower threshold where one has been established by the commissioner for a specified
13.31 service: (1) 50 treatment sessions with any combination of approved CPT codes; and
13.32 (2) one evaluation. Medical assistance covers audiology services and related services.
13.33 Services provided by a person who has been issued a temporary registration under section

14.1 148.5161 shall be reimbursed at the same rate as services performed by a speech language
14.2 pathologist or audiologist as long as the requirements of section 148.5161, subdivision
14.3 3, are met.

14.4 **EFFECTIVE DATE.** This section is effective July 1, 2010, for services provided
14.5 through fee-for-service, and January 1, 2011, for services provided through managed care.

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

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

14.11 Sec. 15. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13h,
14.12 is amended to read:

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

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

14.24 (2) formulating a medication treatment plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.33 (e) The commissioner shall establish a pilot project for an intensive medication
15.34 therapy management program for patients identified by the commissioner with multiple
15.35 chronic conditions and a high number of medications who are at high risk of preventable
15.36 hospitalizations, emergency room use, medication complications, and suboptimal

16.1 treatment outcomes due to medication-related problems. For purposes of the pilot
16.2 project, medication therapy management services may be provided in a patient's home
16.3 or community setting, in addition to other authorized settings. The commissioner may
16.4 waive existing payment policies and establish special payment rates for the pilot project.
16.5 The pilot project must be designed to produce a net savings to the state compared to the
16.6 estimated costs that would otherwise be incurred for similar patients without the program.
16.7 The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

16.9 Sec. 16. Minnesota Statutes 2008, section 256B.0625, subdivision 18a, is amended to
16.10 read:

16.11 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
16.12 meals for persons traveling to receive medical care may not exceed $5.50 for breakfast,
16.13 $6.50 for lunch, or $8 for dinner.

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

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

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

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

16.27 Sec. 17. Minnesota Statutes 2008, section 256B.0625, subdivision 31, is amended to
16.28 read:

16.29 Subd. 31. **Medical supplies and equipment.** Medical assistance covers medical
16.30 supplies and equipment. Separate payment outside of the facility's payment rate shall
16.31 be made for wheelchairs and wheelchair accessories for recipients who are residents
16.32 of intermediate care facilities for the developmentally disabled. Reimbursement for
16.33 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same

17.1 conditions and limitations as coverage for recipients who do not reside in institutions. A
17.2 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
17.3 The commissioner may set reimbursement rates for specified categories of medical
17.4 supplies at levels below the Medicare payment rate.

17.5 Sec. 18. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
17.6 subdivision to read:

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

17.10 (b) Facility services provided by a birth center shall be paid at the lower of billed
17.11 charges or 70 percent of the statewide average for a facility payment rate made to a
17.12 hospital for an uncomplicated vaginal birth as determined using the most recent calendar
17.13 year for which complete claims data is available. If a recipient is transported from a birth
17.14 center to a hospital prior to the delivery, the payment for facility services to the birth center
17.15 shall be the lower of billed charges or 15 percent of the average facility payment made to a
17.16 hospital for the services provided for an uncomplicated vaginal delivery as determined
17.17 using the most recent calendar year for which complete claims data is available.

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

17.22 (d) Professional services provided by traditional midwives licensed under chapter
17.23 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a
17.24 physician performing the same services. If a recipient is transported from a birth center to
17.25 a hospital prior to the delivery, a licensed traditional midwife who does not perform the
17.26 delivery may not bill for any delivery services. Services are not covered if provided by an
17.27 unlicensed traditional midwife.

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

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

17.32 Sec. 19. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
17.33 read:

18.1 Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical
18.2 assistance benefit plan shall include the following co-payments for all recipients, effective
18.3 for services provided on or after October 1, 2003, and before January 1, 2009:
18.4 (1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an
18.5 episode of service which is required because of a recipient's symptoms, diagnosis, or
18.6 established illness, and which is delivered in an ambulatory setting by a physician or
18.7 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
18.8 audiologist, optician, or optometrist;
18.9 (2) $3 for eyeglasses;
18.10 (3) $6 for nonemergency visits to a hospital-based emergency room; and
18.11 (4) $3 per brand-name drug prescription and $1 per generic drug prescription,
18.12 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
18.13 shall apply to antipsychotic drugs when used for the treatment of mental illness.
18.14 (b) Except as provided in subdivision 2, the medical assistance benefit plan shall
18.15 include the following co-payments for all recipients, effective for services provided on
18.16 or after January 1, 2009:
18.17 (1) ~~$6~~ $3.50 for nonemergency visits to a hospital-based emergency room;
18.18 (2) $3 per brand-name drug prescription and $1 per generic drug prescription,
18.19 subject to a $7 per month maximum for prescription drug co-payments. No co-payments
18.20 shall apply to antipsychotic drugs when used for the treatment of mental illness; and
18.21 (3) for individuals identified by the commissioner with income at or below 100
18.22 percent of the federal poverty guidelines, total monthly co-payments must not exceed five
18.23 percent of family income. For purposes of this paragraph, family income is the total
18.24 earned and unearned income of the individual and the individual's spouse, if the spouse is
18.25 enrolled in medical assistance and also subject to the five percent limit on co-payments.
18.26 (c) Recipients of medical assistance are responsible for all co-payments in this
18.27 subdivision.

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

18.29 Sec. 20. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to
18.30 read:
18.31 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider
18.32 shall be reduced by the amount of the co-payment, except that reimbursements shall
18.33 not be reduced:
18.34 (1) once a recipient has reached the $12 per month maximum or the $7 per month
18.35 maximum effective January 1, 2009, for prescription drug co-payments; or

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

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

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

19.8 Sec. 21. Minnesota Statutes 2008, section 256B.0644, as amended by Laws 2010,
19.9 chapter 200, article 1, section 6, is amended to read:

19.10 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
19.11 **PROGRAMS.**

19.12 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
19.13 health maintenance organization, as defined in chapter 62D, must participate as a provider
19.14 or contractor in the medical assistance program, general assistance medical care program,
19.15 and MinnesotaCare as a condition of participating as a provider in health insurance plans
19.16 and programs or contractor for state employees established under section 43A.18, the
19.17 public employees insurance program under section 43A.316, for health insurance plans
19.18 offered to local statutory or home rule charter city, county, and school district employees,
19.19 the workers' compensation system under section 176.135, and insurance plans provided
19.20 through the Minnesota Comprehensive Health Association under sections 62E.01 to
19.21 62E.19. The limitations on insurance plans offered to local government employees shall
19.22 not be applicable in geographic areas where provider participation is limited by managed
19.23 care contracts with the Department of Human Services.

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

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

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

19.31 (3) for dental service providers, at least ten percent of the provider's patients are
19.32 covered by medical assistance, general assistance medical care, and MinnesotaCare as
19.33 their primary source of coverage, or the provider accepts new medical assistance and
19.34 MinnesotaCare patients who are children with special health care needs. For purposes
19.35 of this section, "children with special health care needs" means children up to age 18

20.1 who: (i) require health and related services beyond that required by children generally;
20.2 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
20.3 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
20.4 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
20.5 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
20.6 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
20.7 commissioner after consultation with representatives of pediatric dental providers and
20.8 consumers.

20.9 (c) Patients seen on a volunteer basis by the provider at a location other than
20.10 the provider's usual place of practice may be considered in meeting the participation
20.11 requirement in this section. The commissioner shall establish participation requirements
20.12 for health maintenance organizations. The commissioner shall provide lists of participating
20.13 medical assistance providers on a quarterly basis to the commissioner of management and
20.14 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
20.15 of the commissioners shall develop and implement procedures to exclude as participating
20.16 providers in the program or programs under their jurisdiction those providers who do
20.17 not participate in the medical assistance program. The commissioner of management
20.18 and budget shall implement this section through contracts with participating health and
20.19 dental carriers.

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

20.25 ~~(e) For purposes of paragraphs (a) and (b), participation in the general assistance~~
20.26 ~~medical care program applies only to pharmacy providers.~~

20.27 <u>**EFFECTIVE DATE.** This section is effective July 1, 2010.</u>

20.28 Sec. 22. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5,
20.29 is amended to read:

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

20.33 (b) Home care therapies must be:

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

21.1 (2) prescribed, ordered, or referred by a physician and documented in a plan of care
21.2 and reviewed, according to Minnesota Rules, part 9505.0390;
21.3 (3) assessed by an appropriate therapist; and
21.4 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid
21.5 provider agency.
21.6 (c) Restorative ~~and specialized maintenance~~ therapies must be provided according to
21.7 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be
21.8 used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.
21.9 (d) For both physical and occupational therapies, the therapist and the therapist's
21.10 assistant may not both bill for services provided to a recipient on the same day.

21.11 Sec. 23. **[256B.0755] HEALTH CARE DELIVERY SYSTEMS**
21.12 **DEMONSTRATION PROJECT.**
21.13 Subdivision 1. **Implementation.** (a) The commissioner shall develop and
21.14 authorize a demonstration project to test alternative and innovative health care delivery
21.15 systems, including accountable care organizations that provide services to a specified
21.16 patient population for an agreed upon total cost of care or risk-gain sharing payment
21.17 arrangement. The commissioner shall develop a request for proposals for participation in
21.18 the demonstration project in consultation with hospitals, primary care providers, health
21.19 plans, and other key stakeholders.
21.20 (b) In developing the request for proposals, the commissioner shall:
21.21 (1) establish uniform statewide methods of forecasting utilization and cost of care
21.22 for the appropriate Minnesota public program populations, to be used by the commissioner
21.23 for the health care delivery system projects;
21.24 (2) identify key indicators of quality, access, patient satisfaction, and other
21.25 performance indicators that will be measured, in addition to indicators for measuring
21.26 cost savings;
21.27 (3) allow maximum flexibility to encourage innovation and variation so that a variety
21.28 of provider collaborations are able to become health care delivery systems;
21.29 (4) encourage and authorize different levels and types of financial risk;
21.30 (5) encourage and authorize projects representing a wide variety of geographic
21.31 locations, patient populations, provider relationships, and care coordination models;
21.32 (6) encourage projects that involve close partnerships between the health care
21.33 delivery system and counties and nonprofit agencies that provide services to patients
21.34 enrolled with the health care delivery system, including social services, public health,
21.35 mental health, community-based services, and continuing care;

22.1 (7) encourage projects established by community hospitals, clinics, and other
22.2 providers in rural communities;
22.3 (8) identify required covered services for a total cost of care model or services
22.4 considered in whole or partially in an analysis of utilization for a risk/gain sharing model;
22.5 (9) establish a mechanism to monitor enrollment;
22.6 (10) establish quality standards for the delivery system demonstrations; and
22.7 (11) encourage participation of privately insured population so as to create sufficient
22.8 alignment in demonstration systems.
22.9 (c) To be eligible to participate in the demonstration project, a health care delivery
22.10 system must:
22.11 (1) provide required covered services and care coordination to recipients enrolled in
22.12 the health care delivery system;
22.13 (2) establish a process to monitor enrollment and ensure the quality of care provided;
22.14 (3) in cooperation with counties and community social service agencies, coordinate
22.15 the delivery of health care services with existing social services programs;
22.16 (4) provide a system for advocacy and consumer protection; and
22.17 (5) adopt innovative and cost-effective methods of care delivery and coordination,
22.18 which may include the use of allied health professionals, telemedicine, patient educators,
22.19 care coordinators, and community health workers.
22.20 (d) A health care delivery system demonstration may be formed by the following
22.21 groups of providers of services and suppliers if they have established a mechanism for
22.22 shared governance:
22.23 (1) professionals in group practice arrangements;
22.24 (2) networks of individual practices of professionals;
22.25 (3) partnerships or joint venture arrangements between hospitals and ACO
22.26 professionals;
22.27 (4) hospitals employing professionals; and
22.28 (5) other groups of providers of services and suppliers as the commissioner
22.29 determines appropriate.
22.30 A managed care plan or county-based purchasing plan may participate in this
22.31 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).
22.32 A health care delivery system may contract with a managed care plan or a
22.33 county-based purchasing plan to provide administrative services, including the
22.34 administration of a payment system using the payment methods established by the
22.35 commissioner for health care delivery systems.

23.1 (e) The commissioner may require a health care delivery system to enter into
23.2 additional third-party contractual relationships for the assessment of risk and purchase of
23.3 stop loss insurance or another form of insurance risk management related to the delivery
23.4 of care described in paragraph (c).

23.5 Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or
23.6 MinnesotaCare shall be eligible for enrollment in a health care delivery system.

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

23.13 Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility
23.14 for the quality of care based on standards established under subdivision 1, paragraph (b),
23.15 clause (10), and the cost of care or utilization of services provided to its enrollees under
23.16 subdivision 1, paragraph (b), clause (1).

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

23.20 Subd. 4. **Payment system.** (a) In developing a payment system for health care
23.21 delivery systems, the commissioner shall establish a total cost of care benchmark or a
23.22 risk/gain sharing payment model to be paid for services provided to the recipients enrolled
23.23 in a health care delivery system.

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

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

23.29 Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug
23.30 coverage may be provided through accountable care organizations only if the delivery
23.31 method qualifies for federal prescription drug rebates.

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

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

24.3 Subd. 7. **Expansion.** The commissioner shall explore the expansion of the
24.4 demonstration project to include additional medical assistance and MinnesotaCare
24.5 enrollees, and shall seek participation of Medicare in demonstration projects. The
24.6 commissioner shall seek to include participation of privately insured persons and Medicare
24.7 recipients in the health care delivery demonstration.

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

24.9 Sec. 24. **[256B.0756] HENNEPIN AND RAMSEY COUNTIES PILOT**
24.10 **PROGRAM.**

24.11 (a) The commissioner, upon federal approval of a new waiver request or amendment
24.12 of an existing demonstration, may establish a pilot program in Hennepin County or
24.13 Ramsey County, or both, to test alternative and innovative integrated health care delivery
24.14 networks.

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

24.18 (c) Individuals enrolled in the pilot shall be enrolled in an integrated health care
24.19 delivery network in their county of residence. The integrated health care delivery network
24.20 in Hennepin County shall be a network, such as an accountable care organization or a
24.21 community-based collaborative care network, created by or including Hennepin County
24.22 Medical Center. The integrated health care delivery network in Ramsey County shall be
24.23 a network, such as an accountable care organization or community-based collaborative
24.24 care network, created by or including Regions Hospital.

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

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

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

24.34 (g) The commissioner shall apply to the federal government for, or as appropriate,
24.35 cooperate with counties, providers, or other entities that are applying for any applicable

25.1 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
25.2 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
25.3 111-152, that would further the purposes of or assist in the creation of an integrated health
25.4 care delivery network for the purposes of this subdivision, including, but not limited to, a
25.5 global payment demonstration or the community-based collaborative care network grants.

25.6 Sec. 25. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a,
25.7 is amended to read:
25.8 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
25.9 and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year
25.10 basis beginning January 1, 1996. Managed care contracts which were in effect on June
25.11 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995
25.12 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The
25.13 commissioner may issue separate contracts with requirements specific to services to
25.14 medical assistance recipients age 65 and older.
25.15 (b) A prepaid health plan providing covered health services for eligible persons
25.16 pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms
25.17 of its contract with the commissioner. Requirements applicable to managed care programs
25.18 under chapters 256B, 256D, and 256L, established after the effective date of a contract
25.19 with the commissioner take effect when the contract is next issued or renewed.
25.20 (c) Effective for services rendered on or after January 1, 2003, the commissioner
25.21 shall withhold five percent of managed care plan payments under this section and
25.22 county-based purchasing ~~plan's payment rate~~ plan payments under section 256B.692 for
25.23 the prepaid medical assistance and general assistance medical care programs pending
25.24 completion of performance targets. Each performance target must be quantifiable,
25.25 objective, measurable, and reasonably attainable, except in the case of a performance target
25.26 based on a federal or state law or rule. Criteria for assessment of each performance target
25.27 must be outlined in writing prior to the contract effective date. The managed care plan
25.28 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
25.29 attainment of the performance target is accurate. The commissioner shall periodically
25.30 change the administrative measures used as performance targets in order to improve plan
25.31 performance across a broader range of administrative services. The performance targets
25.32 must include measurement of plan efforts to contain spending on health care services and
25.33 administrative activities. The commissioner may adopt plan-specific performance targets
25.34 that take into account factors affecting only one plan, including characteristics of the
25.35 plan's enrollee population. The withheld funds must be returned no sooner than July of the

26.1 following year if performance targets in the contract are achieved. The commissioner may
26.2 exclude special demonstration projects under subdivision 23.

26.3 (d) Effective for services rendered on or after January 1, 2009, through December 31,
26.4 2009, the commissioner shall withhold three percent of managed care plan payments under
26.5 this section and county-based purchasing plan payments under section 256B.692 for the
26.6 prepaid medical assistance and general assistance medical care programs. The withheld
26.7 funds must be returned no sooner than July 1 and no later than July 31 of the following
26.8 year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

26.18 (f) Effective for services rendered on or after January 1, 2010, through December
26.19 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments
26.20 under this section and county-based purchasing plan payments under section 256B.692
26.21 for the prepaid medical assistance program. The withheld funds must be returned no
26.22 sooner than July 1 and no later than July 31 of the following year. The commissioner may
26.23 exclude special demonstration projects under subdivision 23.

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

26.29 The withheld funds must be returned no sooner than July 1 and no later than July
26.30 31 of the following calendar year if the managed care plan or county-based purchasing
26.31 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
26.32 rate was achieved.

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

cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount. The withhold in this paragraph does not apply to county-based purchasing plans.

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

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

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

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

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

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

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

28.2 Sec. 26. Minnesota Statutes 2008, section 256B.69, is amended by adding a
28.3 subdivision to read:
28.4 Subd. 5k. **Rate modifications.** For services rendered on or after October 1, 2010,
28.5 the total payment made to managed care plans and county-based purchasing plans under
28.6 the medical assistance program shall be increased by 1.28 percent.

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

28.8 Sec. 27. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by
28.9 Laws 2010, chapter 200, article 1, section 10, is amended to read:
28.10 Subd. 20. **Ombudsperson.** ~~(a)~~ The commissioner shall designate an ombudsperson
28.11 to advocate for persons required to enroll in prepaid health plans under this section. The
28.12 ombudsperson shall advocate for recipients enrolled in prepaid health plans through
28.13 complaint and appeal procedures and ensure that necessary medical services are provided
28.14 either by the prepaid health plan directly or by referral to appropriate social services. At
28.15 the time of enrollment in a prepaid health plan, the local agency shall inform recipients
28.16 about the ombudsperson program and their right to a resolution of a complaint by the
28.17 prepaid health plan if they experience a problem with the plan or its providers.
28.18 ~~(b) The commissioner shall designate an ombudsperson to advocate for persons~~
28.19 ~~enrolled in a care coordination delivery system under section 256D.031. The~~
28.20 ~~ombudsperson shall advocate for recipients enrolled in a care coordination delivery~~
28.21 ~~system through the state appeal process and assist enrollees in accessing necessary~~
28.22 ~~medical services through the care coordination delivery systems directly or by referral to~~
28.23 ~~appropriate services. At the time of enrollment in a care coordination delivery system, the~~
28.24 ~~local agency shall inform recipients about the ombudsperson program.~~

28.25 Sec. 28. Minnesota Statutes 2008, section 256B.69, subdivision 27, is amended to read:
28.26 Subd. 27. **Information for persons with limited English-language proficiency.**
28.27 Managed care contracts entered into under this section and ~~sections 256D.03, subdivision~~
28.28 ~~4, paragraph (c), and~~ section 256L.12 must require demonstration providers to provide
28.29 language assistance to enrollees that ensures meaningful access to its programs and
28.30 services according to Title VI of the Civil Rights Act and federal regulations adopted
28.31 under that law or any guidance from the United States Department of Health and Human
28.32 Services.

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

Sec. 29. Minnesota Statutes 2008, section 256B.692, subdivision 1, is amended to read:

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

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

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

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

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

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

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

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates

30.1 in effect on December 31, 1999, except for home health agency and family planning
30.2 agency services. The increases in this paragraph shall be implemented January 1, 2000,
30.3 for managed care.

30.4 (c) Effective for services rendered on or after July 1, 2009, payment rates for
30.5 physician and professional services shall be reduced by five percent over the rates in effect
30.6 on June 30, 2009. This reduction ~~does~~ and the reductions in paragraph (d) do not apply
30.7 to office or other outpatient visits, preventive medicine visits and family planning visits
30.8 billed by physicians, advanced practice nurses, or physician assistants in a family planning
30.9 agency or in one of the following primary care practices: general practice, general internal
30.10 medicine, general pediatrics, general geriatrics, and family medicine. This reduction ~~does~~
30.11 and the reductions in paragraph (d) do not apply to federally qualified health centers,
30.12 rural health centers, and Indian health services. Effective October 1, 2009, payments
30.13 made to managed care plans and county-based purchasing plans under sections 256B.69,
30.14 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

30.15 (d) Effective for services rendered on or after July 1, 2010, payment rates for
30.16 physician and professional services shall be reduced an additional seven percent over the
30.17 rates described in paragraph (c). This additional reduction does not apply to physical
30.18 therapy services, occupational therapy services, and speech pathology and related
30.19 services provided on or after July 1, 2010. This additional reduction does not apply to
30.20 physician services billed by a psychiatrist or advanced practice nurse with a specialty in
30.21 mental health. Effective October 1, 2010, payments made to managed care plans and
30.22 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
30.23 reflect the payment reduction described in this paragraph.

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

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

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

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

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

31.1 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
31.2 percentile of 1989, less the percent in aggregate necessary to equal the above increases.
31.3 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
31.4 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.
31.5 (c) Effective for services rendered on or after January 1, 2000, payment rates for
31.6 dental services shall be increased by three percent over the rates in effect on December
31.7 31, 1999.
31.8 (d) Effective for services provided on or after January 1, 2002, payment for
31.9 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
31.10 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.
31.11 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
31.12 2000, for managed care.
31.13 (f) Effective for dental services rendered on or after October 1, 2010, by a
31.14 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
31.15 on the Medicare principles of reimbursement. This payment shall be effective for services
31.16 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
31.17 county-based purchasing plans.
31.18 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
31.19 in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal
31.20 year, a supplemental state payment equal to the difference between the total payments
31.21 in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated
31.22 services for the operation of the dental clinics.
31.23 (h) If the cost-based payment system for state-operated dental clinics described in
31.24 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
31.25 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
31.26 receive the critical access dental reimbursement rate as described under subdivision 4,
31.27 paragraph (a).

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

31.29 Sec. 32. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:
31.30 Subd. 4. **Critical access dental providers.** (a) Effective for dental services
31.31 rendered on or after January 1, 2002, the commissioner shall increase reimbursements
31.32 to dentists and dental clinics deemed by the commissioner to be critical access dental
31.33 providers. For dental services rendered on or after July 1, 2007, the commissioner shall
31.34 increase reimbursement by 30 percent above the reimbursement rate that would otherwise
31.35 be paid to the critical access dental provider. The commissioner shall pay the ~~health plan~~

~~companies~~ managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner. ~~In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:~~

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

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

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

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

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

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

33.7 Sec. 33. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

33.8 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

33.9 (a) Effective for services provided on or after July 1, 2009, total payments for
33.10 basic care services, shall be reduced by three percent, prior to third-party liability and
33.11 spenddown calculation. This reduction applies to physical therapy services, occupational
33.12 therapy services, and speech language pathology and related services provided on or after
33.13 July 1, 2010. Effective July 1, 2010, the commissioner shall classify physical therapy
33.14 services, occupational therapy services, and speech language pathology and related
33.15 services as basic care services. Effective October 1, 2010, payments made to managed care
33.16 and county-based purchasing plans shall reflect the July 1, 2010, payment adjustments in
33.17 this paragraph. Payments made to managed care plans and county-based purchasing plans
33.18 shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

33.23 Sec. 34. **[256B.767] MEDICARE PAYMENT LIMIT.**

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

33.30 Sec. 35. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as
33.31 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

34.1 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
34.2 the general assistance medical care program shall be administered according to section
34.3 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
34.4 which shall continue to be administered under this section and funded under section
34.5 256D.031, subdivision 9, beginning June 1, 2010.
34.6 (b) Outpatient prescription drug coverage under general assistance medical care is
34.7 limited to prescription drugs that:
34.8 (1) are covered under the medical assistance program as described in section
34.9 256B.0625, subdivisions 13 and 13d; and
34.10 (2) are provided by manufacturers that have fully executed general assistance
34.11 medical care rebate agreements with the commissioner and comply with the agreements.
34.12 Outpatient prescription drug coverage under general assistance medical care must conform
34.13 to coverage under the medical assistance program according to section 256B.0625,
34.14 subdivisions 13 to ~~13g~~ 13h.
34.15 (c) Outpatient prescription drug coverage does not include drugs administered in a
34.16 clinic or other outpatient setting.
34.17 (d) For the period beginning April 1, 2010, to May 31, 2010, general assistance
34.18 medical care covers the services listed in subdivision 4.

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

34.20 Sec. 36. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:
34.21 Subd. 3b. **Cooperation.** ~~(a)~~ General assistance ~~or general assistance medical care~~
34.22 applicants and recipients must cooperate with the state and local agency to identify
34.23 potentially liable third-party payors and assist the state in obtaining third-party payments.
34.24 Cooperation includes identifying any third party who may be liable for care and services
34.25 provided under this chapter to the applicant, recipient, or any other family member for
34.26 whom application is made and providing relevant information to assist the state in pursuing
34.27 a potentially liable third party. ~~General assistance medical care applicants and recipients~~
34.28 ~~must cooperate by providing information about any group health plan in which they may~~
34.29 ~~be eligible to enroll. They must cooperate with the state and local agency in determining~~
34.30 ~~if the plan is cost-effective. For purposes of this subdivision, coverage provided by the~~
34.31 ~~Minnesota Comprehensive Health Association under chapter 62E shall not be considered~~
34.32 ~~group health plan coverage or cost-effective by the state and local agency. If the plan is~~
34.33 ~~determined cost-effective and the premium will be paid by the state or local agency or is~~
34.34 ~~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.~~

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

Sec. 37. Minnesota Statutes 2008, section 256D.031, subdivision 5, as added by Laws 2010, chapter 200, article 1, section 12, subdivision 5, is amended to read:

Subd. 5. **Payment rates and contract modification; April 1, 2010, to ~~May 31~~ June 30, 2010.** (a) For the period April 1, 2010, to ~~May 31~~ June 30, 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, except that for the period June 1, 2010, to June 30, 2010, fee-for-service payment rates for services other than prescription drugs shall be set at 27 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~~ June 30, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

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

Sec. 38. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

36.1 (4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
36.2 episode of service which is required because of a recipient's symptoms, diagnosis, or
36.3 established illness, and which is delivered in an ambulatory setting by a physician or
36.4 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
36.5 audiologist, optician, or optometrist; and

36.6 (5) $6 for nonemergency visits to a hospital-based emergency room for services
36.7 provided through December 31, 2010, and $3.50 effective January 1, 2011.

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

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

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

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

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

36.21 (g) MinnesotaCare reimbursements to fee-for-service providers and payments to
36.22 managed care plans or county-based purchasing plans shall not be increased as a result of
36.23 the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

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

36.25 Sec. 39. Minnesota Statutes 2008, section 256L.11, subdivision 6, is amended to read:

36.26 Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for
36.27 inpatient hospital services provided to MinnesotaCare enrollees eligible under section
36.28 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2,
36.29 with family gross income that exceeds 175 percent of the federal poverty guidelines
36.30 and who are not pregnant, who are 18 years old or older on the date of admission to the
36.31 inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults
36.32 who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and
36.33 whose incomes are equal to or less than 175 percent of the federal poverty guidelines,
36.34 shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) ~~For admissions occurring during the period of July 1, 1997, through June 30, 1998, for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits in excess of the $10,000 annual inpatient benefit limit.~~ For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5.

Sec. 40. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

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

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

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

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed

38.1 by the commissioner is eligible for MinnesotaCare without meeting other eligibility
38.2 requirements of this chapter, but must pay premiums equal to the average expected
38.3 capitation rate for adults with no children paid under section 256L.12. Individuals eligible
38.4 under this subdivision shall receive coverage for the benefit set provided to adults with no
38.5 children.

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

38.7 Sec. 41. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:
38.8 Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who
38.9 become eligible for medical assistance ~~or general assistance medical care~~ will remain in
38.10 the same managed care plan if the managed care plan has a contract for that population.
38.11 ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for
38.12 general assistance medical care pursuant to section 256D.03, subdivision 3, within six
38.13 months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant
38.14 to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care
38.15 plan if the managed care plan has a contract for that population. Managed care plans must
38.16 participate in the MinnesotaCare ~~and general assistance medical care programs~~ program
38.17 under a contract with the Department of Human Services in service areas where they
38.18 participate in the medical assistance program.

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

38.20 Sec. 42. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:
38.21 Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective,
38.22 per capita, where possible. The commissioner may allow health plans to arrange for
38.23 inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with
38.24 an independent actuary to determine appropriate rates.
38.25 (b) ~~For services rendered on or after January 1, 2003, to December 31, 2003, the~~
38.26 ~~commissioner shall withhold .5 percent of managed care plan payments under this section~~
38.27 ~~pending completion of performance targets. The withheld funds must be returned no~~
38.28 ~~sooner than July 1 and no later than July 31 of the following year if performance targets~~
38.29 ~~in the contract are achieved. A managed care plan may include as admitted assets under~~
38.30 ~~section 62D.044 any amount withheld under this paragraph that is reasonably expected~~
38.31 ~~to be returned.~~
38.32 ~~(c)~~ For services rendered on or after January 1, 2004, the commissioner shall
38.33 withhold five percent of managed care plan payments and county-based purchasing

39.1 plan payments under this section pending completion of performance targets. Each
39.2 performance target must be quantifiable, objective, measurable, and reasonably attainable,
39.3 except in the case of a performance target based on a federal or state law or rule. Criteria
39.4 for assessment of each performance target must be outlined in writing prior to the
39.5 contract effective date. The managed care plan must demonstrate, to the commissioner's
39.6 satisfaction, that the data submitted regarding attainment of the performance target is
39.7 accurate. The commissioner shall periodically change the administrative measures used
39.8 as performance targets in order to improve plan performance across a broader range of
39.9 administrative services. The performance targets must include measurement of plan
39.10 efforts to contain spending on health care services and administrative activities. The
39.11 commissioner may adopt plan-specific performance targets that take into account factors
39.12 affecting only one plan, such as characteristics of the plan's enrollee population. The
39.13 withheld funds must be returned no sooner than July 1 and no later than July 31 of the
39.14 following calendar year if performance targets in the contract are achieved. ~~A managed~~
39.15 ~~care plan or a county-based purchasing plan under section 256B.692 may include as~~
39.16 ~~admitted assets under section 62D.044 any amount withheld under this paragraph that is~~
39.17 ~~reasonably expected to be returned.~~

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

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

39.28 The withheld funds must be returned no sooner than July 1 and no later than July
39.29 31 of the following calendar year if the managed care plan or county-based purchasing
39.30 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
39.31 rate was achieved.

39.32 The withhold described in this paragraph shall continue for each consecutive
39.33 contract period until the plan's emergency room utilization rate for state health care
39.34 program enrollees is reduced by 25 percent of the plan's emergency room utilization rate
39.35 for state health care program enrollees for calendar year 2009. Hospitals shall cooperate
39.36 with the health plans in meeting this performance target and shall accept payment

40.1 withholds that may be returned to the hospitals if the performance target is achieved. The
40.2 commissioner shall structure the withhold so that the commissioner returns a portion of
40.3 the withheld funds in amounts commensurate with achieved reductions in utilization less
40.4 than the targeted amount. The withhold described in this paragraph does not apply to
40.5 county-based purchasing plans.
40.6 (e) A managed care plan or a county-based purchasing plan under section 256B.692
40.7 may include as admitted assets under section 62D.044 any amount withheld under this
40.8 section that is reasonably expected to be returned.

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

40.10 Sec. 43. Minnesota Statutes 2008, section 256L.12, is amended by adding a subdivision
40.11 to read:
40.12 Subd. 9c. **Rate setting; increase effective October 1, 2010.** For services
40.13 rendered on or after October 1, 2010, the total payment made to managed care plans and
40.14 county-based purchasing plans under MinnesotaCare for families with children shall be
40.15 increased by 1.28 percent.

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

40.17 Sec. 44. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:
40.18 Subdivision 1. **Medical assistance coverage.** The commissioner of human services
40.19 shall establish a demonstration project to provide additional medical assistance coverage
40.20 for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth
40.21 who are burdened by health disparities associated with the cumulative health impact
40.22 of toxic environmental exposures. Under this demonstration project, the additional
40.23 medical assistance coverage for this population must include, but is not limited to, home
40.24 environmental assessments for triggers of asthma, and in-home asthma education on the
40.25 proper medical management of asthma by a certified asthma educator or public health
40.26 nurse with asthma management training, and must be limited to two visits per child. The
40.27 home visit payment rates must be based on a rate commensurate with a first-time visit rate
40.28 and follow-up visit rate. Coverage also includes the following durable medical equipment:
40.29 high efficiency particulate air (HEPA) cleaners, HEPA vacuum cleaners, allergy bed and
40.30 pillow encasements, high filtration filters for forced air gas furnaces, and dehumidifiers
40.31 with medical tubing to connect the appliance to a floor drain, if the listed item is ~~medically~~
40.32 ~~necessary~~ useful to reduce asthma symptoms. Provision of these items of durable medical
40.33 equipment must be preceded by a home environmental assessment for triggers of asthma

41.1 and in-home asthma education on the proper medical management of asthma by a Certified
41.2 Asthma Educator or public health nurse with asthma management training.

41.3 Sec. 45. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:
41.4 Subd. 5. **Expiration.** This section, with the exception of subdivision 4, expires
41.5 ~~December 31, 2010~~ August 31, 2011. Subdivision 4 expires February 28, 2012.

41.6 Sec. 46. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to
41.7 read:

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

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

41.11 Sec. 47. Laws 2010, chapter 200, article 1, section 16, is amended by adding an
41.12 effective date to read:

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

41.14 Sec. 48. Laws 2010, chapter 200, article 1, section 21, is amended to read:
41.15 Sec. 21. **REPEALER.**
41.16 (a) Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; and 256D.03,
41.17 subdivision 9, are repealed effective April 1, 2010.
41.18 (b) Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is repealed
41.19 effective ~~April~~ June 1, 2010.
41.20 (c) Minnesota Statutes 2008, section 256B.195, subdivisions 4 and 5, are repealed
41.21 effective for federal fiscal year 2010.
41.22 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
41.23 3, are repealed effective for federal fiscal year 2010.
41.24 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
41.25 4; and 256L.17, subdivision 7, are repealed ~~January 1, 2011~~ July 1, 2010.

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

41.27 Sec. 49. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

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

42.1 Appropriations by Fund

	2010	2011
42.2		
42.3 General	34,807,000	118,493,000
42.4 Health Care Access	(42,792,000)	(211,621,000)

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

42.8 **Special Revenue Fund Transfers.**

42.9 (a) The commissioner shall transfer the
42.10 following amounts from special revenue
42.11 fund balances to the general fund by June
42.12 30 of each respective fiscal year: $410,000
42.13 for fiscal year 2010, and $412,000 for fiscal
42.14 year 2011.

42.15 (b) Actual transfers made under paragraph
42.16 (a) must be separately identified and reported
42.17 as part of the quarterly reporting of transfers
42.18 to the chairs of the relevant senate budget
42.19 division and house of representatives finance
42.20 division.

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

42.22 Sec. 50. Laws 2010, chapter 200, article 2, section 2, subdivision 5, is amended to read:

42.23 Subd. 5. **Health Care Management**

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

42.26 **Health Care Administration.** (2,998,000) (5,270,000)

42.27 **Base Adjustment.** The general fund base
42.28 for health care administration is reduced by
42.29 ~~$182,000~~ $36,000 in fiscal year 2012 and
42.30 ~~$182,000~~ $36,000 in fiscal year 2013.

42.31 Sec. 51. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

Subd. 8. **Transfers**

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

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

Compulsive Gambling ~~Special Revenue~~ Administration. The lottery prize fund appropriation for compulsive gambling administration is reduced by $6,000 for fiscal year 2010 and $4,000 for fiscal year 2011 ~~must be transferred from the lottery prize fund appropriation for compulsive gambling administration to the general fund by June 30 of each respective fiscal year~~. These are onetime reductions.

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

Sec. 52. **PREPAID HEALTH PLAN RATES.**

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

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

Sec. 53. **STATE PLAN AMENDMENT; FEDERAL APPROVAL.**

The commissioner of human services shall submit a Medicaid state plan amendment to receive federal fund participation for adults without children whose income is equal

44.1 to or less than 75 percent of federal poverty guidelines in accordance with the Patient
44.2 Protection and Affordable Care Act, Public Law 111-148, or the Health Care and
44.3 Education Reconciliation Act of 2010, Public Law 111-152. The effective date of the
44.4 state plan amendment shall be June 1, 2010.

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

44.6 Sec. 54. **UPPER PAYMENT LIMIT REPORT.**

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

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

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

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

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

44.19 Sec. 55. **REVISOR'S INSTRUCTION.**

44.20 The revisor of statutes shall edit Minnesota Statutes and Minnesota Rules to remove
44.21 references to the general assistance medical care program and references to Minnesota
44.22 Statutes, section 256D.03, subdivision 3, or Minnesota Statutes, chapter 256D, as it
44.23 pertains to general assistance medical care and make other changes as may be necessary
44.24 to remove references to the general assistance medical care program. The revisor may
44.25 consult with the Department of Human Services when making editing decisions on the
44.26 removal of these references.

44.27 Sec. 56. **REPEALER.**

44.28 (a) Minnesota Statutes 2008, section 256D.03, subdivisions 3, 3a, 5, 6, 7, and 8,
44.29 are repealed July 1, 2010.

44.30 (b) Laws 2010, chapter 200, article 1, sections 12; 18; and 19, are repealed July
44.31 1, 2010.

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

45.1 **ARTICLE 2**

45.2 **CONTINUING CARE**

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

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

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

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

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

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

45.18 (5) verification that the establishment is complying with the requirements of section
45.19 325F.72, if applicable;

45.20 (6) the name and address of at least one natural person who shall be responsible
45.21 for dealing with the commissioner on all matters provided for in sections 144D.01 to
45.22 144D.06, and on whom personal service of all notices and orders shall be made, and who
45.23 shall be authorized to accept service on behalf of the owner or owners and the managing
45.24 agent, if any; ~~and~~

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

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

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

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

46.3 Subd. 3. **Certificate of transitional consultation.** (a) A housing with services
46.4 establishment shall not execute a contract or allow a prospective resident to move in until
46.5 the establishment has received certification from the Senior LinkAge Line that transition
46.6 to housing with services consultation under section 256B.0911, subdivision 3c, has been
46.7 completed. Prospective residents may be allowed to move in on an emergency basis prior
46.8 to receiving a certificate, however, the certification must occur within 30 calendar days of
46.9 admission. The housing with services establishment shall maintain copies of contracts and
46.10 certificates for audit for a period of three years. The Senior LinkAge Line shall issue a
46.11 certification within 24 hours of a contact by a prospective resident.

46.12 (b) This subdivision applies to housing with services establishments that are required
46.13 to register under section 144D.02 and:

46.14 (1) include any service in the base rate as described in the contract established
46.15 under section 144D.04; or

46.16 (2) require residents to purchase services as a condition of tenancy.

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

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

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

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

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

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

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

46.32 (6) the term of the contract;

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

47.1 (8) a description of any additional services, including home care services, available
47.2 for an additional fee from the establishment directly or through arrangements with the
47.3 establishment, and a schedule of fees charged for these services;
47.4 (9) a description of the process through which the contract may be modified,
47.5 amended, or terminated;
47.6 (10) a description of the establishment's complaint resolution process available
47.7 to residents including the toll-free complaint line for the Office of Ombudsman for
47.8 Long-Term Care;
47.9 (11) the resident's designated representative, if any;
47.10 (12) the establishment's referral procedures if the contract is terminated;
47.11 (13) requirements of residency used by the establishment to determine who may
47.12 reside or continue to reside in the housing with services establishment;
47.13 (14) billing and payment procedures and requirements;
47.14 (15) a statement regarding the ability of residents to receive services from service
47.15 providers with whom the establishment does not have an arrangement;
47.16 (16) a statement regarding the availability of public funds for payment for residence
47.17 or services in the establishment; and
47.18 (17) a statement regarding the availability of and contact information for
47.19 long-term care consultation services under section 256B.0911 in the county in which the
47.20 establishment is located.

47.21 Sec. 4. **[144D.08] UNIFORM CONSUMER INFORMATION GUIDE.**
47.22 All housing with services establishments shall make available to all prospective
47.23 and current residents information consistent with the uniform format and the required
47.24 components adopted by the commissioner under section 144G.06.

47.25 Sec. 5. **[144D.09] TERMINATION OF LEASE.**
47.26 The housing with services establishment shall include with notice of termination
47.27 of lease information about how to contact the ombudsman for long-term care, including
47.28 the address and phone number along with a statement of how to request problem-solving
47.29 assistance.

47.30 Sec. 6. Minnesota Statutes 2008, section 144G.06, is amended to read:
47.31 **144G.06 UNIFORM CONSUMER INFORMATION GUIDE.**
47.32 (a) The commissioner of health shall establish an advisory committee consisting
47.33 of representatives of consumers, providers, county and state officials, and other

48.1 groups the commissioner considers appropriate. The advisory committee shall present
48.2 recommendations to the commissioner on:
48.3 (1) a format for a guide to be used by individual providers of assisted living, as
48.4 defined in section 144G.01, that includes information about services offered by that
48.5 provider, which services may be covered by Medicare, service costs, and other relevant
48.6 provider-specific information, as well as a statement of philosophy and values associated
48.7 with assisted living, presented in uniform categories that facilitate comparison with guides
48.8 issued by other providers; and
48.9 (2) requirements for informing assisted living clients, as defined in section 144G.01,
48.10 of their applicable legal rights.
48.11 (b) The commissioner, after reviewing the recommendations of the advisory
48.12 committee, shall adopt a uniform format for the guide to be used by individual providers,
48.13 and the required components of materials to be used by providers to inform assisted
48.14 living clients of their legal rights, and shall make the uniform format and the required
48.15 components available to assisted living providers.

48.16 Sec. 7. Minnesota Statutes 2009 Supplement, section 252.27, subdivision 2a, is
48.17 amended to read:
48.18 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
48.19 child, including a child determined eligible for medical assistance without consideration of
48.20 parental income, must contribute to the cost of services used by making monthly payments
48.21 on a sliding scale based on income, unless the child is married or has been married,
48.22 parental rights have been terminated, or the child's adoption is subsidized according to
48.23 section 259.67 or through title IV-E of the Social Security Act. The parental contribution
48.24 is a partial or full payment for medical services provided for diagnostic, therapeutic,
48.25 curing, treating, mitigating, rehabilitation, maintenance, and personal care services as
48.26 defined in United States Code, title 26, section 213, needed by the child with a chronic
48.27 illness or disability.
48.28 (b) For households with adjusted gross income equal to or greater than 100 percent
48.29 of federal poverty guidelines, the parental contribution shall be computed by applying the
48.30 following schedule of rates to the adjusted gross income of the natural or adoptive parents:
48.31 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
48.32 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
48.33 contribution is $4 per month;
48.34 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
48.35 poverty guidelines and less than or equal to 545 percent of federal poverty guidelines,

49.1 the parental contribution shall be determined using a sliding fee scale established by the
49.2 commissioner of human services which begins at one percent of adjusted gross income
49.3 at 175 percent of federal poverty guidelines and increases to 7.5 percent of adjusted
49.4 gross income for those with adjusted gross income up to 545 percent of federal poverty
49.5 guidelines;

49.6 (3) if the adjusted gross income is greater than 545 percent of federal poverty
49.7 guidelines and less than 675 percent of federal poverty guidelines, the parental
49.8 contribution shall be 7.5 percent of adjusted gross income;

49.9 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
49.10 poverty guidelines and less than 975 percent of federal poverty guidelines, the parental
49.11 contribution shall be determined using a sliding fee scale established by the commissioner
49.12 of human services which begins at 7.5 percent of adjusted gross income at 675 percent of
49.13 federal poverty guidelines and increases to ten percent of adjusted gross income for those
49.14 with adjusted gross income up to 975 percent of federal poverty guidelines; and

49.15 (5) if the adjusted gross income is equal to or greater than 975 percent of federal
49.16 poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross
49.17 income.

49.18 If the child lives with the parent, the annual adjusted gross income is reduced by
49.19 $2,400 prior to calculating the parental contribution. If the child resides in an institution
49.20 specified in section 256B.35, the parent is responsible for the personal needs allowance
49.21 specified under that section in addition to the parental contribution determined under this
49.22 section. The parental contribution is reduced by any amount required to be paid directly to
49.23 the child pursuant to a court order, but only if actually paid.

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

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

49.33 (e) The contribution shall be explained in writing to the parents at the time eligibility
49.34 for services is being determined. The contribution shall be made on a monthly basis
49.35 effective with the first month in which the child receives services. Annually upon
49.36 redetermination or at termination of eligibility, if the contribution exceeded the cost of

50.1 services provided, the local agency or the state shall reimburse that excess amount to
50.2 the parents, either by direct reimbursement if the parent is no longer required to pay a
50.3 contribution, or by a reduction in or waiver of parental fees until the excess amount is
50.4 exhausted. All reimbursements must include a notice that the amount reimbursed may be
50.5 taxable income if the parent paid for the parent's fees through an employer's health care
50.6 flexible spending account under the Internal Revenue Code, section 125, and that the
50.7 parent is responsible for paying the taxes owed on the amount reimbursed.

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

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

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

50.26 Parents who have more than one child receiving services shall not be required
50.27 to pay more than the amount for the child with the highest expenditures. There shall
50.28 be no resource contribution from the parents. The parent shall not be required to pay
50.29 a contribution in excess of the cost of the services provided to the child, not counting
50.30 payments made to school districts for education-related services. Notice of an increase in
50.31 fee payment must be given at least 30 days before the increased fee is due.

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

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

50.35 (2) the insurer denied insurance;

51.1 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
51.2 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
51.3 commerce, or litigated the complaint or appeal; and
51.4 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.
51.5 For purposes of this section, "insurance" has the meaning given in paragraph (h).
51.6 A parent who has requested a reduction in the contribution amount under this
51.7 paragraph shall submit proof in the form and manner prescribed by the commissioner or
51.8 county agency, including, but not limited to, the insurer's denial of insurance, the written
51.9 letter or complaint of the parents, court documents, and the written response of the insurer
51.10 approving insurance. The determinations of the commissioner or county agency under this
51.11 paragraph are not rules subject to chapter 14.
51.12 (j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,
51.13 2013, the parental contribution shall be computed by applying the following contribution
51.14 schedule to the adjusted gross income of the natural or adoptive parents:
51.15 (1) if the adjusted gross income is equal to or greater than 100 percent of federal
51.16 poverty guidelines and less than 175 percent of federal poverty guidelines, the parental
51.17 contribution is $4 per month;
51.18 (2) if the adjusted gross income is equal to or greater than 175 percent of federal
51.19 poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,
51.20 the parental contribution shall be determined using a sliding fee scale established by the
51.21 commissioner of human services which begins at one percent of adjusted gross income
51.22 at 175 percent of federal poverty guidelines and increases to eight percent of adjusted
51.23 gross income for those with adjusted gross income up to 525 percent of federal poverty
51.24 guidelines;
51.25 (3) if the adjusted gross income is greater than 525 percent of federal poverty
51.26 guidelines and less than 675 percent of federal poverty guidelines, the parental contribution
51.27 shall be 9.5 percent of adjusted gross income;
51.28 (4) if the adjusted gross income is equal to or greater than 675 percent of federal
51.29 poverty guidelines and less than 900 percent of federal poverty guidelines, the parental
51.30 contribution shall be determined using a sliding fee scale established by the commissioner
51.31 of human services which begins at 9.5 percent of adjusted gross income at 675 percent of
51.32 federal poverty guidelines and increases to 12 percent of adjusted gross income for those
51.33 with adjusted gross income up to 900 percent of federal poverty guidelines; and
51.34 (5) if the adjusted gross income is equal to or greater than 900 percent of federal
51.35 poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross
51.36 income. If the child lives with the parent, the annual adjusted gross income is reduced by

52.1 $2,400 prior to calculating the parental contribution. If the child resides in an institution
52.2 specified in section 256B.35, the parent is responsible for the personal needs allowance
52.3 specified under that section in addition to the parental contribution determined under this
52.4 section. The parental contribution is reduced by any amount required to be paid directly to
52.5 the child pursuant to a court order, but only if actually paid.

52.6 Sec. 8. **[256.4825] REPORT REGARDING PROGRAMS AND SERVICES FOR**
52.7 **PEOPLE WITH DISABILITIES.**

52.8 The Minnesota State Council on Disability, the Minnesota Consortium for Citizens
52.9 with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of
52.10 each year, beginning in 2012, to the chairs and ranking minority members of the legislative
52.11 committees with jurisdiction over programs serving people with disabilities as provided in
52.12 this section. The report must describe the existing state policies and goals for programs
52.13 serving people with disabilities including, but not limited to, programs for employment,
52.14 transportation, housing, education, quality assurance, consumer direction, physical and
52.15 programmatic access, and health. The report must provide data and measurements to
52.16 assess the extent to which the policies and goals are being met. The commissioner of
52.17 human services and the commissioners of other state agencies administering programs for
52.18 people with disabilities shall cooperate with the Minnesota State Council on Disability,
52.19 the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and
52.20 provide those organizations with existing published information and reports that will assist
52.21 in the preparation of the report.

52.22 Sec. 9. Minnesota Statutes 2008, section 256.9657, subdivision 3a, is amended to read:

52.23 Subd. 3a. **ICF/MR license surcharge.** (a) Effective July 1, 2003, each
52.24 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
52.25 to the commissioner an annual surcharge according to the schedule in subdivision 4,
52.26 paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of
52.27 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
52.28 beds the second month following the receipt of timely notice by the commissioner of
52.29 human services that beds have been delicensed. The facility must notify the commissioner
52.30 of health in writing when beds are delicensed. The commissioner of health must notify
52.31 the commissioner of human services within ten working days after receiving written
52.32 notification. If the notification is received by the commissioner of human services by
52.33 the 15th of the month, the invoice for the second following month must be reduced to
52.34 recognize the delicensing of beds. The commissioner may reduce, and may subsequently

53.1 restore, the surcharge under this subdivision based on the commissioner's determination of
53.2 a permissible surcharge.

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

53.5 Sec. 10. Minnesota Statutes 2009 Supplement, section 256.975, subdivision 7, is
53.6 amended to read:

53.7 Subd. 7. **Consumer information and assistance and long-term care options**
53.8 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
53.9 statewide service to aid older Minnesotans and their families in making informed choices
53.10 about long-term care options and health care benefits. Language services to persons with
53.11 limited English language skills may be made available. The service, known as Senior
53.12 LinkAge Line, must be available during business hours through a statewide toll-free
53.13 number and must also be available through the Internet.

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

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

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

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

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

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

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

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

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

53.34 (9) incorporate information about the availability of housing options, as well as
53.35 registered housing with services and consumer rights within the MinnesotaHelp.info

network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information ~~to the commissioner of human services that is consistent with information required by the commissioner of health under section 144G.06, the Uniform Consumer Information Guide~~ that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

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

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

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

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

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

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

counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

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

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

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

Sec. 11. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

56.7 (e)(1) A person whose earned and unearned income is equal to or greater than 100
56.8 percent of federal poverty guidelines for the applicable family size must pay a premium
56.9 to be eligible for medical assistance under this subdivision. The premium shall be based
56.10 on the person's gross earned and unearned income and the applicable family size using a
56.11 sliding fee scale established by the commissioner, which begins at one percent of income
56.12 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income
56.13 for those with incomes at or above 300 percent of the federal poverty guidelines. Annual
56.14 adjustments in the premium schedule based upon changes in the federal poverty guidelines
56.15 shall be effective for premiums due in July of each year.

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

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

56.21 (4) Effective November 1, 2003, for enrollees whose income does not exceed 200
56.22 percent of the federal poverty guidelines and who are also enrolled in Medicare, the
56.23 commissioner must reimburse the enrollee for Medicare Part B premiums under section
56.24 256B.0625, subdivision 15, paragraph (a).

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

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

56.30 (g) Any required premium shall be determined at application and redetermined at
56.31 the enrollee's six-month income review or when a change in income or household size is
56.32 reported. Enrollees must report any change in income or household size within ten days
56.33 of when the change occurs. A decreased premium resulting from a reported change in
56.34 income or household size shall be effective the first day of the next available billing month
56.35 after the change is reported. Except for changes occurring from annual cost-of-living

57.1 increases, a change resulting in an increased premium shall not affect the premium amount
57.2 until the next six-month review.

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

57.6 (i) Nonpayment of the premium shall result in denial or termination of medical
57.7 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
57.8 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
57.9 D, are met. Except when an installment agreement is accepted by the commissioner,
57.10 all persons disenrolled for nonpayment of a premium must pay any past due premiums
57.11 as well as current premiums due prior to being reenrolled. Nonpayment shall include
57.12 payment with a returned, refused, or dishonored instrument. The commissioner may
57.13 require a guaranteed form of payment as the only means to replace a returned, refused,
57.14 or dishonored instrument.

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

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

57.20 Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11,
57.21 is amended to read:

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

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

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

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

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

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

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

58.1 (ii) is disqualified, but the personal care assistant has received a set aside of the
58.2 disqualification under section 245C.22;
58.3 (4) be able to effectively communicate with the recipient and personal care
58.4 assistance provider agency;
58.5 (5) be able to provide covered personal care assistance services according to the
58.6 recipient's personal care assistance care plan, respond appropriately to recipient needs,
58.7 and report changes in the recipient's condition to the supervising qualified professional
58.8 or physician;
58.9 (6) not be a consumer of personal care assistance services;
58.10 (7) maintain daily written records including, but not limited to, time sheets under
58.11 subdivision 12;
58.12 (8) effective January 1, 2010, complete standardized training as determined by the
58.13 commissioner before completing enrollment. Personal care assistant training must include
58.14 successful completion of the following training components: basic first aid, vulnerable
58.15 adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of
58.16 personal care assistants including information about assistance with lifting and transfers
58.17 for recipients, emergency preparedness, orientation to positive behavioral practices, fraud
58.18 issues, and completion of time sheets. Upon completion of the training components,
58.19 the personal care assistant must demonstrate the competency to provide assistance to
58.20 recipients;
58.21 (9) complete training and orientation on the needs of the recipient within the first
58.22 seven days after the services begin; and
58.23 (10) be limited to providing and being paid for up to ~~310~~ 275 hours per month of
58.24 personal care assistance services regardless of the number of recipients being served or the
58.25 number of personal care assistance provider agencies enrolled with.
58.26 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
58.27 for the guardian services and meets the criteria for personal care assistants in paragraph (a).
58.28 (c) Effective January 1, 2010, persons who do not qualify as a personal care assistant
58.29 include parents and stepparents of minors, spouses, paid legal guardians, family foster
58.30 care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or
58.31 staff of a residential setting.

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

58.33 Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 3c,
58.34 is amended to read:

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments ~~offering or providing assisted living under chapter 144G~~ shall inform all prospective residents of the ~~availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident~~ requirement to contact the Senior LinkAge Line for long-term care options counseling and transitional consultation. The Senior LinkAge Line shall provide a certificate to the prospective resident and also send a copy of the certificate to the housing with services establishment that the prospective resident chooses, verifying that consultation has been provided to the prospective resident or the prospective resident's legal representative. The housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line. Prospective residents refusing to contact the Senior LinkAge Line are required to sign a waiver form supplied by the provider. The housing with services establishment shall maintain copies of contracts, waiver forms, and certificates for audit for a period of three years. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units~~, and the Area Agencies on Aging~~ under section 144D.03, subdivision 3, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

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

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

60.1 (3) the prospective resident shall be informed of the availability of long-term care
60.2 consultation services described in subdivision 3a that are available at no charge to the
60.3 prospective resident to assist the prospective resident in assessment and planning to meet
60.4 the prospective resident's long-term care needs. The Senior LinkAge Line and long-term
60.5 care consultation team shall give the highest priority to referrals who are at highest risk of
60.6 nursing facility placement or as needed for determining eligibility.;
60.7 (4) a prospective resident does not include a person moving from the community,
60.8 a hospital, or an institutional setting to housing with services during nonworking hours
60.9 when:
60.10 (i) the move is based on a recent precipitating event that precludes the person from
60.11 living safely in the community or institution, such as sustaining injury, unanticipated
60.12 discharge from hospital or nursing facility, inability of caregivers to provide needed care,
60.13 lack of access to needed care or services, or declining health status; and
60.14 (ii) the Senior LinkAge Line is contacted within ten working days following the
60.15 move to the registered housing with services, or as soon as is reasonable considering
60.16 the prospective resident's condition; and
60.17 (5) the Senior LinkAge Line may provide the long-term care options counseling and
60.18 transitional consultation service.

60.19 Sec. 14. Minnesota Statutes 2008, section 256B.0915, is amended by adding a
60.20 subdivision to read:
60.21 Subd. 3i. **Rate reduction for customized living and 24-hour customized living**
60.22 **services.** (a) Effective July 1, 2010, the commissioner shall reduce service component
60.23 rates and service rate limits for customized living services and 24-hour customized living
60.24 services, from the rates in effect on June 30, 2010, by five percent.
60.25 (b) To implement the rate reductions in this subdivision, capitation rates paid by the
60.26 commissioner to managed care organizations under section 256B.69 shall reflect a ten
60.27 percent reduction for the specified services for the period January 1, 2011, to June 30,
60.28 2011, and a five percent reduction for those services on and after July 1, 2011.

60.29 Sec. 15. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55,
60.30 is amended to read:
60.31 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
60.32 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
60.33 under this section shall be phased in by blending the operating rate with the operating
60.34 payment rate determined under section 256B.434. For purposes of this subdivision, the

rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. ~~For the rate year beginning October 1, 2009, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434. For rate years beginning October 1, 2010; October 1, 2011; and October 1, 2012,~~ For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

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

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

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

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

62.1 shall receive the blended October 1, 2008, operating payment rate increase determined
62.2 under paragraph (a).

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

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

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

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

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

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

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

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

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

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

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

62.32 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
62.33 commissioner may implement demonstration projects to create alternative integrated

63.1 delivery systems for acute and long-term care services to elderly persons and persons
63.2 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
63.3 coordination, improve access to quality services, and mitigate future cost increases.
63.4 The commissioner may seek federal authority to combine Medicare and Medicaid
63.5 capitation payments for the purpose of such demonstrations and may contract with
63.6 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
63.7 services shall be administered according to the terms and conditions of the federal contract
63.8 and demonstration provisions. For the purpose of administering medical assistance funds,
63.9 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
63.10 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
63.11 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
63.12 items B and C, which do not apply to persons enrolling in demonstrations under this
63.13 section. An initial open enrollment period may be provided. Persons who disenroll from
63.14 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
63.15 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
63.16 the health plan's participation is subsequently terminated for any reason, the person shall
63.17 be provided an opportunity to select a new health plan and shall have the right to change
63.18 health plans within the first 60 days of enrollment in the second health plan. Persons
63.19 required to participate in health plans under this section who fail to make a choice of
63.20 health plan shall not be randomly assigned to health plans under these demonstrations.
63.21 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
63.22 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
63.23 the commissioner may contract with managed care organizations, including counties, to
63.24 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
63.25 disabled persons only. For persons with a primary diagnosis of developmental disability,
63.26 serious and persistent mental illness, or serious emotional disturbance, the commissioner
63.27 must ensure that the county authority has approved the demonstration and contracting
63.28 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
63.29 commissioner shall not implement any demonstration project under this subdivision for
63.30 persons with a primary diagnosis of developmental disabilities, serious and persistent
63.31 mental illness, or serious emotional disturbance, without approval of the county board of
63.32 the county in which the demonstration is being implemented.

63.33 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
63.34 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
63.35 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
63.36 under this section projects for persons with developmental disabilities. The commissioner

64.1 may capitate payments for ICF/MR services, waivered services for developmental
64.2 disabilities, including case management services, day training and habilitation and
64.3 alternative active treatment services, and other services as approved by the state and by the
64.4 federal government. Case management and active treatment must be individualized and
64.5 developed in accordance with a person-centered plan. Costs under these projects may not
64.6 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
64.7 and until four years after the pilot project implementation date, subcontractor participation
64.8 in the long-term care developmental disability pilot is limited to a nonprofit long-term
64.9 care system providing ICF/MR services, home and community-based waiver services,
64.10 and in-home services to no more than 120 consumers with developmental disabilities in
64.11 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
64.12 prior to expansion of the developmental disability pilot project. This paragraph expires
64.13 four years after the implementation date of the pilot project.

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

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

64.22 (e) The commissioner, in consultation with the commissioners of commerce and
64.23 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
64.24 according to federal laws and regulations governing that program and state laws or rules
64.25 applicable to participating providers. ~~The process for approval of these programs shall~~
64.26 ~~begin only after the commissioner receives grant money in an amount sufficient to cover~~
64.27 ~~the state share of the administrative and actuarial costs to implement the programs during~~
64.28 ~~state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an~~
64.29 ~~account in the special revenue fund and are appropriated to the commissioner to be used~~
64.30 ~~solely for the purpose of PACE administrative and actuarial costs.~~ A PACE provider is
64.31 not required to be licensed or certified as a health plan company as defined in section
64.32 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
64.33 and found to be eligible for services under the elderly waiver or community alternatives
64.34 for disabled individuals or who are already eligible for Medicaid but meet level of
64.35 care criteria for receipt of waiver services may choose to enroll in the PACE program.
64.36 Medicare and Medicaid services will be provided according to this subdivision and

65.1 federal Medicare and Medicaid requirements governing PACE providers and programs.
65.2 PACE enrollees will receive Medicaid home and community-based services through the
65.3 PACE provider as an alternative to services for which they would otherwise be eligible
65.4 through home and community-based waiver programs and Medicaid State Plan Services.
65.5 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
65.6 costs that would have been incurred under fee-for-service or other relevant managed care
65.7 programs operated by the state.

65.8 (f) The commissioner shall seek federal approval to expand the Minnesota disability
65.9 health options (MnDHO) program established under this subdivision in stages, first to
65.10 regional population centers outside the seven-county metro area and then to all areas of
65.11 the state. Until July 1, 2009, expansion for MnDHO projects that include home and
65.12 community-based services is limited to the two projects and service areas in effect on
65.13 March 1, 2006. Enrollment in integrated MnDHO programs that include home and
65.14 community-based services shall remain voluntary. Costs for home and community-based
65.15 services included under MnDHO must not exceed costs that would have been incurred
65.16 under the fee-for-service program. Notwithstanding whether expansion occurs under
65.17 this paragraph, in determining MnDHO payment rates and risk adjustment methods ~~for~~
65.18 ~~contract years starting in 2012,~~ the commissioner must consider the methods used to
65.19 determine county allocations for home and community-based program participants. If
65.20 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
65.21 for home and community-based services, the commissioner shall achieve the reduction
65.22 by maintaining the base rate for contract ~~years~~ year 2010 ~~and 2011~~ for services provided
65.23 under the community alternatives for disabled individuals waiver at the same level as for
65.24 contract year 2009. The commissioner may apply other reductions to MnDHO rates to
65.25 implement decreases in provider payment rates required by state law. Effective December
65.26 31, 2010, enrollment and operation of the MnDHO program in effect during 2010 shall
65.27 cease. The commissioner may reopen the program provided all applicable conditions of
65.28 this section are met. In developing program specifications for expansion of integrated
65.29 programs, the commissioner shall involve and consult the state-level stakeholder group
65.30 established in subdivision 28, paragraph (d), including consultation on whether and how
65.31 to include home and community-based waiver programs. Plans ~~for further expansion of~~ to
65.32 reopen MnDHO projects shall be presented to the chairs of the house of representatives
65.33 and senate committees with jurisdiction over health and human services policy and finance
65.34 ~~by February 1, 2007~~ prior to implementation.

65.35 (g) Notwithstanding section 256B.0261, health plans providing services under this
65.36 section are responsible for home care targeted case management and relocation targeted

66.1 case management. Services must be provided according to the terms of the waivers and
66.2 contracts approved by the federal government.

66.3 Sec. 18. Laws 2009, chapter 79, article 8, section 51, the effective date, is amended to
66.4 read:

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

66.6 Sec. 19. Laws 2009, chapter 79, article 8, section 84, is amended to read:

66.7 Sec. 84. **HOUSING OPTIONS.**

66.8 The commissioner of human services, in consultation with the commissioner of
66.9 administration and the Minnesota Housing Finance Agency, and representatives of
66.10 counties, residents' advocacy groups, consumers of housing services, and provider
66.11 agencies shall explore ways to maximize the availability and affordability of housing
66.12 choices available to persons with disabilities or who need care assistance due to other
66.13 health challenges. A goal shall also be to minimize state physical plant costs in order to
66.14 serve more persons with appropriate program and care support. Consideration shall be
66.15 given to:

66.16 (1) improved access to rent subsidies;

66.17 (2) use of cooperatives, land trusts, and other limited equity ownership models;

66.18 (3) whether a public equity housing fund should be established that would maintain
66.19 the state's interest, to the extent paid from state funds, including group residential housing
66.20 and Minnesota supplemental aid shelter-needy funds in provider-owned housing, so that
66.21 when sold, the state would recover its share for a public equity fund to be used for future
66.22 public needs under this chapter;

66.23 (4) the desirability of the state acquiring an ownership interest or promoting the
66.24 use of publicly owned housing;

66.25 (5) promoting more choices in the market for accessible housing that meets the
66.26 needs of persons with physical challenges; ~~and~~

66.27 (6) what consumer ownership models, if any, are appropriate; and

66.28 (7) a review of the definition of home and community services and appropriate
66.29 settings where these services may be provided, including the number of people who
66.30 may reside under one roof, through the home and community-based waivers for seniors
66.31 and individuals with disabilities.

66.32 The commissioner shall provide a written report on the findings of the evaluation of
66.33 housing options to the chairs and ranking minority members of the house of representatives
66.34 and senate standing committees with jurisdiction over health and human services policy

67.1 and funding by December 15, 2010. This report shall replace the November 1, 2010,
67.2 annual report by the commissioner required in Minnesota Statutes, sections 256B.0916,
67.3 subdivision 7, and 256B.49, subdivision 21.

67.4 Sec. 20. **CASE MANAGEMENT REFORM.**

67.5 (a) By February 1, 2011, the commissioner of human services shall provide specific
67.6 recommendations and language for proposed legislation to:
67.7 (1) define the administrative and the service functions of case management for
67.8 persons with disabilities and make changes to improve the funding for administrative
67.9 functions;
67.10 (2) standardize and simplify processes, standards, and timelines for case
67.11 management within the Department of Human Services, Disability Services Division,
67.12 including eligibility determinations, resource allocation, management of dollars, provision
67.13 for assignment of one case manager at a time per person, waiting lists, quality assurance,
67.14 host county concurrence requirements, county of financial responsibility provisions, and
67.15 waiver compliance; and
67.16 (3) increase opportunities for consumer choice of case management functions
67.17 involving service coordination.
67.18 (b) In developing these recommendations, the commissioner shall consider the
67.19 recommendations of the 2007 Redesigning Case Management Services for Persons
67.20 with Disabilities report and consult with existing stakeholder groups, which include
67.21 representatives of counties, disability and senior advocacy groups, service providers, and
67.22 representatives of agencies which provide contracted case management.

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

67.24 Sec. 21. **COMMISSIONER TO SEEK FEDERAL MATCH.**

67.25 (a) The commissioner of human services shall seek federal financial participation
67.26 for eligible activity related to fiscal years 2010 and 2011 grants to Advocating Change
67.27 Together to establish a statewide self-advocacy network for persons with developmental
67.28 disabilities and for eligible activities under any future grants to the organization.
67.29 (b) The commissioner shall report to the chairs and ranking minority members of
67.30 the senate Health and Human Services Budget Division and the house of representatives
67.31 Health Care and Human Services Finance Division by December 15, 2010, with the
67.32 results of the application for federal matching funds.

67.33 Sec. 22. **ICF/MR RATE INCREASE.**

68.1 The daily rate at an intermediate care facility for the developmentally disabled
68.2 located in Clearwater County and classified as a Class A facility with 15 beds shall be
68.3 increased from $112.73 to $138.23 for the rate period July 1, 2010, to June 30, 2011.

68.4 **ARTICLE 3**

68.5 **CHILDREN AND FAMILY SERVICES**

68.6 Section 1. Minnesota Statutes 2008, section 256D.0515, is amended to read:

68.7 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

68.8 All food stamp households must be determined eligible for the benefit discussed
68.9 under section 256.029. Food stamp households must demonstrate that~~:~~
68.10 ~~(1)~~ their gross income ~~meets the federal Food Stamp requirements under United~~
68.11 ~~States Code, title 7, section 2014(c); and~~
68.12 ~~(2) they have financial resources, excluding vehicles, of less than $7,000~~ is equal to
68.13 or less than 165 percent of the federal poverty guidelines for the same family size.

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

68.15 Sec. 2. Minnesota Statutes 2008, section 256I.05, is amended by adding a subdivision
68.16 to read:

68.17 Subd. 1n. **Supplemental rate; Mahnomen County.** Notwithstanding the
68.18 provisions of this section, for the rate period July 1, 2010, to June 30, 2011, a county
68.19 agency shall negotiate a supplemental service rate in addition to the rate specified in
68.20 subdivision 1, not to exceed $753 per month or the existing rate, including any legislative
68.21 authorized inflationary adjustments, for a group residential provider located in Mahnomen
68.22 County that operates a 28-bed facility providing 24-hour care to individuals who are
68.23 homeless, disabled, chemically dependent, mentally ill, or chronically homeless.

68.24 Sec. 3. Minnesota Statutes 2008, section 256J.24, subdivision 6, is amended to read:

68.25 Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the
68.26 cash portion of the transitional standard as a result of the birth of a child, unless one of
68.27 the conditions under paragraph (b) is met. The child shall be considered a member of the
68.28 assistance unit according to subdivisions 1 to 3, but shall be excluded in determining
68.29 family size for purposes of determining the amount of the cash portion of the transitional
68.30 standard under subdivision 5. The child shall be included in determining family size for
68.31 purposes of determining the food portion of the transitional standard. The transitional
68.32 standard under this subdivision shall be the total of the cash and food portions as specified

69.1 in this paragraph. The family wage level under this subdivision shall be based on the
69.2 family size used to determine the food portion of the transitional standard.
69.3 (b) A child shall be included in determining family size for purposes of determining
69.4 the amount of the cash portion of the MFIP transitional standard when at least one of
69.5 the following conditions is met:
69.6 (1) for families receiving MFIP assistance on July 1, 2003, the child is born to the
69.7 adult parent before May 1, 2004;
69.8 (2) for families who apply for the diversionary work program under section 256J.95
69.9 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within
69.10 ten months of the date the family is eligible for assistance;
69.11 (3) the child was conceived as a result of a sexual assault or incest, provided that the
69.12 incident has been reported to a law enforcement agency;
69.13 (4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision
69.14 59, and the child, or multiple children, are the mother's first birth; ~~or~~
69.15 (5) the child is the mother's first child subsequent to a pregnancy that did not result
69.16 in a live birth; or
69.17 (6) any child previously excluded in determining family size under paragraph
69.18 (a) shall be included if the adult parent or parents have not received benefits from the
69.19 diversionary work program under section 256J.95 or MFIP assistance in the previous ten
69.20 months. An adult parent or parents who reapply and have received benefits from the
69.21 diversionary work program or MFIP assistance in the past ten months shall be under the
69.22 ten-month grace period of their previous application under clause (2).
69.23 (c) Income and resources of a child excluded under this subdivision, except child
69.24 support received or distributed on behalf of this child, must be considered using the same
69.25 policies as for other children when determining the grant amount of the assistance unit.
69.26 (d) The caregiver must assign support and cooperate with the child support
69.27 enforcement agency to establish paternity and collect child support on behalf of the
69.28 excluded child. Failure to cooperate results in the sanction specified in section 256J.46,
69.29 subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be
69.30 distributed according to section 256.741, subdivision 15.
69.31 (e) County agencies must inform applicants of the provisions under this subdivision
69.32 at the time of each application and at recertification.
69.33 (f) Children excluded under this provision shall be deemed MFIP recipients for
69.34 purposes of child care under chapter 119B.

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

70.1 Sec. 4. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is
70.2 amended to read:

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

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

70.10 (2) a person who:

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

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

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

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

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

71.1 (1) that a qualified professional has determined that the person's condition prevents
71.2 the person from working 20 or more hours per week; or
71.3 (2) for a person who meets the requirements of paragraph (a), clause (2), item (ii), or
71.4 clause (3), a qualified professional has determined the person's condition:
71.5 (i) significantly restricts the range of employment that the person is able to perform;
71.6 or
71.7 (ii) significantly interferes with the person's ability to obtain or maintain suitable
71.8 employment for 20 or more hours per week.

71.9 Sec. 5. **REPEALER.**
71.10 Minnesota Statutes 2009 Supplement, section 256J.621, is repealed.

71.11 **EFFECTIVE DATE.** This section is effective December 1, 2010.

71.12 **ARTICLE 4**
71.13 **MISCELLANEOUS**

71.14 Section 1. **[62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.**
71.15 (a) Private duty nursing services, as provided under section 256B.0625, subdivision
71.16 7, with the exception of section 256B.0654, subdivision 4, shall be covered under a health
71.17 plan for persons who are concurrently covered by both the health plan and enrolled in
71.18 medical assistance under chapter 256B.
71.19 (b) For purposes of this section, a period of private duty nursing services may
71.20 be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing
71.21 requirements that apply under the health plan. Cost-sharing requirements for private
71.22 duty nursing services must not place a greater financial burden on the insured or enrollee
71.23 than those requirements applied by the health plan to other similar services or benefits.
71.24 Nothing in this section is intended to prevent a health plan company from requiring
71.25 prior authorization by the health plan company for such services as required by section
71.26 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions
71.27 of the health plan.

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

71.30 Sec. 2. **[137.32] MINNESOTA COUPLES ON THE BRINK PROJECT.**
71.31 Subdivision 1. **Establishment.** Within the limits of available appropriations, the
71.32 Board of Regents of the University of Minnesota is requested to develop and implement

72.1 a Minnesota couples on the brink project, as provided for in this section. The regents
72.2 may administer the project with federal grants, state appropriations, and in-kind services
72.3 received for this purpose.

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

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

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

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

72.12 Sec. 3. Minnesota Statutes 2008, section 152.126, as amended by Laws 2009, chapter
72.13 79, article 11, sections 9, 10, and 11, is amended to read:

72.14 **152.126 ~~SCHEDULE II AND III~~ CONTROLLED SUBSTANCES**
72.15 **PRESCRIPTION ELECTRONIC REPORTING SYSTEM.**

72.16 Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this
72.17 subdivision have the meanings given.

72.18 (a) "Board" means the Minnesota State Board of Pharmacy established under
72.19 chapter 151.

72.20 (b) "Controlled substances" means those substances listed in section 152.02,
72.21 subdivisions 3 to 5, and those substances defined by the board pursuant to section 152.02,
72.22 subdivisions 7, 8, and 12.

72.23 (c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
72.24 30. Dispensing does not include the direct administering of a controlled substance to a
72.25 patient by a licensed health care professional.

72.26 (d) "Dispenser" means a person authorized by law to dispense a controlled substance,
72.27 pursuant to a valid prescription. For the purposes of this section, a dispenser does not
72.28 include a licensed hospital pharmacy that distributes controlled substances for inpatient
72.29 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

72.30 (e) "Prescriber" means a licensed health care professional who is authorized to
72.31 prescribe a controlled substance under section 152.12, subdivision 1.

72.32 (f) "Prescription" has the meaning given in section 151.01, subdivision 16.

72.33 Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or
72.34 interfere with the legitimate prescribing of controlled substances for pain. No prescriber

73.1 shall be subject to disciplinary action by a health-related licensing board for prescribing a
73.2 controlled substance according to the provisions of section 152.125.

73.3 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish
73.4 by January 1, 2010, an electronic system for reporting the information required under
73.5 subdivision 4 for all controlled substances dispensed within the state.

73.6 (b) The board may contract with a vendor for the purpose of obtaining technical
73.7 assistance in the design, implementation, operation, and maintenance of the electronic
73.8 reporting system.

73.9 Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The
73.10 board shall convene an advisory committee. The committee must include at least one
73.11 representative of:

73.12 (1) the Department of Health;

73.13 (2) the Department of Human Services;

73.14 (3) each health-related licensing board that licenses prescribers;

73.15 (4) a professional medical association, which may include an association of pain
73.16 management and chemical dependency specialists;

73.17 (5) a professional pharmacy association;

73.18 (6) a professional nursing association;

73.19 (7) a professional dental association;

73.20 (8) a consumer privacy or security advocate; and

73.21 (9) a consumer or patient rights organization.

73.22 (b) The advisory committee shall advise the board on the development and operation
73.23 of the electronic reporting system, including, but not limited to:

73.24 (1) technical standards for electronic prescription drug reporting;

73.25 (2) proper analysis and interpretation of prescription monitoring data; and

73.26 (3) an evaluation process for the program.

73.27 ~~(c) The Board of Pharmacy, after consultation with the advisory committee, shall~~
73.28 ~~present recommendations and draft legislation on the issues addressed by the advisory~~
73.29 ~~committee under paragraph (b), to the legislature by December 15, 2007.~~

73.30 Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the
73.31 following data to the board or its designated vendor, subject to the notice required under
73.32 paragraph (d):

73.33 (1) name of the prescriber;

73.34 (2) national provider identifier of the prescriber;

73.35 (3) name of the dispenser;

73.36 (4) national provider identifier of the dispenser;

74.1 (5) prescription number;
74.2 (6) name of the patient for whom the prescription was written;
74.3 (7) address of the patient for whom the prescription was written;
74.4 (8) date of birth of the patient for whom the prescription was written;
74.5 (9) date the prescription was written;
74.6 (10) date the prescription was filled;
74.7 (11) name and strength of the controlled substance;
74.8 (12) quantity of controlled substance prescribed;
74.9 (13) quantity of controlled substance dispensed; and
74.10 (14) number of days supply.
74.11 (b) The dispenser must submit the required information by a procedure and in a
74.12 format established by the board. The board may allow dispensers to omit data listed in this
74.13 subdivision or may require the submission of data not listed in this subdivision provided
74.14 the omission or submission is necessary for the purpose of complying with the electronic
74.15 reporting or data transmission standards of the American Society for Automation in
74.16 Pharmacy, the National Council on Prescription Drug Programs, or other relevant national
74.17 standard-setting body.
74.18 (c) A dispenser is not required to submit this data for those controlled substance
74.19 prescriptions dispensed for:
74.20 (1) individuals residing in licensed skilled nursing or intermediate care facilities;
74.21 (2) individuals receiving assisted living services under chapter 144G or through a
74.22 medical assistance home and community-based waiver;
74.23 (3) individuals receiving medication intravenously;
74.24 (4) individuals receiving hospice and other palliative or end-of-life care; and
74.25 (5) individuals receiving services from a home care provider regulated under chapter
74.26 144A.
74.27 (d) A dispenser must not submit data under this subdivision unless a conspicuous
74.28 notice of the reporting requirements of this section is given to the patient for whom the
74.29 prescription was written.
74.30 Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database
74.31 of the data reported under subdivision 4. The board shall maintain data that could identify
74.32 an individual prescriber or dispenser in encrypted form. The database may be used by
74.33 permissible users identified under subdivision 6 for the identification of:
74.34 (1) individuals receiving prescriptions for controlled substances from prescribers
74.35 who subsequently obtain controlled substances from dispensers in quantities or with a
74.36 frequency inconsistent with generally recognized standards of use for those controlled

75.1 substances, including standards accepted by national and international pain management
75.2 associations; and
75.3 (2) individuals presenting forged or otherwise false or altered prescriptions for
75.4 controlled substances to dispensers.
75.5 (b) No permissible user identified under subdivision 6 may access the database
75.6 for the sole purpose of identifying prescribers of controlled substances for unusual or
75.7 excessive prescribing patterns without a valid search warrant or court order.
75.8 (c) No personnel of a state or federal occupational licensing board or agency may
75.9 access the database for the purpose of obtaining information to be used to initiate or
75.10 substantiate a disciplinary action against a prescriber.
75.11 (d) Data reported under subdivision 4 shall be retained by the board in the database
75.12 for a 12-month period, and shall be removed from the database no later than 12 months
75.13 from ~~the date~~ the last day of the month during which the data was received.
75.14 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
75.15 subdivision, the data submitted to the board under subdivision 4 is private data on
75.16 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.
75.17 (b) Except as specified in subdivision 5, the following persons shall be considered
75.18 permissible users and may access the data submitted under subdivision 4 in the same or
75.19 similar manner, and for the same or similar purposes, as those persons who are authorized
75.20 to access similar private data on individuals under federal and state law:
75.21 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
75.22 delegated the task of accessing the data, to the extent the information relates specifically to
75.23 a current patient, to whom the prescriber is prescribing or considering prescribing any
75.24 controlled substance and with the provision that the prescriber remains responsible for the
75.25 use or misuse of data accessed by a delegated agent or employee;
75.26 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
75.27 delegated the task of accessing the data, to the extent the information relates specifically
75.28 to a current patient to whom that dispenser is dispensing or considering dispensing any
75.29 controlled substance and with the provision that the dispenser remains responsible for the
75.30 use or misuse of data accessed by a delegated agent or employee;
75.31 (3) an individual who is the recipient of a controlled substance prescription for
75.32 which data was submitted under subdivision 4, or a guardian of the individual, parent or
75.33 guardian of a minor, or health care agent of the individual acting under a health care
75.34 directive under chapter 145C;
75.35 (4) personnel of the board specifically assigned to conduct a bona fide investigation
75.36 of a specific licensee;

76.1 (5) personnel of the board engaged in the collection of controlled substance
76.2 prescription information as part of the assigned duties and responsibilities under this
76.3 section;

76.4 (6) authorized personnel of a vendor under contract with the board who are engaged
76.5 in the design, implementation, operation, and maintenance of the electronic reporting
76.6 system as part of the assigned duties and responsibilities of their employment, provided
76.7 that access to data is limited to the minimum amount necessary to carry out such duties
76.8 and responsibilities;

76.9 (7) federal, state, and local law enforcement authorities acting pursuant to a valid
76.10 search warrant; and

76.11 (8) personnel of the medical assistance program assigned to use the data collected
76.12 under this section to identify recipients whose usage of controlled substances may warrant
76.13 restriction to a single primary care physician, a single outpatient pharmacy, or a single
76.14 hospital.

76.15 For purposes of clause (3), access by an individual includes persons in the definition
76.16 of an individual under section 13.02.

76.17 (c) Any permissible user identified in paragraph (b), who directly accesses
76.18 the data electronically, shall implement and maintain a comprehensive information
76.19 security program that contains administrative, technical, and physical safeguards that
76.20 are appropriate to the user's size and complexity, and the sensitivity of the personal
76.21 information obtained. The permissible user shall identify reasonably foreseeable internal
76.22 and external risks to the security, confidentiality, and integrity of personal information
76.23 that could result in the unauthorized disclosure, misuse, or other compromise of the
76.24 information and assess the sufficiency of any safeguards in place to control the risks.

76.25 (d) The board shall not release data submitted under this section unless it is provided
76.26 with evidence, satisfactory to the board, that the person requesting the information is
76.27 entitled to receive the data.

76.28 (e) The board shall not release the name of a prescriber without the written consent
76.29 of the prescriber or a valid search warrant or court order. The board shall provide a
76.30 mechanism for a prescriber to submit to the board a signed consent authorizing the release
76.31 of the prescriber's name when data containing the prescriber's name is requested.

76.32 (f) The board shall maintain a log of all persons who access the data and shall ensure
76.33 that any permissible user complies with paragraph (c) prior to attaining direct access to
76.34 the data.

77.1 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into
77.2 pursuant to subdivision 2. A vendor shall not use data collected under this section for
77.3 any purpose not specified in this section.
77.4 Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to
77.5 the board as required under this section is subject to disciplinary action by the appropriate
77.6 health-related licensing board.
77.7 (b) A prescriber or dispenser authorized to access the data who knowingly discloses
77.8 the data in violation of state or federal laws relating to the privacy of health care data
77.9 shall be subject to disciplinary action by the appropriate health-related licensing board,
77.10 and appropriate civil penalties.
77.11 Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription
77.12 electronic reporting system to determine if the system is negatively impacting appropriate
77.13 prescribing practices of controlled substances. The board may contract with a vendor to
77.14 design and conduct the evaluation.
77.15 (b) The board shall submit the evaluation of the system to the legislature by ~~January~~
77.16 July 15, 2011.
77.17 Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A
77.18 pharmacist, prescriber, or other dispenser making a report to the program in good faith
77.19 under this section is immune from any civil, criminal, or administrative liability, which
77.20 might otherwise be incurred or imposed as a result of the report, or on the basis that the
77.21 pharmacist or prescriber did or did not seek or obtain or use information from the program.
77.22 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser
77.23 to obtain information about a patient from the program, and the pharmacist, prescriber,
77.24 or other dispenser, if acting in good faith, is immune from any civil, criminal, or
77.25 administrative liability that might otherwise be incurred or imposed for requesting,
77.26 receiving, or using information from the program.
77.27 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit
77.28 charitable foundations, the federal government, and other sources to fund the enhancement
77.29 and ongoing operations of the prescription electronic reporting system established under
77.30 this section. Any funds received shall be appropriated to the board for this purpose. The
77.31 board may not expend funds to enhance the program in a way that conflicts with this
77.32 section without seeking approval from the legislature.
77.33 (b) The administrative services unit for the health-related licensing boards shall
77.34 apportion between the Board of Medical Practice, the Board of Nursing, the Board of
77.35 Dentistry, the Board of Podiatric Medicine, the Board of Optometry, and the Board
77.36 of Pharmacy an amount to be paid through fees by each respective board. The amount

78.1 apportioned to each board shall equal each board's share of the annual appropriation to
78.2 the Board of Pharmacy from the state government special revenue fund for operating the
78.3 prescription electronic reporting system under this section. Each board's apportioned
78.4 share shall be based on the number of prescribers or dispensers that each board identified
78.5 in this paragraph licenses as a percentage of the total number of prescribers and dispensers
78.6 licensed collectively by these boards. Each respective board may adjust the fees that the
78.7 boards are required to collect to compensate for the amount apportioned to each board by
78.8 the administrative services unit.

78.9 Sec. 4. **[246.125] CHEMICAL AND MENTAL HEALTH SERVICES**
78.10 **TRANSFORMATION ADVISORY TASK FORCE.**

78.11 Subdivision 1. **Establishment.** The Chemical and Mental Health Services
78.12 Transformation Advisory Task Force is established to make recommendations to the
78.13 commissioner of human services and the legislature on the continuum of services needed
78.14 to provide individuals with complex conditions including mental illness, chemical
78.15 dependency, traumatic brain injury, and developmental disabilities access to quality care
78.16 and the appropriate level of care across the state to promote wellness, reduce cost, and
78.17 improve efficiency.

78.18 Subd. 2. **Duties.** The Chemical and Mental Health Services Transformation
78.19 Advisory Task Force shall make recommendations to the commissioner and the legislature
78.20 no later than December 15, 2010, on the following:

78.21 (1) transformation needed to improve service delivery and provide a continuum of
78.22 care, such as transition of current facilities, closure of current facilities, or the development
78.23 of new models of care, including the redesign of the Anoka-Metro Regional Treatment
78.24 Center;

78.25 (2) gaps and barriers to accessing quality care, system inefficiencies, and cost
78.26 pressures;

78.27 (3) services that are best provided by the state and those that are best provided
78.28 in the community;

78.29 (4) an implementation plan to achieve integrated service delivery across the public,
78.30 private, and nonprofit sectors;

78.31 (5) an implementation plan to ensure that individuals with complex chemical and
78.32 mental health needs receive the appropriate level of care to achieve recovery and wellness;
78.33 and

78.34 (6) financing mechanisms that include all possible revenue sources to maximize
78.35 federal funding and promote cost efficiencies and sustainability.

79.1 Subd. 3. **Membership.** The advisory task force shall be composed of the following,
79.2 who will serve at the pleasure of their appointing authority:
79.3 (1) the commissioner of human services or the commissioner's designee, and two
79.4 additional representatives from the department;
79.5 (2) two legislators appointed by the speaker of the house, one from the minority
79.6 and one from the majority;
79.7 (3) two legislators appointed by the senate rules committee, one from the minority
79.8 and one from the majority;
79.9 (4) one representative appointed by AFSCME Council 5;
79.10 (5) one representative appointed by the ombudsman for mental health and
79.11 developmental disabilities;
79.12 (6) one representative appointed by the Minnesota Association of Professional
79.13 Employees;
79.14 (7) one representative appointed by the Minnesota Hospital Association;
79.15 (8) one representative appointed by the Minnesota Nurses Association;
79.16 (9) one representative appointed by NAMI-MN;
79.17 (10) one representative appointed by the Mental Health Association of Minnesota;
79.18 (11) one representative appointed by the Minnesota Association Of Community
79.19 Mental Health Programs;
79.20 (12) one representative appointed by the Minnesota Dental Association;
79.21 (13) three clients or client family members representing different populations
79.22 receiving services from state-operated services, who are appointed by the commissioner;
79.23 (14) one representative appointed by the chair of the state-operated services
79.24 governing board;
79.25 (15) one representative appointed by the Minnesota Disability Law Center;
79.26 (16) one representative appointed by the Consumer Survivor Network;
79.27 (17) one representative appointed by the Association of Residential Resources
79.28 in Minnesota;
79.29 (18) one representative appointed by the Minnesota Council of Child Caring
79.30 Agencies;
79.31 (19) one representative appointed by the Association of Minnesota Counties; and
79.32 (20) one representative appointed by the Minnesota Pharmacists Association.
79.33 The commissioner may appoint additional members to reflect stakeholders who
79.34 are not represented above.
79.35 Subd. 4. **Administration.** The commissioner shall convene the first meeting of the
79.36 advisory task force and shall provide administrative support and staff.

80.1 Subd. 5. **Recommendations.** The advisory task force must report its
80.2 recommendations to the commissioner and to the legislature no later than December
80.3 15, 2010.
80.4 Subd. 6. **Member requirement.** The commissioner shall provide per diem and
80.5 travel expenses pursuant to section 256.01, subdivision 6, for task force members who
80.6 are consumers or family members and whose participation on the task force is not as a
80.7 paid representative of any agency, organization, or association. Notwithstanding section
80.8 15.059, other task members are not eligible for per diem or travel reimbursement.

80.9 Sec. 5. **[246.128] NOTIFICATION TO LEGISLATURE REQUIRED.**
80.10 The commissioner shall notify the chairs and ranking minority members of
80.11 the relevant legislative committees regarding the redesign, closure, or relocation of
80.12 state-operated services programs. The notification must include the advice of the Chemical
80.13 and Mental Health Services Transformation Advisory Task Force under section 246.125.

80.14 Sec. 6. **[246.129] LEGISLATIVE APPROVAL REQUIRED.**
80.15 If the closure of a state-operated facility is proposed, and the department and
80.16 respective bargaining units fail to arrive at a mutually agreed upon solution to transfer
80.17 affected state employees to other state jobs, the closure of the facility requires legislative
80.18 approval. This does not apply to state-operated enterprise services.

80.19 Sec. 7. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision
80.20 to read:
80.21 Subd. 8. **State-operated services account.** The state-operated services account is
80.22 established in the special revenue fund. Revenue generated by new state-operated services
80.23 listed under this section established after July 1, 2010, that are not enterprise activities must
80.24 be deposited into the state-operated services account, unless otherwise specified in law:
80.25 (1) intensive residential treatment services;
80.26 (2) foster care services; and
80.27 (3) psychiatric extensive recovery treatment services.

80.28 Sec. 8. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:
80.29 Subd. 2. **American Indian.** For purposes of services provided under section
80.30 254B.09, subdivision ~~7~~ 8, "American Indian" means a person who is a member of an
80.31 Indian tribe, and the commissioner shall use the definitions of "Indian" and "Indian tribe"
80.32 and "Indian organization" provided in Public Law 93-638. For purposes of services

81.1 provided under section 254B.09, subdivision ~~4~~ 6, "American Indian" means a resident of
81.2 federally recognized tribal lands who is recognized as an Indian person by the federally
81.3 recognized tribal governing body.

81.4 Sec. 9. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:
81.5 Subdivision 1. **Chemical dependency treatment allocation.** The chemical
81.6 dependency ~~funds appropriated for allocation~~ treatment appropriation shall be placed in
81.7 a special revenue account. The commissioner shall annually transfer funds from the
81.8 chemical dependency fund to pay for operation of the drug and alcohol abuse normative
81.9 evaluation system and to pay for all costs incurred by adding two positions for licensing
81.10 of chemical dependency treatment and rehabilitation programs located in hospitals for
81.11 which funds are not otherwise appropriated. ~~Six percent of the remaining money must~~
81.12 ~~be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The~~
81.13 ~~commissioner shall annually divide the money available in the chemical dependency~~
81.14 ~~fund that is not held in reserve by counties from a previous allocation, or allocated to the~~
81.15 ~~American Indian chemical dependency tribal account. Six percent of the remaining money~~
81.16 ~~must be reserved for the nonreservation American Indian chemical dependency allocation~~
81.17 ~~for treatment of American Indians by eligible vendors under section 254B.05, subdivision~~
81.18 ~~1.~~ The remainder of the money ~~must be allocated among the counties according to the~~
81.19 ~~following formula, using state demographer data and other data sources determined by~~
81.20 ~~the commissioner:~~
81.21 ~~(a) For purposes of this formula, American Indians and children under age 14 are~~
81.22 ~~subtracted from the population of each county to determine the restricted population.~~
81.23 ~~(b) The amount of chemical dependency fund expenditures for entitled persons for~~
81.24 ~~services not covered by prepaid plans governed by section 256B.69 in the previous year is~~
81.25 ~~divided by the amount of chemical dependency fund expenditures for entitled persons for~~
81.26 ~~all services to determine the proportion of exempt service expenditures for each county.~~
81.27 ~~(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt~~
81.28 ~~service expenditures to determine the adjusted prepaid plan months of eligibility for~~
81.29 ~~each county.~~
81.30 ~~(d) The adjusted prepaid plan months of eligibility is added to the number of~~
81.31 ~~restricted population fee for service months of eligibility for the Minnesota family~~
81.32 ~~investment program, general assistance, and medical assistance and divided by the county~~
81.33 ~~restricted population to determine county per capita months of covered service eligibility.~~
81.34 ~~(e) The number of adjusted prepaid plan months of eligibility for the state is added~~
81.35 ~~to the number of fee for service months of eligibility for the Minnesota family investment~~

82.1 ~~program, general assistance, and medical assistance for the state restricted population and~~
82.2 ~~divided by the state restricted population to determine state per capita months of covered~~
82.3 ~~service eligibility.~~
82.4 ~~(f) The county per capita months of covered service eligibility is divided by the~~
82.5 ~~state per capita months of covered service eligibility to determine the county welfare~~
82.6 ~~caseload factor.~~
82.7 ~~(g) The median married couple income for the most recent three-year period~~
82.8 ~~available for the state is divided by the median married couple income for the same period~~
82.9 ~~for each county to determine the income factor for each county.~~
82.10 ~~(h) The county restricted population is multiplied by the sum of the county welfare~~
82.11 ~~caseload factor and the county income factor to determine the adjusted population.~~
82.12 ~~(i) $15,000 shall be allocated to each county.~~
82.13 ~~(j) The remaining funds shall be allocated proportional to the county adjusted~~
82.14 ~~population~~ in the special revenue account must be used according to the requirements
82.15 in this chapter.

82.16 Sec. 10. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:
82.17 Subd. 5. **Administrative adjustment.** The commissioner may make payments to
82.18 local agencies from money allocated under this section to support administrative activities
82.19 under sections 254B.03 and 254B.04. The administrative payment must not exceed
82.20 the lesser of: (1) five percent of the first $50,000, four percent of the next $50,000, and
82.21 three percent of the remaining payments for services from the ~~allocation~~ special revenue
82.22 account according to subdivision 1; or (2) the local agency administrative payment for
82.23 the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in
82.24 the appropriation for this chapter.

82.25 Sec. 11. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:
82.26 Subd. 4. **Division of costs.** Except for services provided by a county under
82.27 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
82.28 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for
82.29 ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services
82.30 provided to persons eligible for medical assistance under chapter 256B and general
82.31 assistance medical care under chapter 256D. Counties may use the indigent hospitalization
82.32 levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent
82.33 of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost
82.34 of payment and collections, must be distributed to the county that paid for a portion of

83.1 the treatment under this section. ~~If all funds allocated according to section 254B.02 are~~
83.2 ~~exhausted by a county and the county has met or exceeded the base level of expenditures~~
83.3 ~~under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the~~
83.4 ~~costs paid by the state under this section. The commissioner may refuse to pay state funds~~
83.5 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~
83.6 ~~financially responsible for the persons has exhausted its allocation.~~

83.7 Sec. 12. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:
83.8 Subd. 4. **Regional treatment centers.** Regional treatment center chemical
83.9 dependency treatment units are eligible vendors. The commissioner may expand the
83.10 capacity of chemical dependency treatment units beyond the capacity funded by direct
83.11 legislative appropriation to serve individuals who are referred for treatment by counties
83.12 and whose treatment will be paid for ~~with a county's allocation under section 254B.02~~ by
83.13 funding under this chapter or other funding sources. Notwithstanding the provisions of
83.14 sections 254B.03 to 254B.041, payment for any person committed at county request to
83.15 a regional treatment center under chapter 253B for chemical dependency treatment and
83.16 determined to be ineligible under the chemical dependency consolidated treatment fund,
83.17 shall become the responsibility of the county.

83.18 Sec. 13. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:
83.19 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal
83.20 financial participation collections to ~~the reserve fund under section 254B.02, subdivision 3~~
83.21 a special revenue account. The commissioner shall ~~retain 85~~ allocate 83.86 percent of
83.22 patient payments and third-party payments to the special revenue account and ~~allocate~~
83.23 ~~the collections to the treatment allocation for the county that is financially responsible~~
83.24 ~~for the person. Fifteen~~ 16.14 percent ~~of patient and third-party payments must be paid~~
83.25 to the county financially responsible for the patient. ~~Collections for patient payment and~~
83.26 ~~third-party payment for services provided under section 254B.09 shall be allocated to the~~
83.27 ~~allocation of the tribal unit which placed the person. Collections of federal financial~~
83.28 ~~participation for services provided under section 254B.09 shall be allocated to the tribal~~
83.29 ~~reserve account under section 254B.09, subdivision 5.~~

83.30 Sec. 14. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:
83.31 Subd. 8. **Payments to improve services to American Indians.** The commissioner
83.32 may set rates for chemical dependency services to American Indians according to the
83.33 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.

84.1 These rates shall supersede rates set in county purchase of service agreements when
84.2 payments are made on behalf of clients eligible according to Public Law 94-437.

84.3 Sec. 15. **[254B.13] PILOT PROJECTS; CHEMICAL HEALTH CARE.**

84.4 Subdivision 1. **Authorization for pilot projects.** The commissioner may approve
84.5 and implement pilot projects developed under the planning process required under Laws
84.6 2009, chapter 79, article 7, section 26, to provide alternatives to and enhance coordination
84.7 of the delivery of chemical health services required under section 254B.03.

84.8 Subd. 2. **Program design and implementation.** (a) The commissioner and counties
84.9 participating in the pilot projects shall continue to work in partnership to refine and
84.10 implement the pilot projects initiated under Laws 2009, chapter 79, article 7, section 26.

84.11 (b) The commissioner and counties participating in the pilot projects shall
84.12 complete the planning phase by June 30, 2010, and, if approved by the commissioner for
84.13 implementation, enter into agreements governing the operation of the pilot projects with
84.14 implementation scheduled no earlier than July 1, 2010.

84.15 Subd. 3. **Program evaluation.** The commissioner shall evaluate pilot projects under
84.16 this section and report the results of the evaluation to the chairs and ranking minority
84.17 members of the legislative committees with jurisdiction over chemical health issues by
84.18 January 15, 2013. Evaluation of the pilot projects must be based on outcome evaluation
84.19 criteria negotiated with the pilot projects prior to implementation.

84.20 Subd. 4. **Notice of project discontinuation.** Each county's participation in the
84.21 pilot project may be discontinued for any reason by the county or the commissioner of
84.22 human services after 30 days' written notice to the other party. Any unspent funds held
84.23 for the exiting county's pro rata share in the special revenue fund under the authority in
84.24 subdivision 5, paragraph (d), shall be transferred to the consolidated chemical dependency
84.25 treatment fund following discontinuation of the pilot project.

84.26 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in
84.27 this chapter, the commissioner may authorize pilot projects to use chemical dependency
84.28 treatment funds to pay for nontreatment pilot services:

84.29 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
84.30 (a); and

84.31 (2) by vendors in addition to those authorized under section 254B.05 when not
84.32 providing chemical dependency treatment services.

84.33 (b) For purposes of this section, "nontreatment pilot services" include navigator
84.34 services, peer support, family engagement and support, housing support, rent subsidies,
84.35 supported employment, and independent living skills.

85.1 (c) State expenditures for chemical dependency services and nontreatment pilot
85.2 services provided by or through the pilot projects must not be greater than the chemical
85.3 dependency treatment fund expected share of forecasted expenditures in the absence of
85.4 the pilot projects. The commissioner may restructure the schedule of payments between
85.5 the state and participating counties under the local agency share and division of cost
85.6 provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the
85.7 operation of the pilot projects.

85.8 (d) To the extent that state fiscal year expenditures within a pilot project are less
85.9 than the expected share of forecasted expenditures in the absence of the pilot projects,
85.10 the commissioner shall deposit the unexpended funds in a separate account within the
85.11 consolidated chemical dependency treatment fund, and make these funds available for
85.12 expenditure by the pilot projects the following year. To the extent that treatment and
85.13 nontreatment pilot services expenditures within the pilot project exceed the amount
85.14 expected in the absence of the pilot projects, the pilot project county or counties are
85.15 responsible for the portion of nontreatment pilot services expenditures in excess of the
85.16 otherwise expected share of forecasted expenditures.

85.17 (e) The commissioner may waive administrative rule requirements that are
85.18 incompatible with the implementation of the pilot project, except that any chemical
85.19 dependency treatment funded under this section must continue to be provided by a
85.20 licensed treatment provider.

85.21 (f) The commissioner shall not approve or enter into any agreement related to pilot
85.22 projects authorized under this section that puts current or future federal funding at risk.

85.23 Subd. 6. **Duties of county board.** The county board, or other county entity that is
85.24 approved to administer a pilot project, shall:

85.25 (1) administer the pilot project in a manner consistent with the objectives described
85.26 in subdivision 2 and the planning process in subdivision 5;

85.27 (2) ensure that no one is denied chemical dependency treatment services for which
85.28 they would otherwise be eligible under section 254A.03, subdivision 3; and

85.29 (3) provide the commissioner with timely and pertinent information as negotiated
85.30 in agreements governing operation of the pilot projects.

85.31 Sec. 16. Minnesota Statutes 2009 Supplement, section 517.08, subdivision 1b, is
85.32 amended to read:

85.33 Subd. 1b. **Term of license; fee; premarital education.** (a) The local registrar
85.34 shall examine upon oath the parties applying for a license relative to the legality of the
85.35 contemplated marriage. If one party is unable to appear in person, the party appearing

86.1 may complete the absent applicant's information. The local registrar shall provide a copy
86.2 of the marriage application to the party who is unable to appear, who must verify the
86.3 accuracy of the party's information in a notarized statement. The marriage license must
86.4 not be released until the verification statement has been received by the local registrar. If
86.5 at the expiration of a five-day period, on being satisfied that there is no legal impediment
86.6 to it, including the restriction contained in section 259.13, the local registrar shall issue
86.7 the license, containing the full names of the parties before and after marriage, and county
86.8 and state of residence, with the county seal attached, and make a record of the date of
86.9 issuance. The license shall be valid for a period of six months. Except as provided in
86.10 paragraph (c), the local registrar shall collect from the applicant a fee of ~~$110~~ $115 for
86.11 administering the oath, issuing, recording, and filing all papers required, and preparing
86.12 and transmitting to the state registrar of vital statistics the reports of marriage required
86.13 by this section. If the license should not be used within the period of six months due to
86.14 illness or other extenuating circumstances, it may be surrendered to the local registrar for
86.15 cancellation, and in that case a new license shall issue upon request of the parties of the
86.16 original license without fee. A local registrar who knowingly issues or signs a marriage
86.17 license in any manner other than as provided in this section shall pay to the parties
86.18 aggrieved an amount not to exceed $1,000.

86.19 (b) In case of emergency or extraordinary circumstances, a judge of the district court
86.20 of the county in which the application is made may authorize the license to be issued at
86.21 any time before expiration of the five-day period required under paragraph (a). A waiver
86.22 of the five-day waiting period must be in the following form:

86.23 STATE OF MINNESOTA, COUNTY OF .... (insert county name)

86.24 APPLICATION FOR WAIVER OF MARRIAGE LICENSE WAITING PERIOD:

86.25 .... (legal names of the applicants)

86.26 Represent and state as follows:

86.27 That on .... (date of application) the applicants applied to the local
86.28 registrar of the above-named county for a license to marry.

86.29 That it is necessary that the license be issued before the expiration of five days
86.30 from the date of the application by reason of the following: (insert reason for requesting
86.31 waiver of waiting period)

86.32 ....

86.33 ....

86.34 ....

87.1 WHEREAS, the applicants request that the judge waive the required five-day
87.2 waiting period and the local registrar be authorized and directed to issue the marriage
87.3 license immediately.

87.4 Date: ....

87.5 ....

87.6 ....

87.7 (Signatures of applicants)

87.8 Acknowledged before me on this .... day of ....

87.9 ....

87.10 NOTARY PUBLIC

87.11 COURT ORDER AND AUTHORIZATION:

87.12 STATE OF MINNESOTA, COUNTY OF .... (insert county name)

87.13 After reviewing the above application, I am satisfied that an emergency or
87.14 extraordinary circumstance exists that justifies the issuance of the marriage license before
87.15 the expiration of five days from the date of the application. IT IS HEREBY ORDERED
87.16 that the local registrar is authorized and directed to issue the license forthwith.

87.17 ....

87.18 .... (judge of district court)

87.19 .... (date).

87.20 (c) The marriage license fee for parties who have completed at least 12 hours of
87.21 premarital education is $40. In order to qualify for the reduced license fee, the parties
87.22 must submit at the time of applying for the marriage license a signed, dated, and notarized
87.23 statement from the person who provided the premarital education on their letterhead
87.24 confirming that it was received. The premarital education must be provided by a licensed
87.25 or ordained minister or the minister's designee, a person authorized to solemnize marriages
87.26 under section 517.18, or a person authorized to practice marriage and family therapy under
87.27 section 148B.33. The education must include the use of a premarital inventory and the
87.28 teaching of communication and conflict management skills.

87.29 (d) The statement from the person who provided the premarital education under
87.30 paragraph (b) must be in the following form:

87.31 "I, ... (name of educator), confirm that .... (names of
87.32 both parties) received at least 12 hours of premarital education that included the use of a
87.33 premarital inventory and the teaching of communication and conflict management skills.
87.34 I am a licensed or ordained minister, a person authorized to solemnize marriages under
87.35 Minnesota Statutes, section 517.18, or a person licensed to practice marriage and family
87.36 therapy under Minnesota Statutes, section 148B.33."

88.1 The names of the parties in the educator's statement must be identical to the legal
88.2 names of the parties as they appear in the marriage license application. Notwithstanding
88.3 section 138.17, the educator's statement must be retained for seven years, after which
88.4 time it may be destroyed.

88.5 (e) If section 259.13 applies to the request for a marriage license, the local registrar
88.6 shall grant the marriage license without the requested name change. Alternatively, the local
88.7 registrar may delay the granting of the marriage license until the party with the conviction:

88.8 (1) certifies under oath that 30 days have passed since service of the notice for a
88.9 name change upon the prosecuting authority and, if applicable, the attorney general and no
88.10 objection has been filed under section 259.13; or

88.11 (2) provides a certified copy of the court order granting it. The parties seeking the
88.12 marriage license shall have the right to choose to have the license granted without the
88.13 name change or to delay its granting pending further action on the name change request.

88.14 Sec. 17. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws
88.15 2010, chapter 200, article 1, section 17, is amended to read:

88.16 Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected
88.17 pursuant to subdivision 1b, paragraph (a), $25 must be retained by the county. The
88.18 local registrar must pay ~~$85~~ $90 to the commissioner of management and budget to be
88.19 deposited as follows:

88.20 (1) $55 in the general fund;

88.21 (2) $3 in the state government special revenue fund to be appropriated to the
88.22 commissioner of public safety for parenting time centers under section 119A.37;

88.23 (3) $2 in the special revenue fund to be appropriated to the commissioner of health
88.24 for developing and implementing the MN ENABL program under section 145.9255; ~~and~~

88.25 (4) $25 in the special revenue fund is appropriated to the commissioner of
88.26 employment and economic development for the displaced homemaker program under
88.27 section 116L.96; and

88.28 (5) $5 in the special revenue fund, which is appropriated to the Board of Regents
88.29 of the University of Minnesota for the Minnesota couples on the brink project under
88.30 section 137.32.

88.31 (b) Of the $40 fee under subdivision 1b, paragraph (b), $25 must be retained by the
88.32 county. The local registrar must pay $15 to the commissioner of management and budget
88.33 to be deposited as follows:

88.34 (1) $5 as provided in paragraph (a), clauses (2) and (3); and

89.1 (2) $10 in the special revenue fund is appropriated to the commissioner of
89.2 employment and economic development for the displaced homemaker program under
89.3 section 116L.96.

89.4 Sec. 18. Laws 2009, chapter 79, article 3, section 18, is amended to read:
89.5 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
89.6 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
89.7 **ANOKA-METRO REGIONAL TREATMENT CENTER.**
89.8 ~~In consultation with community partners, the commissioner of human services~~
89.9 The Chemical and Mental Health Services Transformation Advisory Task Force shall
89.10 ~~develop~~ recommend an array of community-based services in the metro area to transform
89.11 the current services now provided to patients at the Anoka-Metro Regional Treatment
89.12 Center. The community-based services may be ~~provided in facilities with 16 or fewer~~
89.13 ~~beds, and must provide the appropriate level of care for the patients being admitted to~~
89.14 ~~the facilities~~ established in partnership with private and public hospital organizations,
89.15 community mental health centers and other mental health community services providers,
89.16 and community partnerships, and must be staffed by state employees. The planning
89.17 for this transition must be completed by October 1, ~~2009~~ 2010, with ~~an initial~~ a report
89.18 detailing the transition plan, services that will be provided, including incorporating peer
89.19 specialists where appropriate, the location of the services, and the number of patients
89.20 that will be served, to the committee chairs of health and human services by November
89.21 30, ~~2009, and a semiannual report on progress until the transition is completed. The~~
89.22 ~~commissioner of human services shall solicit interest from stakeholders and potential~~
89.23 ~~community partners~~ 2010. The individuals ~~working in~~ employed by the community-based
89.24 services ~~facilities~~ under this section are state employees supervised by the commissioner
89.25 of human services. No layoffs shall occur as a result of restructuring under this section.
89.26 Savings generated as a result of transitioning patients from the Anoka-Metro Regional
89.27 Treatment Center to community-based services may be used to fund supportive housing
89.28 staffed by state employees.

89.29 Sec. 19. **REPORT ON HUMAN SERVICES FISCAL NOTES.**
89.30 The commissioner of management and budget shall issue a report to the legislature
89.31 no later than November 15, 2010, making recommendations for improving the preparation
89.32 and delivery of fiscal notes under Minnesota Statutes, section 3.98, relating to human
89.33 services. The report shall consider: (1) the establishment of an independent fiscal
89.34 note office in the human services department and (2) transferring the responsibility for

90.1 preparing human services fiscal notes to the legislature. The report must include detailed
90.2 information regarding the financial costs, staff resources, training, access to information,
90.3 and data protection issues relative to the preparation of human services fiscal notes. The
90.4 report shall describe methods and procedures used by other states to insure independence
90.5 and accuracy of fiscal estimates on legislative proposals for changes in human services.

90.6 Sec. 20. **PRESCRIPTION DRUG WASTE REDUCTION.**

90.7 The Minnesota Board of Pharmacy, in cooperation with the commissioners of
90.8 human services, pollution control, health, veterans affairs, and corrections, shall study
90.9 prescription drug waste reduction techniques and technologies applicable to long-term
90.10 care facilities, veterans nursing homes, and correctional facilities. In conducting the
90.11 study, the commissioners shall consult with the Minnesota Pharmacists Association, the
90.12 University of Minnesota College of Pharmacy, University of Minnesota's Minnesota
90.13 Technical Assistance Project, consumers, long-term care providers, and other interested
90.14 parties. The board shall evaluate the extent to which new prescription drug waste reduction
90.15 techniques and technologies can reduce the amount of prescription drugs that enter the
90.16 waste stream and reduce state prescription drug costs. The techniques and technologies
90.17 studied must include, but are not limited to, daily, weekly, and automated dose dispensing.
90.18 The study must provide an estimate of the cost of adopting these and other techniques
90.19 and technologies, and an estimate of waste reduction and state prescription drug savings
90.20 that would result from adoption. The study must also evaluate methods of encouraging
90.21 the adoption of effective drug waste reduction techniques and technologies. The board
90.22 shall present recommendations on the adoption of new prescription drug waste reduction
90.23 techniques and technologies to the legislature by December 15, 2011.

90.24 Sec. 21. **VETERINARY PRACTICE AND CONTROLLED SUBSTANCE**
90.25 **ABUSE STUDY.**

90.26 The Board of Pharmacy, in consultation with the Prescription Electronic Reporting
90.27 Advisory Committee and the Board of Veterinary Medical Practice, shall study the issue
90.28 of the diversion of controlled substances from veterinary practice and report to the chairs
90.29 and ranking minority members of the senate health and human services policy and finance
90.30 division and the house of representatives health care and human services policy and
90.31 finance division by December 15, 2011, on recommendations to include veterinarians in
90.32 the prescription electronic reporting system in Minnesota Statutes, section 152.126.

90.33 Sec. 22. **REPEALER.**

91.1 Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09,
91.2 subdivisions 4, 5, and 7, are repealed.

91.3 Sec. 23. **EFFECTIVE DATE.**

91.4 Sections 8 to 14 and 22 are effective for claims paid on or after July 1, 2010.

91.5 **ARTICLE 5**

91.6 **DEPARTMENT OF HEALTH**

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

91.9 Subd. 7. **Consistent administrative expenses and investment income reporting.**
91.10 (a) Every health maintenance organization must directly allocate administrative expenses
91.11 to specific lines of business or products when such information is available. Remaining
91.12 expenses that cannot be directly allocated must be allocated based on other methods, as
91.13 recommended by the Advisory Group on Administrative Expenses. Health maintenance
91.14 organizations must submit this information, including administrative expenses for dental
91.15 services, using the reporting template provided by the commissioner of health.

91.16 (b) Every health maintenance organization must allocate investment income based
91.17 on cumulative net income over time by business line or product and must submit this
91.18 information, including investment income for dental services, using the reporting template
91.19 provided by the commissioner of health.

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

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

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

91.27 Subd. 2. **Membership.** The membership of the advisory group shall be comprised
91.28 of the following, who serve at the pleasure of their appointing authority:

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

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

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

92.1 (4) representatives of health maintenance organizations and county-based purchasers
92.2 appointed by the commissioner of health.

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

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

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

92.14 Sec. 3. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

92.15 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
92.16 community providers. The criteria for essential community provider designation shall be
92.17 the following:

92.18 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
92.19 with medical care for uninsured persons and high-risk and special needs populations,
92.20 underserved, and other special needs populations; and

92.21 (2) a commitment to serve low-income and underserved populations by meeting the
92.22 following requirements:

92.23 (i) has nonprofit status in accordance with chapter 317A;

92.24 (ii) has tax exempt status in accordance with the Internal Revenue Service Code,
92.25 section 501(c)(3);

92.26 (iii) charges for services on a sliding fee schedule based on current poverty income
92.27 guidelines; and

92.28 (iv) does not restrict access or services because of a client's financial limitation;

92.29 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
92.30 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
92.31 government, an Indian health service unit, or a community health board as defined in
92.32 chapter 145A;

92.33 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
92.34 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
92.35 conditions; ~~or~~

93.1 (5) a sole community hospital. For these rural hospitals, the essential community
93.2 provider designation applies to all health services provided, including both inpatient and
93.3 outpatient services. For purposes of this section, "sole community hospital" means a
93.4 rural hospital that:

93.5 (i) is eligible to be classified as a sole community hospital according to Code
93.6 of Federal Regulations, title 42, section 412.92, or is located in a community with a
93.7 population of less than 5,000 and located more than 25 miles from a like hospital currently
93.8 providing acute short-term services;

93.9 (ii) has experienced net operating income losses in two of the previous three
93.10 most recent consecutive hospital fiscal years for which audited financial information is
93.11 available; and

93.12 (iii) consists of 40 or fewer licensed beds; or

93.13 (6) a birth center licensed under section 144.615.

93.14 (b) Prior to designation, the commissioner shall publish the names of all applicants
93.15 in the State Register. The public shall have 30 days from the date of publication to submit
93.16 written comments to the commissioner on the application. No designation shall be made
93.17 by the commissioner until the 30-day period has expired.

93.18 (c) The commissioner may designate an eligible provider as an essential community
93.19 provider for all the services offered by that provider or for specific services designated by
93.20 the commissioner.

93.21 (d) For the purpose of this subdivision, supportive and stabilizing services include at
93.22 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

93.23 Sec. 4. Minnesota Statutes 2008, section 144.05, is amended by adding a subdivision
93.24 to read:

93.25 Subd. 5. **Firearms data.** Notwithstanding any law to the contrary, the commissioner
93.26 of health is prohibited from collecting data on individuals regarding lawful firearm
93.27 ownership in the state or data related to an individual's right to carry a weapon under
93.28 section 624.714.

93.29 Sec. 5. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

93.30 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under
93.31 subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth or
93.32 stillbirth record and for a certification that the vital record cannot be found. The local or
93.33 state registrar shall forward this amount to the commissioner of management and budget
93.34 for deposit into the account for the children's trust fund for the prevention of child abuse

94.1 established under section 256E.22. This surcharge shall not be charged under those
94.2 circumstances in which no fee for a certified birth or stillbirth record is permitted under
94.3 subdivision 1, paragraph (a). Upon certification by the commissioner of management and
94.4 budget that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.
94.5 (b) In addition to any fee prescribed under subdivision 1, there shall be a
94.6 nonrefundable surcharge of $10 for each certified birth record. The local or state registrar
94.7 shall forward this amount to the commissioner of management and budget for deposit in
94.8 the general fund. This surcharge shall not be charged under those circumstances in which
94.9 no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

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

94.11 Sec. 6. Minnesota Statutes 2008, section 144.293, subdivision 4, is amended to read:
94.12 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is
94.13 valid for one year or for a ~~lesser~~ period specified in the consent or for a different period
94.14 provided by law.

94.15 Sec. 7. **[144.615] BIRTH CENTERS.**
94.16 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
94.17 have the meanings given them.
94.18 (b) "Birth center" means a facility licensed for the primary purpose of performing
94.19 low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are
94.20 planned to occur away from the mother's usual residence following a low-risk pregnancy.
94.21 (c) "CABC" means the Commission for the Accreditation of Birth Centers.
94.22 (d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as
94.23 determined by documentation of adequate prenatal care and the anticipation of a normal
94.24 uncomplicated labor and birth, as defined by reasonable and generally accepted criteria
94.25 adopted by professional groups for maternal, fetal, and neonatal health care.
94.26 Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be
94.27 established, operated, or maintained in the state without first obtaining a license from the
94.28 commissioner of health according to this section.
94.29 (b) A license issued under this section is not transferable or assignable and is subject
94.30 to suspension or revocation at any time for failure to comply with this section.
94.31 (c) A birth center licensed under this section shall not assert, represent, offer,
94.32 provide, or imply that the center is or may render care or services other than the services it
94.33 is permitted to render within the scope of the license or the accreditation issued.
94.34 (d) The license must be conspicuously posted in an area where patients are admitted.

95.1 Subd. 3. **Temporary license.** For new birth centers planning to begin operations
95.2 after January 1, 2011, the commissioner may issue a temporary license to the birth center
95.3 that is valid for a period of six months from the date of issuance. The birth center must
95.4 submit to the commissioner an application and applicable fee for licensure as required
95.5 under subdivision 4. The application must include the information required in subdivision
95.6 4, clauses (1) to (3) and (5) to (7), and documentation that the birth center has submitted
95.7 an application for accreditation to the CABC. Upon receipt of accreditation from the
95.8 CABC, the birth center must submit to the commissioner the information required in
95.9 subdivision 4, clause (4), and the applicable fee under subdivision 8. The commissioner
95.10 shall issue a new license.

95.11 Subd. 4. **Application.** An application for a license to operate a birth center and the
95.12 applicable fee under subdivision 8 must be submitted to the commissioner on a form
95.13 provided by the commissioner and must contain:

95.14 (1) the name of the applicant;

95.15 (2) the site location of the birth center;

95.16 (3) the name of the person in charge of the center;

95.17 (4) documentation that the accreditation described under subdivision 6 has been
95.18 issued, including the effective date and the expiration date of the accreditation, and the
95.19 date of the last site visit by the CABC;

95.20 (5) the number of patients the birth center is capable of serving at a given time;

95.21 (6) the names and license numbers, if applicable, of the health care professionals
95.22 on staff at the birth center; and

95.23 (7) any other information the commissioner deems necessary.

95.24 Subd. 5. **Suspension, revocation, and refusal to renew.** The commissioner may
95.25 refuse to grant or renew, or may suspend or revoke, a license on any of the grounds
95.26 described under section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or
95.27 upon the loss of accreditation by the CABC. The applicant or licensee is entitled to notice
95.28 and a hearing as described under section 144.55, subdivision 7, and a new license may be
95.29 issued after proper inspection of the birth center has been conducted.

95.30 Subd. 6. **Standards for licensure.** (a) To be eligible for licensure under this
95.31 section, a birth center must be accredited by the CABC or must obtain accreditation
95.32 within six months of the date of the application for licensure. If the birth center loses its
95.33 accreditation, the birth center must immediately notify the commissioner.

95.34 (b) The center must have procedures in place specifying criteria by which risk status
95.35 will be established and applied to each woman at admission and during labor.

96.1 (c) Upon request, the birth center shall provide the commissioner of health with any
96.2 material submitted by the birth center to the CABC as part of the accreditation process,
96.3 including the accreditation application, the self-evaluation report, the accreditation
96.4 decision letter from the CABC, and any reports from the CABC following a site visit.

96.5 Subd. 7. **Limitations of services.** (a) The following limitations apply to the services
96.6 performed at a birth center:

96.7 (1) surgical procedures must be limited to those normally accomplished during an
96.8 uncomplicated birth, including episiotomy and repair;

96.9 (2) no abortions may be administered; and

96.10 (3) no general or regional anesthesia may be administered.

96.11 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth
96.12 center if the administration of the anesthetic is performed within the scope of practice of a
96.13 health care professional.

96.14 Subd. 8. **Fees.** (a) The biennial license fee for a birth center is $365.

96.15 (b) The temporary license fee is $365.

96.16 (c) Fees shall be collected and deposited according to section 144.122.

96.17 Subd. 9. **Renewal.** (a) Except as provided in paragraph (b), a license issued under
96.18 this section expires two years from the date of issue.

96.19 (b) A temporary license issued under subdivision 3 expires six months from the date
96.20 of issue, and may be renewed for one additional six-month period.

96.21 (c) An application for renewal shall be submitted at least 60 days prior to expiration
96.22 of the license on forms prescribed by the commissioner of health.

96.23 Subd. 10. **Records.** All health records maintained on each client by a birth center
96.24 are subject to sections 144.292 to 144.298.

96.25 Subd. 11. **Report.** (a) The commissioner of health, in consultation with the
96.26 commissioner of human services and representatives of the licensed birth centers,
96.27 the American College of Obstetricians and Gynecologists, the American Academy
96.28 of Pediatrics, the Minnesota Hospital Association, and the Minnesota Ambulance
96.29 Association, shall evaluate the quality of care and outcomes for services provided in
96.30 licensed birth centers, including, but not limited to, the utilization of services provided at a
96.31 birth center, the outcomes of care provided to both mothers and newborns, and the numbers
96.32 of transfers to other health care facilities that are required and the reasons for the transfers.
96.33 The commissioner shall work with the birth centers to establish a process to gather and
96.34 analyze the data within protocols that protect the confidentiality of patient identification.

96.35 (b) The commissioner of health shall report the findings of the evaluation to the
96.36 legislature by January 15, 2014.

97.1 Sec. 8. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:

97.2 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person
97.3 who is admitted to an acute care inpatient facility for a continuous period longer than
97.4 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental
97.5 health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20,
97.6 "patient" also means a person who receives health care services at an outpatient surgical
97.7 center or at a birth center licensed under section 144.615. "Patient" also means a minor
97.8 who is admitted to a residential program as defined in section 253C.01. For purposes of
97.9 subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving
97.10 mental health treatment on an outpatient basis or in a community support program or other
97.11 community-based program. "Resident" means a person who is admitted to a nonacute care
97.12 facility including extended care facilities, nursing homes, and boarding care homes for
97.13 care required because of prolonged mental or physical illness or disability, recovery from
97.14 injury or disease, or advancing age. For purposes of all subdivisions except subdivisions
97.15 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board
97.16 and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised
97.17 living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates
97.18 a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

97.19 Sec. 9. Minnesota Statutes 2008, section 144.9504, is amended by adding a subdivision
97.20 to read:

97.21 Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner
97.22 must revise clinical and case management guidelines to include recommendations
97.23 for protective health actions and follow-up services when a child's blood lead level
97.24 exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be
97.25 implemented to the extent possible using available resources.

97.26 (b) In revising the clinical and case management guidelines for blood lead levels
97.27 greater than five micrograms of lead per deciliter of blood under this subdivision,
97.28 the commissioner of health must consult with a statewide organization representing
97.29 physicians, the public health department of Minneapolis and other public health
97.30 departments, one representative of the residential construction industry, and a nonprofit
97.31 organization with expertise in lead abatement.

97.32 Sec. 10. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

97.33 Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility
97.34 which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a

98.1 facility or that part of a facility which is required to be licensed under any law of this state
98.2 which provides for the licensure of nursing homes.

98.3 Sec. 11. Minnesota Statutes 2008, section 144E.37, is amended to read:

98.4 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

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

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

98.11 Sec. 12. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
98.12 **REDUCTION; REPORTING REQUIREMENTS.**

98.13 (a) Minnesota health plans and county-based purchasing plans may complete an
98.14 inventory of existing data collection and reporting requirements for health plans and
98.15 county-based purchasing plans and submit to the commissioners of health and human
98.16 services a list of data, documentation, and reports that:

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

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

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

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

98.24 (b) The report to the commissioners may also identify the percentage of health
98.25 plan and county-based purchasing plan administrative time and expense attributed to
98.26 fulfilling reporting requirements and include recommendations regarding ways to reduce
98.27 duplicative reporting requirements.

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

99.1 Sec. 13. **VENDOR ACCREDITATION SIMPLIFICATION.**

99.2 The Minnesota Hospital Association must coordinate with the Minnesota
99.3 Credentialing Collaborative to make recommendations by January 1, 2012, on the
99.4 development of standard accreditation methods for vendor services provided within
99.5 hospitals and clinics. The recommendations must be consistent with requirements of
99.6 hospital credentialing organizations and applicable federal requirements.

99.7 Sec. 14. **APPLICATION PROCESS FOR HEALTH INFORMATION**
99.8 **EXCHANGE.**

99.9 To the extent that the commissioner of health applies for additional federal funding
99.10 to support the commissioner's responsibilities of developing and maintaining state level
99.11 health information exchange under section 3013 of the HITECH Act, the commissioner of
99.12 health shall ensure that applications are made through an open process that provides health
99.13 information exchange service providers equal opportunity to receive funding.

99.14 Sec. 15. **TRANSFER.**

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

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

99.20 Sec. 16. **REVISOR'S INSTRUCTION.**

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

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

99.25 **ARTICLE 6**

99.26 **PUBLIC HEALTH**

99.27 Section 1. Minnesota Statutes 2008, section 62J.692, subdivision 4, is amended to read:

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

100.1 (1) a public program volume factor, which is determined by the total volume of
100.2 public program revenue received by each training site as a percentage of all public
100.3 program revenue received by all training sites in the fund pool; and
100.4 (2) a supplemental public program volume factor, which is determined by providing
100.5 a supplemental payment of 20 percent of each training site's grant to training sites whose
100.6 public program revenue accounted for at least 0.98 percent of the total public program
100.7 revenue received by all eligible training sites. Grants to training sites whose public
100.8 program revenue accounted for less than 0.98 percent of the total public program revenue
100.9 received by all eligible training sites shall be reduced by an amount equal to the total
100.10 value of the supplemental payment.
100.11 Public program revenue for the distribution formula includes revenue from medical
100.12 assistance, prepaid medical assistance, general assistance medical care, and prepaid
100.13 general assistance medical care. Training sites that receive no public program revenue
100.14 are ineligible for funds available under this subdivision. For purposes of determining
100.15 training-site level grants to be distributed under paragraph (a), total statewide average
100.16 costs per trainee for medical residents is based on audited clinical training costs per trainee
100.17 in primary care clinical medical education programs for medical residents. Total statewide
100.18 average costs per trainee for dental residents is based on audited clinical training costs
100.19 per trainee in clinical medical education programs for dental students. Total statewide
100.20 average costs per trainee for pharmacy residents is based on audited clinical training costs
100.21 per trainee in clinical medical education programs for pharmacy students.
100.22 (b) $5,350,000 of the available medical education funds shall be distributed as
100.23 follows:
100.24 (1) $1,475,000 to the University of Minnesota Medical Center-Fairview;
100.25 (2) $2,075,000 to the University of Minnesota School of Dentistry; and
100.26 (3) $1,800,000 to the Academic Health Center. $150,000 of the funds distributed to
100.27 the Academic Health Center under this paragraph shall be used for a program to assist
100.28 internationally trained physicians who are legal residents and who commit to serving
100.29 underserved Minnesota communities in a health professional shortage area to successfully
100.30 compete for family medicine residency programs at the University of Minnesota.
100.31 (c) Funds distributed shall not be used to displace current funding appropriations
100.32 from federal or state sources.
100.33 (d) Funds shall be distributed to the sponsoring institutions indicating the amount
100.34 to be distributed to each of the sponsor's clinical medical education programs based on
100.35 the criteria in this subdivision and in accordance with the commissioner's approval letter.
100.36 Each clinical medical education program must distribute funds allocated under paragraph

101.1 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
101.2 institutions, which are accredited through an organization recognized by the Department
101.3 of Education or the Centers for Medicare and Medicaid Services, may contract directly
101.4 with training sites to provide clinical training. To ensure the quality of clinical training,
101.5 those accredited sponsoring institutions must:

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

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

101.11 (e) Any funds not distributed in accordance with the commissioner's approval letter
101.12 must be returned to the medical education and research fund within 30 days of receiving
101.13 notice from the commissioner. The commissioner shall distribute returned funds to the
101.14 appropriate training sites in accordance with the commissioner's approval letter.

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

101.18 Sec. 2. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is
101.19 amended to read:

101.20 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required
101.21 for food and beverage service establishments, youth camps, hotels, motels, lodging
101.22 establishments, public pools, and resorts licensed under this chapter. Food and beverage
101.23 service establishments must pay the highest applicable fee under paragraph (d), clause
101.24 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
101.25 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
101.26 licensed under this chapter for the same calendar year is one-half of the appropriate annual
101.27 license fee, plus any penalty that may be required. The license fee for operators opening
101.28 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
101.29 that may be required.

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

101.33 (c) A special event food stand shall pay a flat fee of $50 annually. "Special event
101.34 food stand" means a fee category where food is prepared or served in conjunction with

102.1 celebrations, county fairs, or special events from a special event food stand as defined
102.2 in section 157.15.

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

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

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

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

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

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

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

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

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

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

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

102.23 (iv) is a boarding establishment; or

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

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

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

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

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

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

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

103.1 (i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a
103.2 medium establishment, (B) seats more than 175 people, and (C) offers the full menu
103.3 selection an average of five or more days a week during the weeks of operation; or
103.4 (ii) a fee category that (A) meets the criteria in clause (3), item (iii), for a medium
103.5 establishment, and (B) prepares and serves 500 or more meals per day.
103.6 (5) Other food and beverage service, including food carts, mobile food units,
103.7 seasonal temporary food stands, and seasonal permanent food stands, $60.
103.8 (6) Beer or wine table service, $60. "Beer or wine table service" means a fee
103.9 category where the only alcoholic beverage service is beer or wine, served to customers
103.10 seated at tables.
103.11 (7) Alcoholic beverage service, other than beer or wine table service, $165.
103.12 "Alcohol beverage service, other than beer or wine table service" means a fee
103.13 category where alcoholic mixed drinks are served or where beer or wine are served from
103.14 a bar.
103.15 (8) Lodging per sleeping accommodation unit, $10, including hotels, motels,
103.16 lodging establishments, and resorts, up to a maximum of $1,000. "Lodging per sleeping
103.17 accommodation unit" means a fee category including the number of guest rooms, cottages,
103.18 or other rental units of a hotel, motel, lodging establishment, or resort; or the number of
103.19 beds in a dormitory.
103.20 (9) First public pool, $325; each additional public pool, $175. "Public pool" means a
103.21 fee category that has the meaning given in section 144.1222, subdivision 4.
103.22 (10) First spa, $175; each additional spa, $100. "Spa pool" means a fee category that
103.23 has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.
103.24 (11) Private sewer or water, $60. "Individual private water" means a fee category
103.25 with a water supply other than a community public water supply as defined in Minnesota
103.26 Rules, chapter 4720. "Individual private sewer" means a fee category with an individual
103.27 sewage treatment system which uses subsurface treatment and disposal.
103.28 (12) Additional food service, $150. "Additional food service" means a location at
103.29 a food service establishment, other than the primary food preparation and service area,
103.30 used to prepare or serve food to the public.
103.31 (13) Additional inspection fee, $360. "Additional inspection fee" means a fee to
103.32 conduct the second inspection each year for elementary and secondary education facility
103.33 school lunch programs when required by the Richard B. Russell National School Lunch
103.34 Act.

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

	Service Area	Type	Fee
104.4	**Service Area**	**Type**	**Fee**
104.5	Food	limited food menu	$275
104.6		small establishment	$400
104.7		medium establishment	$450
104.8		large food establishment	$500
104.9		additional food service	$150
104.10	Transient food service	food cart	$250
104.11		seasonal permanent food stand	$250
104.12		seasonal temporary food stand	$250
104.13		mobile food unit	$350
104.14	Alcohol	beer or wine table service	$150
104.15		alcohol service from bar	$250
104.16	Lodging	less than 25 rooms	$375
104.17		25 to less than 100 rooms	$400
104.18		100 rooms or more	$500
104.19		less than five cabins	$350
104.20		five to less than ten cabins	$400
104.21		ten cabins or more	$450

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

	Service Area	Type	Fee
104.26	**Service Area**	**Type**	**Fee**
104.27	Food	limited food menu	$250
104.28		small establishment	$300
104.29		medium establishment	$350
104.30		large food establishment	$400
104.31		additional food service	$150
104.32	Transient food service	food cart	$250
104.33		seasonal permanent food stand	$250
104.34		seasonal temporary food stand	$250
104.35		mobile food unit	$250
104.36	Alcohol	beer or wine table service	$150
104.37		alcohol service from bar	$250
104.38	Lodging	less than 25 rooms	$250
104.39		25 to less than 100 rooms	$300
104.40		100 rooms or more	$450
104.41		less than five cabins	$250

105.1	five to less than ten cabins	$350
105.2	ten cabins or more	$400

105.3 (g) Special event food stands are not required to submit construction or remodeling
105.4 plans for review.
105.5 (h) Youth camps shall pay an annual single fee for food and lodging as follows:
105.6 (1) camps with up to 99 campers, $325;
105.7 (2) camps with 100 to 199 campers, $550; and
105.8 (3) camps with 200 or more campers, $750.
105.9 (i) A youth camp which pays fees under paragraph (d) is not required to pay fees
105.10 under paragraph (h).

105.11 Sec. 3. Minnesota Statutes 2009 Supplement, section 327.15, subdivision 3, is
105.12 amended to read:
105.13 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)
105.14 The following fees are required for manufactured home parks and recreational camping
105.15 areas licensed under this chapter. Recreational camping areas and manufactured home
105.16 parks shall pay the highest applicable base fee under paragraph ~~(c)~~ (b). The license fee
105.17 for new operators of a manufactured home park or recreational camping area previously
105.18 licensed under this chapter for the same calendar year is one-half of the appropriate annual
105.19 license fee, plus any penalty that may be required. The license fee for operators opening
105.20 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
105.21 that may be required.
105.22 (b) All manufactured home parks and recreational camping areas shall pay the
105.23 following annual base fee:
105.24 (1) a manufactured home park, $150; and
105.25 (2) a recreational camping area with:
105.26 (i) 24 or less sites, $50;
105.27 (ii) 25 to 99 sites, $212; and
105.28 (iii) 100 or more sites, $300.

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

106.1 (c) In addition to the fee in paragraph (b), each manufactured home park or
106.2 recreational camping area shall pay an additional annual fee for each fee category
106.3 specified in this paragraph:
106.4 (1) Manufactured home parks and recreational camping areas with public swimming
106.5 pools and spas shall pay the appropriate fees specified in section 157.16.
106.6 (2) Individual private sewer or water, $60. "Individual private water" means a fee
106.7 category with a water supply other than a community public water supply as defined in
106.8 Minnesota Rules, chapter 4720. "Individual private sewer" means a fee category with a
106.9 subsurface sewage treatment system which uses subsurface treatment and disposal.
106.10 (d) The following fees must accompany a plan review application for initial
106.11 construction of a manufactured home park or recreational camping area:
106.12 (1) for initial construction of less than 25 sites, $375;
106.13 (2) for initial construction of 25 to 99 sites, $400; and
106.14 (3) for initial construction of 100 or more sites, $500.
106.15 (e) The following fees must accompany a plan review application when an existing
106.16 manufactured home park or recreational camping area is expanded:
106.17 (1) for expansion of less than 25 sites, $250;
106.18 (2) for expansion of 25 to 99 sites, $300; and
106.19 (3) for expansion of 100 or more sites, $450.

106.20 Sec. 4. **FOOD SUPPORT FOR CHILDREN WITH SEVERE ALLERGIES.**
106.21 The commissioner of human services must seek a federal waiver from the federal
106.22 Department of Agriculture, Food and Nutrition Service, for the supplemental nutrition
106.23 assistance program, to increase the income eligibility requirements to 375 percent of the
106.24 federal poverty guidelines, in order to cover nutritional food products required to treat
106.25 or manage severe food allergies, including allergies to wheat and gluten, for infants and
106.26 children who have been diagnosed with life-threatening severe food allergies.

106.27 **ARTICLE 7**

106.28 **HEALTH CARE REFORM**

106.29 Section 1. **[62E.20] RELATIONSHIP TO TEMPORARY FEDERAL HIGH-RISK**
106.30 **POOL.**
106.31 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
106.32 this subdivision have the meanings given.
106.33 (b) "Association" means the Minnesota Comprehensive Health Association.

107.1 (c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient
107.2 Protection and Affordable Care Act, Public Law 111-148, including any federal
107.3 regulations adopted under it.
107.4 (d) "Federal qualified high-risk pool" means an arrangement established by the
107.5 federal secretary of health and human services that meets the requirements of the federal
107.6 law.
107.7 Subd. 2. **Timing of this section.** This section applies beginning the date the
107.8 temporary federal qualified high-risk health pool created under the federal law begins
107.9 to provide coverage in this state.
107.10 Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive
107.11 health association on its member insurers must comply with the maintenance of effort
107.12 requirement contained in paragraph (b), clause (3), of the federal law, to the extent that the
107.13 requirement applies to assessments made by the association.
107.14 Subd. 4. **Coordination with state health care programs.** The commissioner
107.15 of commerce and the Minnesota Comprehensive Health Association shall ensure that
107.16 applicants for coverage through the federal qualified high-risk pool, or through the
107.17 Minnesota Comprehensive Health Association, are referred to the medical assistance or
107.18 MinnesotaCare programs if they are determined to be potentially eligible for coverage
107.19 through those programs. The commissioner of human services shall ensure that applicants
107.20 for coverage under medical assistance or MinnesotaCare who are determined not to be
107.21 eligible for those programs are provided information about coverage through the federal
107.22 qualified high-risk pool and the Minnesota Comprehensive Health Association.
107.23 Subd. 5. **Federal funding.** Minnesota shall coordinate its efforts with the United
107.24 States Department of Health and Human Services (HHS) to obtain the federal funds to
107.25 implement in Minnesota the federal qualified high-risk pool.

107.26 Sec. 2. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**
107.27 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
107.28 medical assistance coverage of health home services for eligible individuals with chronic
107.29 conditions who select a designated provider, a team of health care professionals, or a
107.30 health team as the individual's health home.
107.31 (b) The commissioner shall implement this section in compliance with the
107.32 requirements of the state option to provide health homes for enrollees with chronic
107.33 conditions, as provided under the Patient Protection and Affordable Care Act, Public
107.34 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
107.35 provided in that act.

108.1 Subd. 2. **Eligible individual.** An individual is eligible for health home services
108.2 under this section if the individual is eligible for medical assistance under this chapter
108.3 and has at least:
108.4 (1) two chronic conditions;
108.5 (2) one chronic condition and is at risk of having a second chronic condition; or
108.6 (3) one serious and persistent mental health condition.
108.7 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
108.8 timely high-quality services that are provided by a health home. These services include:
108.9 (1) comprehensive care management;
108.10 (2) care coordination and health promotion;
108.11 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
108.12 to other settings;
108.13 (4) patient and family support, including authorized representatives;
108.14 (5) referral to community and social support services, if relevant; and
108.15 (6) use of health information technology to link services, as feasible and appropriate.
108.16 (b) The commissioner shall maximize the number and type of services
108.17 included in this subdivision to the extent permissible under federal law, including
108.18 physician, outpatient, mental health treatment, and rehabilitation services necessary for
108.19 comprehensive transitional care following hospitalization.
108.20 Subd. 4. **Health teams.** The commissioner shall establish health teams to support
108.21 the patient-centered health home and provide the services described in subdivision 3 to
108.22 individuals eligible under subdivision 2. The commissioner shall apply for grants or
108.23 contracts as provided under section 3502 of the Patient Protection and Affordable Care
108.24 Act to establish health teams and provide capitated payments to primary care providers.
108.25 For purposes of this section, "health teams" means community-based, interdisciplinary,
108.26 inter-professional teams of health care providers that support primary care practices.
108.27 These providers may include medical specialists, nurses, advanced practice registered
108.28 nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers,
108.29 doctors of chiropractic, licensed complementary and alternative medicine practitioners,
108.30 and physician assistants.
108.31 Subd. 5. **Payments.** The commissioner shall make payments to each health home
108.32 and each health team for the provision of health home services to each eligible individual
108.33 with chronic conditions that selects the health home as a provider.
108.34 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
108.35 the requirements and payment methods for health homes and health teams developed
108.36 under this section are consistent with the requirements and payment methods for health

109.1 care homes established under sections 256B.0751 and 256B.0753. The commissioner may
109.2 modify requirements and payment methods under sections 256B.0751 and 256B.0753 in
109.3 order to be consistent with federal health home requirements and payment methods.

109.4 Subd. 7. **State plan amendment.** The commissioner shall submit a state plan
109.5 amendment to implement this section to the federal Centers for Medicare and Medicaid
109.6 Services by January 1, 2011.

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

109.9 Sec. 3. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS**
109.10 **AND GRANTS.**

109.11 (a) The commissioner of human services shall seek to participate in the following
109.12 demonstration projects, or apply for the following grants, as described in the federal
109.13 Patient Protection and Affordable Care Act, Public Law 111-148:

109.14 (1) the demonstration project to evaluate integrated care around a hospitalization,
109.15 Public Law 111-148, section 2704;

109.16 (2) the Medicaid global payment system demonstration project, Public Law 111-148,
109.17 section 2705, including a demonstration project for the specific population of childless
109.18 adults under 75 percent of federal poverty guidelines that were to be served by the general
109.19 assistance medical care program;

109.20 (3) the pediatric accountable care organization demonstration project, Public Law
109.21 111-148, section 2706;

109.22 (4) the Medicaid emergency psychiatric demonstration project, Public Law 111-148,
109.23 section 2707; and

109.24 (5) grants to provide incentives for prevention of chronic diseases in Medicaid,
109.25 Public Law 111-148, section 4108.

109.26 (b) The commissioner of human services shall report to the chairs and ranking
109.27 minority members of the house of representatives and senate committees or divisions with
109.28 jurisdiction over health care policy and finance on the status of the demonstration project
109.29 and grant applications. If the state is accepted as a demonstration project participant, or is
109.30 awarded a grant, the commissioner shall notify the chairs and ranking minority members
109.31 of those committees or divisions of any legislative changes necessary to implement the
109.32 demonstration projects or grants.

109.33 (c) The commissioner of health shall apply for federal grants available under the
109.34 federal Patient Protection and Affordable Care Act, Public Law 111-148, for purposes
109.35 of funding wellness and prevention, and health improvement programs. To the extent

110.1 possible under federal law, the commissioner of health must utilize the state health
110.2 improvement program, established under Minnesota Statutes, section 145.986, to
110.3 implement grant programs related to wellness and prevention, and health improvement,
110.4 for which the state receives funding under the federal Patient Protection and Affordable
110.5 Care Act, Public Law 111-148.

110.6 Sec. 4. **HEALTH CARE REFORM TASK FORCE.**

110.7 Subdivision 1. **Task force.** (a) The governor shall convene a Health Care
110.8 Reform Task Force to advise and assist the governor and the legislature regarding state
110.9 implementation of federal health care reform legislation. For purposes of this section,
110.10 "federal health care reform legislation" means the Patient Protection and Affordable Care
110.11 Act, Public Law 111-148, and the health care reform provisions in the Health Care and
110.12 Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:
110.13 (1) two legislators from the house of representatives appointed by the speaker and
110.14 two legislators from the senate appointed by the Subcommittee on Committees of the
110.15 Committee on Rules and Administration;
110.16 (2) two representatives appointed by the governor to represent the governor and
110.17 state agencies;
110.18 (3) three persons appointed by the governor who have demonstrated leadership in
110.19 health care organizations, health plan companies, or health care trade or professional
110.20 associations;
110.21 (4) three persons appointed by the governor who have demonstrated leadership in
110.22 employer and group purchaser activities related to health system improvement of whom
110.23 two must be from a labor organization and one from the business community; and
110.24 (5) five persons appointed by the governor who have demonstrated expertise in the
110.25 areas of health care financing, access, and quality.
110.26 The governor is exempt from the requirements of the open appointments process
110.27 for purposes of appointing task force members. Members shall be appointed for one-year
110.28 terms and may be reappointed.
110.29 (b) The Department of Health, Department of Human Services, and Department of
110.30 Commerce shall provide staff support to the task force. The task force may accept outside
110.31 resources to help support its efforts.
110.32 (c) Task force members must be appointed by July 1, 2010. The task force must hold
110.33 its first meeting by July 15, 2010.
110.34 Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and
110.35 present to the legislature and the governor a preliminary report and recommendations on

111.1 state implementation of federal health care reform legislation. The report must include
111.2 recommendations for state law and program changes necessary to comply with the federal
111.3 health care reform legislation, and also recommendations for implementing provisions of
111.4 the federal legislation that are optional for states. In developing recommendations, the task
111.5 force shall consider the extent to which an approach maximizes federal funding to the state.
111.6 (b) The task force, in consultation with the governor and the legislature, shall also
111.7 establish timelines and criteria for future reports on state implementation of the federal
111.8 health care reform legislation.

111.9 Sec. 5. **AMERICAN HEALTH BENEFIT EXCHANGE; PLANNING**
111.10 **PROVISIONS.**

111.11 Subdivision 1. **Federal planning grants.** The commissioners of commerce, health,
111.12 and human services shall jointly or separately apply to the federal secretary of health and
111.13 human services for one or more planning grants, including renewal grants, authorized
111.14 under section 1311 of the Patient Protection and Affordable Care Act, Public Law
111.15 111-148, including any future amendments of that provision, relating to state creation
111.16 of American Health Benefit Exchanges.

111.17 Subd. 2. **Consideration of early creation and operation of exchange.** (a) The
111.18 commissioners referenced in subdivision 1 shall analyze the advantages and disadvantages
111.19 to the state of planning to have a state health insurance exchange, similar to an American
111.20 Health Benefit Exchange referenced in subdivision 1, begin prior to the federal deadline
111.21 of January 1, 2014.

111.22 (b) The commissioners shall provide a written report to the legislature on the results
111.23 of the analysis required under paragraph (a) no later than December 15, 2010. The written
111.24 report must comply with Minnesota Statutes, sections 3.195 and 3.197.

111.25 **ARTICLE 8**

111.26 **HUMAN SERVICES FORECAST ADJUSTMENTS**

111.27 Section 1. **SUMMARY OF APPROPRIATIONS.**

111.28 The amounts shown in this section summarize direct appropriations, by fund, made
111.29 in this article.

111.30			**2010**		**2011**		**Total**
111.31	General	$	(109,876,000)	$	(28,344,000)	$	(138,220,000)
111.32	Health Care Access	$	99,654,000	$	276,500,000	$	376,154,000
111.33	Federal TANF	$	(9,830,000)	$	15,133,000	$	5,303,000
111.34	**Total**	**$**	**(20,052,000)**	**$**	**263,289,000**	**$**	**243,237,000**

112.1 Sec. 2. **DEPARTMENT OF HUMAN SERVICES APPROPRIATION.**

112.2 The sums shown in the columns marked "Appropriations" are added to or, if shown
112.3 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,
112.4 as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes
112.5 specified in this article. The appropriations are from the general fund, or another named
112.6 fund, and are available for the fiscal years indicated for each purpose. The figures "2010"
112.7 and "2011" used in this article mean that the addition to or subtraction from appropriations
112.8 listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011,
112.9 respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011.
112.10 "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions
112.11 for the fiscal year ending June 30, 2010, are effective the day following final enactment
112.12 unless a different effective date is explicit.

		APPROPRIATIONS Available for the Year Ending June 30	
112.13–112.16		**2010**	**2011**
112.17–112.18	Sec. 3. **DEPARTMENT OF HUMAN SERVICES**		
112.19	Subdivision 1. **Total Appropriation**	**$ (20,052,000)**	**$ 263,289,000**

	Appropriations by Fund		
112.21		2010	2011
112.22	General	(109,876,000)	(28,344,000)
112.23	Health Care Access	99,654,000	276,500,000
112.24	Federal TANF	(9,830,000)	15,133,000

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

112.28 Subd. 2. **Revenue and Pass-through**

	Appropriations by Fund		
112.30	Federal TANF	390,000	(251,000)

112.31 Subd. 3. **Children and Economic Assistance**
112.32 **Grants**

	Appropriations by Fund		
112.34	General	4,489,000	(4,140,000)
112.35	Federal TANF	(10,220,000)	15,384,000

113.1 The amounts that may be spent from this
113.2 appropriation are as follows:

113.3 (a) **MFIP Grants**

113.4 General	7,916,000	(14,481,000)		
113.5 Federal TANF	(10,220,000)	15,384,000		
113.6 (b) **MFIP Child Care Assistance Grants**			(7,832,000)	2,579,000
113.7 (c) **General Assistance Grants**			875,000	1,339,000
113.8 (d) **Minnesota Supplemental Aid Grants**			2,454,000	3,843,000
113.9 (e) **Group Residential Housing Grants**			1,076,000	2,580,000

113.10 Subd. 4. **Basic Health Care Grants**

113.11	Appropriations by Fund			
113.12 General	(62,770,000)	29,192,000		
113.13 Health Care Access	99,654,000	276,500,000		

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

113.16 (a) **MinnesotaCare Grants**

113.17 Health Care Access	99,654,000	276,500,000		
113.18 (b) **Medical Assistance Basic Health Care -** 113.19 **Families and Children**			1,165,000	24,146,000
113.20 (c) **Medical Assistance Basic Health Care -** 113.21 **Elderly and Disabled**			(63,935,000)	5,046,000
113.22 Subd. 5. **Continuing Care Grants**			(51,595,000)	(53,396,000)

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

113.25 (a) **Medical Assistance Long-Term Care** 113.26 **Facilities**	(3,774,000)	(8,275,000)
113.27 (b) **Medical Assistance Long-Term Care** 113.28 **Waivers**	(27,710,000)	(22,452,000)
113.29 (c) **Chemical Dependency Entitlement Grants**	(20,111,000)	(22,669,000)

113.30 Sec. 4. **EFFECTIVE DATE.**

113.31 This article is effective the day following final enactment.

114.1 ARTICLE 9

114.2 HUMAN SERVICES CONTINGENT APPROPRIATIONS

114.3 Section 1. **SUMMARY OF HUMAN SERVICES APPROPRIATIONS.**

114.4 The amounts shown in this section summarize direct appropriations, by fund, made
114.5 in this bill.

		2010		2011		Total
114.6						
114.7 General	$	-0-	$	13,383,000	$	13,383,000
114.8 Health Care Access		-0-		686,000		686,000
114.9 **Total**	**$**	**-0-**	**$**	**14,069,000**	**$**	**14,069,000**

114.10 Sec. 2. **HEALTH AND HUMAN SERVICES CONTINGENT APPROPRIATIONS.**

114.11 (a) The sums shown in the columns marked "Appropriations" are added to the
114.12 appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter
114.13 173, article 2, to the agency and for the purposes specified in this bill. The appropriations
114.14 are from the general fund, or another named fund, and are available for the fiscal years
114.15 indicated for each purpose. The figures "2010" and "2011" used in this bill mean that the
114.16 addition to or subtraction from the appropriation listed under them is available for the
114.17 fiscal year ending June 30, 2010, or June 30, 2011, respectively.

114.18 (b) Upon enactment of the extension of the enhanced federal medical assistance
114.19 percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the
114.20 president's budget for federal fiscal year 2011 or contained in House Resolution 2847,
114.21 the federal "Jobs for Main Street Act, 2010," or contained in House Resolution 4213,
114.22 "American Workers, State, and Business Relief Act of 2010," or subsequent federal
114.23 legislation, the appropriations identified in section 3 shall be made for fiscal year 2011.

114.24 **APPROPRIATIONS**
114.25 **Available for the Year**
114.26 **Ending June 30**
114.27 **2010** **2011**

114.28 Sec. 3. **COMMISSIONER OF HUMAN**
114.29 **SERVICES**

114.30 Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$**	**14,069,000**

114.31 Appropriations by Fund

	2010	2011
114.32		
114.33 General	-0-	13,383,000
114.34 Health Care Access	-0-	686,000

115.1 The appropriations for each purpose are
115.2 shown in the following subdivisions.

115.3 Subd. 2. **Basic Health Care Grants**

115.4 (a) **MinnesotaCare Grants**	-0-	686,000

115.5 This appropriation is from the health care
115.6 access fund.

115.7 (b) **Medical Assistance Basic Health Care** 115.8 **Grants - Families and Children**	-0-	6,297,000
115.9 (c) **Medical Assistance Basic Health Care** 115.10 **Grants - Elderly and Disabled**	-0-	3,697,000

115.11 Subd. 3. **Continuing Care Grants**

115.12 (a) **Medical Assistance - Long-Term Care** 115.13 **Facilities Grants**	-0-	2,486,000
115.14 (b) **Medical Assistance Grants - Long-Term** 115.15 **Care Waivers and Home Care Grants**	-0-	547,000
115.16 (c) **Chemical Dependency Entitlement Grants**	-0-	356,000

115.17 Sec. 4. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to
115.18 read:

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

115.24 **EFFECTIVE DATE.** This section is effective retroactive from March 23, 2010.

115.25 Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 1a,
115.26 is amended to read:

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

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

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

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

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

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

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

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

116.9 (7) determination of home and community-based waiver service eligibility including
116.10 level of care determination for individuals who need an institutional level of care as
116.11 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including
116.12 state plan home care services identified in section 256B.0625, subdivisions 6, 7, and
116.13 19, paragraphs (a) and (c), based on assessment and support plan development with
116.14 appropriate referrals;

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

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

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

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

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

116.27 Sec. 6. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

116.28 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall
116.29 be responsible for a monthly transfer payment of $1,500,000, due before noon on the
116.30 15th of each month and the University of Minnesota shall be responsible for a monthly
116.31 transfer payment of $500,000 due before noon on the 15th of each month, beginning July
116.32 15, 1995. These sums shall be part of the designated governmental unit's portion of the
116.33 nonfederal share of medical assistance costs.

116.34 (b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall
116.35 be $2,066,000 each month.

117.1 (c) Beginning July 1, 2001, the commissioner shall increase annual capitation
117.2 payments to the metropolitan health plan under section 256B.69 for the prepaid medical
117.3 assistance program by approximately ~~$3,400,000, plus any available federal matching~~
117.4 ~~funds,~~ $6,800,000 to recognize higher than average medical education costs.
117.5 (d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a)
117.6 and (b) shall be reduced to $566,000, and the University of Minnesota's payment under
117.7 paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010,
117.8 Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective
117.9 January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be
117.10 $566,000.
117.11 (e) Notwithstanding paragraph (d), upon federal enactment of an extension to June
117.12 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally
117.13 provided under Public Law 111-5, for the six-month period from January 1, 2011, to June
117.14 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

117.15 Sec. 7. Minnesota Statutes 2008, section 256L.15, subdivision 1, is amended to read:
117.16 Subdivision 1. **Premium determination.** (a) Families with children and individuals
117.17 shall pay a premium determined according to subdivision 2.
117.18 (b) Pregnant women and children under age two are exempt from the provisions
117.19 of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment
117.20 for failure to pay premiums. For pregnant women, this exemption continues until the
117.21 first day of the month following the 60th day postpartum. Women who remain enrolled
117.22 during pregnancy or the postpartum period, despite nonpayment of premiums, shall be
117.23 disenrolled on the first of the month following the 60th day postpartum for the penalty
117.24 period that otherwise applies under section 256L.06, unless they begin paying premiums.
117.25 (c) Members of the military and their families who meet the eligibility criteria
117.26 for MinnesotaCare upon eligibility approval made within 24 months following the end
117.27 of the member's tour of active duty shall have their premiums paid by the commissioner.
117.28 The effective date of coverage for an individual or family who meets the criteria of this
117.29 paragraph shall be the first day of the month following the month in which eligibility is
117.30 approved. This exemption applies for 12 months. This paragraph expires June 30, 2010.
117.31 If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this
117.32 provision will expire on the date when it is no longer subject to section 5001 of Public Law
117.33 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

118.1 Sec. 8. Laws 2005, First Special Session chapter 4, article 8, section 66, as amended by
118.2 Laws 2009, chapter 173, article 3, section 24, the effective date, is amended to read:

118.3 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2009, ~~and~~ upon federal
118.4 approval and on the date when it is no longer subject to the maintenance of effort
118.5 requirements of section 5001 of Public Law 111-5. The commissioner of human services
118.6 shall notify the revisor of statutes of that date. Paragraph (e) is effective September 1,
118.7 2006.

118.8 Sec. 9. Laws 2009, chapter 79, article 5, section 17, the effective date, is amended to
118.9 read:

118.10 **EFFECTIVE DATE.** This section is effective January 1, 2011, or upon federal
118.11 approval~~, whichever is later~~ and on the date when it is no longer subject to the maintenance
118.12 of effort requirements of section 5001 of Public Law 111-5. The commissioner of human
118.13 services shall notify the revisor of statutes of that date.

118.14 Sec. 10. Laws 2009, chapter 79, article 5, section 18, the effective date, is amended to
118.15 read:

118.16 **EFFECTIVE DATE.** This section is effective ~~January 1, 2011~~ upon federal
118.17 approval and on the date when it is no longer subject to the maintenance of effort
118.18 requirements of section 5001 of Public Law 111-5. The commissioner of human services
118.19 shall notify the revisor of statutes when federal approval is obtained.

118.20 Sec. 11. Laws 2009, chapter 79, article 5, section 22, the effective date, is amended to
118.21 read:

118.22 **EFFECTIVE DATE.** This section is effective for periods of ineligibility established
118.23 on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.
118.24 If it is in violation of that section, then it shall be effective on the date when it is no longer
118.25 subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The
118.26 commissioner of human services shall notify the revisor of statutes of that date.

118.27 Sec. 12. Laws 2009, chapter 79, article 8, section 4, the effective date, is amended to
118.28 read:

118.29 **EFFECTIVE DATE.** The section is effective ~~January~~ July 1, 2011.

119.1 Sec. 13. Laws 2009, chapter 173, article 1, section 17, the effective date, is amended to
119.2 read:

119.3 **EFFECTIVE DATE.** This section is effective for pooled trust accounts established
119.4 on or after January 1, 2011, unless it is in violation of section 5001 of Public Law 111-5.
119.5 If it is in violation of that section, then it shall be effective on the date when it is no longer
119.6 subject to maintenance of effort requirements of section 5001 of Public Law 111-5. The
119.7 commissioner of human services shall notify the revisor of statutes of that date.

119.8 ARTICLE 10

119.9 HEALTH AND HUMAN SERVICES APPROPRIATIONS

119.10 Section 1. **SUMMARY OF APPROPRIATIONS.**

119.11 The amounts shown in this section summarize direct appropriations by fund made
119.12 in this article.

		2010		2011		Total
119.14 General	$	(6,784,000)	$	215,726,000	$	208,942,000
119.15 State Government Special 119.16 Revenue		113,000		624,000		737,000
119.17 Health Care Access		998,000		11,579,000		12,577,000
119.18 Federal TANF		8,000,000		20,000,000		28,000,000
119.19 Special Revenue		-0-		93,000		93,000
119.20 **Total**	**$**	**2,327,000**	**$**	**248,021,000**	**$**	**250,348,000**

119.21 Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

119.22 The sums shown in the columns marked "Appropriations" are added to or, if shown
119.23 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,
119.24 as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes
119.25 specified in this article. The appropriations are from the general fund, or another named
119.26 fund, and are available for the fiscal years indicated for each purpose. The figures "2010"
119.27 and "2011" used in this article mean that the addition to or subtraction from appropriations
119.28 listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011,
119.29 respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011.
119.30 "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions
119.31 for the fiscal year ending June 30, 2010, are effective the day following final enactment
119.32 unless a different effective date is explicit.

119.33 **APPROPRIATIONS**
119.34 **Available for the Year**

		Ending June 30	
		2010	2011

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	$	**4,409,000** $	**246,347,000**

Appropriations by Fund		
	2010	2011
General	(4,589,000)	215,006,000
Health Care Access	998,000	11,342,000
Federal TANF	8,000,000	20,000,000

The appropriation modifications for each purpose are shown in the following subdivisions.

TANF Financing and Maintenance of Effort. The commissioner, with the approval of the commissioner of management and budget, and after notification of the chairs of the relevant senate budget division and house of representatives finance division, may adjust the amount of TANF transfers between the MFIP transition year child care assistance program and MFIP grant programs within the fiscal year and within the current biennium and the biennium ending June 30, 2013, to ensure that state and federal match and maintenance of effort requirements are met. These transfers and amounts shall be reported to the chairs of the senate and house of representatives Finance Committees, the senate Health and Human Services Budget Division, and the house of representatives Health Care and Human Services Finance Division and Early Childhood Finance and Policy Division by December 1 of each fiscal year. Notwithstanding any contrary

121.1 provision in this article, this paragraph
121.2 expires June 30, 2013.

121.3 **SNAP Enhanced Administrative Funding.**
121.4 The funds available for administration
121.5 of the Supplemental Nutrition Assistance
121.6 Program under the Department of Defense
121.7 Appropriations Act of 2010, Public
121.8 Law 111-118, are appropriated to the
121.9 commissioner to pay the actual costs
121.10 of providing for increased eligibility
121.11 determinations, caseload-related costs,
121.12 timely application processing, and quality
121.13 control. Of these funds, 20 percent shall
121.14 be allocated to the commissioner and 80
121.15 percent shall be allocated to counties.
121.16 The commissioner shall allocate the
121.17 county portion based on recent caseload.
121.18 Reimbursement shall be based on actual
121.19 costs reported by counties through existing
121.20 processes. Tribal reimbursement must be
121.21 made from the state portion, based on a
121.22 caseload factor equivalent to that of a county.

121.23 **TANF Summer Food Programs -**
121.24 **TANF Emergency Fund Non-Recurrent**
121.25 **Short-Term Benefits.** In addition to the
121.26 TANF emergency fund (TEF) non-recurrent
121.27 short-term benefits provided in this
121.28 subdivision, the commissioner may
121.29 supplement funds available under Minnesota
121.30 Statutes, section 256E.34 to provide for
121.31 summer food programs to the extent such
121.32 funds are available and eligible to leverage
121.33 TANF emergency funds non-recurrent
121.34 benefits. The commissioner may contract
121.35 directly with providers or third-party funders
121.36 to maximize these TANF emergency fund

122.1 grants. Up to $800,000 of TEF non-recurrent
122.2 short-term benefit earnings may be used in
122.3 this program. This paragraph is effective the
122.4 day following final enactment.

122.5 **TANF Transfer to Federal Child**
122.6 **Care and Development Fund.** Of the
122.7 TANF appropriation in fiscal year 2011,
122.8 $12,500,000 is to the commissioner for
122.9 the purposes of MFIP and transition year
122.10 child care under Minnesota Statutes, section
122.11 119B.05. The commissioner shall authorize
122.12 the transfer of sufficient TANF funds to the
122.13 federal child care and development fund to
122.14 meet this appropriation and shall ensure that
122.15 all transferred funds are expended according
122.16 to federal child care and development fund
122.17 regulations.

122.18 **Special Revenue Fund Transfers.** (a) The
122.19 commissioner shall transfer the following
122.20 amounts from special revenue fund balances
122.21 to the general fund by June 30 of each
122.22 respective fiscal year: $613,000 in fiscal year
122.23 2010, and $493,000 in fiscal year 2011. This
122.24 provision is effective the day following final
122.25 enactment.

122.26 (b) The actual transfers made under
122.27 paragraph (a) must be separately identified
122.28 and reported as part of the quarterly reporting
122.29 of transfers to the chairs of the relevant senate
122.30 budget division and house of representatives
122.31 finance division.

122.32 Subd. 2. **Agency Management**

122.33 (a) **Financial Operations**	-0-	103,000

123.1 **Base Adjustment.** The general fund base is
123.2 decreased by $3,292,000 in fiscal year 2012
123.3 and $3,292,000 in fiscal year 2013.

123.4 (b) **Legal and Regulatory Operations**	-0-	114,000

123.5 **Base Adjustment.** The general fund base is
123.6 decreased by $18,000 in fiscal year 2012 and
123.7 $18,000 in fiscal year 2013.

123.8 (c) **Management Operations**	-0-	(114,000)

123.9 **Base Adjustment.** The general fund base is
123.10 increased by $18,000 in fiscal year 2012 and
123.11 $18,000 in fiscal year 2013.

123.12 Subd. 3. **Revenue and Pass-Through Revenue** 123.13 **Expenditures**	8,000,000	20,000,000

123.14 These appropriations are from the federal
123.15 TANF fund.

123.16 **TANF Funding for the Working Family**
123.17 **Tax Credit.** In addition to the amounts
123.18 specified in Minnesota Statutes, section
123.19 290.0671, subdivision 6, $15,500,000
123.20 of TANF funds in fiscal year 2010 are
123.21 appropriated to the commissioner to
123.22 reimburse the general fund for the cost of
123.23 the working family tax credit for eligible
123.24 families. With respect to the amounts
123.25 appropriated for fiscal year 2010, the
123.26 commissioner shall reimburse the general
123.27 fund by June 30, 2010. This paragraph is
123.28 effective the day following final enactment.

123.29 **Child Care Development Fund**
123.30 **Unexpended Balance.** In addition to
123.31 the amount provided in this section, the
123.32 commissioner shall carry over and expend
123.33 in fiscal year 2011 $7,500,000 of the TANF
123.34 funds transferred in fiscal year 2010 that

124.1 reflect the child care and development fund
124.2 unexpended balance for the basic sliding
124.3 fee child care assistance program under
124.4 Minnesota Statutes, section 119B.03. The
124.5 commissioner shall ensure that all funds are
124.6 expended according to the federal child care
124.7 and development fund regulations relating to
124.8 the TANF transfers.

124.9 **Base Adjustment.** The general fund base is
124.10 increased by $7,500,000 in fiscal year 2012
124.11 and $7,500,000 in fiscal year 2013.

124.12 Subd. 4. **Economic Support Grants**

124.13 (a) **Support Services Grants**	-0-	-0-

124.14 **Base Adjustment.** The federal TANF fund
124.15 base is decreased by $5,004,000 in fiscal year
124.16 2012 and $5,004,000 in fiscal year 2013.

124.17 (b) **MFIP/DWP Grants**	-0-	(1,520,000)
124.18 (c) **Basic Sliding Fee Child Care Assistance** 124.19 **Grants**	-0-	(7,500,000)
124.20 (d) **Children's Services Grants**	(900,000)	-0-

124.21 **Adoption Assistance.** Of the appropriation
124.22 reduction in fiscal year 2010, $900,000 is
124.23 from the adoption assistance program. This
124.24 reduction is onetime.

124.25 (e) **Child and Community Services Grants**	-0-	(16,750,000)

124.26 **Base adjustment.** The general fund is
124.27 increased by $13,509,000 in fiscal year 2012
124.28 and $13,509,000 in fiscal year 2013.

124.29 (f) **Group Residential Housing Grants**	-0-	84,000

124.30 **Reduction of Supplemental Service Rate.**
124.31 Effective July 1, 2011, to June 30, 2013,
124.32 the commissioner shall decrease the group
124.33 residential housing supplementary service

125.1 rate under Minnesota Statutes, section
125.2 256I.05, subdivision 1a, by five percent
125.3 for services rendered on or after that date,
125.4 except that reimbursement rates for a group
125.5 residential housing facility reimbursed as a
125.6 nursing facility shall not be reduced. The
125.7 reduction in this paragraph is in addition to
125.8 the reduction under Laws 2009, chapter 79,
125.9 article 8, section 79, paragraph (b), clause
125.10 (11).

125.11 **Base Adjustment.** The general fund base is
125.12 decreased by $784,000 in fiscal year 2012
125.13 and $784,000 in fiscal year 2013.

125.14 (g) **Children's Mental Health Grants**	(200,000)	(200,000)
125.15 (h) **Other Children's and Economic Assistance** 125.16 **Grants**	400,000	213,000

125.17 **Minnesota Food Assistance Program.** Of
125.18 the 2011 appropriation, $150,000 is for the
125.19 Minnesota Food Assistance Program. This
125.20 appropriation is onetime.

125.21 Of this appropriation, $400,000 in fiscal
125.22 year 2010 and $63,000 in fiscal year 2011
125.23 is for food shelf programs under Minnesota
125.24 Statutes, section 256E.34. This appropriation
125.25 is available until spent.

125.26 **Base Adjustment.** The general fund base is
125.27 decreased by $20,000 in fiscal year 2012 and
125.28 decreased by $510,000 in fiscal year 2013.

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

125.31 (a) **Children and Economic Assistance** 125.32 **Administration**	-0-	-0-

125.33 **Base Adjustment.** The federal TANF fund
125.34 base is decreased by $700,000 in fiscal year
125.35 2012 and $700,000 in fiscal year 2013.

126.1 126.2	(b) **Children and Economic Assistance Operations**	-0-	195,000

126.3 **Base Adjustment.** The general fund base is
126.4 decreased by $12,000 in fiscal year 2012 and
126.5 $12,000 in fiscal year 2013.

126.6 Subd. 6. **Health Care Grants**

126.7	(a) **MinnesotaCare Grants**	998,000	18,124,000

126.8 This appropriation is from the health care
126.9 access fund.

126.10 **Health Care Access Fund Transfer to**
126.11 **General Fund.** The commissioner of
126.12 management and budget shall transfer
126.13 $998,000 in fiscal year 2010 and
126.14 $199,337,000 in fiscal year 2011 from the
126.15 health care access fund to the general fund.
126.16 This paragraph is effective the day following
126.17 final enactment.

126.18 The amount of this transfer is $178,682,000
126.19 in fiscal year 2012 and $297,135,000 in fiscal
126.20 year 2013.

126.21 **MinnesotaCare Ratable Reduction.**
126.22 Effective for services rendered on or
126.23 after July 1, 2010, to December 31, 2013,
126.24 MinnesotaCare payments to managed care
126.25 plans under Minnesota Statutes, section
126.26 256L.12, for single adults and households
126.27 without children whose income is greater
126.28 than 75 percent of federal poverty guidelines
126.29 shall be reduced by ten percent. Effective
126.30 for services provided from July 1, 2010, to
126.31 June 30, 2011, this reduction shall apply to
126.32 all services. Effective for services provided
126.33 from July 1, 2011, to December 31, 2013, this
126.34 reduction shall apply to all services except

127.1 inpatient hospital services. Notwithstanding
127.2 any contrary provision of this article, this
127.3 paragraph shall expire on December 31,
127.4 2013.

127.5 (b) **Medical Assistance Basic Health Care** 127.6 **Grants - Families and Children**	-0-	318,106,000

127.7 **Critical Access Dental.** Of the general
127.8 fund appropriation, $731,000 in fiscal year
127.9 2011 is to the commissioner for critical
127.10 access dental provider reimbursement
127.11 payments under Minnesota Statutes, section
127.12 256B.76 subdivision 4. This is a onetime
127.13 appropriation.

127.14 **Nonadministrative Rate Reduction.** For
127.15 services rendered on or after July 1, 2010,
127.16 to December 31, 2013, the commissioner
127.17 shall reduce contract rates paid to managed
127.18 care plans under Minnesota Statutes,
127.19 sections 256B.69 and 256L.12, and to
127.20 county-based purchasing plans under
127.21 Minnesota Statutes, section 256B.692, by
127.22 three percent of the contract rate attributable
127.23 to nonadministrative services in effect on
127.24 June 30, 2010. Notwithstanding any contrary
127.25 provision in this article, this rider expires on
127.26 December 31, 2013.

127.27 (c) **Medical Assistance Basic Health Care** 127.28 **Grants - Elderly and Disabled**	-0-	(3,659,000)

127.29 **MnDHO Transition.** Of the general fund
127.30 appropriation for fiscal year 2011, $250,000
127.31 is to the commissioner to be made available
127.32 to county agencies to assist in the transition
127.33 of the approximately 1,290 current MnDHO
127.34 members to the fee-for-service Medicaid
127.35 program or another managed care option by
127.36 January 1, 2011.

128.1 County agencies shall work with the
128.2 commissioner, health plans, and MnDHO
128.3 members and their legal representatives to
128.4 develop and implement transition plans that
128.5 include:

128.6 (1) identification of service needs of MnDHO
128.7 members based on the current assessment or
128.8 through the completion of a new assessment;

128.9 (2) identification of services currently
128.10 provided to MnDHO members and which
128.11 of those services will continue to be
128.12 reimbursable through fee-for-service
128.13 or another managed care option under
128.14 the Medicaid state plan or a home and
128.15 community-based waiver program;

128.16 (3) identification of service providers who do
128.17 not have a contract with the county or who
128.18 are currently reimbursed at a different rate
128.19 than the county contracted rate; and

128.20 (4) development of an individual service
128.21 plan that is within allowable waiver funding
128.22 limits.

128.23	(d) **General Assistance Medical Care Grants**	-0-	(75,389,000)
128.24	(e) **Other Health Care Grants**	-0-	700,000,000

128.25 **Cobra Carryforward.** Unexpended funds
128.26 appropriated in fiscal year 2010 for COBRA
128.27 grants under Laws 2009, chapter 79, article
128.28 5, section 78, do not cancel and are available
128.29 to the commissioner for fiscal year 2011
128.30 COBRA grant expenditures. Up to $111,000
128.31 of the fiscal year 2011 appropriation for
128.32 COBRA grants provided in Laws 2009,
128.33 chapter 79, article 13, section 3, subdivision
128.34 6, may be used by the commissioner for costs

129.1 related to administration of the COBRA
129.2 grants.

129.3 Subd. 7. **Health Care Management**

129.4 (a) **Health Care Administration**	-0-	442,000

129.5 **Fiscal Note Report.** Of this appropriation,
129.6 $50,000 in fiscal year 2011 is for a transfer to
129.7 the commissioner of Minnesota Management
129.8 and Budget for the completion of the human
129.9 services fiscal note report in article 5.

129.10 **PACE Implementation Funding.** For fiscal
129.11 year 2011, $145,000 is appropriated from
129.12 the general fund to the commissioner of
129.13 human services to complete the actuarial and
129.14 administrative work necessary to begin the
129.15 operation of PACE under Minnesota Statutes,
129.16 section 256B.69, subdivision 23, paragraph
129.17 (e). Base level funding for this activity shall
129.18 be $130,000 in fiscal year 2012 and $0 in
129.19 fiscal year 2013.

129.20 **Minnesota Senior Health Options**
129.21 **Reimbursement.** Effective July 1, 2011,
129.22 federal administrative reimbursement
129.23 resulting from the Minnesota senior
129.24 health options project is appropriated
129.25 to the commissioner for this activity.
129.26 Notwithstanding any contrary provision, this
129.27 provision expires June 30, 2013.

129.28 **Utilization Review.** Effective July 1,
129.29 2011, federal administrative reimbursement
129.30 resulting from prior authorization and
129.31 inpatient admission certification by a
129.32 professional review organization shall be
129.33 dedicated to, and is appropriated to, the
129.34 commissioner for these activities. A portion
129.35 of these funds must be used for activities

130.1 to decrease unnecessary pharmaceutical
130.2 costs in medical assistance. Notwithstanding
130.3 any contrary provision of this article, this
130.4 paragraph expires June 30, 2013.

130.5 **Certified Public Expenditures.** (1) The
130.6 entities named in Minnesota Statutes, section
130.7 256B.199, paragraph (b), clause (1), shall
130.8 comply with the requirements of that statute
130.9 by promptly reporting on a quarterly basis
130.10 certified public expenditures that may qualify
130.11 for federal matching funds. Reporting under
130.12 this paragraph shall be voluntary from July 1,
130.13 2010, to December 31, 2010. Upon federal
130.14 enactment of an extension to June 30, 2011,
130.15 of the enhanced federal medical assistance
130.16 percentage (FMAP) originally provided
130.17 under Public Law 111-5, reporting under
130.18 this paragraph shall also be voluntary from
130.19 January 1, 2011, to June 30, 2011.

130.20 (2) To the extent that certified public
130.21 expenditures reported in compliance
130.22 with paragraph (1) earn federal matching
130.23 payments that exceed $8,079,000 in fiscal
130.24 year 2012 and $18,316,000 in fiscal year
130.25 2013, the excess amount shall be deposited
130.26 in the health care access fund. For each fiscal
130.27 year after fiscal year 2013, the commissioner
130.28 shall forecast in November the amount
130.29 of federal payments anticipated to match
130.30 certified public expenditures reported in
130.31 compliance with paragraph (a). Any federal
130.32 match earned in a fiscal year in excess of
130.33 the amount forecasted in November shall be
130.34 deposited to the health care access fund.

131.1 (3) Notwithstanding any contrary provision
131.2 of this article, this rider shall not expire.

131.3 **Poverty Guidelines.** Notwithstanding
131.4 Minnesota Statutes, sections 256B.56,
131.5 subdivision 1c; 256D.03, subdivision 3;
131.6 or 256L.04, subdivision 7b, the poverty
131.7 guidelines for medical assistance, general
131.8 assistance medical care, and MinnesotaCare
131.9 from July 1, 2010, through June 30, 2011,
131.10 shall not be lower than the poverty guidelines
131.11 issued by the Secretary of Health and Human
131.12 Services on January 23, 2009. This section
131.13 shall have no effect on the revision of poverty
131.14 guidelines for the Minnesota health care
131.15 programs that would be in effect starting on
131.16 July 1, 2011. This paragraph is effective the
131.17 day following final enactment.

131.18 **Base Adjustment.** The general fund base is
131.19 decreased by $227,000 in fiscal year 2012
131.20 and $357,000 in fiscal year 2013.

131.21 (b) **Health Care Operations**

131.22	Appropriations by Fund		
131.23	General	-0-	186,000
131.24	Health Care Access	-0-	218,000

131.25 The general fund appropriation is a onetime
131.26 appropriation in fiscal year 2011.

131.27 **Base Adjustment.** The health care access
131.28 fund base for health care operations is
131.29 decreased by $812,000 in fiscal year 2012
131.30 and $944,000 in fiscal year 2013.

131.31 Subd. 8. **Continuing Care Grants**

131.32	(a) **Aging and Adult Services Grants**	-0-	(1,091,000)

131.33 **Base Adjustment.** The general fund base for
131.34 aging and adult services grants is increased

132.1 by $1,139,000 in fiscal year 2012 and
132.2 $1,280,000 in fiscal year 2013.

132.3 **Community Service Development**
132.4 **Reduction.** The appropriation in Laws
132.5 2009, chapter 79, article 13, section 3,
132.6 subdivision 8, paragraph (a), for community
132.7 service development grants, as amended by
132.8 Laws 2009, chapter 173, article 2, section
132.9 1, subdivision 8, paragraph (a), is reduced
132.10 by $154,000 in fiscal year 2011. The
132.11 appropriation base is reduced by $139,000
132.12 for fiscal year 2012 and $0 for fiscal year
132.13 2013. Notwithstanding any law or rule to
132.14 the contrary, this provision expires June 30,
132.15 2012.

132.16 (b) **Medical Assistance Long-Term Care** 132.17 **Facilities Grants**	-0-	4,143,000

132.18 **ICF/MR Occupancy Rate Adjustment**
132.19 **Suspension.** Effective for fiscal years 2012
132.20 and 2013, approval of new applications for
132.21 occupancy rate adjustments for unoccupied
132.22 short-term beds under Minnesota Statutes,
132.23 section 256B.5013, subdivision 7, is
132.24 suspended.

132.25 **Kandiyohi County; ICF/MR Payment**
132.26 **Rate.** $36,000 is appropriated from the
132.27 general fund in fiscal year 2011 and $4,000
132.28 in fiscal year 2012 to increase payment rates
132.29 for an ICF/MR licensed for six beds and
132.30 located in Kandiyohi County to serve persons
132.31 with high behavioral needs. The payment
132.32 rate increase shall be effective for services
132.33 provided from July 1, 2010, through June 30,
132.34 2011. These appropriations are onetime.

132.35 (c) **Medical Assistance Long-Term Care** 132.36 **Waivers and Home Care Grants**	-0-	(4,631,000)

133.1 **Manage Growth in Traumatic Brain**
133.2 **Injury and Community Alternatives for**
133.3 **Disabled Individuals Waivers.** During
133.4 the fiscal year beginning July 1, 2010, the
133.5 commissioner shall allocate money for home
133.6 and community-based waiver programs
133.7 under Minnesota Statutes, section 256B.49,
133.8 to ensure a reduction in state spending that is
133.9 equivalent to limiting the caseload growth
133.10 of the traumatic brain injury waiver to six
133.11 allocations per month and the community
133.12 alternatives for disabled individuals waiver
133.13 to 60 allocations per month. The limits do not
133.14 apply: (1) when there is an approved plan for
133.15 nursing facility bed closures for individuals
133.16 under age 65 who require relocation due to
133.17 the bed closure; (2) to fiscal year 2009 waiver
133.18 allocations delayed due to unallotment; or (3)
133.19 to transfers authorized by the commissioner
133.20 from the personal care assistance program
133.21 of individuals having a home care rating of
133.22 CS, MT, or HL. Priorities for the allocation
133.23 of funds must be for individuals anticipated
133.24 to be discharged from institutional settings or
133.25 who are at imminent risk of a placement in
133.26 an institutional setting.

133.27 **Manage Growth in the Developmental**
133.28 **Disability (DD) Waiver.** The commissioner
133.29 shall manage the growth in the developmental
133.30 disability waiver by limiting the allocations
133.31 included in the November 2010 forecast to
133.32 six additional diversion allocations each
133.33 month for the calendar year that begins on
133.34 January 1, 2011. Additional allocations must
133.35 be made available for transfers authorized
133.36 by the commissioner from the personal care

134.1 assistance program of individuals having a
134.2 home care rating of CS, MT, or HL. This
134.3 provision is effective through December 31,
134.4 2011.

134.5 (d) **Adult Mental Health Grants**	(3,500,000)	(300,000)

134.6 **Compulsive Gambling Special Revenue**
134.7 **Account.** $149,000 for fiscal year 2010
134.8 and $27,000 for fiscal year 2011 from
134.9 the compulsive gambling special revenue
134.10 account established under Minnesota
134.11 Statutes, section 245.982, shall be transferred
134.12 and deposited into the general fund by
134.13 June 30 of each respective fiscal year. This
134.14 paragraph is effective the day following final
134.15 enactment.

134.16 **Compulsive Gambling Lottery Prize**
134.17 **Fund.** The lottery prize fund appropriation
134.18 for compulsive gambling is reduced by
134.19 $80,000 in fiscal year 2010 and $79,000 in
134.20 fiscal year 2011. This is a onetime reduction.

134.21 **Culturally Specific Treatment.** The
134.22 appropriation for culturally specific treatment
134.23 is reduced by $300,000 in fiscal year 2011.
134.24 This is a onetime reduction.

134.25 (1) Of the fiscal year 2010 general fund
134.26 appropriation for grants to counties for
134.27 housing with support services for adults
134.28 with serious and persistent mental illness,
134.29 $3,300,000 is canceled and returned to the
134.30 general fund.

134.31 (2) Of the fiscal year 2010 general
134.32 fund appropriation for additional crisis
134.33 intervention team training for law
134.34 enforcement, $200,000 is canceled and
134.35 returned to the general fund.

135.1	(e) **Chemical Dependency Entitlement Grants**	-0-	(2,433,000)
135.2 135.3	(f) **Chemical Dependency Nonentitlement Grants**	(389,000)	-0-

135.4 **Base adjustment.** The general fund base is
135.5 reduced by $393,000 in fiscal year 2012 and
135.6 fiscal year 2013.

135.7 **Chemical Health.** Of the fiscal year 2010
135.8 general fund appropriation to Mother's First
135.9 and the Native American Program, $389,000
135.10 is canceled and returned to the general fund.

135.11	(g) **Other Continuing Care Grants**	-0-	350,000

135.12 This is a onetime appropriation in fiscal year
135.13 2011.

135.14 **Region 10 Quality Assurance Commission.**
135.15 $100,000 is appropriated from the general
135.16 fund in fiscal year 2011 to the commissioner
135.17 of human services for the purposes
135.18 of the Region 10 Quality Assurance
135.19 Commission under Minnesota Statutes,
135.20 section 256B.0951. This appropriation is
135.21 onetime.

135.22	Subd. 9. **Continuing Care Management**	-0-	414,000

135.23 **PACE Implementation Funding.** For fiscal
135.24 year 2011, $111,000 is appropriated from
135.25 the general fund to the commissioner of
135.26 human services to complete the actuarial
135.27 and administrative work necessary to begin
135.28 the operation of PACE under Minnesota
135.29 Statutes, section 256B.69, subdivision 23,
135.30 paragraph (e). Base level funding for this
135.31 activity shall be $101,000 in fiscal year 2012
135.32 and $0 in fiscal year 2013. For fiscal year
135.33 2013 and beyond, the commissioner must
135.34 work with stakeholders to develop financing

136.1 mechanisms to complete the actuarial
136.2 and administrative costs of PACE. The
136.3 commissioner shall inform the chairs and
136.4 ranking minority members of the legislative
136.5 committee with jurisdiction over health care
136.6 funding by January 15, 2011, on progress to
136.7 develop financing mechanisms.

136.8 **Base Adjustment.** The general fund base for
136.9 continuing care management is increased by
136.10 $97,000 in fiscal year 2012 and decreased by
136.11 $12,000 in fiscal year 2013.

136.12 Subd. 10. **State-Operated Services**

136.13 **Obsolete Laundry Depreciation Account.**
136.14 $669,000, or the balance, whichever is
136.15 greater, must be transferred from the
136.16 state-operated services laundry depreciation
136.17 account in the special revenue fund and
136.18 deposited into the general fund by June 30,
136.19 2010. This paragraph is effective the day
136.20 following final enactment.

136.21 **Operating Budget Reductions.** No
136.22 operating budget reductions enacted in Laws
136.23 2010, chapter 200, or in this act shall be
136.24 allocated to state-operated services.

136.25 **Prohibition on Transferring Funds.** The
136.26 commissioner shall not transfer mental
136.27 health grants to state-operated services
136.28 without specific legislative approval.
136.29 Notwithstanding any contrary provision in
136.30 this article, this paragraph shall not expire.

136.31 (a) **Adult Mental Health Services**	-0-	6,888,000

136.32 **Base Adjustment.** The general fund base is
136.33 decreased by $12,286,000 in fiscal year 2012
136.34 and $12,394,000 in fiscal year 2013.

137.1 **Appropriation Requirements.** (a)
137.2 The general fund appropriation to the
137.3 commissioner includes funding for the
137.4 following:

137.5 (1) to a community collaborative to begin
137.6 providing crisis center services in the
137.7 Mankato area that are comparable to
137.8 the crisis services provided prior to the
137.9 closure of the Mankato Crisis Center. The
137.10 commissioner shall recruit former employees
137.11 of the Mankato Crisis Center who were
137.12 recently laid off to staff the new crisis
137.13 services. The commissioner shall obtain
137.14 legislative approval prior to discontinuing
137.15 this funding;

137.16 (2) to maintain the building in Eveleth
137.17 that currently houses community transition
137.18 services and to establish a psychiatric
137.19 intensive therapeutic foster home as an
137.20 enterprise activity. The commissioner shall
137.21 request a waiver amendment to allow CADI
137.22 funding for psychiatric intensive therapeutic
137.23 foster care services provided in the same
137.24 location and building as the community
137.25 transition services. If the federal government
137.26 does not approve the waiver amendment, the
137.27 commissioner shall continue to pay the lease
137.28 for the building out of the state-operated
137.29 services budget until the commissioner of
137.30 administration subleases the space or until
137.31 the lease expires, and shall establish the
137.32 psychiatric intensive therapeutic foster home
137.33 at a different site. The commissioner shall
137.34 make diligent efforts to sublease the space;

138.1 (3) to convert the community behavioral
138.2 health hospitals in Wadena and Willmar to
138.3 facilities that provide more suitable services
138.4 based on the needs of the community,
138.5 which may include, but are not limited to,
138.6 psychiatric extensive recovery treatment
138.7 services. The commissioner may also
138.8 establish other community-based services in
138.9 the Willmar and Wadena areas that deliver
138.10 the appropriate level of care in response to
138.11 the express needs of the communities. The
138.12 services established under this provision
138.13 must be staffed by state employees.

138.14 (4) to continue the operation of the dental
138.15 clinics in Brainerd, Cambridge, Faribault,
138.16 Fergus Falls, and Willmar at the same level of
138.17 care and staffing that was in effect on March
138.18 1, 2010. The commissioner shall not proceed
138.19 with the planned closure of the dental
138.20 clinics, and shall not discontinue services or
138.21 downsize any of the state-operated dental
138.22 clinics without specific legislative approval.
138.23 The commissioner shall continue to bill
138.24 for services provided to obtain medical
138.25 assistance critical access dental payments
138.26 and cost-based payment rates as provided
138.27 in Minnesota Statutes, section 256B.76,
138.28 subdivision 2, and shall bill for services
138.29 provided three months retroactively from
138.30 the date of this act. This appropriation is
138.31 onetime;

138.32 (5) to convert the Minnesota
138.33 Neurorehabilitation Hospital in Brainerd
138.34 to a neurocognitive psychiatric extensive
138.35 recovery treatment service; and

139.1 (6) to convert the Minnesota extended
139.2 treatment options (METO) program to
139.3 the following community-based services
139.4 provided by state employees: (i) psychiatric
139.5 extensive recovery treatment services;
139.6 (ii) intensive transitional foster homes
139.7 as enterprise activities; and (iii) other
139.8 community-based support services. The
139.9 provisions under Minnesota Statutes, section
139.10 252.025, subdivision 7, are applicable to
139.11 the METO services established under this
139.12 clause. Notwithstanding Minnesota Statutes,
139.13 section 246.18, subdivision 8, any revenue
139.14 lost to the general fund by the conversion
139.15 of METO to new services must be replaced
139.16 by revenue from the new services to offset
139.17 the lost revenue to the general fund until
139.18 June 30, 2013. Any revenue generated in
139.19 excess of this amount shall be deposited into
139.20 the special revenue fund under Minnesota
139.21 Statutes, section 246.18, subdivision 8.

139.22 (b) The commissioner shall not move beds
139.23 from the Anoka-Metro Regional Treatment
139.24 Center to the psychiatric nursing facility
139.25 at St. Peter without specific legislative
139.26 approval.

139.27 (c) The commissioner shall implement
139.28 changes, including the following, to save a
139.29 minimum of $6,006,000 beginning in fiscal
139.30 year 2011, and report to the legislature the
139.31 specific initiatives implemented and the
139.32 savings allocated to each one, including:

139.33 (1) maximizing budget savings through
139.34 strategic employee staffing; and

140.1 (2) identifying and implementing cost
140.2 reductions in cooperation with state-operated
140.3 services employees.

140.4 Base level funding is reduced by $6,006,000
140.5 effective fiscal year 2011.

140.6 (d) The commissioner shall seek certification
140.7 or approval from the federal government for
140.8 the new services under paragraph (a) that are
140.9 eligible for federal financial participation
140.10 and deposit the revenue associated with
140.11 these new services in the account established
140.12 under Minnesota Statutes, section 246.18,
140.13 subdivision 8, unless otherwise specified.

140.14 (e) Notwithstanding any contrary provision
140.15 in this article, this rider shall not expire.

140.16 (b) **Minnesota Sex Offender Services**	-0-	(145,000)

140.17 **Sex Offender Services.** Base level funding
140.18 for Minnesota sex offender services is
140.19 reduced by $418,000 in fiscal year 2012 and
140.20 $419,000 in fiscal year 2013 for the 50-bed
140.21 sex offender treatment program within the
140.22 Moose Lake correctional facility in which
140.23 Department of Human Services staff from
140.24 Minnesota sex offender services provide
140.25 clinical treatment to incarcerated offenders.
140.26 This reduction shall become part of the base
140.27 for the Department of Human Services.

140.28 **Interagency Agreements.** The
140.29 commissioner of human services may
140.30 enter into interagency agreements with the
140.31 commissioner of corrections to continue sex
140.32 offender treatment and chemical dependency
140.33 treatment on a cost-sharing basis, in which
140.34 each department pays 50 percent of the costs
140.35 of these services.

141.1 Sec. 4. **COMMISSIONER OF HEALTH**

141.2 Subdivision 1. **Total Appropriation** **$** **(2,392,000)** **$** **(1,310,000)**

141.3 Appropriations by Fund

	2010	2011
General	(2,392,000)	(1,064,000)
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	237,000

141.9 Subd. 2. **Community and Family Health** (221,000) (47,000)

141.10 **Base Level Adjustment.** The general fund
141.11 base is decreased by $388,000 in fiscal years
141.12 2012 and 2013.

141.13 Subd. 3. **Policy, Quality, and Compliance**

141.14 Appropriations by Fund

	2010	2011
General	(1,797,000)	497,000
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	237,000

141.20 **Health Care Reform.** Funds appropriated
141.21 in Laws 2008, chapter 358, article 5, section
141.22 4, subdivision 3, for health reform activities
141.23 to implement Laws 2008, chapter 358,
141.24 article 4, are available until expended.
141.25 Notwithstanding any contrary provision in
141.26 this article, this provision shall not expire.

141.27 **Health Care Reform Task Force.** $198,000
141.28 from the general fund is for expenses related
141.29 to the Health Care Reform Task Force
141.30 established under article 7.

141.31 **Rural Hospital Capital Improvement**
141.32 **Grants.** Of the general fund reductions in
141.33 fiscal year 2010, $1,755,000 is for the rural
141.34 hospital capital improvement grant program.

142.1 **Section 125 Plans.** The remaining balance
142.2 from the Laws 2008, chapter 358, article 5,
142.3 section 4, subdivision 3, appropriation for
142.4 Section 125 Plan Employer Incentives is
142.5 canceled.

142.6 **Birth Centers.** Of the appropriation in fiscal
142.7 year 2011 from the state government special
142.8 revenue fund, $9,000 is to the commissioner
142.9 to license birth centers. Base level funding
142.10 for this activity shall be $7,000 in fiscal year
142.11 2012 and $7,000 in fiscal year 2013.

142.12 **Comprehensive Advanced Life Support**
142.13 **Program.** Of the general fund appropriation,
142.14 $377,000 in fiscal year 2011 is to the
142.15 commissioner for the comprehensive
142.16 advanced life support educational program.
142.17 For fiscal year 2012, base level funding for
142.18 this program shall be $377,000.

142.19 **Advisory Group on Administrative**
142.20 **Expenses.** Of the health care access fund
142.21 appropriation for fiscal year 2011, $39,000 is
142.22 to the commissioner for the advisory group
142.23 established under Minnesota Statutes, section
142.24 62D.31. This is a onetime appropriation.

142.25 **Base Level Adjustment.** The general fund
142.26 base is decreased by $253,000 in fiscal year
142.27 2012 and $253,000 in fiscal year 2013. The
142.28 state government special revenue fund base
142.29 is decreased by $2,000 in fiscal year 2012
142.30 and $2,000 in fiscal year 2013.

142.31 **Office of Unlicensed Health Care Practice.**
142.32 Of the general fund appropriation, $74,000
142.33 in fiscal year 2011 is for the Office of
142.34 Unlicensed Complementary and Alternative

143.1 Health Care Practice. This is a onetime
143.2 appropriation.

143.3 Subd. 4. **Health Protection**		(374,000)		714,000

143.4 **Lead Base Grant Program.** Of the general
143.5 fund reduction, $25,000 in fiscal year 2010
143.6 and fiscal year 2011 is for the elimination
143.7 of state funding for the temporary lead-safe
143.8 housing base grant program.

143.9 **Birth Defects Information System.** Of the
143.10 general fund appropriation for fiscal year
143.11 2011, $919,000 is for the Minnesota Birth
143.12 Defects Information System established
143.13 under Minnesota Statutes, section 144.2215.

143.14 **Base Adjustment.** The general fund base
143.15 is increased by $440,000 in fiscal year 2012
143.16 and $984,000 in fiscal year 2013.

143.17 Subd. 5. **Administrative Support Services**		-0-		(100,000)

143.18 The general fund base is decreased by
143.19 $22,000 in fiscal year 2012 and $22,000 in
143.20 fiscal year 2013.

143.21 Sec. 5. **DEPARTMENT OF VETERANS** 143.22 **AFFAIRS**	**$**	**(50,000)**	**$**	**-0-**

143.23 **Cancellation of Prior Appropriation.**
143.24 By June 30, 2010, the commissioner of
143.25 management and budget shall cancel the
143.26 $50,000 appropriation for fiscal year 2008 to
143.27 the board in Laws 2007, chapter 147, article
143.28 19, section 5, in the paragraph titled "Pay for
143.29 Performance."

143.30 Sec. 6. **HEALTH-RELATED BOARDS**

143.31 Subdivision 1. **Total Appropriation**	**$**	**113,000**	**$**	**615,000**

143.32 The appropriations in this section are from
143.33 the state government special revenue fund.

144.1 In fiscal year 2010, $591,000 shall be
144.2 transferred from the state government special
144.3 revenue fund to the general fund. In fiscal
144.4 year 2011, $3,052,000 shall be transferred
144.5 from the state government special revenue
144.6 fund to the general fund. These transfers
144.7 are in addition to those made in Laws 2009,
144.8 chapter 79, article 13, section 5, as amended
144.9 by Laws 2009, chapter 173, article 2, section
144.10 3.

144.11 The transfers in this section are onetime in
144.12 the fiscal year 2010-2011 biennium.

144.13 The appropriations for each purpose are
144.14 shown in the following subdivisions.

144.15 144.16	Subd. 2. **Board of Marriage and Family Therapy**	47,000	22,000

144.17 **Operating Costs and Rulemaking.** Of
144.18 this appropriation, $22,000 in fiscal year
144.19 2010 and $22,000 in fiscal year 2011 are
144.20 for operating costs. This is an ongoing
144.21 appropriation. Of this appropriation, $25,000
144.22 in fiscal year 2010 is for rulemaking. This is
144.23 a onetime appropriation.

144.24 144.25	Subd. 3. **Board of Nursing Home Administrators**	51,000	61,000
144.26	Subd. 4. **Board of Pharmacy**	-0-	517,000

144.27 **Prescription Electronic Reporting.** Of
144.28 the state government special revenue fund
144.29 appropriation, $517,000 in fiscal year 2011
144.30 is to the board to operate the prescription
144.31 electronic reporting system in Minnesota
144.32 Statutes, section 152.126. Base level funding
144.33 for this activity in fiscal year 2012 shall be
144.34 $356,000.

144.35	Subd. 5. **Board of Podiatry**	15,000	15,000

145.1 **Purpose.** This appropriation is to pay health
145.2 insurance coverage costs and to cover the
145.3 cost of expert witnesses in disciplinary cases.

145.4 Sec. 7. **EMERGENCY MEDICAL SERVICES** 145.5 **BOARD**	**$**	**247,000**	**$**	**(382,000)**
145.6 Sec. 8. **UNIVERSITY OF MINNESOTA**	**$**	**-0-**	**$**	**93,000**

145.7 This appropriation is from the special
145.8 revenue fund for the couples on the brink
145.9 program.

145.10 Sec. 9. **DEPARTMENT OF CORRECTIONS**	**$**	**-0-**	**$**	**-0-**

145.11 **Sex Offender Services.** From the general
145.12 fund appropriations to the commissioner of
145.13 corrections, the commissioner shall transfer
145.14 $418,000 in fiscal year 2012 and $419,000
145.15 in fiscal year 2013 to the commissioner of
145.16 human services to provide clinical treatment
145.17 to incarcerated offenders. This transfer shall
145.18 become part of the base for the Department
145.19 of Corrections.

145.20 Sec. 10. **DEPARTMENT OF COMMERCE**	**$**	**-0-**	**$**	**38,000**

145.21 **Health Plan Filings.** Of this appropriation:

145.22 (1) $19,000 is for the review and approval
145.23 of new health plan filings due to Minnesota
145.24 Statutes, section 62Q.545. This is a onetime
145.25 appropriation in fiscal year 2011; and

145.26 (2) $19,000 is for regulation of Minnesota
145.27 Statutes, section 62A.3075.

145.28 Sec. 11. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

145.29 Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds
145.30 appropriated for this program, the administrative services unit must purchase medical
145.31 professional liability insurance, if available, for a health care provider who is registered in

146.1 accordance with subdivision 4 and who is not otherwise covered by a medical professional
146.2 liability insurance policy or self-insured plan either personally or through another facility
146.3 or employer. The administrative services unit is authorized to prorate payments or
146.4 otherwise limit the number of participants in the program if the costs of the insurance for
146.5 eligible providers exceed the funds appropriated for the program.
146.6 (b) Coverage purchased under this subdivision must be limited to the provision of
146.7 health care services performed by the provider for which the provider does not receive
146.8 direct monetary compensation.

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

146.10 Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by
146.11 Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

146.12 Subdivision 1. **Total Appropriation** **$ 5,225,451,000 $ 6,002,864,000**

146.13 Appropriations by Fund

		2010	2011
146.15	General	4,375,689,000	5,209,765,000
146.16–146.17	State Government Special Revenue	565,000	565,000
146.18	Health Care Access	450,662,000	527,411,000
146.19	Federal TANF	286,770,000	263,458,000
146.20	Lottery Prize	1,665,000	1,665,000
146.21	Federal Fund	110,000,000	0

146.22 **Receipts for Systems Projects.**
146.23 Appropriations and federal receipts for
146.24 information systems projects for MAXIS,
146.25 PRISM, MMIS, and SSIS must be deposited
146.26 in the state system account authorized in
146.27 Minnesota Statutes, section 256.014. Money
146.28 appropriated for computer projects approved
146.29 by the Minnesota Office of Enterprise
146.30 Technology, funded by the legislature, and
146.31 approved by the commissioner of finance,
146.32 may be transferred from one project to
146.33 another and from development to operations
146.34 as the commissioner of human services
146.35 considers necessary, except that any transfers

147.1 to one project that exceed $1,000,000 or
147.2 multiple transfers to one project that exceed
147.3 $1,000,000 in total require the express
147.4 approval of the legislature. The preceding
147.5 requirement for legislative approval does not
147.6 apply to transfers made to establish a project's
147.7 initial operating budget each year; instead,
147.8 the requirements of section 11, subdivision
147.9 2, of this article apply to those transfers. Any
147.10 unexpended balance in the appropriation
147.11 for these projects does not cancel but is
147.12 available for ongoing development and
147.13 operations. Any computer project with a
147.14 total cost exceeding $1,000,000, including,
147.15 but not limited to, a replacement for the
147.16 proposed HealthMatch system, shall not be
147.17 commenced without the express approval of
147.18 the legislature.

147.19 **HealthMatch Systems Project.** In fiscal
147.20 year 2010, $3,054,000 shall be transferred
147.21 from the HealthMatch account in the state
147.22 systems account in the special revenue fund
147.23 to the general fund.

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

147.29 **TANF Maintenance of Effort.**

147.30 (a) In order to meet the basic maintenance
147.31 of effort (MOE) requirements of the TANF
147.32 block grant specified under Code of Federal
147.33 Regulations, title 45, section 263.1, the
147.34 commissioner may only report nonfederal
147.35 money expended for allowable activities

148.1 listed in the following clauses as TANF/MOE
148.2 expenditures:

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

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

148.11 (3) state and county MFIP administrative
148.12 costs under Minnesota Statutes, chapters
148.13 256J and 256K;

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

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

148.24 (6) qualifying working family credit
148.25 expenditures under Minnesota Statutes,
148.26 section 290.0671~~.~~; and

148.27 (7) qualifying Minnesota education credit
148.28 expenditures under Minnesota Statutes,
148.29 section 290.0674.

148.30 (b) The commissioner shall ensure that
148.31 sufficient qualified nonfederal expenditures
148.32 are made each year to meet the state's
148.33 TANF/MOE requirements. For the activities
148.34 listed in paragraph (a), clauses (2) to

149.1 (6), the commissioner may only report
149.2 expenditures that are excluded from the
149.3 definition of assistance under Code of
149.4 Federal Regulations, title 45, section 260.31.

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

149.15 (d) For the federal fiscal years beginning on
149.16 or after October 1, 2007, the commissioner
149.17 may not claim an amount of TANF/MOE in
149.18 excess of the 75 percent standard in Code
149.19 of Federal Regulations, title 45, section
149.20 263.1(a)(2), except:

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

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

149.32 (3) to provide any additional amounts that
149.33 may contribute to avoiding or reducing
149.34 TANF work participation penalties through
149.35 the operation of the excess MOE provisions

150.1 of Code of Federal Regulations, title 45,
150.2 section 261.43 (a)(2).

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

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

150.16 (f) Notwithstanding any contrary provision
150.17 in this article, this provision expires June 30,
150.18 2013.

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

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

150.29 (1) fiscal year 2010, ~~$50,973,000~~
150.30 $50,897,000;

150.31 (2) fiscal year 2011, ~~$53,793,000~~
150.32 $54,243,000;

150.33 (3) fiscal year 2012, ~~$23,516,000~~
150.34 $23,345,000; and

151.1 (4) fiscal year 2013, ~~$16,808,000~~
151.2 $16,585,000.

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

151.5 **Food Stamps Employment and Training.**
151.6 (a) The commissioner shall apply for and
151.7 claim the maximum allowable federal
151.8 matching funds under United States Code,
151.9 title 7, section 2025, paragraph (h), for
151.10 state expenditures made on behalf of family
151.11 stabilization services participants voluntarily
151.12 engaged in food stamp employment and
151.13 training activities, where appropriate.

151.14 (b) Notwithstanding Minnesota Statutes,
151.15 sections 256D.051, subdivisions 1a, 6b,
151.16 and 6c, and 256J.626, federal food stamps
151.17 employment and training funds received
151.18 as reimbursement of MFIP consolidated
151.19 fund grant expenditures for diversionary
151.20 work program participants and child
151.21 care assistance program expenditures for
151.22 two-parent families must be deposited in the
151.23 general fund. The amount of funds must be
151.24 limited to $3,350,000 in fiscal year 2010
151.25 and $4,440,000 in fiscal years 2011 through
151.26 2013, contingent on approval by the federal
151.27 Food and Nutrition Service.

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

151.34 **ARRA Food Support Administration.**
151.35 The funds available for food support

152.1 administration under the American Recovery
152.2 and Reinvestment Act (ARRA) of 2009
152.3 are appropriated to the commissioner
152.4 to pay actual costs of implementing the
152.5 food support benefit increases, increased
152.6 eligibility determinations, and outreach. Of
152.7 these funds, 20 percent shall be allocated
152.8 to the commissioner and 80 percent shall
152.9 be allocated to counties. The commissioner
152.10 shall allocate the county portion based on
152.11 caseload. Reimbursement shall be based on
152.12 actual costs reported by counties through
152.13 existing processes. Tribal reimbursement
152.14 must be made from the state portion based
152.15 on a caseload factor equivalent to that of a
152.16 county.

152.17 **ARRA Food Support Benefit Increases.**
152.18 The funds provided for food support benefit
152.19 increases under the Supplemental Nutrition
152.20 Assistance Program provisions of the
152.21 American Recovery and Reinvestment Act
152.22 (ARRA) of 2009 must be used for benefit
152.23 increases beginning July 1, 2009.

152.24 **Emergency Fund for the TANF Program.**
152.25 TANF Emergency Contingency funds
152.26 available under the American Recovery
152.27 and Reinvestment Act of 2009 (Public Law
152.28 111-5) are appropriated to the commissioner.
152.29 The commissioner must request TANF
152.30 Emergency Contingency funds from the
152.31 Secretary of the Department of Health
152.32 and Human Services to the extent the
152.33 commissioner meets or expects to meet the
152.34 requirements of section 403(c) of the Social
152.35 Security Act. The commissioner must seek
152.36 to maximize such grants. The funds received

153.1 must be used as appropriated. Each county
153.2 must maintain the county's current level of
153.3 emergency assistance funding under the
153.4 MFIP consolidated fund and use the funds
153.5 under this paragraph to supplement existing
153.6 emergency assistance funding levels.

153.7 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by
153.8 Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

153.9 Subd. 3. **Revenue and Pass-Through Revenue** 153.10 **Expenditures**	68,337,000	70,505,000

153.11 This appropriation is from the federal TANF
153.12 fund.

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

153.19 (1) fiscal year 2010, ~~$6,531,000~~ $862,000;

153.20 (2) fiscal year 2011, ~~$10,241,000~~ $978,000;

153.21 (3) fiscal year 2012, ~~$10,826,000~~ $0; and

153.22 (4) fiscal year 2013, ~~$4,046,000~~ $0.

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

153.30 Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
153.31 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

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

154.4	Appropriations by Fund		
154.5	General	63,205,000	89,033,000
154.6	Federal TANF	100,818,000	84,538,000

154.7 **(b) Support Services Grants**

154.8	Appropriations by Fund		
154.9	General	8,715,000	12,498,000
154.10	Federal TANF	116,557,000	107,457,000

154.11 **MFIP Consolidated Fund.** The MFIP
154.12 consolidated fund TANF appropriation is
154.13 reduced by $1,854,000 in fiscal year 2010
154.14 and fiscal year 2011.

154.15 Notwithstanding Minnesota Statutes, section
154.16 256J.626, subdivision 8, paragraph (b), the
154.17 commissioner shall reduce proportionately
154.18 the reimbursement to counties for
154.19 administrative expenses.

154.20 **Subsidized Employment Funding Through**
154.21 **ARRA.** The commissioner is authorized to
154.22 apply for TANF emergency fund grants for
154.23 subsidized employment activities. Growth
154.24 in expenditures for subsidized employment
154.25 within the supported work program and the
154.26 MFIP consolidated fund over the amount
154.27 expended in the calendar quarters in the
154.28 TANF emergency fund base year shall be
154.29 used to leverage the TANF emergency fund
154.30 grants for subsidized employment and to
154.31 fund supported work. The commissioner
154.32 shall develop procedures to maximize
154.33 reimbursement of these expenditures over the
154.34 TANF emergency fund base year quarters,
154.35 and may contract directly with employers

155.1 and providers to maximize these TANF
155.2 emergency fund grants, including provisions
155.3 of TANF summer youth program wage
155.4 subsidies for MFIP youth and caregivers.
155.5 MFIP youth are individuals up to age 25 who
155.6 are part of an eligible household as defined
155.7 under rules governing TANF maintenance
155.8 of effort with incomes less than 200 percent
155.9 of federal poverty guidelines. Expenditures
155.10 may only be used for subsidized wages and
155.11 benefits and eligible training and supervision
155.12 expenditures. The commissioner shall
155.13 contract with the Minnesota Department of
155.14 Employment and Economic Development
155.15 for the summer youth program. The
155.16 commissioner shall develop procedures
155.17 to maximize reimbursement of these
155.18 expenditures over the TANF emergency fund
155.19 year quarters. No more than $6,000,000 shall
155.20 be reimbursed. This provision is effective
155.21 upon enactment.

155.22 **Supported Work.** Of the TANF
155.23 appropriation, $4,700,000 in fiscal year 2010
155.24 and $4,700,000 in fiscal year 2011 are to the
155.25 commissioner for supported work for MFIP
155.26 recipients and is available until expended.
155.27 Supported work includes paid transitional
155.28 work experience and a continuum of
155.29 employment assistance, including outreach
155.30 and recruitment, program orientation
155.31 and intake, testing and assessment, job
155.32 development and marketing, preworksite
155.33 training, supported worksite experience,
155.34 job coaching, and postplacement follow-up,
155.35 in addition to extensive case management

156.1 and referral services. This is a onetime
156.2 appropriation.

156.3 **Base Adjustment.** The general fund base
156.4 is reduced by $3,783,000 in each of fiscal
156.5 years 2012 and 2013. ~~The TANF fund base~~
156.6 ~~is increased by $5,004,000 in each of fiscal~~
156.7 ~~years 2012 and 2013.~~

156.8 **Integrated Services Program Funding.**
156.9 The TANF appropriation for integrated
156.10 services program funding is $1,250,000 in
156.11 fiscal year 2010 and $0 in fiscal year 2011
156.12 and the base for fiscal years 2012 and 2013
156.13 is $0.

156.14 **TANF Emergency Fund; Nonrecurrent**
156.15 **Short-Term Benefits.** (a) TANF emergency
156.16 contingency fund grants received due to
156.17 increases in expenditures for nonrecurrent
156.18 short-term benefits must be used to offset the
156.19 increase in these expenditures for counties
156.20 under the MFIP consolidated fund, under
156.21 Minnesota Statutes, section 256J.626,
156.22 and the diversionary work program. The
156.23 commissioner shall develop procedures
156.24 to maximize reimbursement of these
156.25 expenditures over the TANF emergency fund
156.26 base year quarters. Growth in expenditures
156.27 for the diversionary work program over the
156.28 amount expended in the calendar quarters in
156.29 the TANF emergency fund base year shall be
156.30 used to leverage these funds.

156.31 (b) To the extent that the commissioner
156.32 can claim eligible tax credit growth as
156.33 nonrecurrent short-term benefits, the
156.34 commissioner shall use those funds to

157.1 leverage the increased expenditures in
157.2 paragraph (a).

157.3 (c) TANF emergency funds for nonrecurrent
157.4 short-term benefits received in excess of the
157.5 amounts necessary for paragraphs (a) and (b)
157.6 shall be used to reimburse the general fund
157.7 for the costs of eligible tax credits in fiscal
157.8 year 2011. The amount of such funds shall
157.9 not exceed $15,500,000 in fiscal year 2010.

157.10 (d) This rider is effective the day following
157.11 final enactment.

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

157.13 **Acceleration of ARRA Child Care and**
157.14 **Development Fund Expenditure.** The
157.15 commissioner must liquidate all child care
157.16 and development money available under
157.17 the American Recovery and Reinvestment
157.18 Act (ARRA) of 2009, Public Law 111-5,
157.19 by September 30, 2010. In order to expend
157.20 those funds by September 30, 2010, the
157.21 commissioner may redesignate and expend
157.22 the ARRA child care and development funds
157.23 appropriated in fiscal year 2011 for purposes
157.24 under this section for related purposes that
157.25 will allow liquidation by September 30,
157.26 2010. Child care and development funds
157.27 otherwise available to the commissioner
157.28 for those related purposes shall be used to
157.29 fund the purposes from which the ARRA
157.30 child care and development funds had been
157.31 redesignated.

157.32 **School Readiness Service Agreements.**
157.33 $400,000 in fiscal year 2010 and $400,000
157.34 in fiscal year 2011 are from the federal
157.35 TANF fund to the commissioner of human

158.1 services consistent with federal regulations
158.2 for the purpose of school readiness service
158.3 agreements under Minnesota Statutes,
158.4 section 119B.231. This is a onetime
158.5 appropriation. Any unexpended balance the
158.6 first year is available in the second year.

158.7 **(d) Basic Sliding Fee Child Care Assistance** 158.8 **Grants**	40,100,000	45,092,000

158.9 **School Readiness Service Agreements.**
158.10 $257,000 in fiscal year 2010 and $257,000
158.11 in fiscal year 2011 are from the general
158.12 fund for the purpose of school readiness
158.13 service agreements under Minnesota
158.14 Statutes, section 119B.231. This is a onetime
158.15 appropriation. Any unexpended balance the
158.16 first year is available in the second year.

158.17 **Child Care Development Fund**
158.18 **Unexpended Balance.** In addition to
158.19 the amount provided in this section, the
158.20 commissioner shall expend $5,244,000 in
158.21 fiscal year 2010 from the federal child care
158.22 development fund unexpended balance
158.23 for basic sliding fee child care under
158.24 Minnesota Statutes, section 119B.03. The
158.25 commissioner shall ensure that all child
158.26 care and development funds are expended
158.27 according to the federal child care and
158.28 development fund regulations.

158.29 **Basic Sliding Fee.** $4,000,000 in fiscal year
158.30 2010 and $4,000,000 in fiscal year 2011 are
158.31 from the federal child care development
158.32 funds received from the American Recovery
158.33 and Reinvestment Act of 2009, Public
158.34 Law 111-5, to the commissioner of human
158.35 services consistent with federal regulations
158.36 for the purpose of basic sliding fee child care

159.1 assistance under Minnesota Statutes, section
159.2 119B.03. This is a onetime appropriation.
159.3 Any unexpended balance the first year is
159.4 available in the second year.

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

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

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

160.1 in this category shall be allocated according
160.2 to paragraph (d).

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

160.9 (d) Funds in excess of the amount necessary
160.10 to serve all families in paragraphs (a) and
160.11 (b) shall be allocated in proportion to each
160.12 county's total expenditures for the basic
160.13 sliding fee child care program reported
160.14 during the most recent fiscal year completed
160.15 at the time of the notice of allocation. To
160.16 the extent that funds are available, and
160.17 notwithstanding Minnesota Statutes, section
160.18 119B.03, subdivision 8, for the period
160.19 January 1, 2011, to December 31, 2011, each
160.20 county's guaranteed floor must be equal to its
160.21 original calendar year 2010 allocation.

160.22 **Base Adjustment.** The general fund base is
160.23 decreased by $257,000 in each of fiscal years
160.24 2012 and 2013.

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

160.26 **Family, friends, and neighbor grants.**
160.27 $375,000 in fiscal year 2010 and $375,000
160.28 in fiscal year 2011 are from the child
160.29 care development fund required targeted
160.30 quality funds for quality expansion and
160.31 infant/toddler from the American Recovery
160.32 and Reinvestment Act of 2009, Public
160.33 Law 111-5, to the commissioner of human
160.34 services for family, friends, and neighbor
160.35 grants under Minnesota Statutes, section

161.1 119B.232. This appropriation may be used
161.2 on programs receiving family, friends, and
161.3 neighbor grant funds as of June 30, 2009,
161.4 or on new programs or projects. This is a
161.5 onetime appropriation. Any unexpended
161.6 balance the first year is available in the
161.7 second year.

161.8 **Voluntary quality rating system training,**
161.9 **coaching, consultation, and supports.**
161.10 $633,000 in fiscal year 2010 and $633,000
161.11 in fiscal year 2011 are from the federal child
161.12 care development fund required targeted
161.13 quality funds for quality expansion and
161.14 infant/toddler from the American Recovery
161.15 and Reinvestment Act of 2009, Public
161.16 Law 111-5, to the commissioner of human
161.17 services consistent with federal regulations
161.18 for the purpose of providing grants to provide
161.19 statewide child-care provider training,
161.20 coaching, consultation, and supports to
161.21 prepare for the voluntary Minnesota quality
161.22 rating system rating tool. This is a onetime
161.23 appropriation. Any unexpended balance the
161.24 first year is available in the second year.

161.25 **Voluntary quality rating system.** $184,000
161.26 in fiscal year 2010 and $1,200,000 in fiscal
161.27 year 2011 are from the federal child care
161.28 development fund required targeted funds for
161.29 quality expansion and infant/toddler from the
161.30 American Recovery and Reinvestment Act of
161.31 2009, Public Law 111-5, to the commissioner
161.32 of human services consistent with federal
161.33 regulations for the purpose of implementing
161.34 the voluntary Parent Aware quality star
161.35 rating system pilot in coordination with the
161.36 Minnesota Early Learning Foundation. The

162.1 appropriation for the first year is to complete
162.2 and promote the voluntary Parent Aware
162.3 quality rating system pilot program through
162.4 June 30, 2010, and the appropriation for
162.5 the second year is to continue the voluntary
162.6 Minnesota quality rating system pilot
162.7 through June 30, 2011. This is a onetime
162.8 appropriation. Any unexpended balance the
162.9 first year is available in the second year.

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

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

162.12	Appropriations by Fund		
162.13	General	48,333,000	50,498,000
162.14	Federal TANF	340,000	240,000

162.15 **Base Adjustment.** The general fund base is
162.16 decreased by $5,371,000 in fiscal year 2012
162.17 and decreased $5,371,000 in fiscal year 2013.

162.18 **Privatized Adoption Grants.** Federal
162.19 reimbursement for privatized adoption grant
162.20 and foster care recruitment grant expenditures
162.21 is appropriated to the commissioner for
162.22 adoption grants and foster care and adoption
162.23 administrative purposes.

162.24 **Adoption Assistance Incentive Grants.**
162.25 Federal funds available during fiscal year
162.26 2010 and fiscal year 2011 for the adoption
162.27 incentive grants are appropriated to the
162.28 commissioner for postadoption services
162.29 including parent support groups.

162.30 **Adoption Assistance and Relative Custody**
162.31 **Assistance.** The commissioner may transfer
162.32 unencumbered appropriation balances for
162.33 adoption assistance and relative custody
162.34 assistance between fiscal years and between
162.35 programs.

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

163.2 **Targeted Case Management Temporary**
163.3 **Funding Adjustment.** The commissioner
163.4 shall recover from each county and tribe
163.5 receiving a targeted case management
163.6 temporary funding payment in fiscal year
163.7 2008 an amount equal to that payment. The
163.8 commissioner shall recover one-half of the
163.9 funds by February 1, 2010, and the remainder
163.10 by February 1, 2011. At the commissioner's
163.11 discretion and at the request of a county
163.12 or tribe, the commissioner may revise
163.13 the payment schedule, but full payment
163.14 must not be delayed beyond May 1, 2011.
163.15 The commissioner may use the recovery
163.16 procedure under Minnesota Statutes, section
163.17 256.017, to recover the funds. Recovered
163.18 funds must be deposited into the general
163.19 fund.

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

163.21 **General Assistance Standard.** The
163.22 commissioner shall set the monthly standard
163.23 of assistance for general assistance units
163.24 consisting of an adult recipient who is
163.25 childless and unmarried or living apart
163.26 from parents or a legal guardian at $203.
163.27 The commissioner may reduce this amount
163.28 according to Laws 1997, chapter 85, article
163.29 3, section 54.

163.30 **Emergency General Assistance.** The
163.31 amount appropriated for emergency general
163.32 assistance funds is limited to no more
163.33 than $7,889,812 in fiscal year 2010 and
163.34 $7,889,812 in fiscal year 2011. Funds
163.35 to counties must be allocated by the

164.1 commissioner using the allocation method
164.2 specified in Minnesota Statutes, section
164.3 256D.06.

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

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

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

164.15 **Group Residential Housing Costs**
164.16 **Refinanced.** (a) Effective July 1, 2011, the
164.17 commissioner shall increase the home and
164.18 community-based service rates and county
164.19 allocations provided to programs for persons
164.20 with disabilities established under section
164.21 1915(c) of the Social Security Act to the
164.22 extent that these programs will be paying
164.23 for the costs above the rate established
164.24 in Minnesota Statutes, section 256I.05,
164.25 subdivision 1.

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

165.1 monthly service expenditures plus the
165.2 amount of the difficulty of care payment.

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

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

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

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

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

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

166.1 **Supportive Housing Services.** $1,500,000
166.2 each year is for supportive services under
166.3 Minnesota Statutes, section 256K.26. This is
166.4 a onetime appropriation.

166.5 **Community Action Grants.** Community
166.6 action grants are reduced one time by
166.7 $1,794,000 each year. This reduction is due
166.8 to the availability of federal funds under the
166.9 American Recovery and Reinvestment Act.

166.10 **Base Adjustment.** The general fund base
166.11 is increased by ~~$773,000~~ $903,000 in fiscal
166.12 year 2012 and ~~$773,000~~ $413,000 in fiscal
166.13 year 2013.

166.14 **Federal ARRA Funds for Existing**
166.15 **Programs.** (a) Federal funds received by the
166.16 commissioner for the emergency food and
166.17 shelter program from the American Recovery
166.18 and Reinvestment Act of 2009, Public
166.19 Law 111-5, but not previously approved
166.20 by the legislature are appropriated to the
166.21 commissioner for the purposes of the grant
166.22 program.

166.23 (b) Federal funds received by the
166.24 commissioner for the emergency shelter
166.25 grant program including the Homelessness
166.26 Prevention and Rapid Re-Housing
166.27 Program from the American Recovery and
166.28 Reinvestment Act of 2009, Public Law
166.29 111-5, are appropriated to the commissioner
166.30 for the purposes of the grant programs.

166.31 (c) Federal funds received by the
166.32 commissioner for the emergency food
166.33 assistance program from the American
166.34 Recovery and Reinvestment Act of 2009,
166.35 Public Law 111-5, are appropriated to the

167.1 commissioner for the purposes of the grant
167.2 program.

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

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

167.17 **Long-Term Homeless Supportive**
167.18 **Service Fund Appropriation.** To the
167.19 extent permitted under federal law, the
167.20 commissioner shall designate $3,000,000
167.21 of the Homelessness Prevention and Rapid
167.22 Re-Housing Program funds provided under
167.23 the American Recovery and Reinvestment
167.24 Act of 2009, Public Law, 111-5, to the
167.25 long-term homeless service fund under
167.26 Minnesota Statutes, section 256K.26. This
167.27 appropriation shall become available by July
167.28 1, 2009. This paragraph is effective the day
167.29 following final enactment.

167.30 Sec. 15. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
167.31 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

167.32 Subd. 8. **Continuing Care Grants**

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

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

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

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

168.13 **Community Service Development Grant**
168.14 **Reduction.** Funding for community service
168.15 development grants must be reduced by
168.16 $260,000 for fiscal year 2010; $284,000 in
168.17 fiscal year 2011; $43,000 in fiscal year 2012;
168.18 and $43,000 in fiscal year 2013. Base level
168.19 funding shall be restored in fiscal year 2014.

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

168.26 **Senior Nutrition Use of Federal Funds.**
168.27 For fiscal year 2010, general fund grants
168.28 for home-delivered meals and congregate
168.29 dining shall be reduced by $500,000. The
168.30 commissioner must replace these general
168.31 fund reductions with equal amounts from
168.32 federal funding for senior nutrition from the
168.33 American Recovery and Reinvestment Act
168.34 of 2009.

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

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

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

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

169.12 **(d) Medical Assistance Long-Term Care**
169.13 **Waivers and Home Care Grants** 853,567,000 1,039,517,000

169.14 **Manage Growth in TBI and CADI**
169.15 **Waivers.** During the fiscal years beginning
169.16 on July 1, 2009, and July 1, 2010, the
169.17 commissioner shall allocate money for home
169.18 and community-based waiver programs
169.19 under Minnesota Statutes, section 256B.49,
169.20 to ensure a reduction in state spending that is
169.21 equivalent to limiting the caseload growth of
169.22 the TBI waiver to 12.5 allocations per month
169.23 each year of the biennium and the CADI
169.24 waiver to 95 allocations per month each year
169.25 of the biennium. Limits do not apply: (1)
169.26 when there is an approved plan for nursing
169.27 facility bed closures for individuals under
169.28 age 65 who require relocation due to the
169.29 bed closure; (2) to fiscal year 2009 waiver
169.30 allocations delayed due to unallotment; or (3)
169.31 to transfers authorized by the commissioner
169.32 from the personal care assistance program
169.33 of individuals having a home care rating
169.34 of "CS," "MT," or "HL." Priorities for the
169.35 allocation of funds must be for individuals

170.1 anticipated to be discharged from institutional
170.2 settings or who are at imminent risk of a
170.3 placement in an institutional setting.

170.4 **Manage Growth in DD Waiver.** The
170.5 commissioner shall manage the growth in
170.6 the DD waiver by limiting the allocations
170.7 included in the February 2009 forecast to 15
170.8 additional diversion allocations each month
170.9 for the calendar years that begin on January
170.10 1, 2010, and January 1, 2011. Additional
170.11 allocations must be made available for
170.12 transfers authorized by the commissioner
170.13 from the personal care program of individuals
170.14 having a home care rating of "CS," "MT,"
170.15 or "HL."

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

170.24 **Alternatives to Personal Care Assistance**
170.25 **Services.** Base level funding of $3,237,000
170.26 in fiscal year 2012 and $4,856,000 in
170.27 fiscal year 2013 is to implement alternative
170.28 services to personal care assistance services
170.29 for persons with mental health and other
170.30 behavioral challenges who can benefit
170.31 from other services that more appropriately
170.32 meet their needs and assist them in living
170.33 independently in the community. These
170.34 services may include, but not be limited to, a
170.35 1915(i) state plan option.

(e) Mental Health Grants

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

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

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

Payments for Substance Abuse Treatment. For ~~services provided~~ placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

(1) rates charged for these services on January 1, 2009; or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, ~~statewide average rates~~ the statewide aggregate payment under

172.1 the new rate methodology to be developed
172.2 under Minnesota Statutes, section 254B.12,
172.3 must not exceed the ~~average rates charged~~
172.4 ~~for these services on January 1, 2009~~
172.5 projected aggregate payment under the rates
172.6 in effect for fiscal year 2011 excluding the
172.7 rate reduction for rates that were below
172.8 the average on January 1, 2009, plus a
172.9 state share increase of $3,787,000 for fiscal
172.10 year 2012 and $5,023,000 for fiscal year
172.11 2013. Notwithstanding any provision to the
172.12 contrary in this article, this provision expires
172.13 on June 30, 2013.

172.14 **Chemical Dependency Special Revenue**
172.15 **Account.** For fiscal year 2010, $750,000
172.16 must be transferred from the consolidated
172.17 chemical dependency treatment fund
172.18 administrative account and deposited into the
172.19 general fund.

172.20 **County CD Share of MA Costs for**
172.21 **ARRA Compliance.** Notwithstanding the
172.22 provisions of Minnesota Statutes, chapter
172.23 254B, for chemical dependency services
172.24 provided during the period October 1, 2008,
172.25 to December 31, 2010, and reimbursed by
172.26 medical assistance at the enhanced federal
172.27 matching rate provided under the American
172.28 Recovery and Reinvestment Act of 2009, the
172.29 county share is 30 percent of the nonfederal
172.30 share. This provision is effective the day
172.31 following final enactment.

172.32 172.33	**(h) Chemical Dependency Nonentitlement Grants**	1,729,000	1,729,000
172.34	**(i) Other Continuing Care Grants**	19,201,000	17,528,000

173.1 **Base Adjustment.** The general fund base is
173.2 increased by $2,639,000 in fiscal year 2012
173.3 and increased by $3,854,000 in fiscal year
173.4 2013.

173.5 **Technology Grants.** $650,000 in fiscal
173.6 year 2010 and $1,000,000 in fiscal year
173.7 2011 are for technology grants, case
173.8 consultation, evaluation, and consumer
173.9 information grants related to developing and
173.10 supporting alternatives to shift-staff foster
173.11 care residential service models.

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

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

173.21 Sec. 16. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by
173.22 Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

173.23 Subd. 8. **Board of Nursing Home** 173.24 **Administrators**	1,211,000	1,023,000

173.25 **Administrative Services Unit - Operating**
173.26 **Costs.** Of this appropriation, $524,000
173.27 in fiscal year 2010 and $526,000 in
173.28 fiscal year 2011 are for operating costs
173.29 of the administrative services unit. The
173.30 administrative services unit may receive
173.31 and expend reimbursements for services
173.32 performed by other agencies.

173.33 **Administrative Services Unit - Retirement**
173.34 **Costs.** Of this appropriation in fiscal year

174.1 2010, $201,000 is for onetime retirement
174.2 costs in the health-related boards. This
174.3 funding may be transferred to the health
174.4 boards incurring those costs for their
174.5 payment. These funds are available either
174.6 year of the biennium.

174.7 **Administrative Services Unit - Volunteer**
174.8 **Health Care Provider Program.** Of this
174.9 appropriation, ~~$79,000~~ $130,000 in fiscal
174.10 year 2010 and ~~$89,000~~ $150,000 in fiscal
174.11 year 2011 are to pay for medical professional
174.12 liability coverage required under Minnesota
174.13 Statutes, section 214.40.

174.14 **Administrative Services Unit - Contested**
174.15 **Cases and Other Legal Proceedings.** Of
174.16 this appropriation, $200,000 in fiscal year
174.17 2010 and $200,000 in fiscal year 2011 are
174.18 for costs of contested case hearings and other
174.19 unanticipated costs of legal proceedings
174.20 involving health-related boards funded
174.21 under this section and for unforeseen
174.22 expenditures of an urgent nature. Upon
174.23 certification of a health-related board to the
174.24 administrative services unit that the costs
174.25 will be incurred and that there is insufficient
174.26 money available to pay for the costs out of
174.27 money currently available to that board, the
174.28 administrative services unit is authorized
174.29 to transfer money from this appropriation
174.30 to the board for payment of those costs
174.31 with the approval of the commissioner of
174.32 finance. This appropriation does not cancel.
174.33 Any unencumbered and unspent balances
174.34 remain available for these expenditures in
174.35 subsequent fiscal years. The boards receiving
174.36 funds under this section shall include these

175.1 amounts when setting fees to cover their
175.2 costs.

175.3 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

175.4 All uncodified language contained in this article expires on June 30, 2011, unless a
175.5 different expiration date is explicit.

175.6 Sec. 18. **EFFECTIVE DATE.**

175.7 The provisions in this article are effective July 1, 2010, unless a different effective
175.8 date is explicit.

APPENDIX
Article locations in H2614-4

ARTICLE 1	HEALTH CARE	Page.Ln 2.5
ARTICLE 2	CONTINUING CARE	Page.Ln 45.1
ARTICLE 3	CHILDREN AND FAMILY SERVICES	Page.Ln 68.4
ARTICLE 4	MISCELLANEOUS	Page.Ln 71.12
ARTICLE 5	DEPARTMENT OF HEALTH	Page.Ln 91.5
ARTICLE 6	PUBLIC HEALTH	Page.Ln 99.25
ARTICLE 7	HEALTH CARE REFORM	Page.Ln 106.27
ARTICLE 8	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 111.25
ARTICLE 9	HUMAN SERVICES CONTINGENT APPROPRIATIONS	Page.Ln 114.1
ARTICLE 10	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 119.8

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.

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.

(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

months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

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

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

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

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 5. **Certain county agencies to pay state for county share.** The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does

not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may

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.

256J.621 WORK PARTICIPATION CASH BENEFITS.

(a) Effective October 1, 2009, upon exiting the diversionary work program (DWP) or upon terminating the Minnesota family investment program with earnings, a participant who is employed may be eligible for work participation cash benefits of $50 per month to assist in meeting the family's basic needs as the participant continues to move toward self-sufficiency.

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

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

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

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

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

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

Laws 2010, chapter 200, article 1, section 12

Sec. 12. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of $1,000 per assistance unit.
Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

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

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

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance

medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

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

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

(1) inpatient hospital services;

(2) outpatient hospital services;

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

(4) prescription drugs;

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

(6) eyeglasses and eye examinations;

(7) hearing aids;

(8) prosthetic devices, if not covered by veterans benefits;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services;

(15) mental health services covered under chapter 256B;

(16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

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

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

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) $25 for nonemergency visits to a hospital-based emergency room; and

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the $7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

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

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 5. **Payment rates and contract modification; April 1, 2010, to May 31, 2010.** (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

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

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

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

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

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

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

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

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

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

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

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

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

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

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

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

Subd. 7. **Payments; rate setting for the hospital coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery

system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

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

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

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

Subd. 8. **Temporary uncompensated care pool.** (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

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

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

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

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

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

Subd. 9. **Prescription drug pool.** (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

Subd. 10. **Assistance for veterans.** Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

EFFECTIVE DATE. This section is effective for services rendered on or after April 1, 2010.

Laws 2010, chapter 200, article 1, section 18

Sec. 18. **DRUG REBATE PROGRAM.**

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.