

A bill for an act

1.1 relating to government finance; appropriating and transferring money and
1.2 supplementing or reducing appropriations for the Departments of Health, Human
1.3 Services, Veterans Affairs, Corrections, and Commerce, health-related boards,
1.4 the Emergency Medical Services Board, and the University of Minnesota;
1.5 establishing, regulating, or modifying health care services programs, continuing
1.6 care services, children and family services, and Department of Health provisions;
1.7 amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision;
1.8 62J.692, subdivision 4; 144.05, by adding a subdivision; 144.226, subdivision
1.9 3; 144D.03, subdivision 2, by adding a subdivision; 144D.04, subdivision
1.10 2; 144E.37; 144G.06; 152.126, as amended; 214.40, subdivision 7; 246.18,
1.11 by adding a subdivision; 254B.01, subdivision 2; 254B.02, subdivisions 1,
1.12 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision
1.13 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.9657, subdivisions
1.14 1, 2, 3, 3a; 256.969, subdivisions 21, 26, by adding a subdivision; 256B.04,
1.15 subdivision 14a; 256B.055, by adding a subdivision; 256B.056, subdivisions 3,
1.16 4; 256B.0625, subdivision 22, by adding a subdivision; 256B.0631, subdivisions
1.17 1, 3; 256B.0644, as amended; 256B.0753, by adding a subdivision; 256B.0915,
1.18 by adding a subdivision; 256B.441, subdivision 53; 256B.49, by adding a
1.19 subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivision 27,
1.20 by adding a subdivision; 256B.692, subdivision 1; 256B.76, subdivisions 2,
1.21 4; 256D.0515; 256J.24, subdivision 6; 256L.12, subdivisions 5, 9, by adding
1.22 a subdivision; 514.982, subdivision 2; 517.08, subdivision 1c, as amended;
1.23 Minnesota Statutes 2009 Supplement, sections 157.16, subdivision 3; 256.969,
1.24 subdivisions 2b, 3a; 256.975, subdivision 7; 256B.0625, subdivision 13h;
1.25 256B.0659, subdivision 11; 256B.0911, subdivision 3c; 256B.441, subdivision
1.26 55; 256B.69, subdivisions 5a, 23; 256B.76, subdivision 1; 256B.766; 256D.03,
1.27 subdivision 3, as amended; 256J.425, subdivision 3; 256L.03, subdivision 5;
1.28 327.15, subdivision 3; 517.08, subdivision 1b; Laws 2009, chapter 79, article
1.29 3, section 18; article 5, sections 75, subdivision 1; 78, subdivision 5; article
1.30 13, sections 3, subdivisions 1, as amended, 4, as amended, 6, 8, as amended;
1.31 5, subdivision 8, as amended; Laws 2010, chapter 200, article 1, sections 12,
1.32 subdivision 7; 16; 21; article 2, section 2, subdivisions 1, 5, 8; proposing coding
1.33 for new law in Minnesota Statutes, chapters 62D; 62Q; 137; 144D; 256B;
1.34 repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4;
1.35 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3, 3a, 5, 6, 7, 8; Laws 2010,
1.36 chapter 200, article 1, sections 12; 18; 19.

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

ARTICLE 1

HEALTH CARE

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

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

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

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

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

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

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

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

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

(b) Effective October 1, 2010, in addition to the surcharge under paragraph (a), each health maintenance organization shall pay to the commissioner a surcharge equal to 0.85 percent of total premium revenues and each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to 1.45 percent of the total premium revenues of the plan, as reported to the commissioner of health, according to the payment schedule in subdivision 4. Notwithstanding section 256.9656,

3.1 money collected under this paragraph shall be deposited in the health care access fund
3.2 established in section 16A.724.

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

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

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

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

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

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

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

3.31 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
3.32 corporation's surcharge shall be based on the revenues earned in the second previous
3.33 calendar year by all of the entities or corporations subject to the merger, consolidation,
3.34 or acquisition regardless of whether one of the entities or corporations does not retain a
3.35 certificate of authority under chapter 62D or a license under chapter 62N until the total

4.1 premium revenues of the surviving corporation include the total premium revenues of all
4.2 the merged entities as reported to the commissioner of health.

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

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

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

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

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

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

5.1 services covered by medical assistance and shall not include property cost information
5.2 and costs recognized in outlier payments.

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

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

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

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

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

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

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

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

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

6.35 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
6.36 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for

7.1 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
7.2 from the current statutory rates. Mental health services with diagnosis related groups
7.3 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
7.4 Payments made to managed care plans shall be reduced for services provided on or after
7.5 July 1, 2010, to reflect this reduction.

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

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

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

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

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

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

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

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

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

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

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

8.26 (2) 90 percent of the average payment rate for that diagnostic category for hospitals
8.27 located within the seven-county metropolitan area, exclusive of disproportionate
8.28 population adjustments received under subdivision 9 and hospital payment adjustments
8.29 received under subdivisions 20 and 23.

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

- 8.32 (1) 370 cesarean section with complicating diagnosis;
8.33 (2) 371 cesarean section without complicating diagnosis;
8.34 (3) 372 vaginal delivery with complicating diagnosis;
8.35 (4) 373 vaginal delivery without complicating diagnosis;

9.1 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;

9.2 (6) 388 full-term neonates with other problems;

9.3 (7) 390 prematurity without major problems;

9.4 (8) 391 normal newborn;

9.5 (9) 385 neonate, died or transferred to another acute care facility;

9.6 (10) 425 acute adjustment reaction and psychosocial dysfunction;

9.7 (11) 430 psychoses;

9.8 (12) 431 childhood mental disorders; and

9.9 (13) 164-167 appendectomy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.9 (3) is not pregnant; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13.15 (2) formulating a medication treatment plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.12 (2) \$3 for eyeglasses;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27.9 (vii) have free care available as needed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31.31 **Medical Education Research Costs**

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

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

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

32.13 **Local Share Payment Modification**

32.14 **Required for ARRA Compliance.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36.26 Sec. 36. **REPEALER.**

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

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

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

ARTICLE 2

CONTINUING CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38.24 (6) the term of the contract;

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

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

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

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

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

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

39.14 All housing with services establishments shall make available to all prospective

39.15 and current residents information consistent with the uniform format and the required

39.16 components adopted by the commissioner under section 144G.06.

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

39.18 The housing with services establishment shall include with notice of termination

39.19 of lease information about how to contact the ombudsman for long-term care, including

39.20 the address and phone number along with a statement of how to request problem-solving

39.21 assistance.

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

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

39.24 (a) The commissioner of health shall establish an advisory committee consisting

39.25 of representatives of consumers, providers, county and state officials, and other

39.26 groups the commissioner considers appropriate. The advisory committee shall present

39.27 recommendations to the commissioner on:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

53.27 **ARTICLE 3**

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

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

53.31 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

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

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

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

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

54.6 Sec. 2. Minnesota Statutes 2008, section 256J.24, subdivision 6, is amended to read:

54.7 Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the
54.8 cash portion of the transitional standard as a result of the birth of a child, unless one of
54.9 the conditions under paragraph (b) is met. The child shall be considered a member of the
54.10 assistance unit according to subdivisions 1 to 3, but shall be excluded in determining
54.11 family size for purposes of determining the amount of the cash portion of the transitional
54.12 standard under subdivision 5. The child shall be included in determining family size for
54.13 purposes of determining the food portion of the transitional standard. The transitional
54.14 standard under this subdivision shall be the total of the cash and food portions as specified
54.15 in this paragraph. The family wage level under this subdivision shall be based on the
54.16 family size used to determine the food portion of the transitional standard.

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

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

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

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

54.27 (4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision
54.28 59, and the child, or multiple children, are the mother's first birth; ~~or~~

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

54.31 (6) any child previously excluded in determining family size under paragraph
54.32 (a) shall be included if the adult parent or parents have not received benefits from the
54.33 diversionary work program under section 256J.95 or MFIP assistance in the previous ten
54.34 months. An adult parent or parents who reapply and have received benefits from the

55.1 diversionary work program or MFIP assistance in the past ten months shall be under the
55.2 ten-month grace period of their previous application under clause (2).

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

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

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

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

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

55.16 Sec. 3. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is
55.17 amended to read:

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

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

55.25 (2) a person who:

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

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

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

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

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

56.22 ARTICLE 4

56.23 DEPARTMENT OF HEALTH

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

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

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

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

57.1 EFFECTIVE DATE. This section is effective January 1, 2013.

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

57.3 Subdivision 1. Establishment. The Advisory Group on Administrative Expenses
57.4 is established to make recommendations on the development of consistent guidelines
57.5 and reporting requirements, including development of a reporting template, for health
57.6 maintenance organizations and county-based purchasing plans that participate in publicly
57.7 funded programs.

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

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

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

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

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

57.15 (5) three members appointed by the commissioner of health to represent:

57.16 (i) hospitals;

57.17 (ii) physicians; and

57.18 (iii) other health care providers; and

57.19 (6) one member appointed by the commissioner of health to represent consumers.

57.20 (b) The appointments required under this subdivision shall be completed by
57.21 November 1, 2010.

57.22 Subd. 3. Administration. The commissioner of health shall convene the first
57.23 meeting of the advisory group by December 1, 2010, and shall provide administrative
57.24 support and staff. The commissioner of health may contract with a consultant to provide
57.25 professional assistance and expertise to the advisory group.

57.26 Subd. 4. Recommendations. The Advisory Group on Administrative Expenses
57.27 must report its recommendations, including any proposed legislation necessary to
57.28 implement the recommendations, to the commissioner of health and to the chairs and
57.29 ranking minority members of the legislative committees and divisions with jurisdiction
57.30 over health policy and finance by February 15, 2012.

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

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

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

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

58.8 (2) a supplemental public program volume factor, which is determined by providing
58.9 a supplemental payment of 20 percent of each training site's grant to training sites whose
58.10 public program revenue accounted for at least 0.98 percent of the total public program
58.11 revenue received by all eligible training sites. Grants to training sites whose public
58.12 program revenue accounted for less than 0.98 percent of the total public program revenue
58.13 received by all eligible training sites shall be reduced by an amount equal to the total
58.14 value of the supplemental payment.

58.15 Public program revenue for the distribution formula includes revenue from medical
58.16 assistance, prepaid medical assistance, general assistance medical care, and prepaid
58.17 general assistance medical care. Training sites that receive no public program revenue
58.18 are ineligible for funds available under this subdivision. For purposes of determining
58.19 training-site level grants to be distributed under paragraph (a), total statewide average
58.20 costs per trainee for medical residents is based on audited clinical training costs per trainee
58.21 in primary care clinical medical education programs for medical residents. Total statewide
58.22 average costs per trainee for dental residents is based on audited clinical training costs
58.23 per trainee in clinical medical education programs for dental students. Total statewide
58.24 average costs per trainee for pharmacy residents is based on audited clinical training costs
58.25 per trainee in clinical medical education programs for pharmacy students.

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

58.28 (1) \$1,475,000 to the University of Minnesota Medical Center-Fairview;

58.29 (2) \$2,075,000 to the University of Minnesota School of Dentistry; and

58.30 (3) \$1,800,000 to the Academic Health Center. \$150,000 of the funds distributed
58.31 to the Academic Health Center under this paragraph shall be used for a program to
58.32 assist foreign-trained physicians to successfully compete for family medicine residency
58.33 programs at the University of Minnesota.

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

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

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

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

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

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

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

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

59.32 (b) In addition to any fee prescribed under subdivision 1, there shall be a
59.33 nonrefundable surcharge of \$10 for each certified birth record. The local or state registrar
59.34 shall forward this amount to the commissioner of management and budget for deposit in

60.1 the general fund. This surcharge shall not be charged under those circumstances in which
60.2 no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

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

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

60.5 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**

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

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

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

60.14 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required
60.15 for food and beverage service establishments, youth camps, hotels, motels, lodging
60.16 establishments, public pools, and resorts licensed under this chapter. Food and beverage
60.17 service establishments must pay the highest applicable fee under paragraph (d), clause
60.18 (1), (2), (3), or (4), and establishments serving alcohol must pay the highest applicable
60.19 fee under paragraph (d), clause (6) or (7). The license fee for new operators previously
60.20 licensed under this chapter for the same calendar year is one-half of the appropriate annual
60.21 license fee, plus any penalty that may be required. The license fee for operators opening
60.22 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
60.23 that may be required.

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

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

60.31 (d) In addition to the base fee in paragraph (b), each food and beverage service
60.32 establishment, other than a special event food stand, and each hotel, motel, lodging
60.33 establishment, public pool, and resort shall pay an additional annual fee for each fee

61.1 category, additional food service, or required additional inspection specified in this
61.2 paragraph:

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

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

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

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

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

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

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

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

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

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

61.18 (iv) is a boarding establishment; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62.33	Service Area	Type	Fee
62.34	Food	limited food menu	\$275
62.35		small establishment	\$400
62.36		medium establishment	\$450
62.37		large food establishment	\$500

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63.1		additional food service	\$150
63.2	Transient food service	food cart	\$250
63.3		seasonal permanent food stand	\$250
63.4		seasonal temporary food stand	\$250
63.5		mobile food unit	\$350
63.6	Alcohol	beer or wine table service	\$150
63.7		alcohol service from bar	\$250
63.8	Lodging	less than 25 rooms	\$375
63.9		25 to less than 100 rooms	\$400
63.10		100 rooms or more	\$500
63.11		less than five cabins	\$350
63.12		five to less than ten cabins	\$400
63.13		ten cabins or more	\$450

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

63.18	Service Area	Type	Fee
63.19	Food	limited food menu	\$250
63.20		small establishment	\$300
63.21		medium establishment	\$350
63.22		large food establishment	\$400
63.23		additional food service	\$150
63.24	Transient food service	food cart	\$250
63.25		seasonal permanent food stand	\$250
63.26		seasonal temporary food stand	\$250
63.27		mobile food unit	\$250
63.28	Alcohol	beer or wine table service	\$150
63.29		alcohol service from bar	\$250
63.30	Lodging	less than 25 rooms	\$250
63.31		25 to less than 100 rooms	\$300
63.32		100 rooms or more	\$450
63.33		less than five cabins	\$250
63.34		five to less than ten cabins	\$350
63.35		ten cabins or more	\$400

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

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

- 63.39 (1) camps with up to 99 campers, \$325;
- 63.40 (2) camps with 100 to 199 campers, \$550; and
- 63.41 (3) camps with 200 or more campers, \$750.

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

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

64.5 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a)
64.6 The following fees are required for manufactured home parks and recreational camping
64.7 areas licensed under this chapter. Recreational camping areas and manufactured home
64.8 parks shall pay the highest applicable base fee under paragraph ~~(e)~~ (b). The license fee
64.9 for new operators of a manufactured home park or recreational camping area previously
64.10 licensed under this chapter for the same calendar year is one-half of the appropriate annual
64.11 license fee, plus any penalty that may be required. The license fee for operators opening
64.12 on or after October 1 is one-half of the appropriate annual license fee, plus any penalty
64.13 that may be required.

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

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

64.17 (2) a recreational camping area with:

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

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

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

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

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

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

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

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

- 65.3 (1) for initial construction of less than 25 sites, \$375;
65.4 (2) for initial construction of 25 to 99 sites, \$400; and
65.5 (3) for initial construction of 100 or more sites, \$500.

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

- 65.8 (1) for expansion of less than 25 sites, \$250;
65.9 (2) for expansion of 25 to 99 sites, \$300; and
65.10 (3) for expansion of 100 or more sites, \$450.

65.11 Sec. 8. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
65.12 **REDUCTION; REPORTING REQUIREMENTS.**

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

- 65.17 (1) are collected from the same health plan or county-based purchasing plan more
65.18 than once;
65.19 (2) are collected directly from the health plan or county-based purchasing plan but
65.20 are available to the state agencies from other sources;
65.21 (3) are not currently being used by state agencies; or
65.22 (4) collect similar information more than once in different formats, at different
65.23 times, or by more than one state agency.

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

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

65.34 Sec. 9. **TRANSFER.**

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

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

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

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

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

66.11 **ARTICLE 5**

66.12 **GENERAL ASSISTANCE MEDICAL CARE AMENDMENTS**

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

66.15 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE** 66.16 **PROGRAMS.**

66.17 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
66.18 health maintenance organization, as defined in chapter 62D, must participate as a provider
66.19 or contractor in the medical assistance program, general assistance medical care program,
66.20 and MinnesotaCare as a condition of participating as a provider in health insurance plans
66.21 and programs or contractor for state employees established under section 43A.18, the
66.22 public employees insurance program under section 43A.316, for health insurance plans
66.23 offered to local statutory or home rule charter city, county, and school district employees,
66.24 the workers' compensation system under section 176.135, and insurance plans provided
66.25 through the Minnesota Comprehensive Health Association under sections 62E.01 to
66.26 62E.19. The limitations on insurance plans offered to local government employees shall
66.27 not be applicable in geographic areas where provider participation is limited by managed
66.28 care contracts with the Department of Human Services.

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

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

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

67.4 (3) for dental service providers, at least ten percent of the provider's patients are
67.5 covered by medical assistance, general assistance medical care, and MinnesotaCare as
67.6 their primary source of coverage, or the provider accepts new medical assistance and
67.7 MinnesotaCare patients who are children with special health care needs. For purposes
67.8 of this section, "children with special health care needs" means children up to age 18
67.9 who: (i) require health and related services beyond that required by children generally;
67.10 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
67.11 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
67.12 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
67.13 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
67.14 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
67.15 commissioner after consultation with representatives of pediatric dental providers and
67.16 consumers.

67.17 (c) Patients seen on a volunteer basis by the provider at a location other than
67.18 the provider's usual place of practice may be considered in meeting the participation
67.19 requirement in this section. The commissioner shall establish participation requirements
67.20 for health maintenance organizations. The commissioner shall provide lists of participating
67.21 medical assistance providers on a quarterly basis to the commissioner of management and
67.22 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
67.23 of the commissioners shall develop and implement procedures to exclude as participating
67.24 providers in the program or programs under their jurisdiction those providers who do
67.25 not participate in the medical assistance program. The commissioner of management
67.26 and budget shall implement this section through contracts with participating health and
67.27 dental carriers.

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

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

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

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

68.2 Subd. 27. **Information for persons with limited English-language proficiency.**
68.3 Managed care contracts entered into under this section and ~~sections 256D.03, subdivision~~
68.4 ~~4, paragraph (c), and section 256L.12~~ must require demonstration providers to provide
68.5 language assistance to enrollees that ensures meaningful access to its programs and
68.6 services according to Title VI of the Civil Rights Act and federal regulations adopted
68.7 under that law or any guidance from the United States Department of Health and Human
68.8 Services.

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

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

68.11 Subdivision 1. **In general.** County boards or groups of county boards may elect
68.12 to purchase or provide health care services on behalf of persons eligible for medical
68.13 assistance ~~and general assistance medical care~~ who would otherwise be required to or may
68.14 elect to participate in the prepaid medical assistance ~~or prepaid general assistance medical~~
68.15 ~~care programs~~ according to ~~sections~~ section 256B.69 and 256D.03. Counties that elect to
68.16 purchase or provide health care under this section must provide all services included in
68.17 prepaid managed care programs according to ~~sections~~ section 256B.69, subdivisions 1
68.18 ~~to 22, and 256D.03~~. County-based purchasing under this section is governed by section
68.19 256B.69, unless otherwise provided for under this section.

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

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

68.23 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
68.24 the general assistance medical care program shall be administered according to section
68.25 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
68.26 which shall continue to be administered under this section and funded under section
68.27 256D.031, subdivision 9, beginning June 1, 2010.

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

68.30 (1) are covered under the medical assistance program as described in section
68.31 256B.0625, subdivisions 13 and 13d; and

68.32 (2) are provided by manufacturers that have fully executed general assistance
68.33 medical care rebate agreements with the commissioner and comply with the agreements.

69.1 Outpatient prescription drug coverage under general assistance medical care must conform
69.2 to coverage under the medical assistance program according to section 256B.0625,
69.3 subdivisions 13 to ~~13g~~ 13h.

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

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

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

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

69.10 Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who
69.11 become eligible for medical assistance ~~or general assistance medical care~~ will remain in
69.12 the same managed care plan if the managed care plan has a contract for that population.
69.13 ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for
69.14 general assistance medical care pursuant to section 256D.03, subdivision 3, within six
69.15 months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant
69.16 to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care
69.17 plan if the managed care plan has a contract for that population. Managed care plans must
69.18 participate in the MinnesotaCare ~~and general assistance medical care programs~~ program
69.19 under a contract with the Department of Human Services in service areas where they
69.20 participate in the medical assistance program.

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

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

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

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

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

69.28 Subd. 7. **Payments; rate setting for the hospital coordinated care delivery**
69.29 **system.** (a) Effective for general assistance medical care services, with the exception
69.30 of outpatient prescription drug coverage, provided on or after June 1, 2010, through a
69.31 coordinated care delivery system, the commissioner shall allocate the annual appropriation

70.1 for the coordinated care delivery system to hospitals participating under subdivision
70.2 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1,
70.3 2010. The payment shall be allocated among all hospitals qualified to participate on the
70.4 allocation date. ~~Each hospital or group of hospitals shall receive a pro rata share of the~~
70.5 ~~allocation based on the hospital's or group of hospitals' calendar year 2008 payments for~~
70.6 ~~general assistance medical care services, provided that, for the purposes of this allocation,~~
70.7 ~~payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical~~
70.8 ~~Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110~~
70.9 ~~percent of the actual amount.~~ as follows:

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

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

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

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

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

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

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

70.34 ~~(e)~~ (d) The commissioner shall apply for federal matching funds under section
70.35 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

71.1 ~~(d)~~ (e) Outpatient prescription drug coverage is provided in accordance with section
 71.2 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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

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

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

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

71.8 Sec. 21. **REPEALER.**

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

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

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

71.15 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
 71.16 3, are repealed effective for federal fiscal year 2010.

71.17 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
 71.18 4; and 256L.17, subdivision 7, are repealed ~~January 1, 2011~~ June 1, 2010.

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

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

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

71.22 Appropriations by Fund

71.23		2010	2011
71.24	General	34,807,000	118,493,000
71.25	Health Care Access	(42,792,000)	(211,621,000)

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

71.29 **Special Revenue Fund Transfers.**

71.30 (a) The commissioner shall transfer the
 71.31 following amounts from special revenue

72.1 fund balances to the general fund by June
72.2 30 of each respective fiscal year: \$410,000
72.3 for fiscal year 2010, and \$412,000 for fiscal
72.4 year 2011.
72.5 (b) Actual transfers made under paragraph
72.6 (a) must be separately identified and reported
72.7 as part of the quarterly reporting of transfers
72.8 to the chairs of the relevant senate budget
72.9 division and house finance division.

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

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

72.12 Subd. 5. **Health Care Management**

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

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

72.16 **Base Adjustment.** The general fund base
72.17 for health care administration is reduced by
72.18 ~~\$182,000~~ \$36,000 in fiscal year 2012 and
72.19 ~~\$182,000~~ \$36,000 in fiscal year 2013.

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

72.21 Subd. 8. **Transfers**

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

72.26 The commissioner must transfer \$4,800,000
72.27 from the consolidated chemical dependency
72.28 treatment fund to the general fund by June
72.29 30, 2010.

72.30 **Compulsive Gambling ~~Special Revenue~~**
72.31 **Administration.** The lottery prize fund

73.1 appropriation for compulsive gambling
73.2 administration is reduced by \$6,000 for fiscal
73.3 year 2010 and \$4,000 for fiscal year 2011
73.4 ~~must be transferred from the lottery prize~~
73.5 ~~fund appropriation for compulsive gambling~~
73.6 ~~administration to the general fund by June~~
73.7 ~~30 of each respective fiscal year. These are~~
73.8 onetime reductions.

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

73.10 **ARTICLE 6**

73.11 **MISCELLANEOUS**

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

73.13 (a) Private duty nursing services, as provided under section 256B.0625, subdivision
73.14 7, with the exception of section 256B.0654, subdivision 4, shall be covered under a health
73.15 plan for persons who are concurrently covered by both the health plan and enrolled in
73.16 medical assistance under chapter 256B.

73.17 (b) For purposes of this section, a period of private duty nursing services may
73.18 be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing
73.19 requirements that apply under the health plan. Cost-sharing requirements for private
73.20 duty nursing services must not place a greater financial burden on the insured or enrollee
73.21 than those requirements applied by the health plan to other similar services or benefits.
73.22 Nothing in this section is intended to prevent a health plan company from requiring
73.23 prior authorization by the health plan company for such services as required by section
73.24 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions
73.25 of the health plan.

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

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

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

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

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

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

74.7 and

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

74.9 Sec. 3. Minnesota Statutes 2008, section 144.05, is amended by adding a subdivision
74.10 to read:

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

74.15 Sec. 4. Minnesota Statutes 2008, section 152.126, as amended by Laws 2009, chapter
74.16 79, article 11, sections 9, 10, and 11, is amended to read:

74.17 **152.126 ~~SCHEDULE H AND H~~ CONTROLLED SUBSTANCES**
74.18 **PRESCRIPTION ELECTRONIC REPORTING SYSTEM.**

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

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

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

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

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

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

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

75.2 Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or
75.3 interfere with the legitimate prescribing of controlled substances for pain. No prescriber
75.4 shall be subject to disciplinary action by a health-related licensing board for prescribing a
75.5 controlled substance according to the provisions of section 152.125.

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

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

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

75.15 (1) the Department of Health;

75.16 (2) the Department of Human Services;

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

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

75.20 (5) a professional pharmacy association;

75.21 (6) a professional nursing association;

75.22 (7) a professional dental association;

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

75.24 (9) a consumer or patient rights organization.

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

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

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

75.29 (3) an evaluation process for the program.

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

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

75.36 (1) name of the prescriber;

- 76.1 (2) national provider identifier of the prescriber;
- 76.2 (3) name of the dispenser;
- 76.3 (4) national provider identifier of the dispenser;
- 76.4 (5) prescription number;
- 76.5 (6) name of the patient for whom the prescription was written;
- 76.6 (7) address of the patient for whom the prescription was written;
- 76.7 (8) date of birth of the patient for whom the prescription was written;
- 76.8 (9) date the prescription was written;
- 76.9 (10) date the prescription was filled;
- 76.10 (11) name and strength of the controlled substance;
- 76.11 (12) quantity of controlled substance prescribed;
- 76.12 (13) quantity of controlled substance dispensed; and
- 76.13 (14) number of days supply.

76.14 (b) The dispenser must submit the required information by a procedure and in a
76.15 format established by the board. The board may allow dispensers to omit data listed in this
76.16 subdivision or may require the submission of data not listed in this subdivision provided
76.17 the omission or submission is necessary for the purpose of complying with the electronic
76.18 reporting or data transmission standards of the American Society for Automation in
76.19 Pharmacy, the National Council on Prescription Drug Programs, or other relevant national
76.20 standard-setting body.

76.21 (c) A dispenser is not required to submit this data for those controlled substance
76.22 prescriptions dispensed for:

- 76.23 (1) individuals residing in licensed skilled nursing or intermediate care facilities;
- 76.24 (2) individuals receiving assisted living services under chapter 144G or through a
76.25 medical assistance home and community-based waiver;
- 76.26 (3) individuals receiving medication intravenously;
- 76.27 (4) individuals receiving hospice and other palliative or end-of-life care; and
- 76.28 (5) individuals receiving services from a home care provider regulated under chapter
76.29 144A.

76.30 (d) A dispenser must not submit data under this subdivision unless a conspicuous
76.31 notice of the reporting requirements of this section is given to the patient for whom the
76.32 prescription was written.

76.33 **Subd. 5. Use of data by board.** (a) The board shall develop and maintain a database
76.34 of the data reported under subdivision 4. The board shall maintain data that could identify
76.35 an individual prescriber or dispenser in encrypted form. The database may be used by
76.36 permissible users identified under subdivision 6 for the identification of:

77.1 (1) individuals receiving prescriptions for controlled substances from prescribers
77.2 who subsequently obtain controlled substances from dispensers in quantities or with a
77.3 frequency inconsistent with generally recognized standards of use for those controlled
77.4 substances, including standards accepted by national and international pain management
77.5 associations; and

77.6 (2) individuals presenting forged or otherwise false or altered prescriptions for
77.7 controlled substances to dispensers.

77.8 (b) No permissible user identified under subdivision 6 may access the database
77.9 for the sole purpose of identifying prescribers of controlled substances for unusual or
77.10 excessive prescribing patterns without a valid search warrant or court order.

77.11 (c) No personnel of a state or federal occupational licensing board or agency may
77.12 access the database for the purpose of obtaining information to be used to initiate or
77.13 substantiate a disciplinary action against a prescriber.

77.14 (d) Data reported under subdivision 4 shall be retained by the board in the database
77.15 for a 12-month period, and shall be removed from the database no later than 12 months
77.16 from the date the last day of the month during which the data was received.

77.17 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
77.18 subdivision, the data submitted to the board under subdivision 4 is private data on
77.19 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

77.20 (b) Except as specified in subdivision 5, the following persons shall be considered
77.21 permissible users and may access the data submitted under subdivision 4 in the same or
77.22 similar manner, and for the same or similar purposes, as those persons who are authorized
77.23 to access similar private data on individuals under federal and state law:

77.24 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
77.25 delegated the task of accessing the data, to the extent the information relates specifically to
77.26 a current patient, to whom the prescriber is prescribing or considering prescribing any
77.27 controlled substance and with the provision that the prescriber remains responsible for the
77.28 use or misuse of data accessed by a delegated agent or employee;

77.29 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
77.30 delegated the task of accessing the data, to the extent the information relates specifically
77.31 to a current patient to whom that dispenser is dispensing or considering dispensing any
77.32 controlled substance and with the provision that the dispenser remains responsible for the
77.33 use or misuse of data accessed by a delegated agent or employee;

77.34 (3) an individual who is the recipient of a controlled substance prescription for
77.35 which data was submitted under subdivision 4, or a guardian of the individual, parent or

78.1 guardian of a minor, or health care agent of the individual acting under a health care
78.2 directive under chapter 145C;

78.3 (4) personnel of the board specifically assigned to conduct a bona fide investigation
78.4 of a specific licensee;

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

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

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

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

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

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

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

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

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

79.4 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into
79.5 pursuant to subdivision 2. A vendor shall not use data collected under this section for
79.6 any purpose not specified in this section.

79.7 Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to
79.8 the board as required under this section is subject to disciplinary action by the appropriate
79.9 health-related licensing board.

79.10 (b) A prescriber or dispenser authorized to access the data who knowingly discloses
79.11 the data in violation of state or federal laws relating to the privacy of health care data
79.12 shall be subject to disciplinary action by the appropriate health-related licensing board,
79.13 and appropriate civil penalties.

79.14 Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription
79.15 electronic reporting system to determine if the system is negatively impacting appropriate
79.16 prescribing practices of controlled substances. The board may contract with a vendor to
79.17 design and conduct the evaluation.

79.18 (b) The board shall submit the evaluation of the system to the legislature by ~~January~~
79.19 July 15, 2011.

79.20 Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A
79.21 pharmacist, prescriber, or other dispenser making a report to the program in good faith
79.22 under this section is immune from any civil, criminal, or administrative liability, which
79.23 might otherwise be incurred or imposed as a result of the report, or on the basis that the
79.24 pharmacist or prescriber did or did not seek or obtain or use information from the program.

79.25 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser
79.26 to obtain information about a patient from the program, and the pharmacist, prescriber,
79.27 or other dispenser, if acting in good faith, is immune from any civil, criminal, or
79.28 administrative liability that might otherwise be incurred or imposed for requesting,
79.29 receiving, or using information from the program.

79.30 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit
79.31 charitable foundations, the federal government, and other sources to fund the enhancement
79.32 and ongoing operations of the prescription electronic reporting system established under
79.33 this section. Any funds received shall be appropriated to the board for this purpose. The
79.34 board may not expend funds to enhance the program in a way that conflicts with this
79.35 section without seeking approval from the legislature.

80.1 (b) The administrative services unit for the health-related licensing boards shall
80.2 apportion between the Board of Medical Practice, the Board of Nursing, the Board of
80.3 Dentistry, the Board of Podiatric Medicine, the Board of Optometry, and the Board
80.4 of Pharmacy an amount to be paid through fees by each respective board. The amount
80.5 apportioned to each board shall equal each board's share of the annual appropriation to
80.6 the Board of Pharmacy from the state government special revenue fund for operating the
80.7 prescription electronic reporting system under this section. Each board's apportioned
80.8 share shall be based on the number of prescribers or dispensers that each board identified
80.9 in this paragraph licenses as a percentage of the total number of prescribers and dispensers
80.10 licensed collectively by these boards. Each respective board may adjust the fees that the
80.11 boards are required to collect to compensate for the amount apportioned to each board by
80.12 the administrative services unit.

80.13 Sec. 5. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision
80.14 to read:

80.15 Subd. 8. **State-operated services account.** The state-operated services account is
80.16 established in the special revenue fund. Revenue generated by new state-operated services
80.17 listed under this section established after July 1, 2010, that are not enterprise activities must
80.18 be deposited into the state-operated services account, unless otherwise specified in law:

- 80.19 (1) intensive residential treatment services;
80.20 (2) foster care services; and
80.21 (3) psychiatric extensive recovery treatment services.

80.22 Sec. 6. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

80.23 Subd. 2. **American Indian.** For purposes of services provided under section
80.24 254B.09, subdivision ~~7~~ 8, "American Indian" means a person who is a member of an
80.25 Indian tribe, and the commissioner shall use the definitions of "Indian" and "Indian tribe"
80.26 and "Indian organization" provided in Public Law 93-638. For purposes of services
80.27 provided under section 254B.09, subdivision ~~4~~ 6, "American Indian" means a resident of
80.28 federally recognized tribal lands who is recognized as an Indian person by the federally
80.29 recognized tribal governing body.

80.30 Sec. 7. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

80.31 Subdivision 1. **Chemical dependency treatment allocation.** The chemical
80.32 dependency ~~funds appropriated for allocation~~ treatment appropriation shall be placed in
80.33 a special revenue account. The commissioner shall annually transfer funds from the

81.1 chemical dependency fund to pay for operation of the drug and alcohol abuse normative
81.2 evaluation system and to pay for all costs incurred by adding two positions for licensing
81.3 of chemical dependency treatment and rehabilitation programs located in hospitals for
81.4 which funds are not otherwise appropriated. ~~Six percent of the remaining money must~~
81.5 ~~be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The~~
81.6 ~~commissioner shall annually divide the money available in the chemical dependency~~
81.7 ~~fund that is not held in reserve by counties from a previous allocation, or allocated to the~~
81.8 ~~American Indian chemical dependency tribal account. Six percent of the remaining money~~
81.9 ~~must be reserved for the nonreservation American Indian chemical dependency allocation~~
81.10 ~~for treatment of American Indians by eligible vendors under section 254B.05, subdivision~~
81.11 ~~4. The remainder of the money must be allocated among the counties according to the~~
81.12 ~~following formula, using state demographer data and other data sources determined by~~
81.13 ~~the commissioner:~~

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

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

81.20 (c) ~~The prepaid plan months of eligibility is multiplied by the proportion of exempt~~
81.21 ~~service expenditures to determine the adjusted prepaid plan months of eligibility for~~
81.22 ~~each county.~~

81.23 (d) ~~The adjusted prepaid plan months of eligibility is added to the number of~~
81.24 ~~restricted population fee for service months of eligibility for the Minnesota family~~
81.25 ~~investment program, general assistance, and medical assistance and divided by the county~~
81.26 ~~restricted population to determine county per capita months of covered service eligibility.~~

81.27 (e) ~~The number of adjusted prepaid plan months of eligibility for the state is added~~
81.28 ~~to the number of fee for service months of eligibility for the Minnesota family investment~~
81.29 ~~program, general assistance, and medical assistance for the state restricted population and~~
81.30 ~~divided by the state restricted population to determine state per capita months of covered~~
81.31 ~~service eligibility.~~

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

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

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

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

82.7 ~~(j) The remaining funds shall be allocated proportional to the county adjusted~~
82.8 ~~population in the special revenue account must be used according to the requirements~~
82.9 ~~in this chapter.~~

82.10 Sec. 8. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

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

82.19 Sec. 9. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

82.20 Subd. 4. **Division of costs.** Except for services provided by a county under
82.21 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
82.22 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for
82.23 ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services
82.24 provided to persons eligible for medical assistance under chapter 256B and general
82.25 assistance medical care under chapter 256D. Counties may use the indigent hospitalization
82.26 levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent
82.27 of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost
82.28 of payment and collections, must be distributed to the county that paid for a portion of
82.29 the treatment under this section. ~~If all funds allocated according to section 254B.02 are~~
82.30 ~~exhausted by a county and the county has met or exceeded the base level of expenditures~~
82.31 ~~under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the~~
82.32 ~~costs paid by the state under this section. The commissioner may refuse to pay state funds~~
82.33 ~~for services to persons not eligible under section 254B.04, subdivision 1, if the county~~
82.34 ~~financially responsible for the persons has exhausted its allocation.~~

83.1 Sec. 10. Minnesota Statutes 2008, section 254B.03, is amended by adding a
83.2 subdivision to read:

83.3 Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding
83.4 subdivision 4, for chemical dependency services provided on or after October 1, 2008, and
83.5 reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

83.6 Sec. 11. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

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

83.17 Sec. 12. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

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

83.29 Sec. 13. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

83.30 Subd. 8. **Payments to improve services to American Indians.** The commissioner
83.31 may set rates for chemical dependency services to American Indians according to the
83.32 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.

S.F. No. 2337, 2nd Engrossment - 86th Legislative Session (2009-2010) [s2337-2]

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. 14. Minnesota Statutes 2008, section 514.982, subdivision 2, is amended to read:

84.4 Subd. 2. **Filing.** Any notice, release, or other document required to be filed
84.5 under sections 514.980 to 514.985 must be recorded or filed in the office of the county
84.6 recorder or registrar of titles, as appropriate, in the county where the real property is
84.7 located. The agency shall redact all but the last four digits of the Social Security number
84.8 of a medical assistance recipient from a document that is recorded or filed under this
84.9 subdivision. Notwithstanding section 386.77, the agency shall pay the applicable filing fee
84.10 for any document filed under sections 514.980 to 514.985. An attestation, certification, or
84.11 acknowledgment is not required as a condition of filing. If the property described in the
84.12 medical assistance lien notice is registered property, the registrar of titles shall record it
84.13 on the certificate of title for each parcel of property described in the lien notice. If the
84.14 property described in the medical assistance lien notice is abstract property, the recorder
84.15 shall file the medical assistance lien in the county's grantor-grantee indexes and any tract
84.16 indexes the county maintains for each parcel of property described in the lien notice. The
84.17 recorder shall return recorded medical assistance lien notices for abstract property to the
84.18 agency at no cost. If the agency provides a duplicate copy of a medical assistance lien
84.19 notice for registered property, the registrar of titles shall show the recording data for the
84.20 medical assistance lien notice on the copy and return it to the agency at no cost. The filing
84.21 or mailing of any notice, release, or other document under sections 514.980 to 514.985 is
84.22 the responsibility of the agency.

84.23 Sec. 15. Minnesota Statutes 2009 Supplement, section 517.08, subdivision 1b, is
84.24 amended to read:

84.25 Subd. 1b. **Term of license; fee; premarital education.** (a) The local registrar
84.26 shall examine upon oath the parties applying for a license relative to the legality of the
84.27 contemplated marriage. If one party is unable to appear in person, the party appearing
84.28 may complete the absent applicant's information. The local registrar shall provide a copy
84.29 of the marriage application to the party who is unable to appear, who must verify the
84.30 accuracy of the party's information in a notarized statement. The marriage license must
84.31 not be released until the verification statement has been received by the local registrar. If
84.32 at the expiration of a five-day period, on being satisfied that there is no legal impediment
84.33 to it, including the restriction contained in section 259.13, the local registrar shall issue
84.34 the license, containing the full names of the parties before and after marriage, and county

85.1 and state of residence, with the county seal attached, and make a record of the date of
85.2 issuance. The license shall be valid for a period of six months. Except as provided in
85.3 paragraph (c), the local registrar shall collect from the applicant a fee of ~~\$110~~ \$115 for
85.4 administering the oath, issuing, recording, and filing all papers required, and preparing
85.5 and transmitting to the state registrar of vital statistics the reports of marriage required
85.6 by this section. If the license should not be used within the period of six months due to
85.7 illness or other extenuating circumstances, it may be surrendered to the local registrar for
85.8 cancellation, and in that case a new license shall issue upon request of the parties of the
85.9 original license without fee. A local registrar who knowingly issues or signs a marriage
85.10 license in any manner other than as provided in this section shall pay to the parties
85.11 aggrieved an amount not to exceed \$1,000.

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

85.16 STATE OF MINNESOTA, COUNTY OF (insert county name)
85.17 APPLICATION FOR WAIVER OF MARRIAGE LICENSE WAITING PERIOD:
85.18 (legal names of the applicants)

85.19 Represent and state as follows:

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

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

85.25
85.26
85.27

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

85.31 Date:
85.32
85.33

85.34 (Signatures of applicants)

85.35 Acknowledged before me on this day of
85.36

86.1 NOTARY PUBLIC

86.2 COURT ORDER AND AUTHORIZATION:

86.3 STATE OF MINNESOTA, COUNTY OF (insert county name)

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

86.8

86.9 (judge of district court)

86.10 (date).

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

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

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

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

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

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

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

87.7 Sec. 16. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws
87.8 2010, chapter 200, article 1, section 17, is amended to read:

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

87.13 (1) \$55 in the general fund;

87.14 (2) \$3 in the state government special revenue fund to be appropriated to the
87.15 commissioner of public safety for parenting time centers under section 119A.37;

87.16 (3) \$2 in the special revenue fund to be appropriated to the commissioner of health
87.17 for developing and implementing the MN ENABL program under section 145.9255; ~~and~~

87.18 (4) \$25 in the special revenue fund is appropriated to the commissioner of
87.19 employment and economic development for the displaced homemaker program under
87.20 section 116L.96; and

87.21 (5) \$5 in the special revenue fund, which is appropriated to the Board of Regents
87.22 of the University of Minnesota for the Minnesota couples on the brink project under
87.23 section 137.32.

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

87.27 (1) \$5 as provided in paragraph (a), clauses (2) and (3); and

87.28 (2) \$10 in the special revenue fund is appropriated to the commissioner of
87.29 employment and economic development for the displaced homemaker program under
87.30 section 116L.96.

87.31 Sec. 17. Laws 2009, chapter 79, article 3, section 18, is amended to read:

87.32 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
87.33 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
87.34 **ANOKA-METRO REGIONAL TREATMENT CENTER.**

88.1 In consultation with community partners, the commissioner of human services
88.2 shall develop an array of community-based services in the metro area to transform the
88.3 current services now provided to patients at the Anoka-Metro Regional Treatment Center.
88.4 The community-based services may be ~~provided in facilities with 16 or fewer beds, and~~
88.5 ~~must provide the appropriate level of care for the patients being admitted to the facilities~~
88.6 established in partnership with private and public hospital organizations, community
88.7 mental health centers and other mental health community services providers, and
88.8 community partnerships, and must be staffed by state employees. The planning for this
88.9 transition must be completed by October 1, ~~2009~~ 2010, with ~~an initial~~ a report detailing
88.10 the transition plan, services that will be provided, including incorporating peer specialists
88.11 where appropriate, the location of the services, and the number of patients that will be
88.12 served, to the committee chairs of health and human services by November 30, ~~2009~~ 2010;
88.13 ~~and a semiannual report on progress until the transition is completed.~~ The commissioner
88.14 of human services shall ~~solicit interest from~~ make a genuine effort to engage stakeholders
88.15 and potential community partners in the process. The individuals ~~working in~~ employed by
88.16 the community-based services ~~facilities~~ under this section are state employees supervised
88.17 by the commissioner of human services. No layoffs shall occur as a result of restructuring
88.18 under this section. Savings generated as a result of transitioning patients from the
88.19 Anoka-Metro Regional Treatment Center to community-based services may be used to
88.20 fund supportive housing staffed by state employees.

88.21 Sec. 18. **CASE MANAGEMENT RECOMMENDATIONS.**

88.22 By February 1, 2011, the commissioner of human services shall provide specific
88.23 recommendations and language for proposed legislation to:

88.24 (1) define the administrative and the service functions of case management for
88.25 persons with disabilities and make changes to improve the funding for administrative
88.26 functions;

88.27 (2) standardize and simplify processes, standards, and timelines for case
88.28 management with the Department of Human Services Disability Services Division,
88.29 including eligibility determinations, resource allocation, management of dollars, provision
88.30 for assignment of one case manager at a time per person, waiting lists, quality assurance,
88.31 host county concurrence requirements, county of financial responsibility provisions, and
88.32 waiver compliance; and

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

89.1 In developing these recommendations, the commissioner of human services shall consider
89.2 the recommendations of the 2007 Redesigning Case Management Services for Persons
89.3 with Disabilities Report and consult with existing stakeholder groups, which include
89.4 representatives of counties, disability and senior advocacy groups, service providers, and
89.5 representatives of agencies that provide contacted case management.

89.6 This provision is effective the day following final enactment.

89.7 Sec. 19. **VETERINARY PRACTICE AND CONTROLLED SUBSTANCE**
89.8 **ABUSE STUDY.**

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

89.16 Sec. 20. **REPEALER.**

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

89.19 **ARTICLE 7**

89.20 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

89.21 Section 1. **SUMMARY OF APPROPRIATIONS.**

89.22 The amounts shown in this section summarize direct appropriations by fund made
89.23 in this article.

	<u>2010</u>	<u>2011</u>	<u>Total</u>
89.24 <u>General</u>	<u>\$ 3,503,000</u>	<u>\$ 243,587,000</u>	<u>\$ 247,090,000</u>
89.25 <u>State Government Special</u>			
89.26 <u>Revenue</u>	<u>113,000</u>	<u>624,000</u>	<u>737,000</u>
89.27 <u>Health Care Access</u>	<u>998,000</u>	<u>27,534,000</u>	<u>28,532,000</u>
89.28 <u>Federal TANF</u>	<u>11,464,000</u>	<u>14,986,000</u>	<u>26,450,000</u>
89.29 <u>Special Revenue</u>	<u>-0-</u>	<u>93,000</u>	<u>93,000</u>
89.30 <u>Total</u>	<u>\$ 16,078,000</u>	<u>\$ 286,824,000</u>	<u>\$ 302,902,000</u>

90.1 Sec. 2. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

90.2 The sums shown in the columns marked "Appropriations" are added to or, if shown
 90.3 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,
 90.4 as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes
 90.5 specified in this article. The appropriations are from the general fund, or another named
 90.6 fund, and are available for the fiscal years indicated for each purpose. The figures "2010"
 90.7 and "2011" used in this article mean that the addition to or subtraction from appropriations
 90.8 listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011,
 90.9 respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011.
 90.10 "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions
 90.11 for the fiscal year ending June 30, 2010, are effective the day following final enactment
 90.12 unless a different effective date is explicit.

	<u>APPROPRIATIONS</u>
	<u>Available for the Year</u>
	<u>Ending June 30</u>
	<u>2010</u> <u>2011</u>

90.17 Sec. 3. COMMISSIONER OF HUMAN
 90.18 SERVICES

90.19 <u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>18,167,000</u>	<u>\$</u>	<u>290,442,000</u>
<u>Appropriations by Fund</u>				
		<u>2010</u>		<u>2011</u>
90.22 <u>General</u>		<u>5,705,000</u>		<u>247,961,000</u>
90.23 <u>Health Care Access</u>		<u>998,000</u>		<u>27,495,000</u>
90.24 <u>Federal TANF</u>		<u>11,464,000</u>		<u>14,986,000</u>

90.25 The appropriations for each purpose are
 90.26 shown in the following subdivisions.

90.27 TANF Financing and Maintenance of
 90.28 Effort. The commissioner, with the approval
 90.29 of the commissioner of management and
 90.30 budget, and after notification of the chairs
 90.31 of the relevant senate budget division and
 90.32 house of representatives finance division,
 90.33 may adjust the amount of TANF transfers
 90.34 between the MFIP transition year child care
 90.35 assistance program and MFIP grant programs
 90.36 within the fiscal year and within the current

91.1 biennium and the biennium ending June 30,
91.2 2013, to ensure that state and federal match
91.3 and maintenance of effort requirements are
91.4 met. These transfers and amounts shall be
91.5 reported to the chairs of the senate and house
91.6 of representatives Finance Committees, the
91.7 senate Health and Human Services Budget
91.8 Division, and the house of representatives
91.9 Health Care and Human Services Finance
91.10 Division and Early Childhood Finance and
91.11 Policy Division by December 1 of each
91.12 fiscal year. Notwithstanding any contrary
91.13 provision in this article, this paragraph
91.14 expires June 30, 2013.

91.15 **TANF Funding for the Working Family**
91.16 **Tax Credit.** In addition to the amounts
91.17 specified in Minnesota Statutes, section
91.18 290.0671, subdivision 6, \$18,964,000
91.19 of TANF funds in fiscal year 2010 are
91.20 appropriated to the commissioner to
91.21 reimburse the general fund for the cost of
91.22 the working family tax credit for eligible
91.23 families. With respect to the amounts
91.24 appropriated for fiscal year 2010, the
91.25 commissioner shall reimburse the general
91.26 fund by June 30, 2010. This paragraph is
91.27 effective the day following final enactment.

91.28 **TANF Transfer to Federal Child**
91.29 **Care and Development Fund.** Of the
91.30 TANF appropriation in fiscal year 2011,
91.31 \$12,500,000 is to the commissioner for
91.32 the purposes of MFIP and transition year
91.33 child care under Minnesota Statutes, section
91.34 119B.05. The commissioner shall authorize
91.35 the transfer of sufficient TANF funds to the
91.36 federal child care and development fund to

92.1 meet this appropriation and shall ensure that
92.2 all transferred funds are expended according
92.3 to federal child care and development fund
92.4 regulations.

92.5 **Special Revenue Fund Transfers.** (a) The
92.6 commissioner shall transfer the following
92.7 amounts from special revenue fund balances
92.8 to the general fund by June 30 of each
92.9 respective fiscal year: \$613,000 in fiscal year
92.10 2010, and \$493,000 in fiscal year 2011. This
92.11 provision is effective the day following final
92.12 enactment.

92.13 (b) The actual transfers made under
92.14 paragraph (a) must be separately identified
92.15 and reported as part of the quarterly reporting
92.16 of transfers to the chairs of the relevant senate
92.17 budget division and house of representatives
92.18 finance division.

92.19 **Supplemental Nutrition Assistance**
92.20 **Program Enhanced Administrative**
92.21 **Funding.** The funds available for
92.22 administration of the Supplemental Nutrition
92.23 Assistance Program under the Department
92.24 of Defense Appropriations Act of 2010,
92.25 Public Law 111-118, are appropriated
92.26 to the commissioner to pay the actual
92.27 costs of providing for increased eligibility
92.28 determinations, caseload-related costs, timely
92.29 application processing, and quality control.
92.30 Of these funds, 20 percent shall be allocated
92.31 to the commissioner and 80 percent shall
92.32 be allocated to counties. The commissioner
92.33 shall allocate the county portion based
92.34 on recent caseload. Reimbursement shall
92.35 be based on actual costs reported by

93.1 counties through existing processes. Tribal
 93.2 reimbursement must be made from the state
 93.3 portion, based on a caseload factor equivalent
 93.4 to that of a county.

93.5 **Subd. 2. Agency Management**

93.6 **(a) Financial Operations** -0- 103,000

93.7 **Base Adjustment.** The general fund base is
 93.8 decreased by \$3,292,000 in fiscal year 2012
 93.9 and \$3,292,000 in fiscal year 2013.

93.10 **(b) Legal and Regulatory Operations** -0- (286,000)

93.11 **Moratorium of Premium Payments.** For
 93.12 fiscal year 2011, there shall be a moratorium
 93.13 on payments made by the commissioner
 93.14 to the Minnesota Joint Underwriting
 93.15 Association for personal injury liability
 93.16 insurance for providers under Minnesota
 93.17 Statutes, section 245.814. Notwithstanding
 93.18 Minnesota Statutes, section 62I.16, the
 93.19 Minnesota Joint Underwriting Association
 93.20 shall continue to insure the providers under
 93.21 Minnesota Statutes, section 245.814. In
 93.22 fiscal year 2011, the amount of the general
 93.23 fund appropriation allocated to payments
 93.24 under Minnesota Statutes, section 245.814,
 93.25 is reduced by \$400,000. This is a onetime
 93.26 reduction in fiscal year 2011.

93.27 **Base Adjustment.** The general fund base
 93.28 is increased by \$382,000 in fiscal year 2012
 93.29 and \$382,000 in fiscal year 2013.

93.30 **(c) Management Operations** -0- (114,000)

93.31 **Base Adjustment.** The general fund base is
 93.32 increased by \$18,000 in fiscal year 2012 and
 93.33 \$18,000 in fiscal year 2013.

94.1	<u>Subd. 3. Revenue and Pass-Through Revenue</u>		
94.2	<u>Expenditures</u>	<u>11,464,000</u>	<u>20,000,000</u>

94.3 These appropriations are from the federal
94.4 TANF fund.

94.5 **Child Care Development Fund**

94.6 **Unexpended Balance.** In addition to
94.7 the amount provided in this section, the
94.8 commissioner shall carry over and expend
94.9 in fiscal year 2011 \$7,500,000 of the TANF
94.10 funds transferred in fiscal year 2010 that
94.11 reflect the child care and development fund
94.12 unexpended balance for the basic sliding
94.13 fee child care assistance program under
94.14 Minnesota Statutes, section 119B.03. The
94.15 commissioner shall ensure that all funds are
94.16 expended according to the federal child care
94.17 and development fund regulations relating to
94.18 the TANF transfers.

94.19 **Base Adjustment.** The general fund base is
94.20 increased by \$7,500,000 in fiscal year 2012
94.21 and \$7,500,000 in fiscal year 2013.

94.22 **TANF Transfer Correction.**

94.23 Notwithstanding any provisions of
94.24 Laws 2009, chapter 79, article 13, section 3,
94.25 subdivision 3, as amended by Laws 2009,
94.26 chapter 173, article 2, section 1, subdivision
94.27 3, the following TANF fund amounts are
94.28 appropriated to the commissioner for the
94.29 purposes of MFIP and transition year child
94.30 care under Minnesota Statutes, section
94.31 119B.05:
94.32 (1) fiscal year 2010, \$862,000;
94.33 (2) fiscal year 2011, \$978,000;
94.34 (3) fiscal year 2012, \$0; and

95.1 (4) fiscal year 2013, \$0.

95.2 Notwithstanding any contrary provision in

95.3 this article, this paragraph expires on June

95.4 30, 2013.

95.5 Subd. 4. **Economic Support Grants**

95.6 (a) **Support Services Grants** -0- -0-

95.7 **Base Adjustment.** The federal TANF fund

95.8 base is decreased by \$5,004,000 in fiscal year

95.9 2012 and \$5,004,000 in fiscal year 2013.

95.10 (b) **MFIP Child Care Assistance Grants** -0- 433,000

95.11 **Base Adjustment.** The general fund base is

95.12 increased by \$94,000 in fiscal year 2012 and

95.13 \$24,000 in fiscal year 2013.

95.14 (c) **Basic Sliding Fee Child Care Assistance**

95.15 **Grants**

95.16 Appropriations by Fund

95.17 General -0- (7,500,000)

95.18 Federal TANF -0- (5,014,000)

95.19 **Base Adjustment.** The general fund base

95.20 is increased by \$2,699,000 in fiscal year

95.21 2012 and \$2,699,000 in fiscal year 2013.

95.22 The federal TANF fund base is increased

95.23 by \$5,014,000 in fiscal year 2012 and

95.24 \$5,014,000 in fiscal year 2013.

95.25 (d) **Child and Community Services Grants** -0- (10,700,000)

95.26 This is a onetime reduction in fiscal year

95.27 2011.

95.28 (e) **Group Residential Housing Grants** -0- -0-

95.29 **Reduction of Supplemental Service Rate.**

95.30 Effective July 1, 2011, to June 30, 2013,

95.31 the commissioner shall decrease the group

95.32 residential housing supplementary service

95.33 rate under Minnesota Statutes, section

96.1 256I.05, subdivision 1a, by five percent
 96.2 for services rendered on or after that date,
 96.3 except that reimbursement rates for a group
 96.4 residential housing facility reimbursed as a
 96.5 nursing facility shall not be reduced. The
 96.6 reduction in this paragraph is in addition to
 96.7 the reduction under Laws 2009, chapter 79,
 96.8 article 8, section 79, paragraph (b), clause
 96.9 (11).

96.10 **Base Adjustment.** The general fund base is
 96.11 decreased by \$700,000 in fiscal year 2012
 96.12 and \$700,000 in fiscal year 2013.

96.13 <u>(f) Children's Mental Health Grants</u>	<u>(200,000)</u>	<u>(200,000)</u>
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96.14 <u>(g) Other Children's and Economic Assistance</u> 96.15 <u>Grants</u>	<u>-0-</u>	<u>-0-</u>
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96.16 **Base Adjustment.** The general fund base is
 96.17 increased by \$130,000 in fiscal year 2012 and
 96.18 decreased by \$360,000 in fiscal year 2013.

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

96.21 <u>(a) Children and Economic Assistance</u> 96.22 <u>Administration</u>	<u>-0-</u>	<u>-0-</u>
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96.23 **Base Adjustment.** The federal TANF fund
 96.24 base is decreased by \$700,000 in fiscal year
 96.25 2012 and \$700,000 in fiscal year 2013.

96.26 <u>(b) Children and Economic Assistance</u> 96.27 <u>Operations</u>	<u>-0-</u>	<u>196,000</u>
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96.28 **Base Adjustment.** The general fund base is
 96.29 decreased by \$13,000 in fiscal year 2012 and
 96.30 \$13,000 in fiscal year 2013.

96.31 **Subd. 6. Health Care Grants**

96.32 <u>(a) MinnesotaCare Grants</u>	<u>998,000</u>	<u>15,312,000</u>
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96.33 This appropriation is from the health care
 96.34 access fund.

97.1 **Health Care Access Fund Transfer to**
97.2 **General Fund.** The commissioner of
97.3 management and budget shall transfer
97.4 \$998,000 in fiscal year 2010 and
97.5 \$217,265,000 in fiscal year 2011 from the
97.6 health care access fund to the general fund.
97.7 This paragraph is effective the day following
97.8 final enactment.

97.9 The base for this transfer is \$262,647,000 in
97.10 fiscal year 2012 and \$174,772,000 in fiscal
97.11 year 2013.

97.12 **MinnesotaCare Ratable Reduction.**
97.13 Effective for services rendered on or
97.14 after July 1, 2010, to December 31, 2013,
97.15 MinnesotaCare payments to managed care
97.16 plans under Minnesota Statutes, section
97.17 256L.12, for single adults and households
97.18 without children whose income is greater
97.19 than 75 percent of federal poverty guidelines
97.20 shall be reduced by ten percent. Managed
97.21 care plans shall not pass these payment
97.22 reductions on to providers. Notwithstanding
97.23 any contrary provision of this article, this
97.24 paragraph shall expire on December 31,
97.25 2013.

97.26 **(b) Medical Assistance Basic Health Care**
97.27 **Grants - Families and Children**

97.28	<u>Appropriations by Fund</u>		
97.29	<u>General</u>	<u>-0-</u>	<u>(7,631,000)</u>
97.30	<u>Health Care Access</u>	<u>-0-</u>	<u>7,714,000</u>

97.31 **Critical Access Dental.** Of the general
97.32 fund appropriation, \$731,000 in fiscal year
97.33 2011 is to the commissioner for critical
97.34 access dental provider reimbursement
97.35 payments under Minnesota Statutes, section

98.1 256B.76 subdivision 4. This is a onetime
 98.2 appropriation.

98.3 **Nonadministrative Rate Reduction.** For
 98.4 services rendered on or after July 1, 2010,
 98.5 to December 31, 2013, the commissioner
 98.6 shall reduce contract rates paid to managed
 98.7 care plans under Minnesota Statutes, sections
 98.8 256B.69 and 256L.12, and to county-based
 98.9 purchasing plans under Minnesota Statutes,
 98.10 section 256B.692, by three percent of the
 98.11 contract rate attributable to nonadministrative
 98.12 services in effect on June 30, 2010. Managed
 98.13 care plans shall not pass these rate reductions
 98.14 on to providers. Notwithstanding any
 98.15 contrary provision in this article, this rider
 98.16 expires on December 31, 2013.

98.17 **(c) Medical Assistance Basic Health Care**
 98.18 **Grants - Elderly and Disabled**

98.19	<u>Appropriations by Fund</u>		
98.20	<u>General</u>	<u>-0-</u>	<u>(3,877,000)</u>
98.21	<u>Health Care Access</u>	<u>-0-</u>	<u>4,319,000</u>

98.22 **MnDHO Transition.** Of the general fund
 98.23 appropriation for fiscal year 2011, \$250,000
 98.24 is to the commissioner to be made available
 98.25 to county agencies to assist in the transition
 98.26 of the approximately 1,290 current MnDHO
 98.27 members to the fee-for-service Medicaid
 98.28 program or another managed care option by
 98.29 January 1, 2011.

98.30 County agencies shall work with the
 98.31 commissioner, health plans, and MnDHO
 98.32 members and their legal representatives to
 98.33 develop and implement transition plans that
 98.34 include:

99.1 (1) identification of service needs of MnDHO
 99.2 members based on the current assessment or
 99.3 through the completion of a new assessment;
 99.4 (2) identification of services currently
 99.5 provided to MnDHO members and which
 99.6 of those services will continue to be
 99.7 reimbursable through fee-for-service
 99.8 or another managed care option under
 99.9 the Medicaid state plan or a home and
 99.10 community-based waiver program;
 99.11 (3) identification of service providers who do
 99.12 not have a contract with the county or who
 99.13 are currently reimbursed at a different rate
 99.14 than the county contracted rate; and
 99.15 (4) development of an individual service
 99.16 plan that is within allowable waiver funding
 99.17 limits.

99.18 **(d) General Assistance Medical Care Grants** -0- (83,689,000)

99.19 **(e) Other Health Care Grants** -0- -0-

99.20 **Cobra Carryforward.** Unexpended funds
 99.21 appropriated in fiscal year 2010 for COBRA
 99.22 grants under Laws 2009, chapter 79, article
 99.23 5, section 78, do not cancel and are available
 99.24 to the commissioner for fiscal year 2011
 99.25 COBRA grant expenditures. Up to \$111,000
 99.26 of the fiscal year 2011 appropriation for
 99.27 COBRA grants provided in Laws 2009,
 99.28 chapter 79, article 13, section 3, subdivision
 99.29 6, may be used by the commissioner for costs
 99.30 related to administration of the COBRA
 99.31 grants.

99.32 **(f) Medical Assistance Health Care Grants;**
 99.33 **Adults Without Children** 9,794,000 350,696,000

100.1 **Medical Assistance Expansion.** If the
100.2 commissioner is not able to implement
100.3 the medical assistance expansion for
100.4 single adults under Minnesota Statutes,
100.5 section 256B.055, subdivision 15, by June
100.6 1, 2010, the commissioner shall make
100.7 medical assistance payments to providers
100.8 retroactively to June 1, 2010.

100.9 **Subd. 7. Health Care Management**

100.10 **(a) Health Care Administration** -0- 218,000

100.11 **Minnesota Senior Health Options**

100.12 **Reimbursement.** Effective July 1, 2011,
100.13 federal administrative reimbursement
100.14 resulting from the Minnesota senior
100.15 health options project is appropriated
100.16 to the commissioner for this activity.
100.17 Notwithstanding any contrary provision, this
100.18 provision expires June 30, 2013.

100.19 **Utilization Review.** Effective July 1,
100.20 2011, federal administrative reimbursement
100.21 resulting from prior authorization and
100.22 inpatient admission certification by a
100.23 professional review organization shall be
100.24 dedicated to, and is appropriated to, the
100.25 commissioner for these activities. A portion
100.26 of these funds must be used for activities
100.27 to decrease unnecessary pharmaceutical
100.28 costs in medical assistance. Notwithstanding
100.29 any contrary provision of this article, this
100.30 paragraph expires June 30, 2013.

100.31 **Reporting Compliance.** The entities named
100.32 in Minnesota Statutes, section 256B.199,
100.33 paragraph (b), clause (1), shall comply with
100.34 the requirements of that statute by promptly
100.35 reporting on a quarterly basis certified public

101.1 expenditures that may qualify for federal
 101.2 matching funds.

101.3 **Base Adjustment.** The general fund base is
 101.4 decreased by \$172,000 in fiscal year 2012
 101.5 and \$172,000 in fiscal year 2013.

101.6 **(b) Health Care Operations**

101.7	<u>Appropriations by Fund</u>		
101.8 <u>General</u>	<u>-0-</u>	<u>177,000</u>	
101.9 <u>Health Care Access</u>	<u>-0-</u>	<u>150,000</u>	

101.10 The general fund appropriation is a onetime
 101.11 appropriation in fiscal year 2011.

101.12 **Base Adjustment.** The health care access
 101.13 fund base for health care operations is
 101.14 decreased by \$755,000 in fiscal year 2012
 101.15 and \$893,000 in fiscal year 2013.

101.16 **Subd. 8. Continuing Care Grants**

101.17 **(a) Aging and Adult Services Grants** -0- (937,000)

101.18 **Base Adjustment.** The general fund base for
 101.19 aging and adult services grants is increased
 101.20 by \$1,124,000 in fiscal year 2012 and
 101.21 \$1,126,000 in fiscal year 2013.

101.22 **(b) Medical Assistance Long-Term Care**
 101.23 **Facilities Grants** -0- 10,173,000

101.24 **Variable Rate Adjustments.** Of this
 101.25 appropriation, \$683,000 in fiscal year 2011
 101.26 is to the commissioner for variable rate
 101.27 adjustments under Minnesota Statutes,
 101.28 section 256B.5013, subdivision 1, for
 101.29 services provided on or after July 1,
 101.30 2010, to June 30, 2011. This is a onetime
 101.31 appropriation.

101.32 **(c) Medical Assistance Long-Term Care**
 101.33 **Waivers and Home Care Grants** -0- (4,515,000)

102.1 **Manage Growth in Traumatic Brain**
102.2 **Injury and Community Alternatives for**
102.3 **Disabled Individuals Waivers.** During
102.4 the fiscal year beginning July 1, 2010, the
102.5 commissioner shall allocate money for home
102.6 and community-based waiver programs
102.7 under Minnesota Statutes, section 256B.49,
102.8 to ensure a reduction in state spending that is
102.9 equivalent to limiting the caseload growth
102.10 of the TBI waiver to six allocations per
102.11 month and the CADI waiver to 60 allocations
102.12 per month. The limits do not apply: (1)
102.13 when there is an approved plan for nursing
102.14 facility bed closures for individuals under
102.15 age 65 who require relocation due to the
102.16 bed closure; (2) to fiscal year 2009 waiver
102.17 allocations delayed due to unallotment; or (3)
102.18 to transfers authorized by the commissioner
102.19 from the personal care assistance program
102.20 of individuals having a home care rating of
102.21 CS, MT, or HL. Priorities for the allocation
102.22 of funds must be for individuals anticipated
102.23 to be discharged from institutional settings or
102.24 who are at imminent risk of a placement in
102.25 an institutional setting.

102.26 **Manage Growth in the Developmental**
102.27 **Disability (DD) Waiver.** The commissioner
102.28 shall manage the growth in the DD waiver
102.29 by limiting the allocations included in the
102.30 November 2010 forecast to six additional
102.31 diversion allocations each month for the
102.32 calendar year that begins on January 1,
102.33 2011. Additional allocations must be
102.34 made available for transfers authorized by
102.35 the commissioner from the personal care
102.36 assistance program of individuals having a

103.1	<u>home care rating of CS, MT, or HL. This</u>		
103.2	<u>provision is effective through December 31,</u>		
103.3	<u>2011.</u>		
103.4	<u>(d) Adult Mental Health Grants</u>	<u>(3,500,000)</u>	<u>-0-</u>
103.5	<u>Compulsive Gambling Lottery Prize</u>		
103.6	<u>Fund.</u> <u>The lottery prize fund appropriation</u>		
103.7	<u>for compulsive gambling is reduced by</u>		
103.8	<u>\$80,000 in fiscal year 2010 and \$79,000 in</u>		
103.9	<u>fiscal year 2011. This is a onetime reduction.</u>		
103.10	<u>Compulsive Gambling Special Revenue</u>		
103.11	<u>Account.</u> <u>\$149,000 for fiscal year 2010</u>		
103.12	<u>and \$27,000 for fiscal year 2011 from</u>		
103.13	<u>the compulsive gambling special revenue</u>		
103.14	<u>account established under Minnesota</u>		
103.15	<u>Statutes, section 245.982, shall be transferred</u>		
103.16	<u>and deposited into the general fund by June</u>		
103.17	<u>30 of each respective fiscal year.</u>		
103.18	<u>(e) Chemical Dependency Entitlement Grants</u>	<u>-0-</u>	<u>(1,738,000)</u>
103.19	<u>(f) Chemical Dependency Nonentitlement</u>		
103.20	<u>Grants</u>	<u>(389,000)</u>	<u>-0-</u>
103.21	<u>(g) Other Continuing Care Grants</u>	<u>-0-</u>	<u>250,000</u>
103.22	<u>This is a onetime appropriation in fiscal year</u>		
103.23	<u>2011.</u>		
103.24	<u>Subd. 9. Continuing Care Management</u>	<u>-0-</u>	<u>303,000</u>
103.25	<u>Base Adjustment.</u> <u>The general fund base for</u>		
103.26	<u>continuing care management is increased by</u>		
103.27	<u>\$107,000 in fiscal year 2012 and \$99,000 in</u>		
103.28	<u>fiscal year 2013.</u>		
103.29	<u>Subd. 10. State-Operated Services</u>		
103.30	<u>Obsolete Laundry Depreciation Account.</u>		
103.31	<u>\$669,000, or the balance, whichever is</u>		
103.32	<u>greater, must be transferred from the</u>		
103.33	<u>state-operated services laundry depreciation</u>		

104.1 account in the special revenue fund and
104.2 deposited into the general fund by June 30,
104.3 2010.

104.4 **Operating Budget Reductions.** No
104.5 operating budget reductions enacted in Laws
104.6 2010, chapter 200, or in this act shall be
104.7 allocated to state-operated services.

104.8 **Prohibition on Commingling Funds.**
104.9 The commissioner shall not commingle
104.10 state-operated services funds and mental
104.11 health funds and grants. The appropriations
104.12 to the commissioner for state-operated
104.13 services and mental health services and
104.14 grants must not be consolidated in any
104.15 manner or transferred within the Department
104.16 of Human Services, without specific
104.17 legislative approval. Notwithstanding
104.18 any contrary provision in this article, this
104.19 paragraph shall not expire.

104.20 **(a) Adult Mental Health Services** -0- 6,888,000

104.21 **Base Adjustment.** The general fund base is
104.22 decreased by \$12,286,000 in fiscal year 2012
104.23 and \$12,394,000 in fiscal year 2013.

104.24 **Appropriation Requirements.** (a)
104.25 The general fund appropriation to the
104.26 commissioner includes funding for the
104.27 following:
104.28 (1) to a community collaborative to begin
104.29 providing crisis center services in the
104.30 Mankato area that are comparable to
104.31 the crisis services provided prior to the
104.32 closure of the Mankato Crisis Center. The
104.33 commissioner shall recruit former employees
104.34 of the Mankato Crisis Center who were
104.35 recently laid off to staff the new crisis

105.1 services. The commissioner shall obtain
105.2 legislative approval prior to discontinuing
105.3 this funding;
105.4 (2) to maintain the building in Eveleth
105.5 that currently houses community transition
105.6 services and to establish a psychiatric
105.7 intensive therapeutic foster home as an
105.8 enterprise activity. The commissioner shall
105.9 request a waiver amendment to allow CADI
105.10 funding for psychiatric intensive therapeutic
105.11 foster care services provided in the same
105.12 location and building as the community
105.13 transition services. If the federal government
105.14 does not approve the waiver amendment, the
105.15 commissioner shall continue to pay the lease
105.16 for the building out of the state-operated
105.17 services budget until the commissioner of
105.18 administration subleases the space or until
105.19 the lease expires, and shall establish the
105.20 psychiatric intensive therapeutic foster home
105.21 at a different site. The commissioner shall
105.22 make diligent efforts to sublease the space;
105.23 (3) to restaff, reopen, and operate the
105.24 community behavioral health hospital with
105.25 hospital level of care in Wadena until June
105.26 30, 2011. The collections associated with
105.27 this hospital continue to be submitted to
105.28 the general fund until June 30, 2011. The
105.29 commissioner shall develop a conversion
105.30 plan and may convert the community
105.31 behavioral health hospital to psychiatric
105.32 extensive recovery treatment services
105.33 after June 30, 2011. This is a onetime
105.34 appropriation and expires on June 30, 2011;

106.1 (4) to continue the operation of the dental
106.2 clinics in Brainerd, Cambridge, Faribault,
106.3 Fergus Falls, and Willmar at the same level of
106.4 care and staffing that was in effect on March
106.5 1, 2010. The commissioner shall not proceed
106.6 with the planned closure of the dental
106.7 clinics, and shall not discontinue services or
106.8 downsize any of the state-operated dental
106.9 clinics without specific legislative approval.
106.10 The commissioner shall continue to bill
106.11 for services provided to obtain medical
106.12 assistance critical access dental payments
106.13 and cost-based payment rates as provided
106.14 in Minnesota Statutes, section 256B.76,
106.15 subdivision 2, and shall bill for services
106.16 provided three months retroactively from
106.17 the date of this act. This appropriation is
106.18 onetime;
106.19 (5) to convert the Minnesota
106.20 Neurorehabilitation Hospital in Brainerd
106.21 to a neurocognitive psychiatric extensive
106.22 recovery treatment service; and
106.23 (6) to convert the Minnesota extended
106.24 treatment options (METO) program to
106.25 the following community-based services
106.26 provided by state employees: (i) psychiatric
106.27 extensive recovery treatment services;
106.28 (ii) intensive transitional foster homes
106.29 as enterprise activities; and (iii) other
106.30 community-based support services. The
106.31 provisions under Minnesota Statutes, section
106.32 252.025, subdivision 7, are applicable to
106.33 the METO services established under this
106.34 clause. Notwithstanding Minnesota Statutes,
106.35 section 246.18, subdivision 8, any revenue
106.36 lost to the general fund by the conversion

107.1 of METO to new services must be replaced
107.2 by revenue from the new services to offset
107.3 the lost revenue to the general fund until
107.4 June 30, 2013. Any revenue generated in
107.5 excess of this amount shall be deposited into
107.6 the special revenue fund under Minnesota
107.7 Statutes, section 246.18, subdivision 8.

107.8 (b) The commissioner shall not move beds
107.9 from the Anoka-Metro Regional Treatment
107.10 Center to the psychiatric nursing facility
107.11 at St. Peter without specific legislative
107.12 approval.

107.13 (c) The commissioner shall implement
107.14 changes, including the following, to save a
107.15 minimum of \$6,006,000 beginning in fiscal
107.16 year 2011, and report to the legislature the
107.17 specific initiatives implemented and the
107.18 savings allocated to each one, including:

107.19 (1) maximizing budget savings through
107.20 strategic employee staffing; and
107.21 (2) identifying and implementing cost
107.22 reductions in cooperation with state-operated
107.23 services employees.

107.24 Base level funding is reduced by \$6,006,000
107.25 effective fiscal year 2011.

107.26 (d) The commissioner shall seek certification
107.27 or approval from the federal government for
107.28 the new services under paragraph (a) that are
107.29 eligible for federal financial participation
107.30 and deposit the revenue associated with
107.31 these new services in the account established
107.32 under Minnesota Statutes, section 246.18,
107.33 subdivision 8, unless otherwise specified.

108.1 (e) Notwithstanding any contrary provision
 108.2 in this article, this rider shall not expire.

108.3 **(b) Minnesota Sex Offender Services** -0- (289,000)

108.4 **Sex Offender Services.** Base level funding
 108.5 for Minnesota sex offender services is
 108.6 reduced by \$837,000 in fiscal year 2012 and
 108.7 \$837,000 in fiscal year 2013 for the 50-bed
 108.8 sex offender treatment program within the
 108.9 Moose Lake correctional facility in which
 108.10 Department of Human Services staff from
 108.11 Minnesota sex offender services provide
 108.12 clinical treatment to incarcerated offenders.
 108.13 This reduction shall become part of the base
 108.14 for the Department of Human Services.

108.15 **Interagency Agreements.** The
 108.16 commissioner shall terminate by June
 108.17 30, 2010, all interagency agreements with
 108.18 the Department of Corrections to provide
 108.19 chemical dependency treatment services.
 108.20 This paragraph is effective the day following
 108.21 final enactment.

108.22 Sec. 4. **COMMISSIONER OF HEALTH**

108.23 **Subdivision 1. Total Appropriation** **\$ (2,367,000) \$ (3,963,000)**

108.24	<u>Appropriations by Fund</u>		
108.25		<u>2010</u>	<u>2011</u>
108.26	<u>General</u>	<u>(2,367,000)</u>	<u>(4,011,000)</u>
108.27	<u>State Government</u>		
108.28	<u>Special Revenue</u>	<u>-0-</u>	<u>9,000</u>
108.29	<u>Health Care Access</u>	<u>-0-</u>	<u>39,000</u>

108.30 **Subd. 2. Community and Family Health** (221,000) (5,347,000)

108.31 **Base Level Adjustment.** The general fund
 108.32 base is increased by \$4,912,000 in fiscal year
 108.33 2012 and \$4,912,000 in fiscal year 2013.

108.34 **Subd. 3. Policy, Quality, and Compliance**

109.1	<u>Appropriations by Fund</u>		
109.2		<u>2010</u>	<u>2011</u>
109.3	<u>General</u>	<u>(1,797,000)</u>	<u>451,000</u>
109.4	<u>State Government</u>		
109.5	<u>Special Revenue</u>	<u>-0-</u>	<u>9,000</u>
109.6	<u>Health Care Access</u>	<u>-0-</u>	<u>39,000</u>

109.7 The health care access fund appropriation is
 109.8 onetime in fiscal year 2011.

109.9 **Public Health Grant Reductions.** The
 109.10 reductions in public health grants shall only
 109.11 be applied to county public health entities
 109.12 and not to municipal or tribal entities.

109.13 **Health Care Reform.** Funds appropriated
 109.14 in Laws 2008, chapter 358, article 5, section
 109.15 4, subdivision 3, for health reform activities
 109.16 to implement Laws 2008, chapter 358,
 109.17 article 4, are available until expended.
 109.18 Notwithstanding any contrary provision in
 109.19 this article, this provision shall not expire.

109.20 **Rural Hospital Capital Improvement**
 109.21 **Grants.** Of the general fund reductions in
 109.22 fiscal year 2010, \$1,755,000 is from the rural
 109.23 hospital capital improvement grant program.
 109.24 This paragraph is effective the day following
 109.25 final enactment.

109.26 **Base Level Adjustment.** The general fund
 109.27 base is decreased by \$207,000 in fiscal year
 109.28 2012 and \$207,000 in fiscal year 2013. The
 109.29 state government special revenue fund base
 109.30 is decreased by \$2,000 in fiscal year 2012
 109.31 and \$2,000 in fiscal year 2013.

109.32 **Comprehensive Advanced Life Support**
 109.33 **Program.** Of the general fund appropriation,
 109.34 \$377,000 in fiscal year 2011 is to the
 109.35 commissioner for the comprehensive

110.1 advanced life support educational program.
110.2 For fiscal year 2012, base level funding for
110.3 this program shall be \$377,000.

110.4 **Birth Centers.** Of the appropriation in fiscal
110.5 year 2011 from the state government special
110.6 revenue fund, \$9,000 is to the commissioner
110.7 to license birth centers. Base level funding
110.8 for this activity shall be \$7,000 in fiscal year
110.9 2012 and \$7,000 in fiscal year 2013.

110.10 **Office of Unlicensed Health Care Practice.**
110.11 Of the general fund appropriation, \$74,000
110.12 in fiscal year 2011 is for the Office of
110.13 Unlicensed Complementary and Alternative
110.14 Health Care Practice. This is a onetime
110.15 appropriation.

110.16 **Section 125 Plans.** The remaining balance
110.17 from the Laws 2008, chapter 358, article 5,
110.18 section 4, subdivision 3, appropriation for
110.19 Section 125 Plan Employer Incentives is
110.20 canceled.

110.21 **Advisory Group on Administrative**
110.22 **Expenses.** Of the health care access fund
110.23 appropriation for fiscal year 2011, \$39,000 is
110.24 to the commissioner for the advisory group
110.25 established under Minnesota Statutes, section
110.26 62D.31. This is a onetime appropriation.

110.27 Subd. 4. **Health Protection** (349,000) 985,000

110.28 **Base Adjustment.** The general fund base
110.29 is increased by \$194,000 in fiscal year 2012
110.30 and \$738,000 in fiscal year 2013.

110.31 **Birth Defects Information System.** Of the
110.32 general fund appropriation for fiscal year
110.33 2011, \$1,165,000 is for the Minnesota Birth

111.1 Defects Information System established
 111.2 under Minnesota Statutes, section 144.2215.
 111.3 Subd. 5. **Administrative Support Services** -0- (100,000)
 111.4 The general fund base is reduced by \$22,000
 111.5 in fiscal year 2012 and \$22,000 in fiscal year
 111.6 2013.

111.7 Sec. 5. **DEPARTMENT OF VETERANS**
 111.8 **AFFAIRS** \$ (50,000) \$ -0-

111.9 **Cancellation of Prior Appropriation.**
 111.10 By June 30, 2010, the commissioner of
 111.11 management and budget shall cancel the
 111.12 \$50,000 appropriation for fiscal year 2008 to
 111.13 the board in Laws 2007, chapter 147, article
 111.14 19, section 5, in the paragraph titled "Pay for
 111.15 Performance."

111.16 Sec. 6. **HEALTH-RELATED BOARDS**
 111.17 Subdivision 1. **Total Appropriation** \$ 113,000 \$ 615,000
 111.18 The appropriations in this section are from
 111.19 the state government special revenue fund.
 111.20 The transfers in this section are onetime in
 111.21 the fiscal year 2010-2011 biennium.
 111.22 The appropriations for each purpose are
 111.23 shown in the following subdivisions.

111.24 **Transfers.** In addition to transfers required
 111.25 under Laws 2009, chapter 79, article 13,
 111.26 section 5, subdivision 1, \$301,000 in fiscal
 111.27 year 2010 and \$442,000 in fiscal year
 111.28 2011 shall be transferred from the state
 111.29 government special revenue fund to the
 111.30 general fund. The boards must allocate
 111.31 this reduction to boards carrying a positive
 111.32 balance as of July 1, 2009.

112.1	<u>Subd. 2. Board of Marriage and Family</u>		
112.2	<u>Therapy</u>	<u>47,000</u>	<u>22,000</u>
112.3	<u>Operating Costs and Rulemaking.</u> <u>Of</u>		
112.4	<u>this appropriation, \$22,000 in fiscal year</u>		
112.5	<u>2010 and \$22,000 in fiscal year 2011 are</u>		
112.6	<u>for operating costs. This is an ongoing</u>		
112.7	<u>appropriation. Of this appropriation, \$25,000</u>		
112.8	<u>in fiscal year 2010 is for rulemaking. This is</u>		
112.9	<u>a onetime appropriation.</u>		
112.10	<u>Subd. 3. Board of Nursing Home</u>		
112.11	<u>Administrators</u>	<u>51,000</u>	<u>61,000</u>
112.12	<u>Subd. 4. Board of Pharmacy</u>	<u>-0-</u>	<u>517,000</u>
112.13	<u>Prescription Electronic Reporting.</u> <u>Of</u>		
112.14	<u>the state government special revenue fund</u>		
112.15	<u>appropriation, \$517,000 in fiscal year 2011</u>		
112.16	<u>is to the board to operate the prescription</u>		
112.17	<u>electronic reporting system in Minnesota</u>		
112.18	<u>Statutes, section 152.126. Base level funding</u>		
112.19	<u>for this activity in fiscal year 2012 shall be</u>		
112.20	<u>\$356,000.</u>		
112.21	<u>Subd. 5. Board of Podiatry</u>	<u>15,000</u>	<u>15,000</u>
112.22	<u>Purpose.</u> <u>This appropriation is to pay health</u>		
112.23	<u>insurance coverage costs and to cover the</u>		
112.24	<u>cost of expert witnesses in disciplinary cases.</u>		
112.25	<u>This is a onetime appropriation.</u>		
112.26	<u>Sec. 7. EMERGENCY MEDICAL SERVICES</u>		
112.27	<u>BOARD</u> \$	<u>215,000</u> \$	<u>(382,000)</u>
112.28	<u>Appropriation Transfer Repeal.</u> <u>Any</u>		
112.29	<u>portion of the \$250,000 appropriation in</u>		
112.30	<u>Laws 2009, chapter 79, article 13, section</u>		
112.31	<u>6, as amended by Laws 2009, chapter</u>		
112.32	<u>173, article 2, section 4, not yet expended</u>		
112.33	<u>or encumbered by the Department of</u>		
112.34	<u>Public Safety for a medical response unit</u>		

113.1 reimbursement pilot program, estimated to
113.2 be \$235,000, must be retained by or returned
113.3 to the Emergency Medical Services Board to
113.4 be spent for board purposes. This section is
113.5 effective the day following final enactment.

113.6 Sec. 8. UNIVERSITY OF MINNESOTA \$ -0- \$ 93,000

113.7 This appropriation is from the special
113.8 revenue fund for the couples on the brink
113.9 program.

113.10 Sec. 9. DEPARTMENT OF CORRECTIONS \$ -0- \$ -0-

113.11 **Sex Offender Services.** From the general
113.12 fund appropriations to the commissioner
113.13 of corrections, the commissioner shall
113.14 transfer \$837,000 each year of the
113.15 biennium beginning on July 1, 2011, to the
113.16 commissioner of human services to provide
113.17 clinical treatment to incarcerated offenders.
113.18 This transfer shall become part of the base
113.19 for the Department of Corrections.

113.20 Sec. 10. DEPARTMENT OF COMMERCE \$ -0- \$ 19,000

113.21 **Health Plan Filings.** This appropriation is
113.22 for the review and approval of new health
113.23 plan filings due to Minnesota Statutes, section
113.24 62Q.545. This is a onetime appropriation in
113.25 fiscal year 2011.

113.26 Sec. 11. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

113.27 Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds
113.28 appropriated for this program, the administrative services unit must purchase medical
113.29 professional liability insurance, if available, for a health care provider who is registered in
113.30 accordance with subdivision 4 and who is not otherwise covered by a medical professional
113.31 liability insurance policy or self-insured plan either personally or through another facility
113.32 or employer. The administrative services unit is authorized to prorate payments or

115.1 approval of the legislature. The preceding
115.2 requirement for legislative approval does not
115.3 apply to transfers made to establish a project's
115.4 initial operating budget each year; instead,
115.5 the requirements of section 11, subdivision
115.6 2, of this article apply to those transfers. Any
115.7 unexpended balance in the appropriation
115.8 for these projects does not cancel but is
115.9 available for ongoing development and
115.10 operations. Any computer project with a
115.11 total cost exceeding \$1,000,000, including,
115.12 but not limited to, a replacement for the
115.13 proposed HealthMatch system, shall not be
115.14 commenced without the express approval of
115.15 the legislature.

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

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

115.26 **TANF Maintenance of Effort.**

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

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

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

116.9 (3) state and county MFIP administrative
116.10 costs under Minnesota Statutes, chapters
116.11 256J and 256K;

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

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

116.22 (6) qualifying working family credit
116.23 expenditures under Minnesota Statutes,
116.24 section 290.0671; and

116.25 (7) qualifying Minnesota education credit
116.26 expenditures under Minnesota Statutes,
116.27 section 290.0674.

116.28 (b) The commissioner shall ensure that
116.29 sufficient qualified nonfederal expenditures
116.30 are made each year to meet the state's
116.31 TANF/MOE requirements. For the activities
116.32 listed in paragraph (a), clauses (2) to
116.33 (6), the commissioner may only report
116.34 expenditures that are excluded from the

117.1 definition of assistance under Code of
117.2 Federal Regulations, title 45, section 260.31.

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

117.13 (d) For the federal fiscal years beginning on
117.14 or after October 1, 2007, the commissioner
117.15 may not claim an amount of TANF/MOE in
117.16 excess of the 75 percent standard in Code
117.17 of Federal Regulations, title 45, section
117.18 263.1(a)(2), except:

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

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

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

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

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

118.14 (f) Notwithstanding any contrary provision
118.15 in this article, this provision expires June 30,
118.16 2013.

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

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

118.27 (1) fiscal year 2010, ~~\$50,973,000~~
118.28 \$50,897,000;

118.29 (2) fiscal year 2011, ~~\$53,793,000~~
118.30 \$54,243,000;

118.31 (3) fiscal year 2012, ~~\$23,516,000~~
118.32 \$23,345,000; and

118.33 (4) fiscal year 2013, ~~\$16,808,000~~
118.34 \$16,585,000.

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

119.3 **Food Stamps Employment and Training.**

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

119.12 (b) Notwithstanding Minnesota Statutes,
119.13 sections 256D.051, subdivisions 1a, 6b,
119.14 and 6c, and 256J.626, federal food stamps
119.15 employment and training funds received
119.16 as reimbursement of MFIP consolidated
119.17 fund grant expenditures for diversionary
119.18 work program participants and child
119.19 care assistance program expenditures for
119.20 two-parent families must be deposited in the
119.21 general fund. The amount of funds must be
119.22 limited to \$3,350,000 in fiscal year 2010
119.23 and \$4,440,000 in fiscal years 2011 through
119.24 2013, contingent on approval by the federal
119.25 Food and Nutrition Service.

119.26 (c) Consistent with the receipt of these federal
119.27 funds, the commissioner may adjust the
119.28 level of working family credit expenditures
119.29 claimed as TANF maintenance of effort.

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

119.32 **ARRA Food Support Administration.**

119.33 The funds available for food support
119.34 administration under the American Recovery
119.35 and Reinvestment Act (ARRA) of 2009

120.1 are appropriated to the commissioner
120.2 to pay actual costs of implementing the
120.3 food support benefit increases, increased
120.4 eligibility determinations, and outreach. Of
120.5 these funds, 20 percent shall be allocated
120.6 to the commissioner and 80 percent shall
120.7 be allocated to counties. The commissioner
120.8 shall allocate the county portion based on
120.9 caseload. Reimbursement shall be based on
120.10 actual costs reported by counties through
120.11 existing processes. Tribal reimbursement
120.12 must be made from the state portion based
120.13 on a caseload factor equivalent to that of a
120.14 county.

120.15 **ARRA Food Support Benefit Increases.**

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

120.22 **Emergency Fund for the TANF Program.**

120.23 TANF Emergency Contingency funds
120.24 available under the American Recovery
120.25 and Reinvestment Act of 2009 (Public Law
120.26 111-5) are appropriated to the commissioner.
120.27 The commissioner must request TANF
120.28 Emergency Contingency funds from the
120.29 Secretary of the Department of Health
120.30 and Human Services to the extent the
120.31 commissioner meets or expects to meet the
120.32 requirements of section 403(c) of the Social
120.33 Security Act. The commissioner must seek
120.34 to maximize such grants. The funds received
120.35 must be used as appropriated. Each county
120.36 must maintain the county's current level of

121.1 emergency assistance funding under the
121.2 MFIP consolidated fund and use the funds
121.3 under this paragraph to supplement existing
121.4 emergency assistance funding levels.

121.5 Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
121.6 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

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

121.12 Appropriations by Fund			
121.13	General	63,205,000	89,033,000
121.14	Federal TANF	100,818,000	84,538,000

121.15 **(b) Support Services Grants**

121.16 Appropriations by Fund			
121.17	General	8,715,000	12,498,000
121.18	Federal TANF	116,557,000	107,457,000

121.19 **MFIP Consolidated Fund.** The MFIP
121.20 consolidated fund TANF appropriation is
121.21 reduced by \$1,854,000 in fiscal year 2010
121.22 and fiscal year 2011.

121.23 Notwithstanding Minnesota Statutes, section
121.24 256J.626, subdivision 8, paragraph (b), the
121.25 commissioner shall reduce proportionately
121.26 the reimbursement to counties for
121.27 administrative expenses.

121.28 **Subsidized Employment Funding Through**
121.29 **ARRA.** The commissioner is authorized to
121.30 apply for TANF emergency fund grants for
121.31 subsidized employment activities. Growth
121.32 in expenditures for subsidized employment
121.33 within the supported work program and the
121.34 MFIP consolidated fund over the amount

122.1 expended in the calendar quarters in the
122.2 TANF emergency fund base year shall be
122.3 used to leverage the TANF emergency fund
122.4 grants for subsidized employment and to
122.5 fund supported work. The commissioner
122.6 shall develop procedures to maximize
122.7 reimbursement of these expenditures over the
122.8 TANF emergency fund base year quarters,
122.9 and may contract directly with employers
122.10 and providers to maximize these TANF
122.11 emergency fund grants, including provisions
122.12 of TANF summer youth program wage
122.13 subsidies for MFIP youth and caregivers.
122.14 MFIP youth are individuals up to age 25 who
122.15 are part of an eligible household as defined
122.16 under rules governing TANF maintenance
122.17 of effort with incomes less than 200 percent
122.18 of federal poverty guidelines. Expenditures
122.19 may only be used for subsidized wages and
122.20 benefits and eligible training and supervision
122.21 expenditures. The commissioner shall
122.22 contract with the Minnesota Department of
122.23 Employment and Economic Development
122.24 for the summer youth program. The
122.25 commissioner shall develop procedures
122.26 to maximize reimbursement of these
122.27 expenditures over the TANF emergency fund
122.28 year quarters. No more than \$6,000,000 shall
122.29 be reimbursed. This provision is effective
122.30 upon enactment.

122.31 **Supported Work.** Of the TANF
122.32 appropriation, \$4,700,000 in fiscal year 2010
122.33 and \$4,700,000 in fiscal year 2011 are to the
122.34 commissioner for supported work for MFIP
122.35 recipients and is available until expended.
122.36 Supported work includes paid transitional

123.1 work experience and a continuum of
123.2 employment assistance, including outreach
123.3 and recruitment, program orientation
123.4 and intake, testing and assessment, job
123.5 development and marketing, preworksite
123.6 training, supported worksite experience,
123.7 job coaching, and postplacement follow-up,
123.8 in addition to extensive case management
123.9 and referral services. This is a onetime
123.10 appropriation.

123.11 **Base Adjustment.** The general fund base
123.12 is reduced by \$3,783,000 in each of fiscal
123.13 years 2012 and 2013. The TANF fund base
123.14 is increased by \$5,004,000 in each of fiscal
123.15 years 2012 and 2013.

123.16 **Integrated Services Program Funding.**
123.17 The TANF appropriation for integrated
123.18 services program funding is \$1,250,000 in
123.19 fiscal year 2010 and \$0 in fiscal year 2011
123.20 and the base for fiscal years 2012 and 2013
123.21 is \$0.

123.22 **TANF Emergency Fund; Nonrecurrent**
123.23 **Short-Term Benefits.** (a) TANF emergency
123.24 contingency fund grants received due to
123.25 increases in expenditures for nonrecurrent
123.26 short-term benefits must be used to offset the
123.27 increase in these expenditures for counties
123.28 under the MFIP consolidated fund, under
123.29 Minnesota Statutes, section 256J.626,
123.30 and the diversionary work program. The
123.31 commissioner shall develop procedures
123.32 to maximize reimbursement of these
123.33 expenditures over the TANF emergency fund
123.34 base year quarters. Growth in expenditures
123.35 for the diversionary work program over the

124.1 amount expended in the calendar quarters in
124.2 the TANF emergency fund base year shall be
124.3 used to leverage these funds.

124.4 (b) To the extent that the commissioner
124.5 can claim eligible tax credit growth as
124.6 nonrecurrent short-term benefits, the
124.7 commissioner shall use those funds to
124.8 leverage the increased expenditures in
124.9 paragraph (a).

124.10 (c) TANF emergency funds for nonrecurrent
124.11 short-term benefits received in excess of the
124.12 amounts necessary for paragraphs (a) and (b)
124.13 shall be used to reimburse the general fund
124.14 for the costs of eligible tax credits in fiscal
124.15 year 2011. The amount of such funds shall
124.16 not exceed \$18,964,000 in fiscal year 2010.

124.17 (d) This rider is effective the day following
124.18 final enactment.

124.19	(c) MFIP Child Care Assistance Grants	61,171,000	65,214,000
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124.20 **Acceleration of ARRA Child Care and**
124.21 **Development Fund Expenditure.** The
124.22 commissioner must liquidate all child care
124.23 and development money available under
124.24 the American Recovery and Reinvestment
124.25 Act (ARRA) of 2009, Public Law 111-5,
124.26 by September 30, 2010. In order to expend
124.27 those funds by September 30, 2010, the
124.28 commissioner may redesignate and expend
124.29 the ARRA child care and development funds
124.30 appropriated in fiscal year 2011 for purposes
124.31 under this section for related purposes that
124.32 will allow liquidation by September 30,
124.33 2010. Child care and development funds
124.34 otherwise available to the commissioner
124.35 for those related purposes shall be used to

125.1 fund the purposes from which the ARRA
 125.2 child care and development funds had been
 125.3 redesignated.

125.4 **School Readiness Service Agreements.**

125.5 \$400,000 in fiscal year 2010 and \$400,000
 125.6 in fiscal year 2011 are from the federal
 125.7 TANF fund to the commissioner of human
 125.8 services consistent with federal regulations
 125.9 for the purpose of school readiness service
 125.10 agreements under Minnesota Statutes,
 125.11 section 119B.231. This is a onetime
 125.12 appropriation. Any unexpended balance the
 125.13 first year is available in the second year.

125.14 **(d) Basic Sliding Fee Child Care Assistance**
 125.15 **Grants**

	40,100,000	45,092,000
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125.16 **School Readiness Service Agreements.**

125.17 \$257,000 in fiscal year 2010 and \$257,000
 125.18 in fiscal year 2011 are from the general
 125.19 fund for the purpose of school readiness
 125.20 service agreements under Minnesota
 125.21 Statutes, section 119B.231. This is a onetime
 125.22 appropriation. Any unexpended balance the
 125.23 first year is available in the second year.

125.24 **Child Care Development Fund**

125.25 **Unexpended Balance.** In addition to
 125.26 the amount provided in this section, the
 125.27 commissioner shall expend \$5,244,000 in
 125.28 fiscal year 2010 from the federal child care
 125.29 development fund unexpended balance
 125.30 for basic sliding fee child care under
 125.31 Minnesota Statutes, section 119B.03. The
 125.32 commissioner shall ensure that all child
 125.33 care and development funds are expended
 125.34 according to the federal child care and
 125.35 development fund regulations.

126.1 **Basic Sliding Fee.** \$4,000,000 in fiscal year
126.2 2010 and \$4,000,000 in fiscal year 2011 are
126.3 from the federal child care development
126.4 funds received from the American Recovery
126.5 and Reinvestment Act of 2009, Public
126.6 Law 111-5, to the commissioner of human
126.7 services consistent with federal regulations
126.8 for the purpose of basic sliding fee child care
126.9 assistance under Minnesota Statutes, section
126.10 119B.03. This is a onetime appropriation.
126.11 Any unexpended balance the first year is
126.12 available in the second year.

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

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

126.33 (b) Up to three-fourths of the funds shall
126.34 be allocated in proportion to the average
126.35 of each county's most recent six months of

127.1 reported waiting list as defined in Minnesota
127.2 Statutes, section 119B.03, subdivision 2, and
127.3 the reinstatement list of those families whose
127.4 assistance was terminated with the approval
127.5 of the commissioner under Minnesota Rules,
127.6 part 3400.0183, subpart 1. Funds in excess
127.7 of the amount necessary to serve all families
127.8 in this category shall be allocated according
127.9 to paragraph (d).

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

127.16 (d) Funds in excess of the amount necessary
127.17 to serve all families in paragraphs (a) and
127.18 (b) shall be allocated in proportion to each
127.19 county's total expenditures for the basic
127.20 sliding fee child care program reported
127.21 during the most recent fiscal year completed
127.22 at the time of the notice of allocation. To
127.23 the extent that funds are available, and
127.24 notwithstanding Minnesota Statutes, section
127.25 119B.03, subdivision 8, for the period
127.26 January 1, 2011, to December 31, 2011, each
127.27 county's guaranteed floor must be equal to its
127.28 original calendar year 2010 allocation.

127.29 **Base Adjustment.** The general fund base is
127.30 decreased by \$257,000 in each of fiscal years
127.31 2012 and 2013.

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

127.33 **Family, friends, and neighbor grants.**
127.34 \$375,000 in fiscal year 2010 and \$375,000
127.35 in fiscal year 2011 are from the child

128.1 care development fund required targeted
128.2 quality funds for quality expansion and
128.3 infant/toddler from the American Recovery
128.4 and Reinvestment Act of 2009, Public
128.5 Law 111-5, to the commissioner of human
128.6 services for family, friends, and neighbor
128.7 grants under Minnesota Statutes, section
128.8 119B.232. This appropriation may be used
128.9 on programs receiving family, friends, and
128.10 neighbor grant funds as of June 30, 2009,
128.11 or on new programs or projects. This is a
128.12 onetime appropriation. Any unexpended
128.13 balance the first year is available in the
128.14 second year.

128.15 **Voluntary quality rating system training,**
128.16 **coaching, consultation, and supports.**
128.17 \$633,000 in fiscal year 2010 and \$633,000
128.18 in fiscal year 2011 are from the federal child
128.19 care development fund required targeted
128.20 quality funds for quality expansion and
128.21 infant/toddler from the American Recovery
128.22 and Reinvestment Act of 2009, Public
128.23 Law 111-5, to the commissioner of human
128.24 services consistent with federal regulations
128.25 for the purpose of providing grants to provide
128.26 statewide child-care provider training,
128.27 coaching, consultation, and supports to
128.28 prepare for the voluntary Minnesota quality
128.29 rating system rating tool. This is a onetime
128.30 appropriation. Any unexpended balance the
128.31 first year is available in the second year.

128.32 **Voluntary quality rating system.** \$184,000
128.33 in fiscal year 2010 and \$1,200,000 in fiscal
128.34 year 2011 are from the federal child care
128.35 development fund required targeted funds for
128.36 quality expansion and infant/toddler from the

129.1 American Recovery and Reinvestment Act of
 129.2 2009, Public Law 111-5, to the commissioner
 129.3 of human services consistent with federal
 129.4 regulations for the purpose of implementing
 129.5 the voluntary Parent Aware quality star
 129.6 rating system pilot in coordination with the
 129.7 Minnesota Early Learning Foundation. The
 129.8 appropriation for the first year is to complete
 129.9 and promote the voluntary Parent Aware
 129.10 quality rating system pilot program through
 129.11 June 30, 2010, and the appropriation for
 129.12 the second year is to continue the voluntary
 129.13 Minnesota quality rating system pilot
 129.14 through June 30, 2011. This is a onetime
 129.15 appropriation. Any unexpended balance the
 129.16 first year is available in the second year.

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

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

129.19	Appropriations by Fund		
129.20	General	48,333,000	50,498,000
129.21	Federal TANF	340,000	240,000

129.22 **Base Adjustment.** The general fund base is
 129.23 decreased by \$5,371,000 in fiscal year 2012
 129.24 and decreased \$5,371,000 in fiscal year 2013.

129.25 **Privatized Adoption Grants.** Federal
 129.26 reimbursement for privatized adoption grant
 129.27 and foster care recruitment grant expenditures
 129.28 is appropriated to the commissioner for
 129.29 adoption grants and foster care and adoption
 129.30 administrative purposes.

129.31 **Adoption Assistance Incentive Grants.**
 129.32 Federal funds available during fiscal year
 129.33 2010 and fiscal year 2011 for the adoption
 129.34 incentive grants are appropriated to the

130.1 commissioner for postadoption services
 130.2 including parent support groups.

130.3 **Adoption Assistance and Relative Custody**

130.4 **Assistance.** The commissioner may transfer
 130.5 unencumbered appropriation balances for
 130.6 adoption assistance and relative custody
 130.7 assistance between fiscal years and between
 130.8 programs.

130.9 (h) Children and Community Services Grants	67,663,000	67,542,000
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130.10 **Targeted Case Management Temporary**

130.11 **Funding Adjustment.** The commissioner
 130.12 shall recover from each county and tribe
 130.13 receiving a targeted case management
 130.14 temporary funding payment in fiscal year
 130.15 2008 an amount equal to that payment. The
 130.16 commissioner shall recover one-half of the
 130.17 funds by February 1, 2010, and the remainder
 130.18 by February 1, 2011. At the commissioner's
 130.19 discretion and at the request of a county
 130.20 or tribe, the commissioner may revise
 130.21 the payment schedule, but full payment
 130.22 must not be delayed beyond May 1, 2011.
 130.23 The commissioner may use the recovery
 130.24 procedure under Minnesota Statutes, section
 130.25 256.017, to recover the funds. Recovered
 130.26 funds must be deposited into the general
 130.27 fund.

130.28 (i) General Assistance Grants	48,215,000	48,608,000
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130.29 **General Assistance Standard.** The
 130.30 commissioner shall set the monthly standard
 130.31 of assistance for general assistance units
 130.32 consisting of an adult recipient who is
 130.33 childless and unmarried or living apart
 130.34 from parents or a legal guardian at \$203.
 130.35 The commissioner may reduce this amount

131.1 according to Laws 1997, chapter 85, article
131.2 3, section 54.

131.3 **Emergency General Assistance.** The
131.4 amount appropriated for emergency general
131.5 assistance funds is limited to no more
131.6 than \$7,889,812 in fiscal year 2010 and
131.7 \$7,889,812 in fiscal year 2011. Funds
131.8 to counties must be allocated by the
131.9 commissioner using the allocation method
131.10 specified in Minnesota Statutes, section
131.11 256D.06.

131.12	(j) Minnesota Supplemental Aid Grants	33,930,000	35,191,000
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131.13 **Emergency Minnesota Supplemental**
131.14 **Aid Funds.** The amount appropriated for
131.15 emergency Minnesota supplemental aid
131.16 funds is limited to no more than \$1,100,000
131.17 in fiscal year 2010 and \$1,100,000 in fiscal
131.18 year 2011. Funds to counties must be
131.19 allocated by the commissioner using the
131.20 allocation method specified in Minnesota
131.21 Statutes, section 256D.46.

131.22	(k) Group Residential Housing Grants	111,778,000	114,034,000
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131.23 **Group Residential Housing Costs**
131.24 **Refinanced.** (a) Effective July 1, 2011, the
131.25 commissioner shall increase the home and
131.26 community-based service rates and county
131.27 allocations provided to programs for persons
131.28 with disabilities established under section
131.29 1915(c) of the Social Security Act to the
131.30 extent that these programs will be paying
131.31 for the costs above the rate established
131.32 in Minnesota Statutes, section 256I.05,
131.33 subdivision 1.

131.34 (b) For persons receiving services under
131.35 Minnesota Statutes, section 245A.02, who

132.1 reside in licensed adult foster care beds
 132.2 for which a difficulty of care payment
 132.3 was being made under Minnesota Statutes,
 132.4 section 256I.05, subdivision 1c, paragraph
 132.5 (b), counties may request an exception to
 132.6 the individual's service authorization not to
 132.7 exceed the difference between the client's
 132.8 monthly service expenditures plus the
 132.9 amount of the difficulty of care payment.

132.10 (l) Children's Mental Health Grants	16,885,000	16,882,000
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132.11 **Funding Usage.** Up to 75 percent of a fiscal
 132.12 year's appropriation for children's mental
 132.13 health grants may be used to fund allocations
 132.14 in that portion of the fiscal year ending
 132.15 December 31.

132.16 (m) Other Children and Economic Assistance 132.17 Grants	16,047,000	15,339,000
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132.18 **Fraud Prevention Grants.** Of this
 132.19 appropriation, \$228,000 in fiscal year 2010
 132.20 and ~~\$228,000~~ \$379,000 in fiscal year 2011
 132.21 is to the commissioner for fraud prevention
 132.22 grants to counties.

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

132.33 **ARRA Homeless Youth Funds.** To the
 132.34 extent permitted under federal law, the
 132.35 commissioner shall designate \$2,500,000

133.1 of the Homeless Prevention and Rapid
133.2 Re-Housing Program funds provided under
133.3 the American Recovery and Reinvestment
133.4 Act of 2009, Public Law 111-5, for agencies
133.5 providing homelessness prevention and rapid
133.6 rehousing services to youth.

133.7 **Supportive Housing Services.** \$1,500,000
133.8 each year is for supportive services under
133.9 Minnesota Statutes, section 256K.26. This is
133.10 a onetime appropriation.

133.11 **Community Action Grants.** Community
133.12 action grants are reduced one time by
133.13 \$1,794,000 each year. This reduction is due
133.14 to the availability of federal funds under the
133.15 American Recovery and Reinvestment Act.

133.16 **Base Adjustment.** The general fund base
133.17 is increased by ~~\$773,000~~ \$903,000 in fiscal
133.18 year 2012 and ~~\$773,000~~ \$413,000 in fiscal
133.19 year 2013.

133.20 **Federal ARRA Funds for Existing**
133.21 **Programs.** (a) Federal funds received by the
133.22 commissioner for the emergency food and
133.23 shelter program from the American Recovery
133.24 and Reinvestment Act of 2009, Public
133.25 Law 111-5, but not previously approved
133.26 by the legislature are appropriated to the
133.27 commissioner for the purposes of the grant
133.28 program.

133.29 (b) Federal funds received by the
133.30 commissioner for the emergency shelter
133.31 grant program including the Homelessness
133.32 Prevention and Rapid Re-Housing
133.33 Program from the American Recovery and
133.34 Reinvestment Act of 2009, Public Law

134.1 111-5, are appropriated to the commissioner
134.2 for the purposes of the grant programs.

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

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

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

134.24 **Long-Term Homeless Supportive**
134.25 **Service Fund Appropriation.** To the
134.26 extent permitted under federal law, the
134.27 commissioner shall designate \$3,000,000
134.28 of the Homelessness Prevention and Rapid
134.29 Re-Housing Program funds provided under
134.30 the American Recovery and Reinvestment
134.31 Act of 2009, Public Law, 111-5, to the
134.32 long-term homeless service fund under
134.33 Minnesota Statutes, section 256K.26. This
134.34 appropriation shall become available by July

135.1 1, 2009. This paragraph is effective the day
135.2 following final enactment.

135.3 Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
135.4 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

135.5 Subd. 8. **Continuing Care Grants**

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

135.8 (a) Aging and Adult Services Grants	13,499,000	15,805,000
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135.9 **Base Adjustment.** The general fund base is
135.10 increased by \$5,751,000 in fiscal year 2012
135.11 and \$6,705,000 in fiscal year 2013.

135.12 **Information and Assistance**

135.13 **Reimbursement.** Federal administrative
135.14 reimbursement obtained from information
135.15 and assistance services provided by the
135.16 Senior LinkAge or Disability Linkage lines
135.17 to people who are identified as eligible for
135.18 medical assistance shall be appropriated to
135.19 the commissioner for this activity.

135.20 **Community Service Development Grant**

135.21 **Reduction.** Funding for community service
135.22 development grants must be reduced by
135.23 \$260,000 for fiscal year 2010; \$284,000 in
135.24 fiscal year 2011; \$43,000 in fiscal year 2012;
135.25 and \$43,000 in fiscal year 2013. Base level
135.26 funding shall be restored in fiscal year 2014.

135.27 **Community Service Development Grant**

135.28 **Community Initiative.** Funding for
135.29 community service development grants shall
135.30 be used to offset the cost of aging support
135.31 grants. Base level funding shall be restored
135.32 in fiscal year 2014.

136.1 **Senior Nutrition Use of Federal Funds.**

136.2 For fiscal year 2010, general fund grants
 136.3 for home-delivered meals and congregate
 136.4 dining shall be reduced by \$500,000. The
 136.5 commissioner must replace these general
 136.6 fund reductions with equal amounts from
 136.7 federal funding for senior nutrition from the
 136.8 American Recovery and Reinvestment Act
 136.9 of 2009.

136.10 (b) Alternative Care Grants	50,234,000	48,576,000
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136.11 **Base Adjustment.** The general fund base is
 136.12 decreased by \$3,598,000 in fiscal year 2012
 136.13 and \$3,470,000 in fiscal year 2013.

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

136.19 (c) Medical Assistance Grants; Long-Term 136.20 Care Facilities.	367,444,000	419,749,000
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136.21 (d) Medical Assistance Long-Term Care 136.22 Waivers and Home Care Grants	853,567,000	1,039,517,000
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136.23 **Manage Growth in TBI and CADI**

136.24 **Waivers.** During the fiscal years beginning
 136.25 on July 1, 2009, and July 1, 2010, the
 136.26 commissioner shall allocate money for home
 136.27 and community-based waiver programs
 136.28 under Minnesota Statutes, section 256B.49,
 136.29 to ensure a reduction in state spending that is
 136.30 equivalent to limiting the caseload growth of
 136.31 the TBI waiver to 12.5 allocations per month
 136.32 each year of the biennium and the CADI
 136.33 waiver to 95 allocations per month each year
 136.34 of the biennium. Limits do not apply: (1)
 136.35 when there is an approved plan for nursing

137.1 facility bed closures for individuals under
137.2 age 65 who require relocation due to the
137.3 bed closure; (2) to fiscal year 2009 waiver
137.4 allocations delayed due to unallotment; or (3)
137.5 to transfers authorized by the commissioner
137.6 from the personal care assistance program
137.7 of individuals having a home care rating
137.8 of "CS," "MT," or "HL." Priorities for the
137.9 allocation of funds must be for individuals
137.10 anticipated to be discharged from institutional
137.11 settings or who are at imminent risk of a
137.12 placement in an institutional setting.

137.13 **Manage Growth in DD Waiver.** The
137.14 commissioner shall manage the growth in
137.15 the DD waiver by limiting the allocations
137.16 included in the February 2009 forecast to 15
137.17 additional diversion allocations each month
137.18 for the calendar years that begin on January
137.19 1, 2010, and January 1, 2011. Additional
137.20 allocations must be made available for
137.21 transfers authorized by the commissioner
137.22 from the personal care program of individuals
137.23 having a home care rating of "CS," "MT,"
137.24 or "HL."

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

137.33 **Alternatives to Personal Care Assistance**
137.34 **Services.** Base level funding of \$3,237,000
137.35 in fiscal year 2012 and \$4,856,000 in

138.1 fiscal year 2013 is to implement alternative
 138.2 services to personal care assistance services
 138.3 for persons with mental health and other
 138.4 behavioral challenges who can benefit
 138.5 from other services that more appropriately
 138.6 meet their needs and assist them in living
 138.7 independently in the community. These
 138.8 services may include, but not be limited to, a
 138.9 1915(i) state plan option.

138.10 **(e) Mental Health Grants**

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

138.15 **Funding Usage.** Up to 75 percent of a fiscal
 138.16 year's appropriation for adult mental health
 138.17 grants may be used to fund allocations in that
 138.18 portion of the fiscal year ending December
 138.19 31.

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

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

138.22 **Payments for Substance Abuse Treatment.**

138.23 For ~~services provided~~ placements beginning
 138.24 during fiscal years 2010 and 2011,
 138.25 county-negotiated rates and provider claims
 138.26 to the consolidated chemical dependency
 138.27 fund must not exceed the lesser of:
 138.28 (1) rates charged for these services on
 138.29 January 1, 2009; or
 138.30 (2) 160 percent of the average rate on January
 138.31 1, 2009, for each group of vendors with
 138.32 similar attributes.
 138.33 Effective July 1, 2010, rates that were above
 138.34 the average rate on January 1, 2009, are

139.1 reduced by five percent from the rates in
139.2 effect on June 1, 2010. Services provided
139.3 under this section by state-operated services
139.4 are exempt from the rate reduction. For
139.5 services provided in fiscal years 2012
139.6 and 2013, ~~statewide average rates~~ the
139.7 statewide aggregate payment under the
139.8 new rate methodology to be developed
139.9 under Minnesota Statutes, section 254B.12,
139.10 must not exceed the ~~average rates charged~~
139.11 ~~for these services on January 1, 2009~~
139.12 projected aggregate payment under the
139.13 rates in effect for fiscal year 2011, plus a
139.14 state share increase of \$3,787,000 for fiscal
139.15 year 2012 and \$5,023,000 for fiscal year
139.16 2013. Notwithstanding any provision to the
139.17 contrary in this article, this provision expires
139.18 on June 30, 2013.

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

139.25 **County CD Share of MA Costs for**
139.26 **ARRA Compliance.** Notwithstanding the
139.27 provisions of Minnesota Statutes, chapter
139.28 254B, for chemical dependency services
139.29 provided during the period October 1, 2008,
139.30 to December 31, 2010, and reimbursed by
139.31 medical assistance at the enhanced federal
139.32 matching rate provided under the American
139.33 Recovery and Reinvestment Act of 2009, the
139.34 county share is 30 percent of the nonfederal
139.35 share. This provision is effective the day
139.36 following final enactment.

140.1	(h) Chemical Dependency Nonentitlement		
140.2	Grants	1,729,000	1,729,000
140.3	(i) Other Continuing Care Grants	19,201,000	17,528,000
140.4	Base Adjustment. The general fund base is		
140.5	increased by \$2,639,000 in fiscal year 2012		
140.6	and increased by \$3,854,000 in fiscal year		
140.7	2013.		
140.8	Technology Grants. \$650,000 in fiscal		
140.9	year 2010 and \$1,000,000 in fiscal year		
140.10	2011 are for technology grants, case		
140.11	consultation, evaluation, and consumer		
140.12	information grants related to developing and		
140.13	supporting alternatives to shift-staff foster		
140.14	care residential service models.		
140.15	Other Continuing Care Grants; HIV		
140.16	Grants. Money appropriated for the HIV		
140.17	drug and insurance grant program in fiscal		
140.18	year 2010 may be used in either year of the		
140.19	biennium.		
140.20	Quality Assurance Commission. Effective		
140.21	July 1, 2009, state funding for the quality		
140.22	assurance commission under Minnesota		
140.23	Statutes, section 256B.0951, is canceled.		
140.24	Sec. 15. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by		
140.25	Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:		
140.26	Subd. 8. Board of Nursing Home		
140.27	Administrators	1,211,000	1,023,000
140.28	Administrative Services Unit - Operating		
140.29	Costs. Of this appropriation, \$524,000		
140.30	in fiscal year 2010 and \$526,000 in		
140.31	fiscal year 2011 are for operating costs		
140.32	of the administrative services unit. The		
140.33	administrative services unit may receive		

141.1 and expend reimbursements for services
141.2 performed by other agencies.

141.3 **Administrative Services Unit - Retirement**

141.4 **Costs.** Of this appropriation in fiscal year
141.5 2010, \$201,000 is for onetime retirement
141.6 costs in the health-related boards. This
141.7 funding may be transferred to the health
141.8 boards incurring those costs for their
141.9 payment. These funds are available either
141.10 year of the biennium.

141.11 **Administrative Services Unit - Volunteer**

141.12 **Health Care Provider Program.** Of this
141.13 appropriation, ~~\$79,000~~ \$130,000 in fiscal
141.14 year 2010 and ~~\$89,000~~ \$150,000 in fiscal
141.15 year 2011 are to pay for medical professional
141.16 liability coverage required under Minnesota
141.17 Statutes, section 214.40.

141.18 **Administrative Services Unit - Contested**

141.19 **Cases and Other Legal Proceedings.** Of
141.20 this appropriation, \$200,000 in fiscal year
141.21 2010 and \$200,000 in fiscal year 2011 are
141.22 for costs of contested case hearings and other
141.23 unanticipated costs of legal proceedings
141.24 involving health-related boards funded
141.25 under this section and for unforeseen
141.26 expenditures of an urgent nature. Upon
141.27 certification of a health-related board to the
141.28 administrative services unit that the costs
141.29 will be incurred and that there is insufficient
141.30 money available to pay for the costs out of
141.31 money currently available to that board, the
141.32 administrative services unit is authorized
141.33 to transfer money from this appropriation
141.34 to the board for payment of those costs
141.35 with the approval of the commissioner of

142.1 finance. This appropriation does not cancel.
142.2 Any unencumbered and unspent balances
142.3 remain available for these expenditures in
142.4 subsequent fiscal years. The boards receiving
142.5 funds under this section shall include these
142.6 amounts when setting fees to cover their
142.7 costs.

142.8 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

142.9 All uncodified language contained in this article expires on June 30, 2011, unless a
142.10 different expiration date is explicit.

142.11 Sec. 17. **EFFECTIVE DATE.**

142.12 The provisions in this article are effective July 1, 2010, unless a different effective
142.13 date is explicit.

142.14 **ARTICLE 8**

142.15 **HUMAN SERVICES FORECAST ADJUSTMENTS**

142.16 Section 1. **SUMMARY OF APPROPRIATIONS.**

142.17 The amounts shown in this section summarize direct appropriations, by fund, made
142.18 in this article.

	<u>2010</u>		<u>2011</u>		<u>Total</u>
142.19					
142.20	<u>General</u>	\$ (109,876,000)	\$ (28,344,000)	\$	(138,220,000)
142.21	<u>Health Care Access</u>	\$ 99,654,000	\$ 276,500,000	\$	376,154,000
142.22	<u>Federal TANF</u>	\$ (9,830,000)	\$ 15,133,000	\$	5,303,000
142.23	<u>Total</u>	<u>\$ (20,052,000)</u>	<u>\$ 263,289,000</u>	<u>\$</u>	<u>243,237,000</u>

142.24 Sec. 2. **DEPARTMENT OF HUMAN SERVICES APPROPRIATION.**

142.25 The sums shown in the columns marked "Appropriations" are added to or, if shown
142.26 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13,
142.27 as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes
142.28 specified in this article. The appropriations are from the general fund, or another named
142.29 fund, and are available for the fiscal years indicated for each purpose. The figures "2010"
142.30 and "2011" used in this article mean that the addition to or subtraction from appropriations
142.31 listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011,
142.32 respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011.

143.1 "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions
 143.2 for the fiscal year ending June 30, 2010, are effective the day following final enactment
 143.3 unless a different effective date is explicit.

143.4 **APPROPRIATIONS**
 143.5 **Available for the Year**
 143.6 **Ending June 30**
 143.7 **2010** **2011**

143.8 **Sec. 3. DEPARTMENT OF HUMAN**
 143.9 **SERVICES**

143.10 **Subdivision 1. Total Appropriation** **\$ (20,052,000)** **\$ 263,289,000**

<u>Appropriations by Fund</u>		
	<u>2010</u>	<u>2011</u>
143.11		
143.12		
143.13	<u>General</u>	<u>(109,876,000)</u> <u>(28,344,000)</u>
143.14	<u>Health Care Access</u>	<u>99,654,000</u> <u>276,500,000</u>
143.15	<u>Federal TANF</u>	<u>(9,830,000)</u> <u>15,133,000</u>

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

143.19 **Subd. 2. Revenue and Pass-through**

<u>Appropriations by Fund</u>		
143.20		
143.21	<u>Federal TANF</u>	<u>390,000</u> <u>(251,000)</u>

143.22 **Subd. 3. Children and Economic Assistance**
 143.23 **Grants**

<u>Appropriations by Fund</u>		
143.24		
143.25	<u>General</u>	<u>4,489,000</u> <u>(4,140,000)</u>
143.26	<u>Federal TANF</u>	<u>(10,220,000)</u> <u>15,384,000</u>

143.27 The amounts that may be spent from this
 143.28 appropriation are as follows:

143.29 **(a) MFIP Grants**

143.30	<u>General</u>	<u>7,916,000</u> <u>(14,481,000)</u>
143.31	<u>Federal TANF</u>	<u>(10,220,000)</u> <u>15,384,000</u>

143.32 **(b) MFIP Child Care Assistance Grants** **(7,832,000)** **2,579,000**

143.33 **(c) General Assistance Grants** **875,000** **1,339,000**

143.34 **(d) Minnesota Supplemental Aid Grants** **2,454,000** **3,843,000**

144.1	<u>(e) Group Residential Housing Grants</u>	<u>1,076,000</u>	<u>2,580,000</u>
144.2	<u>Subd. 4. Basic Health Care Grants</u>		
144.3	<u>Appropriations by Fund</u>		
144.4	<u>General</u>	<u>(62,770,000)</u>	<u>29,192,000</u>
144.5	<u>Health Care Access</u>	<u>99,654,000</u>	<u>276,500,000</u>
144.6	<u>The amounts that may be spent from the</u>		
144.7	<u>appropriation for each purpose are as follows:</u>		
144.8	<u>(a) MinnesotaCare Grants</u>		
144.9	<u>Health Care Access</u>	<u>99,654,000</u>	<u>276,500,000</u>
144.10	<u>(b) Medical Assistance Basic Health Care -</u>		
144.11	<u>Families and Children</u>	<u>1,165,000</u>	<u>24,146,000</u>
144.12	<u>(c) Medical Assistance Basic Health Care -</u>		
144.13	<u>Elderly and Disabled</u>	<u>(63,935,000)</u>	<u>5,046,000</u>
144.14	<u>Subd. 5. Continuing Care Grants</u>	<u>(51,595,000)</u>	<u>(53,396,000)</u>
144.15	<u>The amounts that may be spent from the</u>		
144.16	<u>appropriation for each purpose are as follows:</u>		
144.17	<u>(a) Medical Assistance Long-Term Care</u>		
144.18	<u>Facilities</u>	<u>(3,774,000)</u>	<u>(8,275,000)</u>
144.19	<u>(b) Medical Assistance Long-Term Care</u>		
144.20	<u>Waivers</u>	<u>(27,710,000)</u>	<u>(22,452,000)</u>
144.21	<u>(c) Chemical Dependency Entitlement Grants</u>	<u>(20,111,000)</u>	<u>(22,669,000)</u>
144.22	Sec. 4. <u>EFFECTIVE DATE.</u>		
144.23	<u>This article is effective the day following final enactment.</u>		

APPENDIX
Article locations in s2337-2

ARTICLE 1	HEALTH CARE	Page.Ln 2.1
ARTICLE 2	CONTINUING CARE	Page.Ln 37.1
ARTICLE 3	CHILDREN AND FAMILY SERVICES; DEPARTMENT OF HUMAN SERVICES LICENSING	Page.Ln 53.27
ARTICLE 4	DEPARTMENT OF HEALTH	Page.Ln 56.22
ARTICLE 5	GENERAL ASSISTANCE MEDICAL CARE AMENDMENTS	Page.Ln 66.11
ARTICLE 6	MISCELLANEOUS	Page.Ln 73.10
ARTICLE 7	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 89.19
ARTICLE 8	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 142.14