..... moves to amend H.F. No. 2614 as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

DHS LICENSING

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

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 **Fair hearing when disqualification is not ~~set aside~~ rescinded.** (a) If the commissioner does not ~~set aside~~ rescind a disqualification of an individual under section 245C.22 who is disqualified on the basis of a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

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

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

section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

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

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

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

Subd. 2. **Consolidated fair hearing.** (a) If an individual who is disqualified on the bases of serious or recurring maltreatment requests a fair hearing on the maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, and requests a fair hearing under this section on the disqualification, which has not been ~~set aside~~ rescinded, the scope of the fair hearing under section 256.045 shall include the maltreatment determination and the disqualification.

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

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

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

Subd. 3. **Employees of public employer.** (a) If the commissioner does not ~~set aside~~ rescind the disqualification of an individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, the individual may request a contested case hearing under chapter 14, unless the disqualification is deemed conclusive under section 245C.29. The request for a contested case hearing must be made in writing and must be postmarked and sent within 30 calendar days after the employee receives notice that the disqualification has not been ~~set aside~~ rescinded. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245C.15, the scope of the

contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245C.22.

(b) If the commissioner does not ~~set aside~~ rescind a disqualification that is based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) If the commissioner does not rescind a disqualification that is based on a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, the scope of the contested case hearing must include the disqualification decision. In such cases, a fair hearing must not be conducted under section 256.045.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written

notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit; or

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt.

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

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

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

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

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

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

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

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

(b) Except as provided under paragraphs (e) and (f), if the investigating agency denies the request or fails to act upon the request within 15 working days after receiving the request for reconsideration, the person or facility entitled to a fair hearing under section

256.045 may submit to the commissioner of human services or the commissioner of education a written request for a hearing under that section. Section 256.045 also governs hearings requested to contest a final determination of the commissioner of education. For reports involving maltreatment of a child in a facility, an interested person acting on behalf of the child may request a review by the Child Maltreatment Review Panel under section 256.022 if the investigating agency denies the request or fails to act upon the request or if the interested person contests a reconsidered determination. The investigating agency shall notify persons who request reconsideration of their rights under this paragraph. The request must be submitted in writing to the review panel and a copy sent to the investigating agency within 30 calendar days of receipt of notice of a denial of a request for reconsideration or of a reconsidered determination. The request must specifically identify the aspects of the agency determination with which the person is dissatisfied.

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

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

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

(f) ~~Effective January 1, 2002,~~ If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505

to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision, and reconsideration of a disqualification as provided under section 245C.22, shall also not be conducted when:

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

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

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

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

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

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

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

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the

lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. If mailed, the request for reconsideration must be postmarked and sent to the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead agency within 30 calendar days after the individual's receipt of the notice of disqualification.

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

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

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

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

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

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

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

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

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing

sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

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

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

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

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

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2008, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6. In fiscal year 2011, the commissioner shall transfer $40,467,000 from the general fund to the health care access fund. In fiscal year 2012, the commissioner shall transfer $8,630,000 from the general fund to the health care access fund. In fiscal year 2013, the commissioner shall transfer $16,255,000 from the general fund to the health care access fund.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

EFFECTIVE DATE. This section is effective upon federal approval of the amendments to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4.

Sec. 2. Minnesota Statutes 2008, section 144.291, subdivision 2, is amended to read:

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

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

(b) "Health information exchange" means a legal arrangement between health care providers and group purchasers to enable and oversee the business and legal issues involved in the electronic exchange of health records between the entities for the delivery of patient care.

(c) "Health record" means any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of

a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

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

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

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

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

(h) "Provider" means:

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

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

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

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

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

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

(j) "Related health care entity" means an affiliate, as defined in section 144.6521, subdivision 3, paragraph (b), of the provider releasing the health records, including, but not limited to, affiliates of providers participating in a coordinated care delivery system established under section 256B.031, subdivision 6.

Sec. 3. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

Subd. 30. **Review and evaluation of studies.** The commissioner shall review all published studies, reports, and program evaluations completed by the Department of Human Services, and those requested by the legislature but not completed, for state fiscal years 2000 through 2010. For each item, the commissioner shall report the legislature's original appropriation for that work, if any, and the actual reported cost of the completed work by the Department of Human Services. The commissioner shall make recommendations to the legislature about which studies, reports, and program evaluations required by law are duplicative, unnecessary, or obsolete. The commissioner shall repeat this review every five fiscal years.

Sec. 4. 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 June 1, 2010: (1) the surcharge under paragraph (a) is increased to 2.5 percent; and (2) each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to 2.5 percent of the total premium revenues of the plan, as reported to the commissioner of health, according to the payment schedule in subdivision 4. The increase in the surcharge under this paragraph does not apply to a health maintenance organization that reports a risk-based capital level less than the product of 2.5 and its authorized control level risk-based capital as defined in section 60A.50 in the most recent calendar year for which the data is available.

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

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

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

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

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

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

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

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

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

~~(f)~~ (g) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability

for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

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

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

Sec. 5. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is amended to read:

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

1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related

groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

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

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

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced seven percent from the current statutory rates. Hospitals located outside of the seven-county metropolitan area are exempt from the reduction in this paragraph for the period July 1, 2010, through June 30, 2011. For fee-for-service admissions occurring on or after July 1, 2011, the total payment made to hospitals located outside of the seven-county metropolitan area before third-party liability and spenddown is reduced by seven percent from the rate in effect on June 30, 2010. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) The total payment rate for medical assistance fee-for-service admissions occurring on or after July 1, 2010, through June 30, 2011, made to hospitals located outside of the seven-county metropolitan area for inpatient services before third-party liability and spenddown, shall be increased by 7.15 percent from the current statutory rates. This increase is temporary and shall not be included in the payment rate that is effective July 1, 2011. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the temporary increase in payments provided in this paragraph, and prepaid health plans are required to increase

rates to providers under contract for a temporary period to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

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

(1) eyeglasses;

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

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

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

(6) drugs; and

(7) medical supplies.

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

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

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

Subd. 15. **Adults without children.** Medical assistance may be paid for a person who is over age 21 and under age 65, who is not pregnant, and who is not described in subdivision 4, 7, or another subdivision of this section.

EFFECTIVE DATE. This section is effective upon federal approval and is retroactive to April 1, 2010.

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective upon federal approval and is retroactive to April 1, 2010.

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

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services~~, including specialized maintenance therapy~~. Authorization by the commissioner is required to provide services to a recipient beyond any of the following onetime service thresholds: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or re-evaluations. Services provided by a physical

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

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

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

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

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

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

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

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

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

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

(6) panoramic x-rays or full-mouth radiographs, limited to one every five years, and only if provided in conjunction with a posterior extraction or scheduled outpatient facility procedure, or as medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma. Panoramic x-rays may be taken once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only, and molar root canal therapy as deemed medically necessary for patients that are at high risk of osteonecrosis from molar extractions;

(12) removable prostheses, each dental arch limited to one every six years~~;~~ including:

(i) relines of full dentures once every six years per dental arch;

(ii) repair of acrylic bases of full dentures and acrylic partial dentures, limited to one per year; and

(iii) adding a maximum of two denture teeth and two wrought wire clasps per year to partial dentures per dental arch;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; ~~and~~

(15) full-mouth ~~debridement~~ periodontal scaling and root planing, limited to one every five years; and

(16) moderate sedation, deep sedation, and general anesthesia, limited to when provided by an oral maxillofacial surgeon who is board-certified, or actively participating in the American Board of Oral and Maxillofacial Surgery certification process, when medically necessary to allow the surgical management of acute oral and maxillofacial pathology which cannot be accomplished safely with local anesthesia alone and would otherwise require operating room services.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every ~~five~~ two years.

(d) Medical assistance covers dental services for children that are medically necessary. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants once every five years per permanent molar; and

(3) application of fluoride varnish once every six months.

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

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $4.15 for sole-community pharmacies and $3.65 for all other pharmacies, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. For purposes of this subdivision, a sole-community

pharmacy is defined as any independently owned Minnesota pharmacy located 10 or more miles from the next closest pharmacy. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective ~~July 1, 2009~~ July 1, 2010, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~15~~ 12.5 percent or wholesale acquisition cost plus 5.0 percent, whichever is lower. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus ~~30~~ 28.12 percent or wholesale acquisition cost minus 13.76 percent, whichever is lower. Average wholesale price is defined as the price for a drug product listed as the average wholesale price in the commissioner's primary reference source. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

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

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the

provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

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

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

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

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

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

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

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English

proficiency or who has a hearing loss and uses interpreting services. Coverage for oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

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

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

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

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

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

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

(c) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 65 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform

the delivery may not bill for any delivery services or postpartum care. Services are not covered if provided by an unlicensed traditional midwife.

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

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

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

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

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

(2) $3 for eyeglasses;

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

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

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

(1) ~~$6~~ $3.50 for nonemergency visits to a hospital-based emergency room;

(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a ~~$7~~ $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

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

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

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

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

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

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

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

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

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

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

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to

62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

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

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

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

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

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

(d) Any hospital or other provider that is participating in a coordinated care delivery system under section 256D.031, subdivision 6, or receives payments from the

uncompensated care pool under section 256D.031, subdivision 8, shall not refuse to provide services to any patient enrolled in general assistance medical care regardless of the availability or the amount of payment.

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

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

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

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

(b) Home care therapies must be:

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

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

(3) assessed by an appropriate therapist; and

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

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

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

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

Subdivision 1. **Demonstration project.** (a) The commissioner of human services, in consultation with the commissioner of health, shall establish a payment reform demonstration project implementing an alternative payment system for health care providers serving an identified group of patients who are enrolled in a state health care program, and are either high utilizers of high-cost health care services or have characteristics that put them at high risk of becoming high utilizers. The purpose of the demonstration project is to implement and evaluate methods of reducing hospitalizations,

emergency room use, high-cost medications and specialty services, admissions to nursing facilities, or use of long-term home and community-based services, in order to reduce the total cost of care and services for the patients.

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

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

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

Subd. 2. **Participation.** (a) The commissioner shall request eligible providers or groups of providers to submit a proposal to participate in the demonstration project by September 1, 2010. The providers who are interested in participating shall negotiate with the commissioner to determine:

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

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

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

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

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

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

(7) methods of sharing financial risk and benefit between the commissioner and the provider or groups of providers, which may include but are not limited to stop-loss

arrangements to cover high-cost outlier cases or costs that are beyond the control of the provider, and risk-sharing and benefit-sharing corridors; and

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

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

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

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

Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers and approvals necessary to implement this section and to obtain federal matching funds. To the extent authorized by federal law, the commissioner may waive existing fee-for-service payment rates, provider contract or performance requirements, consumer incentive policies, or other requirements in statute or rule in order to allow the providers or groups of providers to utilize alternative payment and financing methods that will appropriately fund necessary and cost-effective primary care and care coordination services; establish appropriate incentives for prevention, health promotion, and care coordination; and mitigate financial harm to participating providers caused by the successful reduction in preventable hospitalization, emergency room use, and other costly services.

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

Sec. 23. **[256B.0757] INTENSIVE CARE MANAGEMENT PROGRAM.**

Subdivision 1. **Report.** The commissioner shall review medical assistance enrollment and by July 1, 2011, present a report to the legislature that describes the

common characteristics and costs of those enrollees age 18 and over whose annual medical costs are greater than 95 percent of all other enrollees, using de-identified data.

Subd. 2. **Intensive care management system established.** The commissioner shall implement, by January 1, 2012, or upon federal approval, whichever is later, a program to provide intensive care management to medical assistance enrollees age 18 and over currently served under fee-for-service, managed care, or county-based purchasing, whose annual medical care costs are in the top five percent of all medical assistance enrollees. The intensive care management program must reduce these enrollees' medical assistance costs by at least 20 percent on average, improve quality of care through care coordination, and provide financial incentives for providers to deliver care efficiently. The commissioner may require medical assistance enrollees meeting the criteria specified in this subdivision to participate in the intensive care management program, and may reassign enrollees from existing managed care and county-based purchasing plans to those plans that are participating in the demonstration program. The commissioner shall seek all federal approvals and waivers necessary to implement the intensive care management program.

Subd. 3. **Request for proposals.** The commissioner of human services shall request proposals by September 1, 2011, or upon federal approval, whichever is later from health care providers, managed care plans, and county-based purchasing plans to provide intensive care management services under the requirements of subdivision 1. Proposals submitted must:

(1) designate the medical assistance population and geographic area of the state to be served;

(2) describe in detail the proposed intensive care management program;

(3) provide estimates of cost savings to the state and the evidence supporting these estimates;

(4) describe the extent to which the intensive care management program is consistent with and builds upon current state health care home, care coordination, and payment reform initiatives; and

(5) meet quality assurance, data reporting, and other criteria specified by the commissioner in the request for proposals.

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

Sec. 24. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly

transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately ~~$3,400,000, plus any available federal matching funds,~~ $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 30, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law No. 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

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

Subd. 5k. **Payment rate modification.** For services rendered on or after August 1, 2010, the total payment made to managed care and county-based purchasing plans under the medical assistance program and under MinnesotaCare for families with children shall be increased by 2.0 percent.

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

Sec. 26. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5l. **Payment reduction.** For services rendered on or after January 1, 2011, the total payment made to managed care plans for providing covered services under the medical assistance, general assistance medical care, and MinnesotaCare programs is reduced by one percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, home care services covered under section 256B.0651, subdivision 2, payments to demonstration

projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

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

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid

at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

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

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

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

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. This reduction does not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction does not apply to federally qualified health centers, rural health centers, and Indian health services. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

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

(e) Effective for services rendered on or after June 1, 2010, payment rates for physician and professional services delivered in clinics that are owned by a nonprofit

health maintenance organization and recognized as level three patient centered medical homes by the National Committee for Quality Assurance, shall be increased by 15 percent. Effective October 1, 2010, payments to managed care and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

Sec. 30. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2008, section 256B.76, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

(1) post-investigative action;

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

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

The commissioner may review post-investigative actions taken by a health plan under contract to provide dental services to Minnesota health care program enrollees. After an investigation conducted by the Department of Human Services surveillance unit, the findings of the health plan may be incorporated to determine if a provider will be designated or terminated from the program.

(d) A provider who has been terminated or not designated under this section may appeal only through the contested hearing process as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after notification of termination or nondesignation.

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

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

Sec. 32. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

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

purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

Sec. 33. **[256B.767] MEDICARE PAYMENT LIMIT.**

Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service.

Sec. 34. **[256B.768] FEE-FOR-SERVICE PAYMENT INCREASE.**

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

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

(b) The adjustments the commissioner shall use must be implemented in this order, but shall not be implemented before July 1, 2014: first, stop enrollment of single adults and households without children; and second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program~~; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program~~. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall ~~further limit enrollment or decrease premium subsidies~~notify the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access,

and present recommendations to the chairs and commission for limiting expenditures to the estimated amount of revenue.

EFFECTIVE DATE. This section is effective upon federal approval of the amendments to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4.

Sec. 37. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

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

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

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

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

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

Sec. 38. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision to read:

Subd. 3c. **Supplemental hospital coverage.** (a) Effective January 1, 2011, or upon federal approval, whichever is later, the commissioner shall offer all MinnesotaCare applicants, and all enrollees during the open enrollment periods specified in paragraph (b), the opportunity to purchase at full cost, supplemental hospital coverage to cover

inpatient hospital expenses in excess of the inpatient hospital annual limit established under subdivision 3. Premiums for this coverage may vary only for age and shall be collected by the commissioner using the procedures established for the sliding scale premium determined under section 256L.15.

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

Sec. 39. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if

applicable, and if supplemental coverage has not been purchased under subdivision 3c, amounts which exceed the $10,000 inpatient hospital benefit limit.

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

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

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

Sec. 40. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision to read:

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

Sec. 41. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision to read:

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

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

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

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

under this subdivision shall receive coverage for the benefit set provided to adults with no children.

Sec. 42. Minnesota Statutes 2009 Supplement, section 256L.11, subdivision 1, is amended to read:

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

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

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

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

Sec. 43. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

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

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

Sec. 44. Minnesota Statutes 2008, section 256L.12, subdivision 6, is amended to read:

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

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

Sec. 45. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

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

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

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

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

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

Sec. 46. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

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

Sec. 47. Laws 2010, chapter 200, article 1, section 12, subdivision 6, is amended to read:

Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital

establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

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

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

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

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

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

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems that provide services within 25 miles of the individual's community of residence. The commissioner may assign an applicant or recipient to a coordinated care delivery system that provides services within 25 miles of the individual's community of residence, if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to

November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

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

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

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

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

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

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

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

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

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

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

Sec. 48. Laws 2010, chapter 200, article 1, section 12, subdivision 7, is amended to read:

Subd. 7. **Payments; rate setting for the hospital coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount. The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual

coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

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

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

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

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

Sec. 49. Laws 2010, chapter 200, article 1, section 12, subdivision 8, is amended to read:

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

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to ~~November 30~~ December 31, 2010, or until medical assistance coverage is expanded to include adults without children, whichever is later.

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

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

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

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

Sec. 50. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services rendered on or after April 1, 2010, except that subdivision 4 is effective June 1, 2010.

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

Sec. 51. Laws 2010, chapter 200, article 1, section 16, is amended to read:

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

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

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

Sec. 52. Laws 2010, chapter 200, article 1, section 21, is amended to read:

Sec. 21. **REPEALER.**

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

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

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

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

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

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

Sec. 53. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

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

Appropriations by Fund		
	2010	2011
General	34,807,000	118,493,000
Health Care Access	(42,792,000)	(211,621,000)

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

Special Revenue Fund Transfers.

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

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

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

Sec. 54. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

Subd. 8. **Transfers**

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

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

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

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

Sec. 55. **EARLY EXPANSION.**

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

EFFECTIVE DATE. This section is effective upon federal approval and is retroactive to April 1, 2010.

Sec. 56. **FISCAL AND ACTUARIAL ANALYSIS.**

The commissioner of human services shall offer a request for proposal and accept bids for the completion of a complete fiscal and actuarial analysis of 2010 House File 135 and 2010 Senate File 118. The commissioner shall report this analysis to the chairs of the health and human services finance and policy divisions in the house of representatives and senate no later than December 15, 2010.

Sec. 57. **PREPAID HEALTH PLAN RATES.**

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

Sec. 58. **REPEALER; TRANSFER.**

(a)Laws 2010, chapter 200, sections 6; 10; 12; 18; and 19, are repealed effective 30 days after federal approval of the amendments to Minnesota Statutes, sections 256B.055, subdivision 15 and 256B.056, subdivision 4, or January 1, 2011, whichever is later, and all remaining unspent appropriations for the program established by Laws 2010, chapter 200 are transferred to the health care access fund.

(b) Minnesota Statutes 2008, section 256D.03, subdivisions 3a, 3b, 5, 6, 7, and 8, and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3,are repealed effective 30 days after federal approval of the amendments to Minnesota Statutes, sections 256B.055, subdivision 15 and 256B.056, subdivision 4, or January 1, 2011, whichever is later.

ARTICLE 3

CONTINUING CARE

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

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

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

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

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

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

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

~~(5) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income~~ if the adjusted gross income is greater than 545 percent of federal poverty guidelines, the parental contribution shall be 12.5 percent of adjusted gross income.

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

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes

in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

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

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

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

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

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

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

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

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

(2) the insurer denied insurance;

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

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

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

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

Sec. 2. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the

commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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

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

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

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

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

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

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

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

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

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with (1) no dependencies in activities of daily living, (2) only one dependency in bathing, dressing, grooming, or walking, or (3) a dependency score of less than three if eating is the only dependency, shall be the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A effective on October 1, 2008, per month for all new participants enrolled in the program on or after July 1, 2009. This monthly limit shall be applied to all other participants who meet this criteria at reassessment.

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

Sec. 4. Minnesota Statutes 2008, section 256B.0915, subdivision 3b, is amended to read:

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the resident currently resides, but in effect on June 30, 2010, and adjusted annually by any legislatively adopted percentage change in the elderly waiver services rates. That per diem shall be multiplied by 365, ~~and~~ divided by 12, ~~less~~ and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved conversion rate ~~may~~ must be adjusted by ~~the greater of~~ any subsequent legislatively adopted home and community-based services percentage rate ~~increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 60. **Nursing facility rate reductions effective July 1, 2010.** (a) Effective for the rate period July 1, 2010, through June 30, 2011, the commissioner shall reduce the operating payment rate of each nursing facility reimbursed under this section or section 256B.434 by 1.0 percent of the operating payment rate in effect on June 30, 2010.

(b) Effective July 1, 2011, the commissioner shall restore the operating payment rate of each nursing facility reimbursed under this section or section 256B.434 to the operating payment rate in effect on June 30, 2010.

Sec. 6. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/MR rate reductions effective July 1, 2010.** Effective for the rate period July 1, 2010, through June 30, 2011, the commissioner shall reduce the operating payment rate of each facility reimbursed under this section by 1.0 percent of the operating payment rates in effect on June 30, 2010. Effective July 1, 2011, the commissioner shall restore the operating payment rate of each facility reimbursed under this section to the operating rates in effect on June 30, 2010. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.5012, subdivision 7.

Sec. 7. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,

items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

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

prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

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

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

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

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and

community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods for contract years starting in 2012, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract years 2010 and 2011 for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

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

Sec. 8. **COLA COMPENSATION REQUIREMENTS.**

Effective July 1, 2010, providers who received rate increases under Minnesota Statutes, sections 256B.431, subdivision 41; 256B.434, subdivision 19; and 256B.5012, subdivision 7; Laws 2007, chapter 147, article 7, section 71, as amended by Laws 2008, chapter 363, article 15, section 17; and Laws 2008, chapter 363, article 18, section 3, subdivision 6, paragraph (c), for state fiscal years 2008 and 2009 are no longer required to continue or retain employee compensation or wage-related increases required by those sections or by other laws or statutes enacted earlier in which compensation-related increases were required as a condition of receiving a rate increase.

Sec. 9. **PROVIDER RATE AND GRANT REDUCTIONS.**

(a) The commissioner of human services, for the rate period July 1, 2010, through June 30, 2011, shall reduce grants, allocations, reimbursement rates, or rate limits, as applicable, by 1.0 percent from the applicable amount in effect on June 30, 2010. Effective July 1, 2011, the commissioner of human services shall restore grants, allocations, reimbursement rates, or rate limits, as applicable, to the applicable amount in effect on June 30, 2010. County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(12) community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2; and deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233, 256C.25, and 256C.261; Laws 1985, First Special Session chapter 9, article 1; Laws 1997, chapter 203, article 1, section 2, subdivision 8, as amended by Laws 1997, First Special Session chapter 5, section 20; and Laws 2007, chapter 147, article 19, section 3, subdivision 8, as amended by Laws 2008, chapter 317, section 3;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) aging grants under Minnesota Statutes, sections 256.975 to 256.977, 256B.0917, and 256B.0928;

(16) disability linkage line grants under Minnesota Statutes, section 256.01, subdivision 24; and

(17) housing access grants under Minnesota Statutes, section 256B.0658.

(c) To implement the rate reductions in this section and in Minnesota Statutes, section 256B.434, subdivision 22, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, must reflect a 5.0 percent reduction for the specified services for the period January 1, 2011, through June 30, 2011, and a 2.5 percent reduction for those services on and after July 1, 2011.

Sec. 10. **CASE MANAGEMENT REFORM.**

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

(1) define and separate the administrative from the service functions of case management;

(2) standardize and simplify processes, standards, and timelines for administrative functions of case management within the Department of Human Services, Disability Services Division, including eligibility determinations, resource allocation, management of dollars, waiting lists, quality assurance, host county concurrence requirements, county of financial responsibility provisions, and waiver compliance; and

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

(b) In developing these recommendations, the commissioner shall consider the recommendations of the 2007 Redesigning Case Management Services for Persons with Disabilities report and consult with existing stakeholder groups, which include

representatives of counties, disability and senior advocacy groups, service providers, and representatives of agencies which provide contracted case management.

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

Sec. 11. **COMMISSIONER TO SEEK FEDERAL MATCH.**

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

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

ARTICLE 4

CHILDREN AND FAMILY SERVICES

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

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

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

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

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

Sec. 2. Minnesota Statutes 2008, section 256J.20, subdivision 3, is amended to read:

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

(1) a licensed vehicle up to a loan value of less than or equal to ~~$15,000~~ $7,500. ~~If the assistance unit owns more than one licensed vehicle, the county agency shall determine the loan value of all additional vehicles and exclude the combined loan value of less than or equal to $7,500.~~ The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section~~;~~. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the vehicle with the highest loan

value and count only the loan value over $7,500, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a disabled member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

The county agency shall count the loan value of all other vehicles and apply this amount as if it were equity value to the asset limit described in this section. To establish the loan value of vehicles, a county agency must use the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the guidebook, or when the applicant or participant disputes the loan value listed in the guidebook as unreasonable given the condition of the particular vehicle, the county agency may require the applicant or participant document the loan value by securing a written statement from a motor vehicle dealer licensed under section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The county agency shall reimburse the applicant or participant for the cost of a written statement that documents a lower loan value;

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

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

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

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

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

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

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

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

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

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

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

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

(14) income received in a budget month through the end of the payment month;

(15) savings from earned income of a minor child or a minor parent that are set aside in a separate account designated specifically for future education or employment costs;

(16) the federal earned income credit, Minnesota working family credit, state and federal income tax refunds, state homeowners and renters credits under chapter 290A, property tax rebates and other federal or state tax rebates in the month received and the following month;

(17) payments excluded under federal law as long as those payments are held in a separate account from any nonexcluded funds;

(18) the assets of children ineligible to receive MFIP benefits because foster care or adoption assistance payments are made on their behalf; and

(19) the assets of persons whose income is excluded under section 256J.21, subdivision 2, clause (43).

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

Sec. 3. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:

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

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

Sec. 4. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

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

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

(1) age 60 or older;

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

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

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

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

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

ARTICLE 5

MISCELLANEOUS

Section 1. Minnesota Statutes 2008, section 3.971, subdivision 2, is amended to read:

Subd. 2. **Staff; compensation.** The legislative auditor shall establish a Financial Audits Division and a Program Evaluation Division to fulfill the duties prescribed in

this section. The legislative auditor shall establish a Legislative Budget Office Division to fulfill the duties in section 3.98, subdivision 5. Each division may be supervised by a deputy auditor, appointed by the legislative auditor, with the approval of the commission, for a term coterminous with the legislative auditor's term. The deputy auditors may be removed before the expiration of their terms only for cause. The legislative auditor and deputy auditors may each appoint a confidential secretary to serve at pleasure. The salaries and benefits of the legislative auditor, deputy auditors and confidential secretaries shall be determined by the compensation plan approved by the Legislative Coordinating Commission. The deputy auditors may perform and exercise the powers, duties and responsibilities imposed by law on the legislative auditor when authorized by the legislative auditor. The deputy auditors and the confidential secretaries serve in the unclassified civil service, but all other employees of the legislative auditor are in the classified civil service. Compensation for employees of the legislative auditor in the classified service shall be governed by a plan prepared by the legislative auditor and approved by the Legislative Coordinating Commission and the legislature under section 3.855, subdivision 3. While in office, a person appointed deputy for the Financial Audit Division must hold an active license as a certified public accountant.

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

Sec. 2. Minnesota Statutes 2008, section 3.98, is amended by adding a subdivision to read:

Subd. 5. **Fiscal notes; Department of Human Services.** (a) The responsibilities of the Department of Human Services for the preparation of fiscal notes under this chapter are transferred to the Legislative Budget Office Division under section 3.971.

(b) The Legislative Budget Office Division shall prepare a fiscal note for any bill that increases or decreases expenditures at the Department of Human Services at the request of the chair of the budget or finance division to which a bill relating to the department has been referred, or at the request of either the chair of the house of representatives Ways and Means Committee, or the chair of the senate Finance Committee. At the request of the commissioner of human services, the Legislative Budget Office Division shall include a statement from the commissioner:

(1) concurring with the information provided;

(2) suggesting alternative dollar amounts for a specific program or function; or

(3) indicating any other information which the commissioner deems relevant.

Sec. 3. **[62A.3075] CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

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

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

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

EFFECTIVE DATE. Paragraphs (a) and (c) are effective August 1, 2010, and apply to health plans providing coverage to a Minnesota resident offered, issued, sold, renewed, or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after that date. Paragraph (b) is effective the day following final enactment.

Sec. 4. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

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

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

(1) autism or autistic disorder;

(2) Asperger's syndrome; or

(3) pervasive developmental disorder - not otherwise specified.

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

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

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

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

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

(h) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (4).

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

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

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

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

(1) a complete medical and psychological evaluation performed by a licensed physician and psychologist using empirically validated tools or tests that incorporate measures for intellectual functioning, language development, adaptive skills, and behavioral problems, which must include:

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

(ii) a family history, including whether there are other family members with an autism spectrum disorder, mental retardation, fragile X syndrome, or tuberous sclerosis;

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

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

(v) an evaluation for intellectual functioning;

(vi) a lead screening for those children with mental retardation; and

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

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

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

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

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

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

(3) speech therapy;

(4) occupational therapy;

(5) physical therapy; and

(6) prescription medications.

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

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

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

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

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

(A) use robust experimental designs;

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **State health care programs.** This section does not affect benefits available under the medical assistance, MinnesotaCare, and general assistance medical care programs, and the state employee group insurance plan offered under sections 43A.22 to 43A.30. These programs and the state employee group insurance plan must maintain current levels of coverage, and section 256B.0644 shall continue to apply. The

commissioner shall monitor these services and report to the chairs of the house and senate standing committees that have jurisdiction over health and human services by February 1, 2011, whether there are gaps in the level of service provided by these programs and the state employee group insurance plan, and the level of service provided by private health plans following enactment of this legislation.

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

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

Sec. 5. **[62J.27] PROVIDER PARTICIPATION IN TRICARE.**

Subdivision 1. **Participation required.** A vendor of medical care, as defined in section 256B.02, subdivision 7, must participate as a provider or contractor in the federal TRICARE program, as a condition of participating as a provider or contractor in: (1) health insurance plans and programs for state employees established under section 43A.18; (2) the public employees insurance program under section 43A.316; (3) health insurance plans offered to local statutory or home rule charter city, county, and school district employees; (4) the workers' compensation program under section 176.135; and (5) insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19.

Subd. 2. **Participation defined; exemption.** For purposes of this section, participation in TRICARE means that the provider accepts new TRICARE patients. A provider is exempt from this section, if the provider is no longer accepting new patients under any of the programs listed in subdivision 1.

Subd. 3. **Agency duties.** The commissioner of health shall obtain a listing of TRICARE providers and contractors from the TRICARE administration, and shall provide this list on a quarterly basis to the commissioners of management and budget, labor and industry, and commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the TRICARE program and who are not exempt under subdivision 2.

Sec. 6. **[62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.**

(a) A health plan must cover private duty nursing services as provided under section 256B.0625, subdivision 7, for persons who are covered under the health plan and require private duty nursing services.

(b) For purposes of this section, a period of private duty nursing services may be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing requirements that apply under the health plan. Cost-sharing requirements for private duty nursing services must not place a greater financial burden on the insured or enrollee than those requirements applied by the health plan to other similar services or benefits.

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

Sec. 7. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

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

Sec. 8. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

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

~~determined by the commissioner.~~ in the special revenue account must be used according to the requirements in this chapter.

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

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed

the lesser of (1) five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the ~~allocation~~ special revenue account according to subdivision 1; or (2) the local agency administrative payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

Sec. 10. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

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

Sec. 11. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision to read:

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

Sec. 12. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

Subd. 4. **Regional treatment centers.** Regional treatment center chemical dependency treatment units are eligible vendors. The commissioner may expand the capacity of chemical dependency treatment units beyond the capacity funded by direct legislative appropriation to serve individuals who are referred for treatment by counties and whose treatment will be paid for ~~with a county's allocation under section 254B.02~~ by funding under this chapter or other funding sources. Notwithstanding the provisions of

sections 254B.03 to 254B.041, payment for any person committed at county request to a regional treatment center under chapter 253B for chemical dependency treatment and determined to be ineligible under the chemical dependency consolidated treatment fund, shall become the responsibility of the county.

Sec. 13. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

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

Sec. 14. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

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

Sec. 15. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

Subd. 30. **Office of Health Care Inspector General.** (a) The commissioner shall create within the Department of Human Services an Office of Health Care Inspector General to enhance antifraud activities and to protect the integrity of the state health care programs, as well as the health and welfare of the beneficiaries of those programs. The Office of Health Care Inspector General must periodically report to the commissioner and to the legislature program and management problems and recommendations to correct them.

(b) The duties of the Office of Health Care Inspector General include, but are not limited to:

(1) promoting economy, efficiency, and effectiveness through the elimination of waste, fraud, and abuse;

(2) conducting and supervising audits, investigations, inspections, and evaluations relating to the state health care programs under chapters 256B, 256D, and 256L;

(3) identifying weaknesses giving rise to opportunities for fraud and abuse in the state health care programs and operations and making recommendations to prevent their recurrence;

(4) leading and coordinating activities to prevent and detect fraud and abuse in the state health care programs and operations;

(5) detecting wrongdoers and abusers of the state health care programs and beneficiaries so appropriate remedies may be brought to bear;

(6) keeping the commissioner and the legislature fully and currently informed about problems and deficiencies in the administration of the state health care programs and operations and about the need for and progress of corrective action;

(7) operating a toll-free hotline to permit individuals to call in suspected fraud, waste, or abuse, referring the calls for appropriate action by the agency, and analyzing the calls to identify trends and patterns of fraud and abuse needing attention;

(8) developing and reviewing legislative, regulatory, and program proposals to reduce vulnerabilities to fraud, waste, and mismanagement; and

(9) recommending changes in program policies, regulations, and laws to improve efficiency and effectiveness, and to prevent fraud, waste, abuse, and mismanagement.

(c) Beginning July 1, 2011, the commissioner, in consultation with the Office of Health Care Inspector General, shall annually report to the legislature and the governor new results from the two ongoing federal Medicaid audits. The commissioner shall report (1) the most recent Medicaid Integrity Program (MIP) audit results, with any corrective actions needed, and (2) certify the rate of errors determined for the state health care programs under chapters 256B, 256D, and 256L, as determined from the most recent Payment Error Rate Measurement (PERM) audit results for Minnesota. When the PERM audit rate for Minnesota is greater than the national rate for the year or the MIP audit determines the need for corrective action, the commissioner shall present a plan to the legislature and the governor for the corrective actions and reduction of the error rate in the next calendar year.

Sec. 16. **APPROPRIATION.**

$..... or an amount equal to 90 percent of the administrative funds expended by the commissioner of human services related to the preparation and drafting of fiscal notes

during fiscal year 2009, is transferred from the Department of Human Services to the Office of the Legislative Auditor, and appropriated for the fiscal year beginning July 1, 2011, for completion of the duties described in section 3.98.

Sec. 17. **REPEALER.**

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

Sec. 18. **EFFECTIVE DATE.**

Sections 7 to 14 and 17 are effective for claims paid on or after July 1, 2010.

ARTICLE 6

DEPARTMENT OF HEALTH

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2012.

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

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

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

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

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

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

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

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

Subd. 4. **Recommendations.** The Advisory Group on Administrative Expenses must report its recommendations, including any proposed legislation necessary to implement the recommendations, to the commissioner of health and to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health policy and finance by July 1, 2011.

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

Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

(b) "Commissioner" means the commissioner of health.

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third-party administrators, and pharmacy benefit managers in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that

meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

(2) support physician order entry;

(3) capture and query information relevant to health care quality; and

(4) exchange electronic health information with, and integrate such information from, other sources.

Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be a qualified electronic health record.

(b) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers ~~only~~ if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(c) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(d) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(e) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

~~(c)~~ (f) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 6. **State agency information system.** Development of state agency information systems necessary to implement this section is subject to the authority of the Office of Enterprise Technology in chapter 16E, including, but not limited to:

(1) evaluation and approval of the system as specified in section 16E.03, subdivisions 3 and 4;

(2) review of the system to ensure compliance with security policies, guidelines, and standards as specified in section 16E.03, subdivision 7; and

(3) assurance that the system complies with accessibility standards developed under section 16E.03, subdivision 9.

Sec. 6. **[62J.498] HEALTH INFORMATION EXCHANGE.**

Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical transaction" means any meaningful use transaction that is not covered by section 62J.536.

(b) "Commissioner" means the commissioner of health.

(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not include health care providers engaged in direct health information exchange.

(f) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization that has been issued a certificate of authority by the commissioner under section 62J.4981.

(h) "Health information organization" means an organization that oversees, governs, and facilitates the exchange of health-related information among organizations according to nationally recognized standards.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health information organization.

(k) "Meaningful use" means use of certified electronic health record technology that includes e-prescribing, and is connected in a manner that provides for the electronic exchange of health information and used for the submission of clinical quality measures as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(l) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(m) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health data intermediary has contracts or other agreements for the provision of health information exchange service providers:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a

medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(n) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of meaningful use transactions.

(o) "State-certified health data intermediary" means a health data intermediary that:

(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;

(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and

(3) has been issued a certificate of authority to operate in Minnesota.

(p) "State-certified health information organization" means a nonprofit health information organization that provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biannual report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences;

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall make all portions of the application classified as public data available to the public at least ten days in advance of the hearing. The applicant shall participate in the hearing by presenting an overview of their application and responding to questions from interested parties;

(2) make available all feedback and recommendations from the hearing available to the public prior to issuing a certificate of authority; and

(3) consult with hospitals, physicians, and other professionals eligible to receive meaningful use incentive payments or subject to penalties as established in the HITECH Act, and their respective statewide associations, prior to issuing a certificate of authority.

(c)(1) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(2) The commissioner may disclose data classified as protected nonpublic or confidential under this paragraph if disclosing the data will protect the health or safety of patients.

(d) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 7. **[62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.**

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require an entity providing health information exchange services to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is

considered a health information organization whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use must be registered with the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) interoperate with at least one state-certified health information organization;

(2) provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;

(3) have a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and

(4) hold reciprocal agreements with at least one state-certified health information organization to enable access to record locator services to find patient data, and for the transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements established in subdivision 5.

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do so may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information

organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established, nonprofit organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans clearly address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time;

(4) the entity addresses the parameters to be used with participating entities and other health information organizations for meaningful use transactions, compliance with Minnesota law, and interstate health information exchange in trust agreements;

(5) the entity's board of directors is comprised of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with criteria established under the Health Information Exchange Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC) or equivalent criteria established by the commissioner;

(8) the entity maintains a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and

(ii) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(3) develop and maintain a business plan that addresses:

(i) plans for ensuring the necessary capacity to support meaningful use transactions;

(ii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iii) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(iv) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(4) annually submit a rate plan outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:

(i) distributes costs equitably among users of health information services;

(ii) provides predictable costs for participating entities;

(iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and

(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;

(5) enter into reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and transmission and receipt of meaningful use transactions consistent with the format and

content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements in subdivision 5; and

(6) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following:

(1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;

(6) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;

(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;

(9) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(10) a description of the complaint procedures to be used as required under this section;

(11) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(12) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(13) a copy of the conflict of interest policy that applies to all members of the board of directors and the principal officers of the health information organization; and

(14) other information as the commissioner may reasonably require to be provided.

(b) Thirty days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Ninety days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information exchange entities.** (a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of transactions necessary to achieve meaningful use;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use.

(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.

Subd. 6. **State participation in health information exchange.** A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency and necessary for meaningful use by the participating entities of the other health information service providers.

Sec. 8. **[62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.**

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information exchange service provider, levy an administrative penalty in an amount up to $25,000 for each violation. In

determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization or a health data intermediary by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information exchange service provider;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information exchange service provider attempted to correct previous violations;

(11) how the health information exchange service provider responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information exchange service provider including, but not limited to, whether the health information exchange service provider had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information exchange service provider to continue to deliver health information exchange services.

Reasonable notice in writing to the health information exchange service provider shall be given of the intent to levy the penalty and the reasons for them. A health information exchange service provider may have 15 days within which to contest whether the finding of facts constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information exchange service provider and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with

the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information exchange service provider or a representative of a health information exchange service provider to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information exchange service provider may contest whether the finding of facts constitutes a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a health data intermediary or health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information exchange service provider is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information exchange service provider is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information exchange service provider is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information exchange service provider has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information exchange service provider, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information exchange service provider would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information exchange service provider has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information exchange service provider is suspended, the health information exchange service provider shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information exchange service provider is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exists, the commissioner shall notify the health information exchange service provider in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information exchange service provider may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings that shall be mailed to the health information exchange service provider.

(c) If suspension, revocation, or an administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information exchange service provider written notice of

the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and/or amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information exchange service provider's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** (a) The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers when implementing sections 62J.498 to 62J.4982.

(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.

Subd. 5. **Fees and monetary penalties.** (a) Every health information exchange service provider subject to sections 62J.4981 and 62J.4982 shall be assessed fees as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $10,500;

(2) filing an application for certificate of authority to operate as a health data intermediary, $7,000;

(3) annual health information organization certificate fee, $14,000;

(4) annual health data intermediary certificate fee, $7,000; and

(5) fees for other filings, as specified by rule.

(b) Administrative monetary penalties imposed under this subdivision shall be deposited into a revolving fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 9. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) a birth center licensed under section 144.615.

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

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

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

Sec. 10. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

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

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The local or state registrar shall forward this amount to the commissioner of finance for deposit in the general fund for the Minnesota Birth Defects Information System established under section 144.2215. This surcharge shall not be charged under those circumstances in which no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

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

Sec. 11. **[144.615] BIRTH CENTERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions have the meanings given to them.

(b) "Birth center" means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy.

(c) "CABC" means the Commission for the Accreditation of Birth Centers.

(d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be established, operated, or maintained in the state without first obtaining a license from the commissioner of health according to this section.

(b) A license issued under this section is not transferable or assignable and is subject to suspension or revocation at any time for failure to comply with this section.

(c) A birth center licensed under this section shall not assert, represent, offer, provide, or imply that the center is or may render care or services other than the services it is permitted to render within the scope of the license or the accreditation issued.

(d) The license must be conspicuously posted in an area where patients are admitted.

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

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

(1) the name of the applicant;

(2) the site location of the birth center;

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

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

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

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

(7) any other information the commissioner deems necessary.

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

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

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

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

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

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

(2) no abortions may be administered; and

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

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

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

(b) The temporary license fee is $365.

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

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

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

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

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

Subd. 11. **Report.** (a) The commissioner of health, in consultation with the commissioner of human services and representatives of the licensed birth centers, shall evaluate the quality of care and outcomes for services provided in licensed birth centers, including, but not limited to, the utilization of services provided at a birth center, the outcomes of care provided to both mothers and newborns, and the numbers of transfers to other health care facilities that are required and the reasons for the transfers. The commissioner shall work with the birth centers to establish a process to gather and analyze the data within protocols that protect the confidentiality of patient identification.

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

Sec. 12. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:

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

Sec. 13. Minnesota Statutes 2008, section 144.9504, is amended by adding a subdivision to read:

Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner must revise clinical and case management guidelines to include recommendations for protective health actions and follow-up services when a child's blood lead level

exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be implemented to the extent possible using available resources.

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

Sec. 14. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:

Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a facility or that part of a facility which is required to be licensed under any law of this state which provides for the licensure of nursing homes.

Sec. 15. Minnesota Statutes 2008, section 144E.37, is amended to read:

144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.

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

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

Sec. 16. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST REDUCTION; REPORTING REQUIREMENTS.**

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

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

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

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

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

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

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

Sec. 17. **APPLICATION PROCESS FOR HEALTH INFORMATION EXCHANGE.**

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

Sec. 18. **TRANSFER.**

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

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

Sec. 19. **REVISOR'S INSTRUCTION.**

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

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

ARTICLE 7

HEALTH CARE REFORM

Section 1. **[62E.20] RELATIONSHIP TO TEMPORARY FEDERAL HIGH RISK POOL.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "The association" means the Minnesota Comprehensive Health Association.

(c) "The federal law" means Title I, subtitle B, section 1101, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, including any federal regulations adopted under it.

(d) "Federal qualified high risk pool" means an arrangement established by the federal secretary of health and human services that meets the requirements of the federal law.

Subd. 2. **Timing of this section.** This section applies beginning as of the date the temporary federal qualified high risk health pool created under the federal law begins to provide coverage in this state.

Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive health association on its member insurers must comply with the maintenance of effort requirement contained in paragraph (b), clause (3), of the federal law, to the extent that requirement applies to assessments made by the association.

Subd. 4. **Coordination with federal law.** Effective upon the date a federal qualified high risk pool begins to provide coverage in this state, the comprehensive health association shall not enroll new enrollees, notwithstanding section 62E.14 or any other law to the contrary. If the lack of new enrollees would otherwise lead to noncompliance with subdivision 3, the association shall reduce the premiums to levels below those otherwise required under section 62E.08, to the extent necessary to comply with subdivision 3.

Subd. 5. **Coordination with state health care programs.** The commissioner of human services, in consultation with the commissioner of commerce and the Minnesota Comprehensive Health Association, shall coordinate enrollment between medical assistance, MinnesotaCare, the federal qualified high risk pool, and the Minnesota Comprehensive Health Association, to ensure that:

(1) applicants for coverage through the federal qualified high risk pool, or through the Minnesota Comprehensive Health Association to the extent the association is enrolling new members, are referred to the medical assistance or MinnesotaCare programs if they are determined to be potentially eligible for coverage through those programs; and

(2) applicants for coverage under medical assistance or MinnesotaCare, who are determined not to be eligible for those programs, are provided information about coverage through the federal qualified high risk pool and the Minnesota Comprehensive Health Association.

Sec. 2. Minnesota Statutes 2008, section 62U.05, is amended to read:

62U.05 PROVIDER PRICING FOR BASKETS OF CARE; ACCOUNTABLE CARE ORGANIZATIONS.

Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care must incorporate a patient-directed, decision-making support model.

(d) By January 1, 2012, the commissioner shall establish uniform definitions for the total cost of providing all necessary services to a patient through an accountable care organization meeting the standards specified in section 3022 of the Patient Protection and Affordable Care Act (Public Law No. 111-148) and shall develop a standard method and format for accountable care organizations to use for submitting package prices for the total cost of care. This method shall be published in the State Register and must be made available to all providers.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1. Beginning July 1, 2012, accountable care organizations may establish package prices for the total cost of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section, and beginning July 1, 2012, no accountable care organization that has established a package price for the total cost of care under this section, shall vary the payment amount that the provider

or organization accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner shall establish quality measures for the total cost of care for services delivered through an accountable care organization by June 30, 2012. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available. Beginning January 1, 2013, the commissioner or the commissioner's designee shall publish comparative price and quality information on the total cost of care for services delivered through an accountable care organization in a manner that is easily accessible and understandable to the public, as this information becomes available.

Sec. 3. Minnesota Statutes 2008, section 256B.0754, is amended by adding a subdivision to read:

Subd. 3. **Accountable care organizations.** By July 1, 2012, the commissioner of human services shall deliver services to enrollees in state health care programs through accountable care organizations, and shall provide incentive payments to accountable care organizations that meet or exceed annual quality and performance targets. Accountable care organizations and incentive payments must meet the standards specified in the Patient Protection and Affordable Care Act (Public Law No. 111-148).

Sec. 4. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act (H.R. 3590/Public Law No. 111-148). Terms used in this section have the meaning provided in that act.

Subd. 2. **Eligible individual.** An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has at least:

(1) two chronic conditions;

(2) one chronic condition and is at risk of having a second chronic condition; or

(3) one serious and persistent mental health condition.

Subd. 3. **Health home services.** (a) Health home services means comprehensive and timely high-quality services that are provided by a health home. These services include:

(1) comprehensive care management;

(2) care coordination and health promotion;

(3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(4) patient and family support, including authorized representatives;

(5) referral to community and social support services, if relevant; and

(6) use of health information technology to link services, as feasible and appropriate.

(b) The commissioner shall maximize the number and type of services included in this subdivision to the extent permissible under federal law, including physician, outpatient, mental health treatment, and rehabilitation services necessary for comprehensive transitional care following hospitalization.

Subd. 4. **Payments.** The commissioner shall make payments to each health home for the provision of health home services to each eligible individual with chronic conditions that selects the health home as a provider.

Subd. 5. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for health homes developed under this section are consistent with the requirements and payment methods for health care homes established under section 256B.0751. The commissioner may modify requirements and payment

methods under section 256B.0751, in order to be consistent with federal health home requirements and payment methods.

Subd. 6. **State plan amendment.** The commissioner shall submit a state plan amendment to implement this section to the federal Centers for Medicare and Medicaid Services by January 1, 2011.

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

Sec. 5. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS AND GRANTS.**

(a) The commissioner of human services shall seek to participate in the following demonstration projects, or apply for the following grants, as described in the federal Patient Protection and Affordable Care Act (H.R. 3590/Public Law No. 111-148):

(1) the demonstration project to evaluate integrated care around a hospitalization (section 2704);

(2) the Medicaid global payment system demonstration project (section 2705);

(3) the pediatric accountable care organization demonstration project (section 2706);

(4) the Medicaid emergency psychiatric demonstration project (section 2707); and

(5) grants to provide incentives for prevention of chronic diseases in Medicaid (section 4108).

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

Sec. 6. **HEALTH CARE REFORM TASK FORCE.**

Subdivision 1. **Task force.** (a) The governor shall convene a Health Care Reform Task Force to advise and assist the governor and the legislature regarding state implementation of federal health care reform legislation. For purposes of this section, "federal health care reform legislation" means the Patient Protection and Affordable Care Act (H.R. 3590/Public Law No. 111-148) and the health care reform provisions in the

Health Care and Education Reconciliation Act of 2010 (H.R. 4872/Public Law No. 111-152). The task force shall consist of:

(1) two legislators from the house of representatives appointed by the speaker, and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(2) two representatives of the governor and state agencies, appointed by the governor;

(3) three persons appointed by the governor who have demonstrated leadership in health care organizations, health plan companies, or health care trade or professional associations;

(4) three persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least two of which must be from a labor organization; and

(5) five persons appointed by the governor who have demonstrated expertise in the areas of health care financing, access, and quality.

The governor is exempt from the requirements of the open appointments process for purposes of appointing task force members. Members shall be appointed for one-year terms and may be reappointed.

(b) The Department of Health, Department of Human Services, and the Department of Commerce shall provide staff support to the task force. The task force may accept outside resources to help support its efforts.

Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and present to the legislature and the governor a preliminary report and recommendations on state implementation of federal health care reform legislation. The report must include recommendations for state law and program changes necessary to comply with the federal health care reform legislation, and also recommendations for implementing provisions of the federal legislation that are optional for states. In developing recommendations, the task force shall consider the extent to which an approach maximizes federal funding to the state.

(b) The task force, in consultation with the governor and the legislature, shall also establish timelines and criteria for future reports on state implementation of the federal health care reform legislation.

Sec. 7. **AMERICAN HEALTH BENEFIT EXCHANGE; PLANNING PROVISIONS.**

Subdivision 1. **Federal planning grants.** The commissioners of commerce, health, and human services shall jointly or separately apply to the federal secretary of health and

human services for one or more planning and establishment grants, including renewal grants, authorized under section 1311 of the Patient Protection and Affordable Care Act (Public Law No. 111-148), including any future amendments of that provision, relating to state creation of American Health Benefit Exchanges.

Subd. 2. **Consideration of early creation and operation of exchange.** (a) The commissioners referenced in subdivision 1 shall analyze the advantages and disadvantages to the state of planning to have a state health insurance exchange, similar to an American Health Benefit Exchange, referenced in subdivision 1, begin prior to the federal deadline of January 1, 2014.

(b) The commissioners shall provide a written report to the legislature on the results of the analysis required under paragraph (a) no later than December 15, 2010. The written report must comply with Minnesota Statutes, sections 3.195 and 3.197.

ARTICLE 8

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT**

The dollar amounts shown are added to or if shown in parentheses, are subtracted from the appropriations in Laws of 2009, chapter 79, article 13, as amended by Laws of 2009, chapter 173, article 2. from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2010" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2010. The figure "2011" used in this article means that the appropriation or appropriations listed are available for the fiscal year ending June 30, 2011.

		2010	**2011**
General	$	(109,876,000)	(28,344,000)
Health Care Access	$	99,654,000	276,500,000
Federal TANF	$	(9,830,000)	15,133,000
Total	**$**	**(20,052,000)**	**263,289,000**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**(20,052,000)**	**263,289,000**

Appropriations by Fund

	2010	2011
General	(109,876,000)	(28,344,000)

Health Care Access	99,654,000	276,500,000	
Federal TANF	(9,830,000)	15,133,000	

Subd. 2. **Revenue and Pass-Through**

Federal TANF	390,000	(251,000)	

Subd. 3. **Children and Economic Assistance Grants**

General Fund	4,489,000	(4,140,000)	
Federal TANF	(10,220,000)	15,384,000	

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

(a) **MFIP Grants**

General Fund	7,916,000	(14,481,000)	
TANF Fund	(10,220,000)	15,384,000	

(b) **MFIP Child Care Assistance Grants**	(7,832,000)	2,579,000
(c) **General Assistance Grants**	875,000	1,339,000
(d) **Minnesota Supplemental Aid Grants**	2,454,000	3,843,000
(e) **Group Residential Housing Grants**	1,076,000	2,580,000

Subd. 4. **Basic Health Care Grants**

General Fund	(62,770,000)	29,192,000	
TANF Fund	99,654,000	276,500,000	

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

(a) **MinnesotaCare Grants**

Health Care Access Fund	99,654,000	276,500,000	

(b) **MA Basic Health Care – Families and Children**	1,165,000	24,146,000
(c) **MA Basic Health Care – Elderly and Disabled**	(63,935,000)	5,046,000

Subd. 5. **Continuing Care Grants**

General Fund	(51,595,000)	(53,396,000)	

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

(a) **MA Long-Term Care Facilities**	(3,774,000)	(8,275,000)
(b) **MA Long-Term Care Waivers**	(27,710,000)	(22,452,000)
(c) **Chemical Dependency Entitlement Grants**	(20,111,000)	(22,669,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the date following final enactment.

ARTICLE 9

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (10,162,000)	$ (108,327,000)	$ (118,489,000)
State Government Special Revenue	(608,000)	(245,000)	(853,000)
Health Care Access	(1,094,000)	69,166,000	68,072,000
Federal TANF	-0-	27,918,000	27,918,000
Total	**$ (11,864,000)**	**$ (11,488,000)**	**$ (23,352,000)**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2010, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2010	**2011**

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (9,467,000) $ (17,148,000)**

Appropriations by Fund	2010	2011
General	(8,365,000)	(114,216,000)
State Government Special Revenue	(8,000)	(16,000)
Health Care Access	(1,094,000)	69,166,000
Federal TANF	-0-	27,918,000

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

fiscal year 2011, $38,000.

Notwithstanding any provision to the contrary, this rider expires June 30, 2013.

TANF Financing and Maintenance of Effort. The commissioner of human services, with the approval of the commissioner of management and budget, and after notification of the chairs of the relevant senate budget division and house of representatives finance division, may adjust the amount of TANF transfers between the MFIP transition year child care assistance program and MFIP grant programs within the fiscal year, and within the current biennium and the biennium ending June 30, 2013, to ensure that state and federal match and maintenance of effort requirements are met. These transfers and amounts shall be reported to the chairs of the senate and house of representatives Finance Committees, the senate Health and Human Services Budget

Division, the house of representatives Health Care and Human Services Finance Division, and Early Childhood Finance and Policy Division by December 1 of each fiscal year. Notwithstanding any provision to the contrary, this provision expires June 30, 2013.

The appropriation reductions for each purpose are shown in the following subdivisions.

Subd. 2. **Agency Management; Financial Operations**	(8,000)	(16,000)

This appropriation reduction is from the state government special revenue fund.

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	-0-	28,000,000

TANF Funding for the Working Family Tax Credit. In addition to the amounts specified in Minnesota Statutes, section 290.0671, subdivision 6, $18,722,000 of TANF funds in fiscal year 2010 and $18,689,000 of TANF funds in fiscal year 2011 are appropriated to the commissioner of human services to reimburse the cost of the working family tax credit for eligible families. Beginning January 1, 2011, the commissioner shall reimburse the general fund on a monthly basis according to a schedule based on the pattern of working family credit expenditures through June 20, 2011. This rider is effective upon enactment.

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

(a) **MFIP and Diversionary Work Program Grants**	-0-	(2,033,000)

This appropriation reduces the general fund appropriation by $5,691,000 and increases the federal TANF appropriation by $3,658,000.

(b) **Support Services Grants** -0- (7,646,000)

Supported Work. The fiscal year 2011 TANF appropriation to the commissioner of human services for supported work for MFIP recipients is reduced by $4,000,000. This reduction is onetime.

Base Adjustment. The general fund base shall be increased by $2,642,000 for fiscal years 2012 and 2013.

(c) **MFIP Child Care Assistance Grants** -0- (38,000)

This appropriation reduces the general fund appropriation by $4,000,000 and increases the federal TANF appropriation by $3,962,000.

(d) **Children and Community Services Grants** -0- (9,900,000)

CCSA Grant Reduction. The fiscal year 2011 general fund appropriation to the commissioner of human services for the children and community services grants under Minnesota Statutes. section 256M.40, is reduced by $9,900,000. This reduction is ongoing and is subtracted from the base.

(e) **Children's Mental Health Grants** -0- (8,028,000)

(a) The general fund appropriation for respite care services for children with severe emotional disturbance who are at risk of out-of-home placement is reduced by $1,024,000 for fiscal year 2011. This reduction is onetime.

(b) The general fund appropriation for children's early intervention services is reduced by $1,024,000 for fiscal year 2011. This reduction is onetime.

(c) The general fund appropriation for children's capacity school based services is reduced by $4,777,000 for fiscal year 2011.

(d) The general fund appropriation for children's mental health targeted case management grants is reduced by $1,210,000 for fiscal year 2011.

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

(a) **Children and Economic Assistance Administration** -0- -0-

The general fund appropriation is reduced by $172,000 in fiscal year 2010 and by $176,000 in fiscal year 2011.

The federal TANF appropriation is increased by $172,000 in fiscal year 2010 and by $176,000 in fiscal year 2011. The TANF fund base shall be reduced by $700,000 in fiscal years 2012 and 2013.

(b) **Children and Economic Assistance Operations** (1,580,000) (1,692,000)

The general fund appropriation is reduced by $1,408,000 in fiscal year 2010 and by $1,534,000 in fiscal year 2011. The general fund base is reduced by $26,000 in each of fiscal years 2012 and 2013.

$74,000 in fiscal year 2011 is appropriated from the health care access fund. This appropriation is onetime.

The federal TANF appropriation is reduced by $172,000 in fiscal year 2010 and by $232,000 in fiscal year 2011.

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

(a) **MinnesotaCare Grants**	-0-	(70,842,000)

This appropriation reduction is from the health care access fund.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	2,046,000
(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	(3,127,000)
(d) **General Assistance Medical Care Grants**	-0-	(52,614,000)

Funding Reduction; Coordinated Care Delivery Systems. The appropriation for payments to coordinated care delivery systems in Laws 2010, chapter 200, article 2, section 2, subdivision 4, paragraph (g) is reduced by $20,000,000 in fiscal year 2011.

(e) **Medical Assistance; Adults Without Children**	-0-	145,172,000

Of this appropriation, $142,768,000 is from the health care access fund.

(f) **Other Health Care Grants**	-0-	(1,831,000)

Of this appropriation, the general fund is increased by $19,000 and the health care access fund appropriation is reduced by $1,850,000. This appropriation is onetime.

COBRA Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel and are available to the commissioner of human services for fiscal year 2011 COBRA grant

expenditures. Up to $110,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner of human services for costs related to administration of the COBRA grants.

Transfer. The commissioner shall transfer $19,000 to the commissioner of commerce for regulation of Minnesota Statutes, section 62A.3075.

Subd. 7. **Health Care Management**

(a) **Health Care Administration**	(2,853,000)	(4,383,000)

For fiscal year 2011 the health care access fund appropriation is increased by $250,000 and the general fund appropriation is reduced by $4,633,000.

Reduction in Appropriation. The base funding under the current law forecast used to calculate the state appropriation for the medical assistance program is reduced by one percent for the 2012-2013 biennium. This reduction is subject to federal approval of the intensive care management program authorized under Minnesota Statutes, section 256B.0755, and is ongoing and shall apply to future bienniums, or for as long as the intensive care management program is determined to be cost-effective by the commissioner of human services.

PACE Implementation Funding. For fiscal year 2011, $145,000 is appropriated from the general fund to the commissioner of human services to complete the actuarial and

administrative work necessary to begin the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $130,000 in fiscal year 2012 and $0 in fiscal year 2013.

Minnesota Senior Health Options Reimbursement. Effective July 1, 2011, federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity. Notwithstanding any contrary provision, this provision expires June 30, 2013.

Health Care Inspector General. $120,000 from the general fund in fiscal year 2011 is for the Office of Health Care Inspector General, established under Minnesota Statutes, section 256.01, subdivision 30.

Health Care Reform Task Force. $200,000 from the general fund is for expenses related to the Health Care Reform Task Force, established under article 7.

Fiscal and Actuarial Analysis. $250,000 from the general fund is for the fiscal and actuarial analysis of 2010 House File 135 and 2010 Senate File 118. This appropriation is onetime.

Utilization Review. Effective July 1, 2011, federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to, and is appropriated to, the commissioner for these activities. A portion

of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance. Notwithstanding any contrary provision, this provision expires June 30, 2013.

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

The general fund base is reduced by $416,000 in each of fiscal years 2012 and 2013.

(b) **Health Care Operations**

	Appropriations by Fund	
General	-0-	64,000
Health Care Access	(1,094,000)	(1,234,000)

Base Adjustment. The health care access fund base for health care operations is reduced by $1,272,000 in fiscal year 2012 and $1,337,000 in fiscal year 2013. The general fund appropriation is onetime.

Subd. 8. **Continuing Care Grants**

(a) **Aging and Adult Services Grants** (154,000) (248,000)

This reduction is onetime and must not be applied to the base.

Community Service Development Reduction. The appropriation in Laws 2009, chapter 79, article 13, section 3, subdivision 8, paragraph (a), for community service development grants, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, paragraph (a), is reduced by $154,000 in fiscal year 2011. The appropriation base is reduced by $139,000 for fiscal year 2012 and $0 for fiscal year 2013. Notwithstanding any law or rule to

the contrary, this provision expires June 30, 2012.

(b) **Alternative Care Grants** -0- (280,000)

This reduction is onetime.

(c) **Medical Assistance Long-Term Care Facilities Grants** -0- (3,521,000)

(d) **Medical Assistance Long-Term Care Waivers and Home Care Grants** -0- (11,086,000)

Manage Growth in Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waivers. During the fiscal year beginning July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to six allocations per month and the CADI waiver to 60 allocations per month. The limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in the Developmental Disability (DD) Waiver. The commissioner

shall manage the growth in the DD waiver by limiting the allocations included in the November 2010 forecast to six additional diversion allocations each month for the calendar year that begins on January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. This provision is effective through December 31, 2011.

(e) **Adult Mental Health Grants**	(3,500,000)	(9,903,000)

Compulsive Gambling Special Revenue Account. $149,000 for fiscal year 2010 and $27,000 for fiscal year 2011 from the compulsive gambling special revenue account established under Minnesota Statutes, section 245.982, must be transferred and deposited into the general fund by June 30 of each respective fiscal year.

Compulsive Gambling Lottery Prize Fund Appropriation. The lottery prize fund appropriation for compulsive gambling, is reduced by $80,000 in fiscal year 2010 and $79,000 in fiscal year 2011. This is a onetime reduction.

Adult Mental Health. (a) The general fund appropriation for adult mental health evidence-based practices, including by not limited to, assertive community treatment and integrated dual diagnosis treatment services, is reduced by $750,000 for fiscal year 2011. This reduction is onetime.

(b) The general fund appropriation for mental health grants to increase availability of culturally specific adult mental health services is reduced by $300,000 for fiscal year 2011. This reduction is onetime.

(c) The general fund appropriation for adult mental health specialty care grants is reduced by $200,000 for fiscal year 2011. This reduction is onetime.

(d) The general fund appropriation for grants to community hospitals to provide alternatives to RTC mental health programs is reduced by $2,653,000 for fiscal year 2011. This reduction is onetime.

(e) The general fund appropriation for grants to counties for adult mental health services is reduced by $6,000,000 for fiscal year 2011.

(f) Of the fiscal year 2010 general fund appropriation for grants to counties for housing with support services for adults with serious and persistent mental illness, $3,300,000 is canceled and returned to the general fund.

(g) Of the fiscal year 2010 general fund appropriation for additional crisis intervention team training for law enforcement, $200,000 is canceled and returned to the general fund.

(f) **Deaf and Hard-of-Hearing Grants**	-0-	(15,000)

This reduction is onetime.

(g) **Chemical Dependency Entitlement Grants**	-0-	(3,986,000)

Consolidated Chemical Dependency Treatment Fund Balance. $4,800,000

must be transferred from the consolidated chemical dependency treatment fund and deposited into the general fund by June 30, 2010.

(h) **Chemical Dependency Nonentitlement Grants** (389,000) -0-

Chemical Health. Of the fiscal year 2010 general fund appropriation to Mother's First and the Native American Program, $389,000 is canceled and returned to the general fund.

(i) **Other Continuing Care Grants** -0- (108,000)

ICF/MR Payment Rates. $36,000 is appropriated from the general fund in fiscal year 2011 and $4,000 in fiscal year 2012 to increase payment rates for an ICF/MR licensed for six beds and located in Kandiyohi County to serve persons with high behavioral needs. The payment rate increase shall be effective for services provided from July 1, 2010, through June 30, 2011. These appropriations are onetime.

Region 10 Quality Assurance Commission. $100,000 is appropriated from the general fund in fiscal year 2011 to the commissioner of human services for the purposes of the region 10 Quality Assurance Commission under Minnesota Statutes, section 256B.0951. This appropriation is onetime.

Subd. 9. **Continuing Care Management** 111,000 101,000

PACE Implementation Funding. For fiscal year 2011, $111,000 is appropriated from the general fund to the commissioner of human services to complete the actuarial and administrative work necessary to begin

the operation of PACE under Minnesota Statutes, section 256B.69, subdivision 23, paragraph (e). Base level funding for this activity shall be $101,000 in fiscal year 2012 and $0 in fiscal year 2013. For fiscal year 2013 and beyond, the commissioner must work with stakeholders to develop financing mechanisms to complete the actuarial and administrative costs of PACE. The commissioner shall inform the chairs and ranking minority members of the legislative committee with jurisdiction over health care funding by January 15, 2011, on progress to develop financing mechanisms.

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010.

Subd. 11. **Contingent Appropriations Reductions.**

Upon enactment of the extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the president's budget for federal fiscal year 2011 or contained in House Resolution 2847, the federal "Jobs for Main Street Act, 2010," or subsequent federal legislation, the reductions identified in each clause shall be made to the specified general fund appropriations for fiscal year 2011. These contingent

reductions, if implemented, are in addition to the reductions specified in subdivision 6, paragraphs (a), (b), and (c), and subdivision 8, paragraphs (c) and (d), respectively.

(1) MinnesotaCare Grants	-0-	(9,200,000)
(2) Medical Assistance Basic Health Care Grants - Families and Children	-0-	(109,662,500)
(3) Medical Assistance Basic Health Care Grants - Elderly and Disabled	-0-	(110,437,500)
(4) Medical Assistance Long-Term Care Facilities Grants	-0-	(51,925,000)
(5) Medical Assistance Long-Term Care Waivers and Home Care Grants	-0-	(115,475,000)

Sec. 4. **COMMISSIONER OF HEALTH**

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Subdivision 1. **Total Appropriation**	**$ (2,397,000)**	**$ 5,660,000**

Appropriations by Fund

	2010	2011
General	(1,797,000)	5,889,000
State Government Special Revenue	(600,000)	(229,000)

Subd. 2. **Community and Family Health**	-0-	100,000

Grant for Memory Care Clinic. $100,000 from the general fund in fiscal year 2011 is for a grant to a nonprofit, multispecialty clinic located in the city of St. Cloud that provides early identification, diagnosis, and treatment of memory loss, and information and support for family members who care for persons with memory impairment. In order to receive the grant, the clinic must certify to the commissioner that it has a commitment from a private foundation to provide a 50

percent match of the grant amount. This appropriation is onetime.

Statewide Health Improvement Program. $8,500,000 from the health care access fund in fiscal year 2012 and $8,500,000 in fiscal year 2013 is for the statewide health improvement program under Minnesota Statutes, section 145.986. These additions are onetime.

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

Appropriations by Fund		
	2010	2011
General	(1,797,000)	5,289,000
State Government Special Revenue	(600,000)	(232,000)

Health Care Reform. Funds appropriated in Laws 2008, chapter 358, article 5, section 4, subdivision 3, for health reform activities to implement Laws 2008, chapter 358, article 4, are available until expended. Notwithstanding any contrary provision in this article, this provision shall not expire.

Autism Coverage Study. $50,000 in fiscal year 2011 is appropriated to the commissioner of commerce to monitor the gaps in the level of service provided by state health programs, the state employee group insurance plan and private health plans for autism spectrum disorder. This appropriation is onetime.

Blood Lead Level Guidelines. of the general fund appropriation, $79,000 in fiscal year 2011 is for revision of clinical and case management guidelines related to blood lead levels, under Minnesota Statutes, section

144.9504, subdivision 12. This appropriation is onetime.

Rural Hospital Capital Improvement Grants. Of the general fund reductions in fiscal year 2010, $1,755,000 is for the rural hospital improvement grant program.

Health Information Exchange Oversight. Of the state government special revenue fund appropriations, $104,000 in fiscal year 2011 is for the duties required under Minnesota Statutes, section 62J.498 to 62J.4982.

Birth Centers. Of the state government special revenue fund appropriations, $9,000 is for licensing birth centers under Minnesota Statutes, section 144.651. Base funding shall be $7,000 in fiscal year 2012 and $7,000 in fiscal year 2013.

Advisory Group on Administrative Expenses. Of the general fund appropriation, $40,000 in fiscal year 2011 is for the advisory group established under Minnesota Statutes, section 62D.31.

Community Clinic Grants. Of this appropriation, $2,500,000 in fiscal year 2011 is for the commissioner to provide community clinic grants under Minnesota Statutes, section 145.9268. This appropriation is onetime. In awarding grants using this funding, the commissioner shall give priority to proposals that seek to serve medically underserved areas of the state that are not served by a coordinated care delivery system established under Laws 2010, chapter 200, article 1, section 12, subdivision 6.

FQHC subsidies. Of this appropriation, $2,500,000 in fiscal year 2011 is for the commissioner to increase subsidies to federally qualified health centers provided under Minnesota Statutes, section 145.9269. This appropriation is onetime. In awarding subsidies using this funding, the commissioner shall give priority to federally qualified health centers that serve medically underserved areas of the state that are not served by a coordinated care delivery system established under Laws 2010, chapter 200, article 1, section 12, subdivision 6.

Base Level Adjustment. The general fund base is decreased by $173,000 in fiscal year 2012 and $173,000 in fiscal year 2013. The state government special revenue fund base is increased by $360,000 in fiscal year 2012 and $355,000 in fiscal year 2013.

Subd. 4. **Health Protection** -0- 500,000

BDIS. Of the general fund appropriation, $500,000 in fiscal year 2011 is for the Minnesota Birth Defects Information System established under Minnesota Statutes, section 144.2215.

Sec. 5. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$** 5,225,451,000 **$** 6,002,864,000

Appropriations by Fund

	2010	2011
General	4,375,689,000	5,209,765,000
State Government Special Revenue	565,000	565,000
Health Care Access	450,662,000	527,411,000
Federal TANF	286,770,000	263,458,000

Lottery Prize	1,665,000	1,665,000
Federal Fund	110,000,000	0

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary, except that any transfers to one project that exceed $1,000,000 or multiple transfers to one project that exceed $1,000,000 in total require the express approval of the legislature. The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations. Any computer project with a total cost exceeding $1,000,000, including, but not limited to, a replacement for the proposed HealthMatch system, shall not be commenced without the express approval of the legislature.

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

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

TANF Maintenance of Effort.

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

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

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

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

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

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

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

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

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

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

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

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

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

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

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

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

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

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

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

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

(1) fiscal year 2010, ~~$50,973,000~~ $50,897,000;

(2) fiscal year 2011, ~~$53,793,000~~ $54,243,000;

(3) fiscal year 2012, ~~$23,516,000~~ $23,345,000; and

(4) fiscal year 2013, ~~$16,808,000~~ $16,585,000.

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

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

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

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

ARRA Food Support Administration. The funds available for food support administration under the American Recovery and Reinvestment Act (ARRA) of 2009 are appropriated to the commissioner to pay actual costs of implementing the food support benefit increases, increased eligibility determinations, and outreach. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion based

on a caseload factor equivalent to that of a county.

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

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

Sec. 6. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	68,337,000	70,505,000

This appropriation is from the federal TANF fund.

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

(1) fiscal year 2010, ~~$6,531,000~~ $862,000;

(2) fiscal year 2011, ~~$10,241,000~~ $978,000;

(3) fiscal year 2012, ~~$10,826,000~~ $0; and

(4) fiscal year 2013, ~~$4,046,000~~ $0.

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

Sec. 7. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	63,205,000	89,033,000
Federal TANF	100,818,000	84,538,000

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	12,498,000
Federal TANF	116,557,000	107,457,000

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

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

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

Supported Work. Of the TANF appropriation, $4,700,000 in fiscal year 2010 and $4,700,000 in fiscal year 2011 are to the commissioner for supported work for MFIP recipients and is available until expended. Supported work includes paid transitional work experience and a continuum of employment assistance, including outreach

and recruitment, program orientation and intake, testing and assessment, job development and marketing, preworksite training, supported worksite experience, job coaching, and postplacement follow-up, in addition to extensive case management and referral services. This is a onetime appropriation.

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

Integrated Services Program Funding. The TANF appropriation for integrated services program funding is $1,250,000 in fiscal year 2010 and $0 in fiscal year 2011 and the base for fiscal years 2012 and 2013 is $0.

TANF Emergency Fund; Nonrecurrent Short-Term Benefits. (1) TANF emergency contingency fund grants received due to increases in expenditures for nonrecurrent short-term benefits must be used to offset the increase in these expenditures for counties under the MFIP consolidated fund, under Minnesota Statutes, section 256J.626, and the diversionary work program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters. Growth in expenditures for the diversionary work program over the amount expended in the calendar quarters in

the TANF emergency fund base year shall be used to leverage these funds.

(2) To the extent that the commissioner can claim eligible tax credit growth as nonrecurrent short-term benefits, the commissioner shall use those funds to leverage the increased expenditures in clause (1).

(3) TANF emergency funds for nonrecurrent short-term benefits received in excess of the amounts necessary for clauses (1) and (2) shall be used to reimburse the general fund for the costs of eligible tax credits in fiscal year 2011. The amount of such funds shall not exceed $28,000,000.

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

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

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

(d) Basic Sliding Fee Child Care Assistance Grants	40,100,000	45,092,000

School Readiness Service Agreements. $257,000 in fiscal year 2010 and $257,000 in fiscal year 2011 are from the general fund for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

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

Basic Sliding Fee. $4,000,000 in fiscal year 2010 and $4,000,000 in fiscal year 2011 are from the federal child care development

funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of basic sliding fee child care assistance under Minnesota Statutes, section 119B.03. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

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

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

(b) Up to three-fourths of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in Minnesota Statutes, section 119B.03, subdivision 2, and the reinstatement list of those families whose

assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

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

(d) Funds in excess of the amount necessary to serve all families in paragraphs (a) and (b) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation. To the extent that funds are available, and notwithstanding Minnesota Statutes, section 119B.03, subdivision 8, for the period January 1, 2011, to December 31, 2011, each county's guaranteed floor must be equal to its original calendar year 2010 allocation.

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

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

Family, friends, and neighbor grants. $375,000 in fiscal year 2010 and $375,000 in fiscal year 2011 are from the child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery

and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services for family, friends, and neighbor grants under Minnesota Statutes, section 119B.232. This appropriation may be used on programs receiving family, friends, and neighbor grant funds as of June 30, 2009, or on new programs or projects. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

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

Voluntary quality rating system. $184,000 in fiscal year 2010 and $1,200,000 in fiscal year 2011 are from the federal child care development fund required targeted funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal

regulations for the purpose of implementing the voluntary Parent Aware quality star rating system pilot in coordination with the Minnesota Early Learning Foundation. The appropriation for the first year is to complete and promote the voluntary Parent Aware quality rating system pilot program through June 30, 2010, and the appropriation for the second year is to continue the voluntary Minnesota quality rating system pilot through June 30, 2011. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

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

(g) Children's Services Grants

	Appropriations by Fund	
General	48,333,000	50,498,000
Federal TANF	340,000	240,000

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

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

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for postadoption services including parent support groups.

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

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

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

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

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

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

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

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

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

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

(b) For persons receiving services under Minnesota Statutes, section 245A.02, who reside in licensed adult foster care beds for which a difficulty of care payment

was being made under Minnesota Statutes, section 256I.05, subdivision 1c, paragraph (b), counties may request an exception to the individual's service authorization not to exceed the difference between the client's monthly service expenditures plus the amount of the difficulty of care payment.

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

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

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

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

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

ARRA Homeless Youth Funds. To the extent permitted under federal law, the commissioner shall designate $2,500,000 of the Homeless Prevention and Rapid Re-Housing Program funds provided under

the American Recovery and Reinvestment Act of 2009, Public Law 111-5, for agencies providing homelessness prevention and rapid rehousing services to youth.

Supportive Housing Services. $1,500,000 each year is for supportive services under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

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

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

Federal ARRA Funds for Existing Programs. ~~(a)~~ (1) Federal funds received by the commissioner for the emergency food and shelter program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, but not previously approved by the legislature are appropriated to the commissioner for the purposes of the grant program.

~~(b)~~ (2) Federal funds received by the commissioner for the emergency shelter grant program including the Homelessness Prevention and Rapid Re-Housing Program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

~~(c)~~ (3) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

~~(d)~~ (4) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

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

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

Sec. 8. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

Subd. 8. **Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:		
(a) Aging and Adult Services Grants	13,499,000	15,805,000
Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.		
Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.		
Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.		
Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.		
Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The		

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

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

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

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

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3)

to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

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

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

Alternatives to Personal Care Assistance Services. Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit

from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.

(e) Mental Health Grants

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

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

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

Payments for Substance Abuse Treatment. For services provided during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of: (1) rates charged for these services on January 1, 2009; or (2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. For services provided in fiscal years 2012 and 2013, the statewide ~~average rates~~ aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the ~~average rates charged for these services on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year~~

~~2013~~ projected aggregate payment under the rates in effect for fiscal year 2010 minus 1.25 percent. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

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

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

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and

supporting alternatives to shift-staff foster care residential service models.

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

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

Sec. 9. **CANCELLATIONS.**

The remaining balance from Laws 2008, chapter 358, article 5, section 4, subdivision 3, appropriation for Section 125 employer incentives is canceled.

Sec. 10. **TRANSFERS.**

The commissioner of management and budget shall transfer from the general fund to the health care access fund $44,265,000 in fiscal year 2011, $5,570,000 in fiscal year 2012, and $23,613,000 in 2013.

Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2011, unless a different expiration date is explicit.

Sec. 12. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2010, unless a different effective date is explicit."

Delete the title and insert:

"A bill for an act

relating to human services; licensing; state health care programs; continuing care; children and family services; health reform; public health; appropriating money; amending Minnesota Statutes 2008, sections 3.971, subdivision 2; 3.98, by adding a subdivision; 16A.724, subdivision 2; 62D.08, by adding a subdivision; 62Q.19, subdivision 1; 62U.05; 144.226, subdivision 3; 144.291, subdivision 2; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144E.37; 245C.27, subdivision 2; 245C.28, subdivision 3; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2;

254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivision 3; 256B.04, subdivision 14; 256B.055, by adding a subdivision; 256B.056, subdivision 4; 256B.057, subdivision 9; 256B.0625, subdivisions 8, 8a, 8b, 18a, 31, by adding subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644, as amended; 256B.0754, by adding a subdivision; 256B.0915, subdivision 3b; 256B.19, subdivision 1c; 256B.441, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivision 27, by adding subdivisions; 256B.692, subdivision 1; 256B.76, subdivision 4, by adding a subdivision; 256D.0515; 256J.20, subdivision 3; 256J.24, subdivision 10; 256J.37, subdivision 3a; 256L.02, subdivision 3; 256L.03, subdivision 3, by adding a subdivision; 256L.05, by adding a subdivision; 256L.07, by adding a subdivision; 256L.12, subdivisions 5, 6, 9; 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 245C.27, subdivision 1; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969, subdivision 3a; 256B.0625, subdivisions 9, 13e; 256B.0653, subdivision 5; 256B.0915, subdivision 3a; 256B.69, subdivision 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256L.03, subdivision 5; 256L.11, subdivision 1; Laws 2009, chapter 79, article 5, section 78, subdivision 5; article 13, section 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; Laws 2010, chapter 200, article 1, sections 12; 16; 21; article 2, section 2, subdivisions 1, 8; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 62E; 62J; 62Q; 144; 256B; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; Laws 2010, chapter 200, sections 6; 10; 12; 18; 19."