..... moves to amend H.F. No. 927, the delete everything amendment (A11-0177), as follows:

Page 6, delete section 10

Page 7, delete section 11

Page 6, after line 32, insert:

"Sec. 10. **[119B.135] QUALITY RATING AND IMPROVEMENT SYSTEM IMPLEMENTATION.**

Subdivision 1. **Implementation of a quality rating and improvement system.** (a) The commissioner of human services shall phase in the implementation of a voluntary quality rating and improvement system for child care centers. The system must build on the quality rating and improvement system in use in fiscal year 2011. The program must be designed to ensure that Minnesota's children have access to high-quality services in child care centers so that children entering kindergarten are ready for kindergarten by 2020, as stated in section 124D.142.

(b) The quality rating and improvement system must:

(1) set research-based program standards and quality indicators designed to improve the educational outcomes of children so that they are ready for school;

(2) assess program quality using the program standards and indicators and issue quality ratings to participating child care centers;

(3) establish a database to collect, store, analyze, and report data for quality ratings and to track improvement supports and incentives to programs. The database must incorporate data from or be linked to related databases, such as those maintained by the child care resource and referral system;

(4) provide rating information to consumers to facilitate informed choices of child care centers;

(5) provide information to child care centers to enable them to measure the results of their quality improvement efforts; and

(6) provide supports to participating programs to help them improve their quality rating.

(c) A program that is accredited or has otherwise been evaluated may submit information to the commissioner of human services in the form and manner prescribed by the commissioner and may be rated on the basis of that information.

(d) A program that has previously been rated under this section or has been rated through the Parent Aware pilot program may continue with that rating for two years.

Subd. 2. **Phase-in of quality rating and improvement system.** The commissioner must continue the quality rating and improvement system in use in fiscal year 2011 in the original pilot areas and must expand the system to at least two new, rural geographic locations by June 30, 2012. The commissioner must use a competitive process to select the new pilot areas by targeting areas that meet one or more of the following criteria: existence of a local early care and education collaborative, existence of local matching funds, and demonstration of local support from community-based early learning and care programs. The commissioner must add one new pilot area per year and work toward statewide availability of ratings by 2015."

Page 16, delete section 19 and insert:

"Sec. 19. Minnesota Statutes 2010, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Group residential housing agreements.** (a) Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections. Group residential housing agreements may be terminated with or without cause by either the county or the provider with two calendar months prior notice.

(b) Beginning July 1, 2011, counties may not enter into agreements with providers of group residential housing that do not include a residency requirement of at least 20 hours

per week of volunteer or paid work. A person who is unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity will not be made ineligible for group residential housing under this section.

Sec. 20. Minnesota Statutes 2010, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and can demonstrate a chemical dependency success rate of at least 30 percent for participants six months after completing the program, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. The county agency is limited to negotiating a payment not to exceed $100 for residences that provide other services necessary to provide room and board if the residence does not allow alcohol on the property, provides minimal services, and is unable to demonstrate a chemical dependency success rate of at least 30 percent for participants six months after completing the program. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department

after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the GRH fund to county human service agencies for beds permanently removed from the GRH census under a plan submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) The provisions of paragraph (b) do not apply to a facility that has its reimbursement rate established under section 256B.431, subdivision 4, paragraph (c)."

Page 22, after line 15, insert:

"Sec. 28. **HOMELESS SHELTERS; SCHOOL DISTRICTS.**

School districts may coordinate with local units of government and homeless services providers to use empty school buildings as homeless shelters."

Page 23, line 18, delete "and" and delete the second comma and insert "; and 256I.05, subdivisions 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, and 1n,"

Page 23, after line 22, insert:

"Section 1. Minnesota Statutes 2010, section 62D.08, subdivision 7, is amended 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. The definition of administrative expenses must be consistent with that of the National Association of Insurance Commissioners (NAIC) as provided in the most current NAIC Blank. 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.

Sec. 2. Minnesota Statutes 2010, section 62J.04, subdivision 3, is amended to read:

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 ~~to 62J.41~~ and 62J.40 to monitor statewide achievement of the cost containment goals;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

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

Sec. 3. Minnesota Statutes 2010, section 62J.17, subdivision 4a, is amended to read:

Subd. 4a. **Expenditure reporting.** Each hospital, outpatient surgical center, and diagnostic imaging center~~, and physician clinic~~ shall report annually to the

commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(a) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

(b) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(c) the cost of purchased or leased medical equipment, by type of equipment;

(d) expenditures by type for specialty care and new specialized services;

(e) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(f) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. ~~For physician clinics, this information shall be included in reports to the commissioner that are required under section 62J.41.~~ For all other health care providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

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

Page 43, delete section 18 and insert:

"Sec. 18. Minnesota Statutes 2010, section 144A.102, is amended to read:

144A.102 WAIVER FROM FEDERAL RULES AND REGULATIONS; PENALTIES.

(a) By January 2000, the commissioner of health shall work with providers to examine state and federal rules and regulations governing the provision of care in licensed nursing facilities and apply for federal waivers and identify necessary changes in state law to:

(1) allow the use of civil money penalties imposed upon nursing facilities to abate any deficiencies identified in a nursing facility's plan of correction; and

(2) stop the accrual of any fine imposed by the Health Department when a follow-up inspection survey is not conducted by the department within the regulatory deadline.

(b) By January 2012, the commissioner of health shall work with providers to examine state and federal rules and regulations governing the provision of care in licensed

nursing facilities and apply for federal waivers and identify necessary changes in state law to:

(1) eliminate the requirement for written plans of correction from nursing homes for federal deficiencies issued at a scope and severity that is neither widespread nor immediate jeopardy; and

(2) issue the federal survey form electronically to nursing homes.

The commissioner shall issue a report to the legislative chairs of the committees with jurisdiction over health and human services by January 31, 2012, on the status of implementation of this paragraph."

Page 45, line 24, delete "Minneapolis" and insert "the Minneapolis area or greater Minnesota"

Page 50, line 6, delete "obtain" and insert "request"

Page 51, line 3, strike the first "and" and insert a comma and strike the second "and" and insert ", $8,337,000 in fiscal year 2012 and $6,781,000 each year thereafter"

Page 52, delete sections 34 and 35 and insert:

"Sec. 34. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

(a) The commissioner of health, in consultation with the commissioner of human services, shall evaluate and recommend options for reorganizing health and human services regulatory responsibilities in both agencies to provide better efficiency and operational cost savings while maintaining the protection of health, safety, and welfare of the public. Regulatory responsibilities that are to be evaluated are those found in chapters 62D, 62N, 62R, 62T, 144A, 144D, 144G, 146A, 146B, 149A, 153A, 245A, 245B, and 245C, and sections 62Q.19, 144.058, 144.0722, 144.50, 144.651, 148.511, 148.6401, 148.995, 256B.692, 626.556, and 626.557.

(b) The evaluation and recommendations shall be submitted in a report to the legislative committees with jurisdiction over health and human services no later than February 15, 2012, and shall include, at a minimum, the following:

(1) whether the regulatory responsibilities of each agency should be combined into a separate agency;

(2) whether the regulatory responsibilities of each agency should be merged into an existing agency;

(3) what cost savings would result by merging the activities regardless of where they are located;

(4) what additional costs would result if the activities were merged;

(5) whether there are additional regulatory responsibilities in both agencies that should be considered in any reorganization; and

(6) for each option recommended, projected cost and a timetable and identification of the necessary steps and requirements for a successful transition period."

Page 55, after line 17, insert:

"Sec. 39. **NURSING HOME REGULATORY EFFICIENCY.**

The commissioner of health shall work with stakeholders to review, develop, implement, and recommend legislative changes in the nursing home licensure process that address efficiency, eliminate duplication, and assure positive resident clinical outcomes. The commissioner shall assure that the changes are cost neutral."

Page 55, delete section 39 and insert:

"Sec. 39. **REPEALER.**

(a) Minnesota Statutes 2010, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1 and 2; 144.1464; and 150A.22, are repealed.

(b) Minnesota Statutes 2010, section 145A.14, subdivisions 1 and 2, are repealed effective January 1, 2012.

(c) Minnesota Rules, parts 4651.0100, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 16a, 18, 19, 20, 20a, 21, 22, and 23; 4651.0110, subparts 2, 2a, 3, 4, and 5; 4651.0120; 4651.0130; 4651.0140; and 4651.0150, are repealed effective July 1, 2011."

Page 56, delete section 2

Page 57, delete section 3

Page 63, delete section 5

Page 79, delete section 24

Page 88, after line 31, insert:

"Sec. 35. **WORKING GROUP; PSYCHIATRIC MEDICATIONS.**

(a) The commissioner of health shall convene a working group composed of the executive directors of the Boards of Medical Practice, Psychology, Social Work, and Behavioral Health and Therapy, and one representative from each professional association to make recommendations on the feasibility of developing collaborative agreements between psychiatrists and psychologists, social workers, and licensed professional clinical counselors for administration and management of psychiatric medications.

(b) The executive directors shall take the lead in setting the agenda, convening subsequent meetings, and presenting a written report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services.

The report and recommendations for legislation shall be submitted no later than January 1, 2012.

(c) The working group is not subject to the provisions of section 15.059."

Page 101, line 9, delete "$145" and insert "$105"

Page 120, after line 5, insert:

"Sec. 9. Minnesota Statutes 2010, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** (a) ~~By no later~~ As coverage is offered, sold, issued, or renewed, but not less than 12 months after the commissioner publishes the information in subdivision 3, paragraph (e):

(1) the commissioner of management and budget shall use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(3) all health plan companies shall use the information and methods developed under subdivision 3 to develop products that encourage consumers to use high-quality, low-cost providers; and

(4) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies."

Page 121, after line 7, insert:

"Sec. 12. Minnesota Statutes 2010, 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, 2011, 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, 2011, 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, 2011, 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, 2011, 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, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 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 January 1, 2011, to reflect this reduction.

(j) In addition to the reductions in paragraphs (b), (c), (d), (g), (h), and (i), the total payment for medical assistance fee-for-service admissions occurring on or after July 1, 2011 through June 30, 2013, made to hospitals for inpatient services before third-party liability and spenddown, is reduced by ... percent from the current statutory rates. Inpatient hospital fee-for-service payments to hospitals located in the seven-county metropolitan area that are not government owned with a disproportionate population adjustment under section 256.969, subdivision 9, paragraph (b), that is greater than 17 percent on January 1, 2011, are excluded from this reduction. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, through June 30, 2013, to reflect the full 24-month reduction in fee-for-service rates."

Page 121, delete section 13

Page 121, line 11, delete "level III pediatric" and after "hospitals" insert "with a level III neonatal intensive care unit"

Page 122, line 30, before the period insert "and expires January 1, 2014"

Page 126, delete section 18 and insert:

"Sec. 18. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 1b. **Care coordination services provided through pediatric hospitals.** (a) Medical assistance covers care coordination services provided by certain pediatric hospitals to children with high-cost medical conditions and children at risk of recurrent hospitalization for acute or chronic illnesses. There must be Level I and Level II pediatric care coordination services.

(b) Level I pediatric care coordination services are provided by advanced practice nurses employed by or under contract with pediatric hospitals that have a neonatal intensive care unit and are either recipients of payments to support the training of residents from an approved graduate medical residency program under United States Code, title 42, section 256e or the major pediatric teaching hospital affiliate of the University of Minnesota medical school, and that meet the criteria in this subdivision.

(c) The services in paragraph (b) must be available through in-home video telehealth management and other methods, and must be designed to improve patient outcomes

and reduce unnecessary hospital and emergency room utilization. The services must streamline communication, reduce redundancy, and eliminate unnecessary documentation through the use of a Web-accessible, uniform document that contains critical patient care management information, and which is accessible to all providers with patient consent. The commissioner shall develop the uniform document and associated Web site and shall implement procedures to assess patient outcomes and evaluate the effectiveness of the care coordination services provided under this subdivision.

(d) Medical assistance also covers, as durable medical equipment, computers, webcams, and other technology necessary to allow in-home video telehealth management.

(e) For purposes of paragraph (b), a child has a high-cost medical condition if inpatient hospital expenses for that child related to complex or chronic illnesses or conditions for the most recent calendar year exceeded $100,000, or if the expenses for that child are projected to exceed $100,000 for the current calendar year. For purposes of this subdivision, a child is at risk of recurrent hospitalization if the child was hospitalized three or more times for acute or chronic illness in the most recent calendar year.

(f) For purposes of paragraph (b), "care coordination" means collaboration between the advanced practice nurse and primary care physicians and specialists to manage care and reduce hospitalizations, patient case management, development of medical management plans for chronic illnesses and recurrent acute illnesses, oversight and coordination of all aspects of care in partnership with families, organization of medical information into a summary of critical information, coordination and appropriate sequencing of tests and multiple appointments, information and assistance with accessing resources, and telephone triage for acute illnesses or problems.

(g) The commissioner shall adjust managed care and county-based purchasing plan capitation rates to reflect savings from the coverage of this service.

(h) Level II pediatric care coordination services are provided by registered nurses employed by or under contract with a pediatric hospital that has been designated as an essential community provider under Minnesota Statutes, section 62Q.19, subdivision 1, clause (4), and has been a recipient of payments to support the training of residents from an approved graduate medical residency program pursuant to United States Code, title 42, section 256E, and that meets the following criteria:

(1) the services must be provided through telehealth management and other methods, be available on a regular schedule seven days per week, and be designed to provide collaboration in patient care as provided by the patient's family, primary care providers, and the hospital and specialized physicians;

(2) for purposes of this paragraph, a child has a high-cost medical condition if the child has a serious chronic physical disability caused by a congenital anomaly, birth injury or traumatic injury, complications with which can be expected to cause further injury, hospitalization, or death, but that can be effectively addressed through ongoing family and primary care supported by communication of ongoing care information and care coordination; and

(3) for purposes of this paragraph, "care coordination" means the ready availability of telehealth management services to support collaboration through a registered nurse between a child's family, the primary care professional that is available to care for the child, and appropriate professionals to address urgent questions about and minimize the consequences of medical complications, develop medical management plans for complex conditions, and avoid serious health consequences and hospitalizations to treat such complications.

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

Page 126, line 35, delete "level III pediatric" and after "hospitals" insert "with a level III neonatal intensive care unit"

Page 127, delete section 19 and insert:

"Sec. 19. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

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

Page 128, line 24, after the period insert "Authorization determinations shall be communicated within three working days."

Page 128, delete section 20

Page 130, line 18, strike "The actual acquisition"

Page 130, strike line 19

Page 130, line 20, strike "minus 30 percent"

Page 137, delete section 32

Page 140, line 2, delete the new language and reinstate the stricken language

Page 140, line 22, after "apply" insert "to providers included in provider peer grouping"

Page 141, line 26, delete the new language and reinstate the stricken "$12"

Page 151, delete lines 17 to 20

Page 151, line 26, delete "reinsurance" and insert "malpractice insurance"

Page 151, delete lines 30 and 31 and insert "licensed traditional midwives, certified nurse midwives, family practitioners, obstetricians, perinatologists, neonatologists, and other advanced practice registered nurses."

Page 152, line 14, delete "appropriate and" and insert "competent"

Page 152, line 15, delete "language-appropriate"

Page 202, line 11, after "are" insert "not"

Page 203, line 23, delete "the" and insert "any applicable federal"

Page 203, delete line 24

Page 207, after line 36, insert:

"Sec. 112. **CONTINGENCY BASED CONTRACT.**

When the commissioner of human services enters into a contingency based contract for the purpose of recovering Minnesota Health Care program funds, the commissioner may retain that portion of the recovered funds equal to the amount of the contingency fee.

Sec. 113. **TRANSPARENCY AND QUALITY REPORTING FOR PUBLIC HEALTH CARE PROGRAMS.**

When negotiating with external vendors to provide managed care services, the commissioner of human services shall require use of an advanced request for information tool. This tool must provide the department with an evidence-based assessment that focuses on the cost control, quality, and information transparency of the health care vendor. The assessment may include evidence-based performance measures that have been shown to influence better health, better health care, and more cost-effective use of resources including, but not limited to, areas that determine each plan's capabilities and performance with respect to:

(1) consumer engagement, support, and incentives;

(2) processes and outcomes for closing gaps in care according to clinical guideline expectations;

(3) provider management, including outcome and population-based reimbursement, transparent measurement of provider performance, and support of physician practice structures that lead to better care; and

(4) measures of clinical outcomes and waste approved by the National Quality Forum.

Sec. 114. **RISK CORRIDORS.**

(a) Effective for services rendered on or after January 1, 2012, the commissioner shall establish risk corridors for state public programs that are actuarially sound for each

managed care plan and each county-based purchasing plan. The risk corridors will be calculated annually based on the calendar year's net underwriting gain or loss. If the managed care plan or county-based purchasing plan has achieved a net underwriting gain of greater than three percent of revenue, 80 percent of any excess must be repaid to the commissioner by July 31 of the year following calculation of the risk corridor year, and 20 percent must be invested by the plan directly into programs for improving quality of care or access to care for state public health care program enrollees. If the managed care plan or county-based purchasing plan has incurred a net underwriting loss greater than three percent of total revenue, 50 percent of any excess must be repaid to the plan by the commissioner by July 31 of the year following calculation of the risk corridor year. Determination of total revenues and net underwriting gain or loss must be based on the Minnesota Supplement Report #1 which is filed on April 1 of the year following calculation of the risk corridor and adjusted for the actual withhold calculation under sections 256B.69, subdivision 5a and 256L.12, subdivision 9. The report must be filed with and publicly disclosed by the Minnesota Department of Health.

(b) For purposes of this section, "state public programs" means those prepaid medical assistance and MinnesotaCare programs for which a managed care plan or county-based purchasing plan contracts with the commissioner to provide coverage under sections 256B.69, 256B.692, and 256L.12. The risk corridors shall not apply to plans for persons who are enrolled in integrated Medicare and medical assistance programs under section 256B.69, subdivisions 23 and 28.

(c) This section expires January 1, 2014."

Page 209, line 28, delete "article 8" and insert "article 3"

Page 231, line 17, reinstate the stricken "and"

Page 231, delete line 18

Page 231, line 19, reinstate the stricken "(4)" and delete "(5)"

Page 231, line 20, after "section" insert ", including assisting recipients with rehabilitation exercises that are part of a recipient's care plan if trained in the procedures and tasks and no additional PCA service time is necessary to complete this task"

Page 233, line 24, delete everything after the period

Page 233, delete lines 25 and 26 and insert "When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild."

Page 233, after line 26, insert:

"Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; ~~and~~

(5) agency marketing and advertising materials and documentation of marketing activities and costs; and

(6) for each personal care assistant, whether or not the personal care assistant is providing care to a relative as defined in subdivision 11.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision."

Page 259, delete section 32

Page 266, line 7, delete "five" and insert "three"

Page 267, line 7, delete "five" and insert "two"

Page 284, line 23, delete "and"

Page 284, line 25, delete the period and after "models" insert "; and"

Page 284, after line 25, insert:"(4) implementation of a methodology to fully fund county case management administrative functions."

Page 285, line 14, after the period insert "Appointed nongovernmental members of the task force shall serve as staff for the task force and take on the responsibilities of coordinating meetings, reporting on committee recommendations, and providing other staff support as needed to meet the responsibilities of the task force as described in subdivision 3. Legislative appointment of nongovernmental members of the task force shall be conditioned upon agreement from the appointees to provide staff assistance to execute the work of the task force."

Page 285, line 28, after the period insert "The task force shall be independently staffed and coordinated by nongovernmental appointees who serve on the task force, no state funding shall be appropriated for expenses related to the task force under this section."

Page 309, line 25, delete "deemed necessary" and insert "the person meets the criteria established"

Page 309, line 27, delete "deemed appropriate" and insert "the person meets the criteria established"

Page 310, after line 20, insert:

"**EFFECTIVE DATE.** This section is effective for all chemical dependency residential treatment beginning or after July 1, 2011."

Page 313, after line 21, insert:

"Sec. .... **COMMISSIONER'S CRITERIA FOR RESIDENTIAL TREATMENT.**

The commissioner shall develop specific criteria to approve treatment for individuals who require residential chemical dependency treatment in excess of the maximum allowed in section 254B.04, subdivision 1, due to co-occurring disorders, including disorders related to cognition, traumatic brain injury, or documented disability. Criteria shall be developed for use no later than October 1, 2011."

Page 325, line 5, delete "$1,924,434,000" and insert "$1,964,344,000"

Page 325, line 8, delete "$453,836,000" and insert "$530,566,000"

Page 325, line 10, delete "$38,592,000" and insert "$41,444,000"

Page 325, line 11, delete "190,844,000" and insert "$194,092,000"

Page 326, line 31, delete "$3,950,500" and insert "$2,536,949,000"

Page 326, line 35, delete "$526,251" and insert "$526,251,000"

Page 329, after line 18, insert:

"**Northern Connections.** $100,000 is appropriated in fiscal year 2012 and $100,000 is appropriated in fiscal year 2013 from the general fund to the commissioner of human services for a grant to expand Northern Connections workforce program that provides one-stop supportive services to individuals as they transition into the workforce to up to two interested counties in rural Minnesota."

Page 330, after line 1, insert:

"**Child Care Development Funds.** The commissioner of human services shall direct $..... in federal child care development funds from ..... for the purpose of continuing the quality rating and improvement system as described in Minnesota Statutes, section 119B.135, in the original pilot area and expanding the system to two new rural geographic locations."

Page 338, after line 29, insert:

"Sec. ... **CARRY FORWARD.**

Funds appropriated for fiscal year 2011 are available until expended."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Adjust amounts accordingly