..... moves to amend H.F. No. 927, the first engrossment, as follows:

Page 8, delete section 10

Page 11, line 7, strike "if" and after the comma insert "and"

Page 11, lines 33 to 36, reinstate the stricken language

Page 12, line 34, strike "and 9530.2500 to"

Page 13, line 1, strike "9530.4000" and after the semicolon insert "and" and strike " persons"

Page 13, strike lines 2 and 3

Page 13, line 4, strike "and (3)"

Page 13, line 8, strike everything after the period

Page 13, strike lines 9 and 10

Page 13, line 11, strike everything before "A"

Page 13, after line 22, insert:

"Sec. 15. Minnesota Statutes 2010, section 256D.06, subdivision 2, is amended to read:

Subd. 2. **Emergency need.** (a) Notwithstanding the provisions of subdivision 1, a grant of emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need~~, as defined in rules promulgated by the commissioner,~~ where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist ~~and the individual or family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP~~ under written criteria adopted by the county agency. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision.

(b) The applicant must be ineligible for assistance under chapter 256J, must have annual net income no greater than 200 percent of the federal poverty guidelines for

the previous calendar year, and may receive An emergency ~~general~~ assistance grant ~~is available to a recipient~~ not more than once in any 12-month period.

(c) Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. No county shall be allocated less than $1,000 for a fiscal year.

(d)Any emergency general assistance expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds."

Page 15, delete section 16 and insert:

"Sec. 16. Minnesota Statutes 2010, section 256D.46, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** ~~A county agency must grant emergency Minnesota supplemental aid, to the extent funds are available, if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.~~ Applicants for or recipients of SSI or Minnesota supplemental aid who have emergency need may apply for emergency general assistance under section 256D.06, subdivision 2. "

Page 15, line 13, delete "prior month's"

Page 15, after line 26, insert:

"Sec. .... Minnesota Statutes 2010, section 256I.03, is amended by adding a subdivision to read:

Subd. 8. **Supplementary services.** "Supplementary Services" means services provided to residents of group residential housing providers in addition to room and board including, but not limited to, oversight and up to 24 hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services."

Page 16, line 11, after "housing" insert ", licensed as board and lodge with special services,"

Page 16, line 12, delete "week" and insert "month"

Page 16, lines 21 and 22, delete the new language

Page 16, line 29, delete "The county"

Page 16, delete lines 30 to 33

Page 16, line 34, delete "the program."

Page 17, after line 18, insert:

"(d) Beginning July 1, 2011, counties must not negotiate supplementary service rates with providers of group residential housing, licensed as board and lodge with special services, that do not enforce a policy of sobriety on their premises."

Page 24, line 1, strike "and issue food stamps to"

Page 24, line 3, strike "either:"

Page 24, strike line 4

Page 24, line 5, strike "(2)" and strike "coupons" and insert "benefits"

Page 24, after line 8, insert:

"Sec. .... Minnesota Statutes 2010, section 518A.51, is amended to read:

**518A.51 FEES FOR IV-D SERVICES.**

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) An application fee of $25 shall be paid by the person who applies for child support and maintenance collection services, except persons who are receiving public assistance as defined in section 256.741 and the diversionary work program under section 256J.95, persons who transfer from public assistance to nonpublic assistance status, and minor parents and parents enrolled in a public secondary school, area learning center, or alternative learning program approved by the commissioner of education.

(c) In the case of an individual who has never received assistance under a state program funded under Title IV-A of the Social Security Act and for whom the public authority has collected at least $500 of support, the public authority must impose an annual federal collections fee of $25 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first $500 collected.

(d) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of one percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, medical assistance, or MinnesotaCare programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(e) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of one percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(f) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(g) Federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e), retained by the commissioner of human services, shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established under paragraph (i). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

(h) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under Title IV-A and Title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(i) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (c) and cost recovery fees collected under paragraphs (d) and (e). A portion of the nonfederal share of these fees may be retained for expenditures necessary to administer the fees and must be transferred to the child support system special revenue account. ~~The remaining nonfederal share of the federal collections fees and cost recovery fees must be retained by the commissioner and dedicated to the child support general fund county performance-based grant account authorized under sections 256.979 and 256.9791.~~ The commissioner shall distribute the remaining nonfederal share of these fees to the counties quarterly using the methodology specified in section 256.979, subdivision 11. The funds

received by the counties must be reinvested in the child support enforcement program, and the counties shall not reduce the funding of their child support programs by the amount of funding distributed."

Page 27, after line 7, insert:

"Sec. .... **STREAMLINING CHILDREN AND COMMUNITY SERVICES ACT REPORTING REQUIREMENTS.**

The commissioner of human services and county human services representatives, in consultation with other interested parties, shall develop a streamlined alternative to current reporting requirements related to the Children and Community Services Act service plan. The commissioner shall submit recommendations and draft legislation to the chairs and ranking minority members of the committees having jurisdiction over human services no later than November 15, 2012."

Page 27, line 10, delete everything after "and" and insert "256D.46, subdivisions 2 and 3"

Page 27, line 11, delete everything before "are"

Page 27, line 12, delete "part" and insert "parts" and delete", is" and insert "; and 9500.1261, subpart 3, clauses D and E, and subparts 4 and 5 are"

Page 55, delete sections 30 and 31, and insert:

"Sec. .... Minnesota Statutes 2010, section 157.15, is amended by adding a subdivision to read:

Subd. 7a. **Limited food establishment.** "Limited food establishment" means a food and beverage service establishment that primarily provides beverages that consist of combining dry mixes and water or ice for immediate service to the consumer. Limited food establishments must use equipment and utensils that are nontoxic, durable, and retain their characteristic qualities under normal use conditions and may request a variance for plumbing requirements from the commissioner."

Page 55, line 26, delete the first "and" and insert "such as"

Page 60, line 27, before "144.1464" insert "and" and delete "; and 150A.22,"

Page 61, delete article 3

Page 86, after line 32, insert:

"Sec. .... Minnesota Statutes 2010, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services or the commissioner of health, and

an acute care inpatient facility that provides services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance."

Page 122, line 26, delete "with a level III neonatal intensive care unit"

Page 123, delete section 18

Page 124, before line 3, insert:

"Sec. 19. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2010, 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) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size.~~

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

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

Page 126, line 29, after "organ" insert "and stem cell"

Page 131, delete sections 22 and 23

Page 141, after line 16, insert:

"Sec. 38. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Payment for noncovered services.** (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescriptive drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service."

Page 143, after line 34, insert:

"Sec. 41. Minnesota Statutes 2010, section 256B.0644, 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) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers.

(e) A provider described in section 256B.76, subdivision 5, may limit the eligibility of new medical assistance, general assistance medical care, and MinnesotaCare patients for specific categories of rehabilitative services, if medical assistance, general assistance medical care, and MinnesotaCare patients served by the provider in the aggregate exceed 30 percent of the provider's overall patient population."

Page 144, line 13, after the second comma, insert "or"

Page 144, lines 14 to 15, delete the new language

Page 144, line 28, after the first comma insert "and" and delete ", and chiropractors"

Page 146, line 27, after the period, insert "Effective July 1, 2012,"

Page 165, line 13, delete "$6,404,000" and insert "$4,500,000"

Page 179, after line 19, insert:

"Sec. 81. Minnesota Statutes 2010, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) Beginning ~~April 1, 2010~~ January 1, 2012, 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 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 January 1, 2012.

Sec. 82. Minnesota Statutes 2010, section 256D.031, subdivision 6, is amended to read:

Subd. 6. **Coordinated care delivery systems.** (a) Effective ~~June 1, 2010~~ January 1, 2012, the commissioner shall contract with hospitals or groups of hospitals, or

county-based purchasing plans, that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals or plans 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 or plan 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, or a county-based purchasing plan established under section 256B.692, may contract with the commissioner to develop and implement a coordinated care delivery system ~~as follows:~~ if the hospital or group of hospitals or plan agrees to satisfy the requirements of this subdivision.

~~(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 or plans shall become effective quarterly on ~~June 1, September 1, December 1, or March 1~~ January 1, April 1, July 1, or October 1. Hospital or plan participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system but services are only available through 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 February 28, 2011, 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 February 28, 2011, services are available only through a coordinated care delivery system.~~

(d) The hospital or plan 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. When contracting with providers and clinics, the hospital or plan shall give preference to providers and clinics certified as health care homes under section 256B.0751. The hospital or plan must contract with federally qualified health centers or federally qualified health center look-alikes, as defined in section 145.9269, subdivision 1, that agree to accept the terms, conditions, and payment rates offered by the hospital or plan to similarly situated providers. If a provider or clinic or health center contracts with a hospital or plan 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 or plan and paid by the hospital or plan 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;

(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 or plan may require a recipient to designate a primary care provider or a primary care clinic. The hospital or plan may limit the delivery of services to a network of providers who have contracted with the hospital or plan to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital or plan 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 or plan must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital or plan 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) Notwithstanding any other provision in this section to the contrary, ~~for participation beginning September 1, 2010,~~ the commissioner ~~shall offer the same contract terms related to~~ shall negotiate an enrollment threshold formula and financial liability

protections ~~to~~ with a hospital or group of hospitals or plan qualified under this subdivision to develop and implement a coordinated care delivery system ~~as those contained in the coordinated care delivery system contracts effective June 1, 2010~~.

~~(l) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.~~

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

Sec. 83. Minnesota Statutes 2010, section 256D.031, 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 or plans participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after ~~June 1, 2010~~ March 1, 2012. The payment shall be allocated among all hospitals or plans qualified to participate on the allocation date ~~as follows:~~ based upon the enrollment thresholds negotiated with the commissioner.

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

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

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

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

The commissioner may prospectively reallocate payments to participating hospitals or plans 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.~~

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

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

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

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

Sec. 84. Minnesota Statutes 2010, section 256D.031, subdivision 10, is amended to read:

Subd. 10. **Assistance for veterans.** Hospitals and plans participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified."

Page 187, delete section 88 and insert:

"Sec. 88. Minnesota Statutes 2010, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons, through December 31, 2011, includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.

(b) Effective ~~July 1, 2009~~ January 1, 2012, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are greater than 75 percent of the federal poverty guidelines and equal to or less than ~~250~~ 200 percent of the federal poverty guidelines. Effective July 1, 2013, the maximum income limit under this paragraph is increased to 250 percent of the federal poverty guidelines.

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

Page 198, after line 26, insert:

"Sec. 100. Laws 2010, First Special Session chapter 1, article 25, section 3, subdivision 6, is amended to read:

Subd. 6. **Health Care Grants**

(a) **MinnesotaCare Grants** 998,000 (13,376,000)

This appropriation is from the health care access fund.

**Health Care Access Fund Transfer to General Fund.** The commissioner of management and budget shall transfer the following amounts in the following years from the health care access fund to the general fund: ~~$998,000~~ $0 in fiscal year 2010; ~~$176,704,000~~ $59,901,000 in fiscal year 2011; $141,041,000 in fiscal year 2012; and $286,150,000 in fiscal year 2013. If at any time the governor issues an executive order not to participate in early medical assistance expansion, no funds shall be transferred from the health care access fund to the general fund until early medical assistance expansion takes effect. This paragraph is effective the day following final enactment.

**MinnesotaCare Ratable Reduction.** Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by 15 percent. Effective for services provided from July 1, 2010, to June 30, 2011, this reduction shall apply to all services. Effective for services provided from July 1, 2011, to December 31, 2013, this reduction shall apply to all services except inpatient hospital services. Notwithstanding

any contrary provision of this article, this paragraph shall expire on December 31, 2013.

| | | |
|---|---|---|
| (b) **Medical Assistance Basic Health Care Grants - Families and Children** | -0- | 295,512,000 |

**Critical Access Dental.** Of the general fund appropriation, $731,000 in fiscal year 2011 is to the commissioner for critical access dental provider reimbursement payments under Minnesota Statutes, section 256B.76 subdivision 4. This is a onetime appropriation.

**Nonadministrative Rate Reduction.** For services rendered on or after July 1, 2010, to December 31, 2013, the commissioner shall reduce contract rates paid to managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, by three percent of the contract rate attributable to nonadministrative services in effect on June 30, 2010. Notwithstanding any contrary provision in this article, this rider expires on December 31, 2013.

| | | |
|---|---|---|
| (c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled** | -0- | (30,265,000) |
| | | ~~(75,389,000)~~ |
| (d) **General Assistance Medical Care Grants** | -0- | (59,583,000) |

The reduction to general assistance medical care grants is contingent upon the effective date in Laws 2010, First Special Session, chapter 1, article 16, section 48. The reduction shall be reestimated based upon the actual effective date of the law. The

commissioner of management and budget shall make adjustments in fiscal year 2011 to general assistance medical care appropriations to conform to the total expected expenditure reductions specified in this section.

(e) **Other Health Care Grants** -0- (7,000,000)

**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 for fiscal year 2011 COBRA grant expenditures. Up to $111,000 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 for costs related to administration of the COBRA grants.

Sec. 101. **COMMISSIONER'S ACTIONS; REPEAL OF EARLY MEDICAL ASSISTANCE EXPANSION.**

Effective January 1, 2012, the commissioner of human services shall suspend implementation and administration of Minnesota Statutes 2010, sections 256B.055, subdivision 15; 256B.056, subdivision 3, paragraph (b); and 256B.056, subdivision 4, paragraph (d). The commissioner shall refer persons enrolled under these provisions, and applicants for coverage under these provisions, to the general assistance medical care program established under Minnesota Statutes, section 256D.031.

Sec. 102. **GENERAL ASSISTANCE MEDICAL CARE PROGRAM; PROVISIONS REVIVED.**

Notwithstanding their contingent repeal in Laws of Minnesota 2010, First Special Session, chapter 1, article 16, section 47, the following statutes are revived and have the force of law effective January 1, 2012:

(1) Minnesota Statutes 2010, section 256D.03, subdivisions 3, 3a, 6, 7, and 8;

(2) Minnesota Statutes 2010, section 256D.031, subdivisions 1, 2, 3, 4, 6, 7, and 10; and

(3) Laws of Minnesota 2010, chapter 200, article 1, section 18."

Page 205, delete section 111

Page 207, delete section 113, and insert:

"Sec. 113. **REPEALER; EARLY MEDICAL ASSISTANCE EXPANSION.**

Minnesota Statutes 2010, section 256B.055, subdivision 15, is repealed January 1, 2012."

Page 214, delete section 3

Page 219, line 30, after "subdivision" insert ", except as provided under section 256.01, subdivision 18b"

Page 220, line 7, after "amount" insert ", except as provided under section 256.01, subdivision 18b"

Page 221, line 12, strike "OPTION" and insert "OPTIONS"

Page 221, line 17, delete "Managing partner" and insert "Individual representative"

Page 221, line 22, delete "other"

Page 221, line 24, strike "option" and insert "options"

Page 222, line 2, strike "not" and insert "except for services provided by those" and after "or" insert "family"

Page 222, line 3, after "care" insert "consistent with the requirements of section 256B.0651, subdivision 1, paragraph (e)"

Page 222, line 7, delete "managing partner" and insert "individual representative"

Page 222, line 8, delete "managing partner" and insert "individual representative"

Page 222, line 13, delete "managing partners" and insert "individual representatives"

Page 222, line 14, strike "Primary Care Utilization Review" and insert "Minnesota Restricted Recipient Program"

Page 222, line 15, strike "Committee"

Page 223, line 13, after "and" insert "monthly average authorization for the"

Page 223, line 18, after "monthly" insert "average authorization for the"

Page 223, line 21, after "plan" insert "and provider"

Page 224, after line 9, insert:

"(1) assure that outreach activities and information materials on self-directed options are developed and provided across the state to persons who use or are seeking community support services;"

Page 224, line 10, strike "(1)" and insert "(2)" and after "plan" insert a semicolon and delete the new language and strike the existing language

Page 224, lines 11 to 13, delete the new language and strike the existing language

Page 224, line 14, strike "(2)" and insert "(3)"

Page 224, line 16, strike "(3)" and insert "(4)" and delete "managing partner" and insert "individual representative"

Page 224, line 19, strike "(4)" and insert "(5)"

Page 224, after line 20, insert:

"(c) The commissioner shall:

(1) establish provider enrollment requirements for provision of fiscal support entity services and person-centered support plan services, including benefits counseling to support employment; and

(2) collect a fee to cover the costs of certifying providers for the services described in subdivision 5."

Page 224, line 25, after "settings" insert "unless the services are provided in a family foster care setting which meets the requirements of section 256B.0651, subdivision 1, paragraph (e)"

Page 226, line 9, after "(iii)" insert "for persons using home and community-based waiver services,"

Page 226, line 13, delete everything after "efforts"

Page 226, line 14, delete everything before the period

Page 226, line 17, delete "and monitored"

Page 226, line 18, delete everything before the period

Page 226, line 29, delete "managing partner" and insert "individual representative"

Page 226, line 33, delete "managing partner" and insert "individual representative"

Page 227, line 35, after "including" insert "recommendations on possible"

Page 227, line 36, delete "include" and insert "provide"

Page 228, delete section 11

Page 232, delete section 14

Page 239, line 14, delete the first "and" and insert "or"

Page 239, line 15, delete "amount authorized" and insert "average authorized amount"

Page 239, line 32, delete "working" and insert "calendar"

Page 240, line 22, delete the new language

Page 240, delete lines 23 to 25, and insert "For persons determined ineligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the community support plan must also include the estimated annual and monthly average authorized budget amount for those services."

Page 240, line 28, after the period insert:

"The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For persons determined eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (10), the community support plan must also include:

(6) identification of individual goals;

(7) identification of short and long-term service outcomes. Short-term service outcomes are defined as achievable within six months;

(8) a recommended schedule for case management visits. When achievement of short-term service outcomes may affect the amount of service required, the schedule must be at least every six months and must reflect evaluation and progress toward identified short-term service outcomes; and

(9) the estimated annual and monthly budget amount for services.

In addition, for persons determined eligible for state plan home care under subdivision 1a, paragraph (a), clause (8), the person or person's representative must also receive a copy of the home care service plan developed by a certified assessor."

Page 241, line 25, strike "in a"

Page 241, line 26, strike "face-to-face visit"

Page 241, line 28, after "telephone" insert "as determined by the commissioner to establish statewide consistency"

Page 254, line 36, delete "2012" and insert "2013, except subdivision 1a, paragraph (b), clause (6) is effective July 1, 2011"

Page 255, line 18, strike "and"

Page 255, line 19, after "resources" insert ", and other services the person needs that are not available. The individual coordinated service and support plan shall also specify service outcomes and the provider's responsibility to monitor the achievement of the service outcomes" and delete the new language and strike the existing language

Page 255, strike line 20

Page 256, line 4, delete "2012" and insert "2013"

Page 256, line 19, after "services" insert "and service outcomes"

Page 256, line 33, strike "program" and insert "provider"

Page 258, line 22, delete "amount authorized" and insert "average authorized amount"

Page 259, line 18, delete "1.27"

Page 259, line 24, delete "2.7"

Page 260, line 25, delete the semicolon and insert a period

Page 261, line 31, delete "4.14"

Page 263, line 30, delete "counsels" and insert "councils"

Page 263, line 36, delete "6.20"

Page 264, line 1, delete everything after the period

Page 264, delete lines 2 and 3

Page 270, delete section 40

Page 274, delete section 42

Page 276, delete lines 23 to 28

Page 276, line 35, delete "subdivision" and insert "subdivisions" and after "1b" inert "and 1e"

Page 277, delete lines 9 to 35

Page 278, delete lines 1 to 13

Page 278, line 14, reinstate the stricken "(b)" and delete "(e)"

Page 278, lines 17 and 18, delete the new language

Page 285, delete lines 29 to 34

Page 286, delete lines 1 to 10

Page 286, line 20, after the period, insert "A facility licensed for five to eight people must be an existing residential building, such as a duplex, that is owned by the same company and meets all other licensing requirements."

Page 286, delete lines 21 to 25

Page 287, line 25, delete "be paid" and insert "begin paying"

Page 288, line 1, delete "January" and insert "July"

Page 288, line 2, after "sections" insert "256B.0621, subdivision 2, clause (4),"

Page 292, delete lines 14 to 19, and insert:

"(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal,

definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012."

Page 293, line 12, delete everything after the period

Page 293, delete lines 13 and 14 and insert "The commissioner shall seek and use any funds available, including federal funds, foundation funds, existing grant funds, and other state funds as available."

Page 294, delete section 6

Page 310, after line 28, insert:

"Sec. .... Minnesota Statutes 2010, section 245.50, is amended to read:

**245.50 INTERSTATE CONTRACTS, MENTAL HEALTH, CHEMICAL HEALTH, DETOXIFICATION SERVICES.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency" means a public or private hospital, mental health center, chemical health treatment facility, detoxification facility, or other person or organization which provides mental health ~~or~~, chemical health, or detoxification services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment or detoxification under this section.

(e) "Sending state" means the state in which the sending agency is located.

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment or detoxification services to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board or the commissioner of human services may contract with an agency or facility in a bordering state for mental health ~~or~~, chemical health, or detoxification services for residents of Minnesota, and a Minnesota mental health ~~or~~, chemical health, or detoxification agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state,

including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

(2) are on probation or parole;

(3) are the subject of a presentence investigation; or

(4) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

Subd. 4. **Contracts.** Contracts entered into under this section must, at a minimum:

(1) describe the services to be provided;

(2) establish responsibility for the costs of services;

(3) establish responsibility for the costs of transporting individuals receiving services under this section;

(4) specify the duration of the contract;

(5) specify the means of terminating the contract;

(6) specify the terms and conditions for refusal to admit or retain an individual; and

(7) identify the goals to be accomplished by the placement of an individual under this section.

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness ~~or~~, chemical dependency, or detoxification. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section

continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

(f) If a Minnesota resident is admitted to a facility in a bordering state under this chapter, a physician, licensed psychologist who has a doctoral degree in psychology, or an advance practice registered nurse certified in mental health, who is licensed in the bordering state, may act as an examiner under sections 253B.07, 253B.08, 253B.092, 253B.12, and 253B.17 subject to the same requirements and limitations in section 253B.02, subdivision 7. Such examiner may initiate an emergency hold under section 253B.05 on a Minnesota resident who is in a hospital that is under contract with a Minnesota governmental entity under this section provided the resident, in the opinion of the examiner, meets the criteria in section 253B.05.

(g) This section shall apply to detoxification services that are unrelated to treatment whether the services are provided on a voluntary or involuntary basis."

Page 311, line 1, delete "30" and insert "25"

Page 317, delete section 13 and insert:

"Sec. .... **STATE-OPERATED SERVICES FACILITIES.**

(a) The commissioner shall close the Willmar Community Behavioral Health Hospital no later than October 1, 2011.

(b) The commissioner shall present a plan to the legislative committees with jurisdiction over health and human services finance no later than January 1, 2012, on how the department will:

(1) accommodate the mental health needs of clients impacted by the closure or redesign of any state-operated services facilities; and

(2) accommodate the state employees adversely affected by the closure or redesign of any state-operated services facilities."

Page 327, delete line 4 and insert:

"(g) **GAMC Grants** 120,000,000 280,000,000"

Page 327, before line 5, insert:

"**CCDS.** This appropriation is to fund coordinated care delivery systems under Minnesota Statutes, section 256D.031, subdivision 6."

Page 327, after line 13, insert:

"**Base Adjustment.** The general fund base is reduced by $120,000,000 in fiscal year 2014 and by $280,000,000 in fiscal year 2015."

Page 327, delete lines 20 to 34

Page 328, delete lines 1 to 24

Page 329, line 14, delete "(a)"

Page 329, line 17, delete "the elderly and"

Page 329, line 18, delete "elderly"

Page 329, delete line 19

Page 329, line 20, delete "256B.0915;"

Page 329, line 21, delete "CAC,"

Page 329, line 22, delete the comma

Page 329, line 25, delete "$1,964,344,000" and insert "$2,038,330,000" and delete " elderly waiver"

Page 329, delete lines 26 and 27

Page 329, line 28, delete everything before "the"

Page 329, line 29, delete "$820,176,000" and insert "$963,854,000" and delete everything after the semicolon

Page 329, line 30, delete everything before "and"

Page 329, line 31, delete "$194,092,000" and insert "$206,408,000"

Page 330, line 2, delete "22" and insert "30"

Page 330, line 27, after "provision" insert "unless the reduction is due to a change in the type or amount of services to be delivered"

Page 330, delete lines 29 to 35

Page 331, delete lines 1 to 10

Page 331, delete lines 21 to 33 and insert

"(a) Total state and federal funding for fee-for-service medical assistance basic care for the elderly and persons with disabilities is limited to $950,183,000 for fiscal year 2012 and $1,115,961,000 for fiscal year 20013.

(b) The commissioner shall contract with a vendor to manage spending within these limits, beginning January 1, 2012. The vendor selected may:

(1) manage and coordinate the care provided by high-cost providers;

(2) implement payment reform initiatives to encourage efficient and cost-effective service provision;

(3) identify and deny payment for unnecessary services; and

(4) implement other initiatives proven to improve the efficiency of fee-for-service care delivery.

The contract with the vendor must be on a contingency basis, under which the vendor retains six percent of any savings obtained from management of fee-for-service spending.

(c) The commissioner, by October 1, 2012, shall evaluate the extent to which initiatives implemented by the vendor will be successful in managing spending within the specified

limits. If the commissioner determines that the vendor will not be successful in managing spending within the specified limits, the commissioner shall reduce medical assistance provider payments by an amount sufficient to comply with the spending limits. In implementing rate reductions, the commissioner shall exempt payments to nursing facilities and providers of home and community-based waiver services."

Page 332, delete lines 1 and 2

Page 334, delete lines 31 to 35

Page 335, delete lines 1 to 4

Page 335, after line 16, insert:

"**Adoption Assistance and Relative Custody Assistance Payments.** $1,661,000 each year is for continuation of current payments for adoption assistance and relative custody assistance."

Page 338, after line 2, insert:

"**Region 10.** Any unspent allocation for Region 10 Quality Assurance from the biennium beginning on July 1, 2009, may be carried over into the biennium beginning on July 1, 2011."

Page 338, after line 2, insert:

"**Money Follows the Person Rebalancing Demonstration Project.** Notwithstanding the provisions of Minnesota Statutes, section 256.011, subdivision 3, estimated general fund savings resulting from the operation of the Money Follows the Person federal grant fund must be retained within the medical assistance general fund appropriation for the payment of federally required rebalancing

expenditures. If a rebalancing expenditure is not eligible for medical assistance, the corresponding portion of estimated savings must be transferred to and paid from a special revenue account established for this purpose. Monies in the account do not cancel and are appropriated to the commissioner for the purposes of the demonstration project."

Page 342, after line 7, insert:

"**Comprehensive Advanced Life Support.** Of the general fund appropriation, $31,000 each year is added to the base of the Comprehensive Advanced Life Support (CALS) program under Minnesota Statutes, section 144.6062."

Page 349, line 5, reinstate the stricken "suspended to June 30," and delete " eliminated" and insert "2012"

Renumber the sections and subdivisions in sequence and correct the internal references

Amend the title accordingly

Adjust amounts accordingly