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HOUSE FILE NO. 2614

FIRST COMMITTEE ENGROSSMENT

February 4, 2010
Authored by Huntley
The bill was read for the first time and referred to the Committee on Finance

Referred by Chair to Health Care and Human Services Finance Division.
April 28, 2010
Returned to the Committee on Finance as Amended.

1.1 A bill for an act
1.2 relating to human services; licensing; state health care programs; continuing
1.3 care; children and family services; health reform; public health; assessing
1.4 administrative penalties; requiring reports; making supplemental appropriations
1.5 and reductions; amending Minnesota Statutes 2008, sections 3.971, subdivision
1.6 2; 3.98, by adding a subdivision; 62D.08, by adding a subdivision; 62J.07,
1.7 subdivision 2, by adding a subdivision; 62J.38; 62Q.19, subdivision 1;
1.8 62Q.76, subdivision 1; 62U.05; 144.226, subdivision 3; 144.291, subdivision
1.9 2; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51,
1.10 subdivision 5; 144E.37; 245C.27, subdivision 2; 245C.28, subdivision 3;
1.11 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4,
1.12 by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2;
1.13 254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivision
1.14 3; 256B.04, subdivision 14; 256B.055, by adding a subdivision; 256B.056,
1.15 subdivision 4; 256B.057, subdivision 9; 256B.0625, subdivisions 8, 8a, 8b,
1.16 18a, 31, by adding subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644, as
1.17 amended; 256B.0754, by adding a subdivision; 256B.0915, subdivision 3b;
1.18 256B.19, subdivision 1c; 256B.69, subdivisions 20, as amended, 27, by adding
1.19 subdivisions; 256B.692, subdivision 1; 256B.75; 256B.76, subdivisions 2, 4, by
1.20 adding a subdivision; 256D.0515; 256J.20, subdivision 3; 256J.24, subdivision
1.21 10; 256J.37, subdivision 3a; 256L.02, subdivision 3; 256L.03, subdivision
1.22 3, by adding a subdivision; 256L.05, by adding a subdivision; 256L.07, by
1.23 adding a subdivision; 256L.12, subdivisions 5, 6, 9; 626.556, subdivision
1.24 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections
1.25 62J.495, subdivisions 1a, 3, by adding a subdivision; 245C.27, subdivision 1;
1.26 252.025, subdivision 7; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969,
1.27 subdivision 3a; 256B.0625, subdivisions 9, 13e; 256B.0653, subdivision 5;
1.28 256B.0915, subdivision 3a; 256B.69, subdivision 23; 256B.76, subdivision
1.29 1; 256B.766; 256D.03, subdivision 3, as amended; 256J.425, subdivision 3;
1.30 256L.03, subdivision 5; 256L.11, subdivision 1; Laws 2009, chapter 79, article 3,
1.31 section 18; article 5, section 78, subdivision 5; article 13, section 3, subdivisions
1.32 1, as amended, 3, as amended, 4, as amended, 8, as amended; Laws 2010, chapter
1.33 200, article 1, sections 12, subdivisions 6, 7, 8; 16; 21; article 2, section 2,
1.34 subdivisions 1, 8; proposing coding for new law in Minnesota Statutes, chapters
1.35 62A; 62D; 62E; 62J; 62Q; 144; 245; 254B; 256; 256B; repealing Minnesota
1.36 Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5,
1.37 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8; Minnesota Statutes 2009 Supplement,
1.38 section 256D.03, subdivision 3; Laws 2009, chapter 79, article 7, section 26,

subdivision 3; Laws 2010, chapter 200, article 1, sections 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9; 18; 19.

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

ARTICLE 1

DHS LICENSING

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

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

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

(c) Except as provided under paragraph (e), if the individual was disqualified based on a conviction of, admission to, or Alford Plea to any crimes listed in section 245C.15, subdivisions 1 to 4, or for a disqualification under section 256.98, subdivision 8, the reconsideration decision under section 245C.22 is the final agency determination for purposes of appeal by the disqualified individual and is not subject to a hearing under section 256.045. If the individual was disqualified based on a judicial determination, that determination is treated the same as a conviction for purposes of appeal.

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

(e) Notwithstanding paragraph (c), if the commissioner does not set aside a disqualification of an individual who was disqualified based on both a preponderance of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245C.29. The scope of the hearing conducted under section 256.045 with regard to the

disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case, the reconsideration decision under section 245C.22 is not the final agency decision for purposes of appeal by the disqualified individual.

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

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

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

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

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

Subd. 3. **Employees of public employer.** (a) If the commissioner does not ~~set aside~~ rescind the disqualification of an individual who is an employee of an employer, as defined in section 179A.03, subdivision 15, the individual may request a contested case hearing under chapter 14, unless the disqualification is deemed conclusive under section 245C.29. The request for a contested case hearing must be made in writing and must be postmarked and sent within 30 calendar days after the employee receives notice that the disqualification has not been ~~set aside~~ rescinded. If the individual was disqualified based on a conviction or admission to any crimes listed in section 245C.15, the scope of the contested case hearing shall be limited solely to whether the individual poses a risk of harm pursuant to section 245C.22.

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

(c) If the commissioner does not rescind a disqualification that is based on a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, the scope of the contested case

<u>hearing must include the disqualification decision. In such cases, a fair hearing must not be conducted under section 256.045.</u>

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

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

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

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

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

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

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

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

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

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

5.1 (6) any person to whom a right of appeal according to this section is given by other
5.2 provision of law;
5.3 (7) an applicant aggrieved by an adverse decision to an application for a hardship
5.4 waiver under section 256B.15;
5.5 (8) an applicant aggrieved by an adverse decision to an application or redetermination
5.6 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;
5.7 (9) except as provided under chapter 245A, an individual or facility determined
5.8 to have maltreated a minor under section 626.556, after the individual or facility has
5.9 exercised the right to administrative reconsideration under section 626.556;
5.10 (10) except as provided under chapter 245C, an individual disqualified under
5.11 sections 245C.14 and 245C.15, which has not been ~~set aside~~ rescinded under sections
5.12 245C.22 and 245C.23, on the basis of serious or recurring maltreatment; a preponderance
5.13 of the evidence that the individual has committed an act or acts that meet the definition
5.14 of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make
5.15 reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings
5.16 regarding a maltreatment determination under clause (4) or (9) and a disqualification under
5.17 this clause in which the basis for a disqualification is serious or recurring maltreatment,
5.18 which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, shall be
5.19 consolidated into a single fair hearing. In such cases, the scope of review by the human
5.20 services referee shall include both the maltreatment determination and the disqualification.
5.21 The failure to exercise the right to an administrative reconsideration shall not be a bar to a
5.22 hearing under this section if federal law provides an individual the right to a hearing to
5.23 dispute a finding of maltreatment. Individuals and organizations specified in this section
5.24 may contest the specified action, decision, or final disposition before the state agency by
5.25 submitting a written request for a hearing to the state agency within 30 days after receiving
5.26 written notice of the action, decision, or final disposition, or within 90 days of such written
5.27 notice if the applicant, recipient, patient, or relative shows good cause why the request
5.28 was not submitted within the 30-day time limit; or
5.29 (11) any person with an outstanding debt resulting from receipt of public assistance,
5.30 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
5.31 Department of Human Services or a county agency. The scope of the appeal is the validity
5.32 of the claimant agency's intention to request a setoff of a refund under chapter 270A
5.33 against the debt.
5.34 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or
5.35 (10), is the only administrative appeal to the final agency determination specifically,
5.36 including a challenge to the accuracy and completeness of data under section 13.04.

6.1 Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment
6.2 that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing
6.3 homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a
6.4 contested case proceeding under the provisions of chapter 14. Hearings requested under
6.5 paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after
6.6 July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is
6.7 only available when there is no juvenile court or adult criminal action pending. If such
6.8 action is filed in either court while an administrative review is pending, the administrative
6.9 review must be suspended until the judicial actions are completed. If the juvenile court
6.10 action or criminal charge is dismissed or the criminal action overturned, the matter may be
6.11 considered in an administrative hearing.

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

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

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

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

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

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

6.31 Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative
6.32 reconsideration is not applicable in family assessments since no determination concerning
6.33 maltreatment is made. For investigations, except as provided under paragraph (e), an
6.34 individual or facility that the commissioner of human services, a local social service
6.35 agency, or the commissioner of education determines has maltreated a child, an interested

7.1 person acting on behalf of the child, regardless of the determination, who contests
7.2 the investigating agency's final determination regarding maltreatment, may request the
7.3 investigating agency to reconsider its final determination regarding maltreatment. The
7.4 request for reconsideration must be submitted in writing to the investigating agency within
7.5 15 calendar days after receipt of notice of the final determination regarding maltreatment
7.6 or, if the request is made by an interested person who is not entitled to notice, within
7.7 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the
7.8 request for reconsideration must be postmarked and sent to the investigating agency
7.9 within 15 calendar days of the individual's or facility's receipt of the final determination. If
7.10 the request for reconsideration is made by personal service, it must be received by the
7.11 investigating agency within 15 calendar days after the individual's or facility's receipt of the
7.12 final determination. Effective January 1, 2002, an individual who was determined to have
7.13 maltreated a child under this section and who was disqualified on the basis of serious or
7.14 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
7.15 of the maltreatment determination and the disqualification. The request for reconsideration
7.16 of the maltreatment determination and the disqualification must be submitted within 30
7.17 calendar days of the individual's receipt of the notice of disqualification under sections
7.18 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment
7.19 determination and the disqualification must be postmarked and sent to the investigating
7.20 agency within 30 calendar days of the individual's receipt of the maltreatment
7.21 determination and notice of disqualification. If the request for reconsideration is made by
7.22 personal service, it must be received by the investigating agency within 30 calendar days
7.23 after the individual's receipt of the notice of disqualification.

7.24 (b) Except as provided under paragraphs (e) and (f), if the investigating agency
7.25 denies the request or fails to act upon the request within 15 working days after receiving
7.26 the request for reconsideration, the person or facility entitled to a fair hearing under section
7.27 256.045 may submit to the commissioner of human services or the commissioner of
7.28 education a written request for a hearing under that section. Section 256.045 also governs
7.29 hearings requested to contest a final determination of the commissioner of education. For
7.30 reports involving maltreatment of a child in a facility, an interested person acting on behalf
7.31 of the child may request a review by the Child Maltreatment Review Panel under section
7.32 256.022 if the investigating agency denies the request or fails to act upon the request or
7.33 if the interested person contests a reconsidered determination. The investigating agency
7.34 shall notify persons who request reconsideration of their rights under this paragraph.
7.35 The request must be submitted in writing to the review panel and a copy sent to the
7.36 investigating agency within 30 calendar days of receipt of notice of a denial of a request

8.1 for reconsideration or of a reconsidered determination. The request must specifically
8.2 identify the aspects of the agency determination with which the person is dissatisfied.
8.3 (c) If, as a result of a reconsideration or review, the investigating agency changes
8.4 the final determination of maltreatment, that agency shall notify the parties specified in
8.5 subdivisions 10b, 10d, and 10f.
8.6 (d) Except as provided under paragraph (f), if an individual or facility contests the
8.7 investigating agency's final determination regarding maltreatment by requesting a fair
8.8 hearing under section 256.045, the commissioner of human services shall assure that the
8.9 hearing is conducted and a decision is reached within 90 days of receipt of the request for
8.10 a hearing. The time for action on the decision may be extended for as many days as the
8.11 hearing is postponed or the record is held open for the benefit of either party.
8.12 (e) ~~Effective January 1, 2002,~~ If an individual was disqualified under sections
8.13 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was
8.14 serious or recurring, and the individual has requested reconsideration of the maltreatment
8.15 determination under paragraph (a) and requested reconsideration of the disqualification
8.16 under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and
8.17 reconsideration of the disqualification shall be consolidated into a single reconsideration.
8.18 If reconsideration of the maltreatment determination is denied or the disqualification is not
8.19 ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair
8.20 hearing under section 256.045. If an individual requests a fair hearing on the maltreatment
8.21 determination and the disqualification, the scope of the fair hearing shall include both the
8.22 maltreatment determination and the disqualification.
8.23 (f) ~~Effective January 1, 2002,~~ If a maltreatment determination or a disqualification
8.24 based on serious or recurring maltreatment is the basis for a denial of a license under
8.25 section 245A.05 or a licensing sanction under section 245A.07, the license holder has the
8.26 right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505
8.27 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the
8.28 contested case hearing shall include the maltreatment determination, disqualification,
8.29 and licensing sanction or denial of a license. In such cases, a fair hearing regarding
8.30 the maltreatment determination and disqualification shall not be conducted under
8.31 section 256.045. Except for family child care and child foster care, reconsideration of a
8.32 maltreatment determination as provided under this subdivision, and reconsideration of a
8.33 disqualification as provided under section 245C.22, shall also not be conducted when:
8.34 (1) a denial of a license under section 245A.05 or a licensing sanction under section
8.35 245A.07, is based on a determination that the license holder is responsible for maltreatment
8.36 or the disqualification of a license holder based on serious or recurring maltreatment;

9.1 (2) the denial of a license or licensing sanction is issued at the same time as the
9.2 maltreatment determination or disqualification; and
9.3 (3) the license holder appeals the maltreatment determination or disqualification, and
9.4 denial of a license or licensing sanction.
9.5 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
9.6 determination or disqualification, but does not appeal the denial of a license or a licensing
9.7 sanction, reconsideration of the maltreatment determination shall be conducted under
9.8 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
9.9 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
9.10 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
9.11 626.557, subdivision 9d.
9.12 If the disqualified subject is an individual other than the license holder and upon
9.13 whom a background study must be conducted under chapter 245C, the hearings of all
9.14 parties may be consolidated into a single contested case hearing upon consent of all parties
9.15 and the administrative law judge.
9.16 (g) For purposes of this subdivision, "interested person acting on behalf of the
9.17 child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult
9.18 stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been
9.19 determined to be the perpetrator of the maltreatment.

9.20 Sec. 6. Minnesota Statutes 2008, section 626.557, subdivision 9d, is amended to read:
9.21 Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided
9.22 under paragraph (e), any individual or facility which a lead agency determines has
9.23 maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on
9.24 behalf of the vulnerable adult, regardless of the lead agency's determination, who contests
9.25 the lead agency's final disposition of an allegation of maltreatment, may request the
9.26 lead agency to reconsider its final disposition. The request for reconsideration must be
9.27 submitted in writing to the lead agency within 15 calendar days after receipt of notice of
9.28 final disposition or, if the request is made by an interested person who is not entitled to
9.29 notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable
9.30 adult's legal guardian. If mailed, the request for reconsideration must be postmarked and
9.31 sent to the lead agency within 15 calendar days of the individual's or facility's receipt of
9.32 the final disposition. If the request for reconsideration is made by personal service, it must
9.33 be received by the lead agency within 15 calendar days of the individual's or facility's
9.34 receipt of the final disposition. An individual who was determined to have maltreated a
9.35 vulnerable adult under this section and who was disqualified on the basis of serious or

10.1 recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration
10.2 of the maltreatment determination and the disqualification. The request for reconsideration
10.3 of the maltreatment determination and the disqualification must be submitted in writing
10.4 within 30 calendar days of the individual's receipt of the notice of disqualification
10.5 under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of
10.6 the maltreatment determination and the disqualification must be postmarked and sent
10.7 to the lead agency within 30 calendar days of the individual's receipt of the notice of
10.8 disqualification. If the request for reconsideration is made by personal service, it must be
10.9 received by the lead agency within 30 calendar days after the individual's receipt of the
10.10 notice of disqualification.

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

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

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

10.32 (e) If an individual was disqualified under sections 245C.14 and 245C.15, on
10.33 the basis of a determination of maltreatment, which was serious or recurring, and
10.34 the individual has requested reconsideration of the maltreatment determination under
10.35 paragraph (a) and reconsideration of the disqualification under sections 245C.21 to
10.36 245C.27, reconsideration of the maltreatment determination and requested reconsideration

11.1 of the disqualification shall be consolidated into a single reconsideration. If reconsideration
11.2 of the maltreatment determination is denied or if the disqualification is not ~~set aside~~
11.3 rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing
11.4 under section 256.045. If an individual requests a fair hearing on the maltreatment
11.5 determination and the disqualification, the scope of the fair hearing shall include both the
11.6 maltreatment determination and the disqualification.

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

11.17 (1) a denial of a license under section 245A.05, or a licensing sanction under section
11.18 245A.07, is based on a determination that the license holder is responsible for maltreatment
11.19 or the disqualification of a license holder based on serious or recurring maltreatment;

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

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

11.24 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
11.25 determination or disqualification, but does not appeal the denial of a license or a licensing
11.26 sanction, reconsideration of the maltreatment determination shall be conducted under
11.27 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
11.28 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
11.29 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
11.30 626.557, subdivision 9d.

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

11.35 (g) Until August 1, 2002, an individual or facility that was determined by the
11.36 commissioner of human services or the commissioner of health to be responsible for

12.1 neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August
12.2 1, 2001, that believes that the finding of neglect does not meet an amended definition of
12.3 neglect may request a reconsideration of the determination of neglect. The commissioner
12.4 of human services or the commissioner of health shall mail a notice to the last known
12.5 address of individuals who are eligible to seek this reconsideration. The request for
12.6 reconsideration must state how the established findings no longer meet the elements of
12.7 the definition of neglect. The commissioner shall review the request for reconsideration
12.8 and make a determination within 15 calendar days. The commissioner's decision on this
12.9 reconsideration is the final agency action.
12.10 (1) For purposes of compliance with the data destruction schedule under subdivision
12.11 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as
12.12 a result of a reconsideration under this paragraph, the date of the original finding of a
12.13 substantiated maltreatment must be used to calculate the destruction date.
12.14 (2) For purposes of any background studies under chapter 245C, when a
12.15 determination of substantiated maltreatment has been changed as a result of a
12.16 reconsideration under this paragraph, any prior disqualification of the individual under
12.17 chapter 245C that was based on this determination of maltreatment shall be rescinded,
12.18 and for future background studies under chapter 245C the commissioner must not use the
12.19 previous determination of substantiated maltreatment as a basis for disqualification or as a
12.20 basis for referring the individual's maltreatment history to a health-related licensing board
12.21 under section 245C.31.

12.22 **ARTICLE 2**

12.23 **HEALTH CARE**

12.24 Section 1. Minnesota Statutes 2008, section 144.291, subdivision 2, is amended to read:
12.25 Subd. 2. **Definitions.** For the purposes of sections 144.291 to 144.298, the following
12.26 terms have the meanings given.
12.27 (a) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.
12.28 (b) "Health information exchange" means a legal arrangement between health care
12.29 providers and group purchasers to enable and oversee the business and legal issues
12.30 involved in the electronic exchange of health records between the entities for the delivery
12.31 of patient care.
12.32 (c) "Health record" means any information, whether oral or recorded in any form or
12.33 medium, that relates to the past, present, or future physical or mental health or condition of
12.34 a patient; the provision of health care to a patient; or the past, present, or future payment
12.35 for the provision of health care to a patient.

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

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

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

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

(h) "Provider" means:

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

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

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

14.10 Sec. 3. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:
14.11 Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a)
14.12 Effective October 1, 1992, each health maintenance organization with a certificate of
14.13 authority issued by the commissioner of health under chapter 62D and each community
14.14 integrated service network licensed by the commissioner under chapter 62N shall pay to
14.15 the commissioner of human services a surcharge equal to six-tenths of one percent of the
14.16 total premium revenues of the health maintenance organization or community integrated
14.17 service network as reported to the commissioner of health according to the schedule in
14.18 subdivision 4.
14.19 (b) Effective June 1, 2010: (1) the surcharge under paragraph (a) is increased to 3.0
14.20 percent; and (2) each county-based purchasing plan authorized under section 256B.692
14.21 shall pay to the commissioner a surcharge equal to 3.0 percent of the total premium
14.22 revenues of the plan, as reported to the commissioner of health, according to the payment
14.23 schedule in subdivision 4.
14.24 (c) For purposes of this subdivision, total premium revenue means:
14.25 (1) premium revenue recognized on a prepaid basis from individuals and groups
14.26 for provision of a specified range of health services over a defined period of time which
14.27 is normally one month, excluding premiums paid to a health maintenance organization
14.28 or community integrated service network from the Federal Employees Health Benefit
14.29 Program;
14.30 (2) premiums from Medicare wrap-around subscribers for health benefits which
14.31 supplement Medicare coverage;
14.32 (3) Medicare revenue, as a result of an arrangement between a health maintenance
14.33 organization or a community integrated service network and the Centers for Medicare
14.34 and Medicaid Services of the federal Department of Health and Human Services, for
14.35 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited

from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

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

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

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

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

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

16.5 Sec. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is
16.6 amended to read:
16.7 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
16.8 assistance program must not be submitted until the recipient is discharged. However,
16.9 the commissioner shall establish monthly interim payments for inpatient hospitals that
16.10 have individual patient lengths of stay over 30 days regardless of diagnostic category.
16.11 Except as provided in section 256.9693, medical assistance reimbursement for treatment
16.12 of mental illness shall be reimbursed based on diagnostic classifications. Individual
16.13 hospital payments established under this section and sections 256.9685, 256.9686, and
16.14 256.9695, in addition to third party and recipient liability, for discharges occurring during
16.15 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
16.16 inpatient services paid for the same period of time to the hospital. This payment limitation
16.17 shall be calculated separately for medical assistance and general assistance medical
16.18 care services. The limitation on general assistance medical care shall be effective for
16.19 admissions occurring on or after July 1, 1991. Services that have rates established under
16.20 subdivision 11 or 12, must be limited separately from other services. After consulting with
16.21 the affected hospitals, the commissioner may consider related hospitals one entity and
16.22 may merge the payment rates while maintaining separate provider numbers. The operating
16.23 and property base rates per admission or per day shall be derived from the best Medicare
16.24 and claims data available when rates are established. The commissioner shall determine
16.25 the best Medicare and claims data, taking into consideration variables of recency of the
16.26 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
16.27 The commissioner shall notify hospitals of payment rates by December 1 of the year
16.28 preceding the rate year. The rate setting data must reflect the admissions data used to
16.29 establish relative values. Base year changes from 1981 to the base year established for the
16.30 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
16.31 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
16.32 1. The commissioner may adjust base year cost, relative value, and case mix index data
16.33 to exclude the costs of services that have been discontinued by the October 1 of the year
16.34 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
16.35 that encompass portions of two or more rate years shall have payments established based

17.1 on payment rates in effect at the time of admission unless the date of admission preceded
17.2 the rate year in effect by six months or more. In this case, operating payment rates for
17.3 services rendered during the rate year in effect and established based on the date of
17.4 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

17.13 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
17.14 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
17.15 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
17.16 from the current statutory rates. Mental health services within diagnosis related groups
17.17 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
17.18 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
17.19 assistance does not include general assistance medical care. Payments made to managed
17.20 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
17.21 this reduction.

17.22 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
17.23 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
17.24 to hospitals for inpatient services before third-party liability and spenddown, is reduced
17.25 3.46 percent from the current statutory rates. Mental health services with diagnosis related
17.26 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
17.27 paragraph. Payments made to managed care plans shall be reduced for services provided
17.28 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

17.29 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
17.30 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made
17.31 to hospitals for inpatient services before third-party liability and spenddown, is reduced
17.32 1.9 percent from the current statutory rates. Mental health services with diagnosis related
17.33 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
17.34 paragraph. Payments made to managed care plans shall be reduced for services provided
17.35 on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

18.1 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
18.2 for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for
18.3 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
18.4 from the current statutory rates. Mental health services with diagnosis related groups
18.5 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
18.6 Payments made to managed care plans shall be reduced for services provided on or after
18.7 July 1, 2010, to reflect this reduction.

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

18.14 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
18.15 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
18.16 hospitals for inpatient services before third-party liability and spenddown, is reduced
18.17 seven percent from the current statutory rates. Facilities defined under subdivision 16 are
18.18 excluded from this paragraph. Payments made to managed care plans shall be reduced
18.19 for services provided on or after January 1, 2012, to reflect this reduction. Hospitals that,
18.20 prior to December 31, 2007, received payment to support the training of residents from an
18.21 approved graduate medical residency training program pursuant to United States Code,
18.22 title 42, section 256e, are not subject to the provisions of this paragraph.

18.23 Sec. 5. Minnesota Statutes 2008, section 256B.04, subdivision 14, is amended to read:

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

18.28 (1) eyeglasses;

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

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

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

18.34 (i) hospital beds;

18.35 (ii) commodes;

19.1 (iii) glide-about chairs;
19.2 (iv) patient lift apparatus;
19.3 (v) wheelchairs and accessories;
19.4 (vi) oxygen administration equipment;
19.5 (vii) respiratory therapy equipment;
19.6 (viii) electronic diagnostic, therapeutic and life-support systems;
19.7 (5) nonemergency medical transportation level of need determinations, disbursement
19.8 of public transportation passes and tokens, and volunteer and recipient mileage and
19.9 parking reimbursements; ~~and~~
19.10 (6) drugs; and
19.11 (7) medical supplies.
19.12 (b) Rate changes under this chapter and chapters 256D and 256L do not affect
19.13 contract payments under this subdivision unless specifically identified.
19.14 (c) The commissioner may not utilize volume purchase through competitive bidding
19.15 and negotiation for special transportation services under the provisions of chapter 16C.

19.16 Sec. 6. Minnesota Statutes 2008, section 256B.055, is amended by adding a
19.17 subdivision to read:
19.18 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
19.19 who is over age 21 and under age 65, who is not pregnant, and who is not described in
19.20 subdivision 4, 7, or another subdivision of this section.

19.21 **EFFECTIVE DATE.** This section is effective upon federal approval and is
19.22 retroactive from April 1, 2010.

19.23 Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:
19.24 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under
19.25 section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of
19.26 the federal poverty guidelines. Effective January 1, 2000, and each successive January,
19.27 recipients of supplemental security income may have an income up to the supplemental
19.28 security income standard in effect on that date.
19.29 (b) To be eligible for medical assistance, families and children may have an income
19.30 up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,
19.31 AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,
19.32 1996, shall be increased by three percent.
19.33 (c) Effective July 1, 2002, to be eligible for medical assistance, families and children
19.34 may have an income up to 100 percent of the federal poverty guidelines for the family size.

20.1 (d) In computing income to determine eligibility of persons under paragraphs (a)
20.2 to (c) and (e) who are not residents of long-term care facilities, the commissioner shall
20.3 disregard increases in income as required by Public Law Numbers 94-566, section 503;
20.4 99-272; and 99-509. Veterans aid and attendance benefits and Veterans Administration
20.5 unusual medical expense payments are considered income to the recipient.

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

20.9 **EFFECTIVE DATE.** This section is effective upon federal approval and is
20.10 retroactive from April 1, 2010.

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

20.12 Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related
20.13 services~~, including specialized maintenance therapy~~. Authorization by the commissioner
20.14 is required to provide services to a recipient beyond any of the following onetime service
20.15 thresholds: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality
20.16 sessions; and (3) three evaluations or reevaluations. Services provided by a physical
20.17 therapy assistant shall be reimbursed at the same rate as services performed by a physical
20.18 therapist when the services of the physical therapy assistant are provided under the
20.19 direction of a physical therapist who is on the premises. Services provided by a physical
20.20 therapy assistant that are provided under the direction of a physical therapist who is not on
20.21 the premises shall be reimbursed at 65 percent of the physical therapist rate.

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

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

21.1 Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 8b, is amended to
21.2 read:
21.3 Subd. 8b. **Speech language pathology and audiology services.** Medical assistance
21.4 covers speech language pathology and related services~~, including specialized maintenance~~
21.5 ~~therapy~~. Authorization by the commissioner is required to provide services to a recipient
21.6 beyond any of the following onetime service thresholds: (1) 50 treatment sessions with
21.7 any combination of approved CPT codes; and (2) one evaluation. Medical assistance
21.8 covers audiology services and related services. Services provided by a person who has
21.9 been issued a temporary registration under section 148.5161 shall be reimbursed at the
21.10 same rate as services performed by a speech language pathologist or audiologist as long as
21.11 the requirements of section 148.5161, subdivision 3, are met.

21.12 Sec. 11. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
21.13 subdivision to read:
21.14 Subd. 8d. **Chiropractic services.** Payment for chiropractic services is limited to
21.15 one annual evaluation and 12 visits per year unless prior authorization of a greater number
21.16 of visits is obtained.

21.17 Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9,
21.18 is amended to read:
21.19 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.
21.20 (b) Medical assistance dental coverage for nonpregnant adults is limited to the
21.21 following services:
21.22 (1) comprehensive exams, limited to once every five years;
21.23 (2) periodic exams, limited to one per year;
21.24 (3) limited exams;
21.25 (4) bitewing x-rays, limited to one set per year;
21.26 (5) periapical x-rays;
21.27 (6) panoramic x-rays or full-mouth radiographs, limited to one every five years,
21.28 and only if provided in conjunction with a posterior extraction or scheduled outpatient
21.29 facility procedure, or as medically necessary for the diagnosis and follow-up of oral and
21.30 maxillofacial pathology and trauma. Panoramic x-rays may be taken once every two years
21.31 for patients who cannot cooperate for intraoral film due to a developmental disability or
21.32 medical condition that does not allow for intraoral film placement;
21.33 (7) prophylaxis, limited to one per year;
21.34 (8) application of fluoride varnish, limited to one per year;

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

22.2 (10) anterior fillings;

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

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

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

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

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

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

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

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

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

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

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

22.28 (2) general anesthesia; and

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

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

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

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

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

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

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective ~~July 1, 2009~~ July 1, 2010, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus ~~15~~ 12.5 percent or wholesale acquisition cost plus 5.0 percent, whichever is lower. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus ~~30~~ 28.12 percent or wholesale acquisition cost minus 13.76 percent, whichever is lower. Average wholesale price is defined as the price for a drug product listed as the average wholesale price in the commissioner's primary reference source. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the

24.1 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
24.2 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
24.3 will be required to credit the department for the actual acquisition cost of all unused
24.4 drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the
24.5 manufacturer's unopened package. The commissioner may permit the drug clozapine to be
24.6 dispensed in a quantity that is less than a 30-day supply.

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

24.10 (d) The basis for determining the amount of payment for drugs administered in an
24.11 outpatient setting shall be the lower of the usual and customary cost submitted by the
24.12 provider or the amount established for Medicare by the United States Department of
24.13 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
24.14 Security Act.

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

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

24.34 Sec. 14. Minnesota Statutes 2008, section 256B.0625, subdivision 18a, is amended to
24.35 read:

25.1 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
25.2 meals for persons traveling to receive medical care may not exceed $5.50 for breakfast,
25.3 $6.50 for lunch, or $8 for dinner.
25.4 (b) Medical assistance reimbursement for lodging for persons traveling to receive
25.5 medical care may not exceed $50 per day unless prior authorized by the local agency.
25.6 (c) Medical assistance direct mileage reimbursement to the eligible person or the
25.7 eligible person's driver may not exceed 20 cents per mile.
25.8 (d) Regardless of the number of employees that an enrolled health care provider
25.9 may have, medical assistance covers sign and oral language interpreter services when
25.10 provided by an enrolled health care provider during the course of providing a direct,
25.11 person-to-person covered health care service to an enrolled recipient with limited English
25.12 proficiency or who has a hearing loss and uses interpreting services. Coverage for oral
25.13 language interpreter services shall be provided only if the oral language interpreter used
25.14 by the enrolled health care provider is listed in the registry or roster established under
25.15 section 144.058.

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

25.17 Sec. 15. Minnesota Statutes 2008, section 256B.0625, subdivision 31, is amended to
25.18 read:
25.19 Subd. 31. **Medical supplies and equipment.** Medical assistance covers medical
25.20 supplies and equipment. Separate payment outside of the facility's payment rate shall
25.21 be made for wheelchairs and wheelchair accessories for recipients who are residents
25.22 of intermediate care facilities for the developmentally disabled. Reimbursement for
25.23 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
25.24 conditions and limitations as coverage for recipients who do not reside in institutions. A
25.25 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
25.26 The commissioner may set reimbursement rates for specified categories of medical
25.27 supplies at levels below the Medicare payment rate.

25.28 Sec. 16. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
25.29 subdivision to read:
25.30 Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers
25.31 services provided in a birth center licensed under section 144.615 by a licensed health
25.32 professional if the service would otherwise be covered if provided in a hospital.
25.33 (b) Facility services provided by a birth center shall be paid at the lower of billed
25.34 charges or 70 percent of the statewide average for a facility payment rate made to a

26.1 hospital for an uncomplicated vaginal birth as determined using the most recent calendar
26.2 year for which complete claims data is available. If a recipient is transported from a birth
26.3 center to a hospital prior to the delivery, the payment for facility services to the birth center
26.4 shall be the lower of billed charges or 15 percent of the average facility payment made to a
26.5 hospital for the services provided for an uncomplicated vaginal delivery as determined
26.6 using the most recent calendar year for which complete claims data is available.
26.7 (c) Professional services provided by traditional midwives licensed under chapter
26.8 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a
26.9 physician performing the same services. If a recipient is transported from a birth center to
26.10 a hospital prior to the delivery, a licensed traditional midwife who does not perform the
26.11 delivery may not bill for any delivery services. Services are not covered if provided by an
26.12 unlicensed traditional midwife.
26.13 (d) The commissioner shall apply for any necessary waivers from the Centers for
26.14 Medicare and Medicaid Services to allow birth centers and birth center providers to be
26.15 reimbursed.

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

26.18 Sec. 17. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to
26.19 read:
26.20 Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical
26.21 assistance benefit plan shall include the following co-payments for all recipients, effective
26.22 for services provided on or after October 1, 2003, and before January 1, 2009:
26.23 (1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an
26.24 episode of service which is required because of a recipient's symptoms, diagnosis, or
26.25 established illness, and which is delivered in an ambulatory setting by a physician or
26.26 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
26.27 audiologist, optician, or optometrist;
26.28 (2) $3 for eyeglasses;
26.29 (3) $6 for nonemergency visits to a hospital-based emergency room; and
26.30 (4) $3 per brand-name drug prescription and $1 per generic drug prescription,
26.31 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
26.32 shall apply to antipsychotic drugs when used for the treatment of mental illness.
26.33 (b) Except as provided in subdivision 2, the medical assistance benefit plan shall
26.34 include the following co-payments for all recipients, effective for services provided on
26.35 or after January 1, 2009:

27.1 (1) ~~$6~~ $3.50 for nonemergency visits to a hospital-based emergency room;
27.2 (2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject
27.3 to a ~~$7~~ $12 per month maximum for prescription drug co-payments. No co-payments shall
27.4 apply to antipsychotic drugs when used for the treatment of mental illness; and
27.5 (3) for individuals identified by the commissioner with income at or below 100
27.6 percent of the federal poverty guidelines, total monthly co-payments must not exceed five
27.7 percent of family income. For purposes of this paragraph, family income is the total
27.8 earned and unearned income of the individual and the individual's spouse, if the spouse is
27.9 enrolled in medical assistance and also subject to the five percent limit on co-payments.
27.10 (c) Recipients of medical assistance are responsible for all co-payments in this
27.11 subdivision.

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

27.16 Sec. 18. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to
27.17 read:
27.18 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider
27.19 shall be reduced by the amount of the co-payment, except that reimbursements shall
27.20 not be reduced:
27.21 (1) once a recipient has reached the $12 per month maximum ~~or the $7 per month~~
27.22 ~~maximum effective January 1, 2009,~~ for prescription drug co-payments; or
27.23 (2) for a recipient identified by the commissioner under 100 percent of the federal
27.24 poverty guidelines who has met their monthly five percent co-payment limit.
27.25 (b) The provider collects the co-payment from the recipient. Providers may not deny
27.26 services to recipients who are unable to pay the co-payment.
27.27 (c) Medical assistance reimbursement to fee-for-service providers and payments to
27.28 managed care plans shall not be increased as a result of the removal of ~~the~~ co-payments
27.29 effective on or after January 1, 2009.

27.30 Sec. 19. Minnesota Statutes 2008, section 256B.0644, as amended by Laws 2010,
27.31 chapter 200, article 1, section 6, is amended to read:

27.32 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
27.33 **PROGRAMS.**

28.1 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
28.2 health maintenance organization, as defined in chapter 62D, must participate as a provider
28.3 or contractor in the medical assistance program, general assistance medical care program,
28.4 and MinnesotaCare as a condition of participating as a provider in health insurance plans
28.5 and programs or contractor for state employees established under section 43A.18, the
28.6 public employees insurance program under section 43A.316, for health insurance plans
28.7 offered to local statutory or home rule charter city, county, and school district employees,
28.8 the workers' compensation system under section 176.135, and insurance plans provided
28.9 through the Minnesota Comprehensive Health Association under sections 62E.01 to
28.10 62E.19. The limitations on insurance plans offered to local government employees shall
28.11 not be applicable in geographic areas where provider participation is limited by managed
28.12 care contracts with the Department of Human Services.

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

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

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

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

28.33 (c) Patients seen on a volunteer basis by the provider at a location other than
28.34 the provider's usual place of practice may be considered in meeting the participation
28.35 requirement in this section. The commissioner shall establish participation requirements
28.36 for health maintenance organizations. The commissioner shall provide lists of participating

29.1 medical assistance providers on a quarterly basis to the commissioner of management and
29.2 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
29.3 of the commissioners shall develop and implement procedures to exclude as participating
29.4 providers in the program or programs under their jurisdiction those providers who do
29.5 not participate in the medical assistance program. The commissioner of management
29.6 and budget shall implement this section through contracts with participating health and
29.7 dental carriers.

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

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

29.16 **EFFECTIVE DATE.** The amendment striking the existing paragraph (d) is effective
29.17 30 days after federal approval of the amendments in this article to Minnesota Statutes,
29.18 sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011,
29.19 whichever is later. The amendment to the new paragraph (d) is effective June 1, 2010.

29.20 Sec. 20. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5,
29.21 is amended to read:

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

29.25 (b) Home care therapies must be:

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

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

29.30 (3) assessed by an appropriate therapist; and

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

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

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

30.3 Sec. 21. **[256B.0755] PAYMENT REFORM DEMONSTRATION PROJECT FOR**
30.4 **SPECIAL PATIENT POPULATIONS.**

30.5 Subdivision 1. **Demonstration project.** (a) The commissioner of human services,
30.6 in consultation with the commissioner of health, shall establish a payment reform
30.7 demonstration project implementing an alternative payment system for health care
30.8 providers serving an identified group of patients who are enrolled in a state health
30.9 care program, and are either high utilizers of high-cost health care services or have
30.10 characteristics that put them at high risk of becoming high utilizers. The purpose of the
30.11 demonstration project is to implement and evaluate methods of reducing hospitalizations,
30.12 emergency room use, high-cost medications and specialty services, admissions to nursing
30.13 facilities, or use of long-term home and community-based services, in order to reduce the
30.14 total cost of care and services for the patients.

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

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

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

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

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

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

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

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

31.1 (5) the implementation of a risk adjustment mechanism to adjust for factors that are
31.2 beyond the control of the provider including nonclinical factors that will affect the cost
31.3 or outcomes of treatment;
31.4 (6) the payment reforms and payment methods to be used under the project, which
31.5 may include but are not limited to adjustments in fee-for-service payments, payment of
31.6 care coordination fees, payments for start-up and implementation costs to be recovered or
31.7 repaid later in the project, payments adjusted based on a provider's proportion of patients
31.8 who are enrolled in state health care programs; payments adjusted for the clinical or
31.9 socioeconomic complexity of the patients served, payment incentives tied to use of
31.10 inpatient and emergency room services, and periodic settle-up adjustments;
31.11 (7) methods of sharing financial risk and benefit between the commissioner and
31.12 the provider or groups of providers, which may include but are not limited to stop-loss
31.13 arrangements to cover high-cost outlier cases or costs that are beyond the control of the
31.14 provider, and risk-sharing and benefit-sharing corridors; and
31.15 (8) performance and outcome benchmarks to be used to measure performance,
31.16 achievement of cost-savings targets, and quality of care provided.
31.17 (b) A provider or group of providers may submit a proposal for a demonstration
31.18 project in partnership with a health maintenance organization or county-based purchasing
31.19 plan for the purposes of sharing risk, claims processing, or administration of the project,
31.20 or to extend participation in the project to persons who are enrolled in prepaid health
31.21 care programs.
31.22 Subd. 3. **Total cost of care agreement.** Based on negotiations, the commissioner
31.23 must enter into an agreement with interested and eligible providers or groups of providers
31.24 to implement projects that are designed to reduce the total cost of care for the identified
31.25 patients. To the extent possible, the projects shall begin implementation on January 1,
31.26 2011, or upon federal approval, whichever is later.
31.27 Subd. 4. **Eligibility.** To be eligible to participate, providers or groups of providers
31.28 must meet certification standards for health care homes established by the Department of
31.29 Health and the Department of Human Services under section 256B.0751.
31.30 Subd. 5. **Alternative payments.** The commissioner shall seek all federal waivers
31.31 and approvals necessary to implement this section and to obtain federal matching funds. To
31.32 the extent authorized by federal law, the commissioner may waive existing fee-for-service
31.33 payment rates, provider contract or performance requirements, consumer incentive
31.34 policies, or other requirements in statute or rule in order to allow the providers or groups
31.35 of providers to utilize alternative payment and financing methods that will appropriately
31.36 fund necessary and cost-effective primary care and care coordination services; establish

32.1 appropriate incentives for prevention, health promotion, and care coordination; and
32.2 mitigate financial harm to participating providers caused by the successful reduction in
32.3 preventable hospitalization, emergency room use, and other costly services.

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

32.9 Sec. 22. **[256B.0757] INTENSIVE CARE MANAGEMENT PROGRAM.**

32.10 Subdivision 1. **Report.** The commissioner shall review medical assistance
32.11 enrollment and by July 1, 2011, present a report to the legislature that describes the
32.12 common characteristics and costs of those enrollees age 18 and over whose annual medical
32.13 costs are greater than 95 percent of all other enrollees, using deidentified data.

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

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

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

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

33.1 (3) provide estimates of cost savings to the state and the evidence supporting these
33.2 estimates;
33.3 (4) describe the extent to which the intensive care management program is consistent
33.4 with and builds upon current state health care home, care coordination, and payment
33.5 reform initiatives; and
33.6 (5) meet quality assurance, data reporting, and other criteria specified by the
33.7 commissioner in the request for proposals.

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

33.9 Sec. 23. Minnesota Statutes 2008, section 256B.19, subdivision 1c, is amended to read:
33.10 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall
33.11 be responsible for a monthly transfer payment of $1,500,000, due before noon on the
33.12 15th of each month and the University of Minnesota shall be responsible for a monthly
33.13 transfer payment of $500,000 due before noon on the 15th of each month, beginning July
33.14 15, 1995. These sums shall be part of the designated governmental unit's portion of the
33.15 nonfederal share of medical assistance costs.
33.16 (b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall
33.17 be $2,066,000 each month.
33.18 (c) Beginning July 1, 2001, the commissioner shall increase annual capitation
33.19 payments to the metropolitan health plan under section 256B.69 for the prepaid medical
33.20 assistance program by approximately ~~$3,400,000, plus any available federal matching~~
33.21 ~~funds,~~ $6,800,000 to recognize higher than average medical education costs.
33.22 (d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a)
33.23 and (b) shall be reduced to $566,000, and the University of Minnesota's payment under
33.24 paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 30, 2010,
33.25 Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective
33.26 January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be
33.27 $566,000.
33.28 (e) Notwithstanding paragraph (d), upon federal enactment of an extension to June
33.29 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally
33.30 provided under Public Law 111-5, for the six-month period from January 1, 2011, to June
33.31 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

33.32 Sec. 24. Minnesota Statutes 2008, section 256B.69, is amended by adding a
33.33 subdivision to read:

34.1 Subd. 5k. **Payment rate modification.** For services rendered on or after August
34.2 1, 2010, the total payment made to managed care and county-based purchasing plans
34.3 under the medical assistance program and under MinnesotaCare for families with children
34.4 shall be increased by 1.4 percent.

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

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

34.8 Subd. 5l. **Payment reduction.** For services rendered on or after January 1, 2011,
34.9 the total payment made to managed care plans for providing covered services under
34.10 the medical assistance, general assistance medical care, and MinnesotaCare programs
34.11 is reduced by one percent from their current statutory rates. This provision excludes
34.12 payments for nursing home services, home and community-based waivers, home care
34.13 services covered under section 256B.0651, subdivision 2, payments to demonstration
34.14 projects for persons with disabilities, and mental health services added as covered benefits
34.15 after December 31, 2007.

34.16 Sec. 26. Minnesota Statutes 2008, section 256B.69, subdivision 20, as amended by
34.17 Laws 2010, chapter 200, article 1, section 10, is amended to read:

34.18 Subd. 20. **Ombudsperson.** ~~(a)~~ The commissioner shall designate an ombudsperson
34.19 to advocate for persons required to enroll in prepaid health plans under this section. The
34.20 ombudsperson shall advocate for recipients enrolled in prepaid health plans through
34.21 complaint and appeal procedures and ensure that necessary medical services are provided
34.22 either by the prepaid health plan directly or by referral to appropriate social services. At
34.23 the time of enrollment in a prepaid health plan, the local agency shall inform recipients
34.24 about the ombudsperson program and their right to a resolution of a complaint by the
34.25 prepaid health plan if they experience a problem with the plan or its providers.

34.26 ~~(b) The commissioner shall designate an ombudsperson to advocate for persons~~
34.27 ~~enrolled in a care coordination delivery system under section 256D.031. The~~
34.28 ~~ombudsperson shall advocate for recipients enrolled in a care coordination delivery~~
34.29 ~~system through the state appeal process and assist enrollees in accessing necessary~~
34.30 ~~medical services through the care coordination delivery systems directly or by referral to~~
34.31 ~~appropriate services. At the time of enrollment in a care coordination delivery system, the~~
34.32 ~~local agency shall inform recipients about the ombudsperson program.~~

EFFECTIVE DATE. This section is effective 30 days after federal approval of the amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later.

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2008, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal

36.1 maximum allowable payment. Services for which there is a federal maximum allowable
36.2 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
36.3 allowable payment. Total aggregate payment for outpatient hospital facility fee services
36.4 shall not exceed the Medicare upper limit. If it is determined that a provision of this
36.5 section conflicts with existing or future requirements of the United States government with
36.6 respect to federal financial participation in medical assistance, the federal requirements
36.7 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
36.8 avoid reduced federal financial participation resulting from rates that are in excess of
36.9 the Medicare upper limitations.

36.10 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
36.11 ambulatory surgery hospital facility fee services for critical access hospitals designated
36.12 under section 144.1483, clause (10), shall be paid on a cost-based payment system that is
36.13 based on the cost-finding methods and allowable costs of the Medicare program.

36.14 (c) Effective for services provided on or after July 1, 2003, rates that are based
36.15 on the Medicare outpatient prospective payment system shall be replaced by a budget
36.16 neutral prospective payment system that is derived using medical assistance data. The
36.17 commissioner shall provide a proposal to the 2003 legislature to define and implement
36.18 this provision.

36.19 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
36.20 before third-party liability and spenddown, made to hospitals for outpatient hospital
36.21 facility services is reduced by .5 percent from the current statutory rate.

36.22 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
36.23 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
36.24 facility services before third-party liability and spenddown, is reduced five percent from
36.25 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
36.26 excluded from this paragraph.

36.27 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
36.28 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
36.29 hospital facility services before third-party liability and spenddown, is reduced three
36.30 percent from the current statutory rates. Mental health services and facilities defined under
36.31 section 256.969, subdivision 16, are excluded from this paragraph.

36.32 (g) Notwithstanding any contrary provision in this section, payment for all outpatient
36.33 and emergency services provided by any hospital that, prior to December 31, 2007, has
36.34 received payment to support the training of residents from an approved graduate medical
36.35 residency training program under United States Code, title 42, section 256e, must be paid

37.1 for fiscal years 2012 and 2013 an additional $7,000,000. Payment rates for subsequent
37.2 fiscal years are as follows:
37.3 (1) 2014: 50 percent of costs;
37.4 (2) 2015: 60 percent of costs;
37.5 (3) 2016: 70 percent of costs;
37.6 (4) 2017: 80 percent of costs;
37.7 (5) 2018: 90 percent of costs; and
37.8 (6) 2019 and thereafter: 100 percent of costs.

37.9 Sec. 30. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is
37.10 amended to read:
37.11 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
37.12 or after October 1, 1992, the commissioner shall make payments for physician services
37.13 as follows:
37.14 (1) payment for level one Centers for Medicare and Medicaid Services' common
37.15 procedural coding system codes titled "office and other outpatient services," "preventive
37.16 medicine new and established patient," "delivery, antepartum, and postpartum care,"
37.17 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
37.18 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
37.19 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
37.20 30, 1992. If the rate on any procedure code within these categories is different than the
37.21 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
37.22 then the larger rate shall be paid;
37.23 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
37.24 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and
37.25 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
37.26 percentile of 1989, less the percent in aggregate necessary to equal the above increases
37.27 except that payment rates for home health agency services shall be the rates in effect
37.28 on September 30, 1992.
37.29 (b) Effective for services rendered on or after January 1, 2000, payment rates for
37.30 physician and professional services shall be increased by three percent over the rates
37.31 in effect on December 31, 1999, except for home health agency and family planning
37.32 agency services. The increases in this paragraph shall be implemented January 1, 2000,
37.33 for managed care.
37.34 (c) Effective for services rendered on or after July 1, 2009, payment rates for
37.35 physician and professional services shall be reduced by five percent over the rates in

38.1 effect on June 30, 2009. This reduction does not apply to office or other outpatient visits,
38.2 preventive medicine visits and family planning visits billed by physicians, advanced
38.3 practice nurses, or physician assistants in a family planning agency or in one of the
38.4 following primary care practices: general practice, general internal medicine, general
38.5 pediatrics, general geriatrics, and family medicine. This reduction does not apply to
38.6 federally qualified health centers, rural health centers, and Indian health services. This
38.7 reduction does not apply to physical therapy services, occupational therapy services,
38.8 and speech pathology and related services provided on or after July 1, 2010. Effective
38.9 October 1, 2009, payments made to managed care plans and county-based purchasing
38.10 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction
38.11 described in this paragraph.

38.12 (d) Effective for services rendered on or after July 1, 2010, payment rates for
38.13 physician and professional services shall be reduced by three percent over the rates in
38.14 effect on June 30, 2010. This reduction does not apply to those providers and entities
38.15 exempt from the reduction in paragraph (c). Effective October 1, 2010, payments made
38.16 to managed care plans and county-based purchasing plans under sections 256B.69,
38.17 256B.692, and 256L.12 shall reflect the payment reductions in this paragraph.

38.18 (e) Effective for services rendered on or after June 1, 2010, payment rates for
38.19 physician and professional services billed by physicians employed by and clinics that are
38.20 owned by a nonprofit health maintenance organization shall be increased by 15 percent.
38.21 Effective October 1, 2010, payments to managed care and county-based purchasing
38.22 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
38.23 described in this paragraph.

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

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

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

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

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

38.33 (c) Effective for services rendered on or after January 1, 2000, payment rates for
38.34 dental services shall be increased by three percent over the rates in effect on December
38.35 31, 1999.

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

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. For services performed by a state-operated dental clinic pursuant to a contract between the clinic and a managed care plan or a county-based purchasing plan, a supplemental payment shall be made to the clinic by the commissioner that is equal to the amount by which the amount determined under this paragraph exceeds the amount of the payments provided under the contract. Managed care plans and county-based purchasing plans participating in medical assistance must provide to the commissioner any expenditure, cost, and revenue information deemed necessary by the commissioner for purposes of obtaining federal Medicaid matching funds for cost-based reimbursement for state-operated dental clinics. Cost-based reimbursement shall be implemented in managed care contracts beginning January 1, 2011.

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

Sec. 32. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

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

40.1 (1) the utilization rate in the service area in which the dentist or dental clinic operates
40.2 for dental services to patients covered by medical assistance, general assistance medical
40.3 care, or MinnesotaCare as their primary source of coverage;
40.4 (2) the level of services provided by the dentist or dental clinic to patients covered
40.5 by medical assistance, general assistance medical care, or MinnesotaCare as their primary
40.6 source of coverage; and. The commissioner shall pay critical access dental provider
40.7 payments to a dentist or dental clinic that meets any one of the following criteria:
40.8 (i) at least 40 percent of patient encounters are with patients who are uninsured or
40.9 covered by medical assistance, general assistance medical care, or MinnesotaCare;
40.10 (ii) the dental clinic or dental group is owned and operated by a nonprofit operation
40.11 under chapter 317A with more than 10,000 patient encounters per year with patients
40.12 who are uninsured or covered by medical assistance, general assistance medical care,
40.13 or MinnesotaCare;
40.14 (iii) the dental clinic is associated with an oral health or dental education program
40.15 operated by the University of Minnesota or an institution within the Minnesota State
40.16 Colleges and Universities system; or
40.17 (iv) the dental clinic is a state-operated dental clinic;
40.18 (3) whether the level of services provided by the dentist or dental clinic is critical to
40.19 maintaining adequate levels of patient access within the a geographic service area, and
40.20 to ensure that the maximum travel distance or travel time is the lesser of 60 miles or 60
40.21 minutes;
40.22 (4) whether the provider has completed the application for critical access dental
40.23 provider designation by the due date, and has provided correct information;
40.24 (5) whether the dentist or dental clinic meets the quality and continuity of care
40.25 criteria recommended by the dental services advisory committee and adopted by the
40.26 department; and
40.27 (6) whether the dentist or dental clinic serves people in all Minnesota health care
40.28 programs.

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

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

41.1 Sec. 33. Minnesota Statutes 2008, section 256B.76, is amended by adding a
41.2 subdivision to read:
41.3 Subd. 4a. **Designation and termination of critical access dental providers.** (a)
41.4 Notwithstanding the provisions in subdivision 4, the commissioner may review and not
41.5 designate an individual dentist or dental clinic as a critical access dental provider under
41.6 subdivision 4 or section 256L.11, subdivision 7, when the dentist or clinic:
41.7 (1) has been subject to a corrective or disciplinary action by the Board of Dentistry
41.8 related to fraud or direct patient care. Designation shall not be made until the provider is no
41.9 longer subject to a corrective or disciplinary action related to fraud or direct patient care; or
41.10 (2) has been subject, within the past three years, to a postinvestigation action by the
41.11 commissioner of human services or issuance of a warning as specified in Minnesota Rules,
41.12 parts 9505.2160 to 9505.2245. The provider shall not be considered for critical access
41.13 dental designation until the January following the year in which the action has ended.
41.14 (b) The commissioner may terminate a critical access designation of an individual
41.15 dentist or clinic if the dentist or clinic:
41.16 (1) becomes subject to a disciplinary or corrective action by the Board of Dentistry
41.17 related to fraud or direct patient care. The provider shall not be considered for critical
41.18 access designation until the January following the year in which the action has ended;
41.19 (2) becomes subject to a postinvestigation action by the commissioner of human
41.20 services or issuance of a warning as specified in Minnesota Rules, parts 9505.2160
41.21 to 9505.2245;
41.22 (3) does not meet the quality and continuity of care criteria that have been
41.23 recommended by the Dental Services Advisory Committee and adopted by the department;
41.24 or
41.25 (4) does not serve people in all Minnesota public health care programs.
41.26 (c) Any termination is effective on the date of notification of the:
41.27 (1) postinvestigative action;
41.28 (2) disciplinary or corrective action by the Minnesota Board of Dentistry; or
41.29 (3) determination of not meeting quality and continuity of care criteria.
41.30 The commissioner may review postinvestigative actions taken by a health plan
41.31 under contract to provide dental services to Minnesota health care program enrollees.
41.32 After an investigation conducted by the Department of Human Services surveillance unit,
41.33 the findings of the health plan may be incorporated to determine if a provider will be
41.34 designated or terminated from the program.
41.35 (d) A provider who has been terminated or not designated under this section may
41.36 appeal only through the contested hearing process as defined in section 14.02, subdivision

42.1 3, by filing with the commissioner a written request of appeal. The appeal request must
42.2 be received by the commissioner no later than 30 days after notification of termination
42.3 or nondesignation.

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

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

42.9 Sec. 34. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

42.10 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

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

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

42.24 Sec. 35. **[256B.767] MEDICARE PAYMENT LIMIT.**

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

42.29 Sec. 36. **[256B.768] FEE-FOR-SERVICE PAYMENT INCREASE.**

42.30 Effective for services rendered on or after January 1, 2011, the commissioner shall
42.31 increase fee-for-service payment rates by seven percent for physician and professional

43.1 services under section 256B.76, subdivision 1, and basic care services subject to the rate
43.2 reduction specified in section 256B.766.

43.3 Sec. 37. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as
43.4 amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

43.5 Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010,
43.6 the general assistance medical care program shall be administered according to section
43.7 256D.031, unless otherwise stated, except for outpatient prescription drug coverage,
43.8 which shall continue to be administered under this section and funded under section
43.9 256D.031, subdivision 9, beginning June 1, 2010.

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

43.12 (1) are covered under the medical assistance program as described in section
43.13 256B.0625, subdivisions 13 and 13d; and

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

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

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

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

43.24 Sec. 38. Minnesota Statutes 2008, section 256L.02, subdivision 3, is amended to read:

43.25 Subd. 3. **Financial management.** (a) The commissioner shall manage spending for
43.26 the MinnesotaCare program in a manner that maintains a minimum reserve. As part of
43.27 each state revenue and expenditure forecast, the commissioner must make an assessment
43.28 of the expected expenditures for the covered services for the remainder of the current
43.29 biennium and for the following biennium. The estimated expenditure, including the
43.30 reserve, shall be compared to an estimate of the revenues that will be available in the health
43.31 care access fund. Based on this comparison, and after consulting with the chairs of the
43.32 house of representatives Ways and Means Committee and the senate Finance Committee,
43.33 and the Legislative Commission on Health Care Access, the commissioner shall, as
43.34 necessary, make the adjustments specified in paragraph (b) to ensure that expenditures

44.1 remain within the limits of available revenues for the remainder of the current biennium
44.2 and for the following biennium. The commissioner shall not hire additional staff using
44.3 appropriations from the health care access fund until the commissioner of management
44.4 and budget makes a determination that the adjustments implemented under paragraph (b)
44.5 are sufficient to allow MinnesotaCare expenditures to remain within the limits of available
44.6 revenues for the remainder of the current biennium and for the following biennium.

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

44.22 **EFFECTIVE DATE.** This section is effective upon federal approval of the
44.23 amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and
44.24 256B.056, subdivision 4.

44.25 Sec. 39. Minnesota Statutes 2008, section 256L.03, subdivision 3, is amended to read:

44.26 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
44.27 inpatient hospital services, including inpatient hospital mental health services and inpatient
44.28 hospital and residential chemical dependency treatment, subject to those limitations
44.29 necessary to coordinate the provision of these services with eligibility under the medical
44.30 assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under
44.31 section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and
44.32 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or
44.33 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not
44.34 pregnant, is subject to an annual limit of $10,000, unless supplemental hospital coverage
44.35 has been purchased under subdivision 3c.

45.1 (b) Admissions for inpatient hospital services paid for under section 256L.11,
45.2 subdivision 3, must be certified as medically necessary in accordance with Minnesota
45.3 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):
45.4 (1) all admissions must be certified, except those authorized under rules established
45.5 under section 254A.03, subdivision 3, or approved under Medicare; and
45.6 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
45.7 for admissions for which certification is requested more than 30 days after the day of
45.8 admission. The hospital may not seek payment from the enrollee for the amount of the
45.9 payment reduction under this clause.

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

45.12 Sec. 40. Minnesota Statutes 2008, section 256L.03, is amended by adding a subdivision
45.13 to read:
45.14 Subd. 3c. **Supplemental hospital coverage.** (a) Effective January 1, 2011, or upon
45.15 federal approval, whichever is later, the commissioner shall offer all MinnesotaCare
45.16 applicants, and all enrollees during the open enrollment periods specified in paragraph
45.17 (b), the opportunity to purchase at full cost, supplemental hospital coverage to cover
45.18 inpatient hospital expenses in excess of the inpatient hospital annual limit established
45.19 under subdivision 3. Premiums for this coverage may vary only for age and shall be
45.20 collected by the commissioner using the procedures established for the sliding scale
45.21 premium determined under section 256L.15.
45.22 (b) The commissioner shall notify all persons submitting applications of the option to
45.23 purchase this coverage at the time of application. The commissioner shall provide persons
45.24 enrolled in MinnesotaCare on the effective date of this subdivision with the opportunity to
45.25 purchase this supplemental coverage during an initial open enrollment period. Following
45.26 this initial open enrollment period, the commissioner shall provide all enrollees with the
45.27 opportunity to purchase this supplemental coverage during an annual open enrollment
45.28 period during the month of November with coverage to take effect the following January 1.

45.29 Sec. 41. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is
45.30 amended to read:
45.31 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
45.32 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
45.33 coinsurance requirements for all enrollees:

46.1 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
46.2 subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;
46.3 (2) $3 per prescription for adult enrollees;
46.4 (3) $25 for eyeglasses for adult enrollees;
46.5 (4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
46.6 episode of service which is required because of a recipient's symptoms, diagnosis, or
46.7 established illness, and which is delivered in an ambulatory setting by a physician or
46.8 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
46.9 audiologist, optician, or optometrist; and
46.10 (5) $6 for nonemergency visits to a hospital-based emergency room for services
46.11 provided through December 31, 2010, and $3.50 effective January 1, 2011.
46.12 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
46.13 children under the age of 21.
46.14 (c) Paragraph (a) does not apply to pregnant women and children under the age of 21.
46.15 (d) Paragraph (a), clause (4), does not apply to mental health services.
46.16 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal
46.17 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,
46.18 and who are not pregnant shall be financially responsible for the coinsurance amount, if
46.19 applicable, and if supplemental coverage has not been purchased under subdivision 3c,
46.20 amounts which exceed the $10,000 inpatient hospital benefit limit.
46.21 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
46.22 or changes from one prepaid health plan to another during a calendar year, any charges
46.23 submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket
46.24 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
46.25 prior to enrollment, or prior to the change in health plans, shall be disregarded.
46.26 (g) MinnesotaCare reimbursement to fee-for-service providers and payments to
46.27 managed care plans shall not be increased as a result of the reduction of the co-payments
46.28 in paragraph (a), clause (5), effective January 1, 2011.

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

46.31 Sec. 42. Minnesota Statutes 2008, section 256L.05, is amended by adding a subdivision
46.32 to read:
46.33 Subd. 6. **Disclosure statement for inpatient hospital limit.** The commissioner
46.34 shall develop, and include with MinnesotaCare application and renewal materials, a
46.35 disclosure statement that contains the following or similar language: "For adults without

47.1 children, and for parents and relative caretakers with family gross income that exceeds
47.2 215 percent of the federal poverty guidelines, who are not pregnant, coverage of inpatient
47.3 hospital services under MinnesotaCare is subject to an annual limit of $10,000. Enrollees
47.4 subject to the limit may be responsible for inpatient hospital costs that exceed the $10,000
47.5 annual limit."

47.6 Sec. 43. Minnesota Statutes 2008, section 256L.07, is amended by adding a subdivision
47.7 to read:

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

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

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

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

47.20 Sec. 44. Minnesota Statutes 2009 Supplement, section 256L.11, subdivision 1, is
47.21 amended to read:

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

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

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

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

48.6 Sec. 45. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:
48.7 Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who
48.8 become eligible for medical assistance ~~or general assistance medical care~~ will remain in
48.9 the same managed care plan if the managed care plan has a contract for that population.
48.10 ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for
48.11 general assistance medical care pursuant to section 256D.03, subdivision 3, within six
48.12 months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant
48.13 to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care
48.14 plan if the managed care plan has a contract for that population. Managed care plans must
48.15 participate in the MinnesotaCare ~~and general assistance medical care programs~~ program
48.16 under a contract with the Department of Human Services in service areas where they
48.17 participate in the medical assistance program.

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

48.19 Sec. 46. Minnesota Statutes 2008, section 256L.12, subdivision 6, is amended to read:
48.20 Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all
48.21 co-payments in sections 256L.03, subdivision 5, and 256L.035, and shall pay co-payments
48.22 to the managed care plan or to its participating providers. The enrollee is also responsible
48.23 for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit,
48.24 unless supplemental hospital coverage has been purchased under subdivision 3c.

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

48.27 Sec. 47. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:
48.28 Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective,
48.29 per capita, where possible. The commissioner may allow health plans to arrange for
48.30 inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with
48.31 an independent actuary to determine appropriate rates.

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

49.8 (c) For services rendered on or after January 1, 2004, the commissioner shall
49.9 withhold five percent of managed care plan payments under this section pending
49.10 completion of performance targets. Each performance target must be quantifiable,
49.11 objective, measurable, and reasonably attainable, except in the case of a performance target
49.12 based on a federal or state law or rule. Criteria for assessment of each performance target
49.13 must be outlined in writing prior to the contract effective date. The managed care plan
49.14 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
49.15 attainment of the performance target is accurate. The commissioner shall periodically
49.16 change the administrative measures used as performance targets in order to improve plan
49.17 performance across a broader range of administrative services. The performance targets
49.18 must include measurement of plan efforts to contain spending on health care services and
49.19 administrative activities. The commissioner may adopt plan-specific performance targets
49.20 that take into account factors affecting only one plan, such as characteristics of the plan's
49.21 enrollee population. The withheld funds must be returned no sooner than July 1 and no
49.22 later than July 31 of the following calendar year if performance targets in the contract are
49.23 achieved. ~~A managed care plan or a county-based purchasing plan under section 256B.692~~
49.24 ~~may include as admitted assets under section 62D.044 any amount withheld under this~~
49.25 ~~paragraph that is reasonably expected to be returned.~~

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

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

49.34 Sec. 48. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

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

50.3 Sec. 49. Laws 2010, chapter 200, article 1, section 12, subdivision 6, is amended to
50.4 read:

50.5 Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the
50.6 commissioner shall contract with hospitals or groups of hospitals that qualify under
50.7 paragraph (b) and agree to deliver services according to this subdivision. Contracting
50.8 hospitals shall develop and implement a coordinated care delivery system to provide health
50.9 care services to individuals who are eligible for general assistance medical care under this
50.10 section and who either choose to receive services through the coordinated care delivery
50.11 system or who are enrolled by the commissioner under paragraph (c). A contracting
50.12 hospital may negotiate a limit to the number of general assistance medical care enrollees it
50.13 serves, but must comply with the emergency care requirements of United States Code, title
50.14 42, 1395dd (EMTALA). The health care services provided by the system must include:
50.15 (1) the services described in subdivision 4 with the exception of outpatient prescription
50.16 drug coverage but shall include drugs administered in a clinic or other outpatient setting;
50.17 or (2) a set of comprehensive and medically necessary health services that the recipients
50.18 might reasonably require to be maintained in good health and that has been approved by
50.19 the commissioner, including at a minimum, but not limited to, emergency care, medical
50.20 transportation services, inpatient hospital and physician care, outpatient health services,
50.21 preventive health services, mental health services, and prescription drugs administered
50.22 in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered
50.23 on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded
50.24 under subdivision 9. A hospital establishing a coordinated care delivery system under this
50.25 subdivision must ensure that the requirements of this subdivision are met.

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

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

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

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

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

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems that provide services within 25 miles of the individual's community of residence. The commissioner may assign an applicant or recipient to a coordinated care delivery system that provides services within 25 miles of the individual's community of residence, if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to November 30, 2010, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After November 30, 2010, services are available only through a coordinated care delivery system.

(d) A hospital must provide access to cost-effective outpatient services available in its service area. The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with federally qualified health centers and essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider

52.1 may not refuse to provide services to any recipient enrolled in the system, and payment for
52.2 services shall be negotiated with the hospital and paid by the hospital from the system's
52.3 allocation under subdivision 7.

52.4 (e) A coordinated care delivery system must:

52.5 (1) provide the covered services required under paragraph (a) to recipients enrolled
52.6 in the coordinated care delivery system, and comply with the requirements of subdivision
52.7 4, paragraphs (b) to (g);

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

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

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

52.16 (f) The hospital may require a recipient to designate a primary care provider or
52.17 a primary care clinic. The hospital may limit the delivery of services to a network of
52.18 providers who have contracted with the hospital to deliver services in accordance with
52.19 this subdivision, and require a recipient to seek services only within this network. The
52.20 hospital may also require a referral to a provider before the service is eligible for payment.
52.21 A coordinated care delivery system is not required to provide payment to a provider who
52.22 is not employed by or under contract with the system for services provided to a recipient
52.23 enrolled in the system, except in cases of an emergency. For purposes of this section,
52.24 emergency services are defined in accordance with Code of Federal Regulations, title
52.25 42, section 438.114 (a).

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

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

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

53.1 (j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2,
53.2 paragraph (b), do not apply to general assistance medical care provided under this section.
53.3 (k) If a recipient is transferred from a hospital that is not participating in a
53.4 coordinated care delivery system to a hospital participating in a coordinated care delivery
53.5 system, in order to receive a higher level of care, the transferring hospital remains eligible
53.6 to receive any available funding through the temporary uncompensated care pool for the
53.7 care initially provided at that hospital. The hospital participating in the coordinated care
53.8 delivery system shall be responsible only for care provided at that hospital, and is not
53.9 financially liable for the initial care provided by the transferring hospital.

53.10 Sec. 50. Laws 2010, chapter 200, article 1, section 12, subdivision 7, is amended to
53.11 read:
53.12 Subd. 7. **Payments; rate setting for the hospital coordinated care delivery**
53.13 **system.** (a) Effective for general assistance medical care services, with the exception
53.14 of outpatient prescription drug coverage, provided on or after June 1, 2010, through a
53.15 coordinated care delivery system, the commissioner shall allocate the annual appropriation
53.16 for the coordinated care delivery system to hospitals participating under subdivision
53.17 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1,
53.18 2010. The payment shall be allocated among all hospitals qualified to participate on the
53.19 allocation date. Each hospital or group of hospitals shall receive a pro rata share of the
53.20 allocation based on the hospital's or group of hospitals' calendar year 2008 payments for
53.21 general assistance medical care services, adjusted for any limits on the number of general
53.22 assistance medical care enrollees accepted by a hospital, provided that, for the purposes of
53.23 this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint
53.24 Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be
53.25 weighted at 110 percent of the actual amount. The commissioner may prospectively
53.26 reallocate payments to participating hospitals on a biannual basis to ensure that final
53.27 allocations reflect actual coordinated care delivery system enrollment. The 2008 base year
53.28 shall be updated by one calendar year each June 1, beginning June 1, 2011.
53.29 (b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the
53.30 commissioner shall make one-third of the quarterly payment in June and the remaining
53.31 two-thirds of the quarterly payment in July to each participating hospital or group of
53.32 hospitals.
53.33 ~~(b)~~ (c) In order to be reimbursed under this section, nonhospital providers of health
53.34 care services shall contract with one or more hospitals described in paragraph (a) to
53.35 provide services to general assistance medical care recipients through the coordinated care

delivery system established by the hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

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

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

Sec. 51. Laws 2010, chapter 200, article 1, section 12, subdivision 8, is amended to read:

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

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

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

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

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

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

55.1 Sec. 52. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to
55.2 read:

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

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

55.6 Sec. 53. Laws 2010, chapter 200, article 1, section 16, is amended to read:
55.7 Sec. 16. Minnesota Statutes 2008, section 256L.05, subdivision 3c, is amended to
55.8 read:
55.9 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
55.10 date of coverage shall be the first day of the month following termination from medical
55.11 assistance for families and individuals who are eligible for MinnesotaCare and who
55.12 submitted a written request for retroactive MinnesotaCare coverage with a completed
55.13 application within 30 days of the mailing of notification of termination from medical
55.14 assistance. The applicant must provide all required verifications within 30 days of the
55.15 written request for verification. For retroactive coverage, premiums must be paid in full
55.16 for any retroactive month, current month, and next month within 30 days of the premium
55.17 billing. General assistance medical care recipients may qualify for retroactive coverage
55.18 under this subdivision at six-month renewal.

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

55.20 Sec. 54. Laws 2010, chapter 200, article 1, section 21, is amended to read:
55.21 Sec. 21. **REPEALER.**
55.22 (a) Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; and 256D.03,
55.23 subdivision 9, are repealed effective April 1, 2010.
55.24 (b) Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is repealed
55.25 effective ~~April~~ June 1, 2010.
55.26 (c) Minnesota Statutes 2008, section 256B.195, subdivisions 4 and 5, are repealed
55.27 effective for federal fiscal year 2010.
55.28 (d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and
55.29 3, are repealed effective for federal fiscal year 2010.
55.30 (e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision
55.31 4; and 256L.17, subdivision 7, are repealed January 1, 2011.

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

56.1 Sec. 55. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

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

56.3 Appropriations by Fund

56.4	2010	2011
56.5 General	34,807,000	118,493,000
56.6 Health Care Access	(42,792,000)	(211,621,000)

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

56.10 **Special Revenue Fund Transfers.**

56.11 (1) The commissioner shall transfer the
56.12 following amounts from special revenue
56.13 fund balances to the general fund by June
56.14 30 of each respective fiscal year: $410,000
56.15 for fiscal year 2010, and $412,000 for fiscal
56.16 year 2011.

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

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

56.24 Sec. 56. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

56.25 Subd. 8. **Transfers**

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

56.30 The commissioner must transfer $4,800,000
56.31 from the consolidated chemical dependency
56.32 treatment fund to the general fund by June
56.33 30, 2010.

57.1 **Compulsive Gambling ~~Special Revenue~~**
57.2 **Administration.** The lottery prize fund
57.3 appropriation for compulsive gambling
57.4 administration is reduced by $6,000 for fiscal
57.5 year 2010 and $4,000 for fiscal year 2011
57.6 ~~must be transferred from the lottery prize~~
57.7 ~~fund appropriation for compulsive gambling~~
57.8 ~~administration to the general fund by June~~
57.9 ~~30 of each respective fiscal year~~. These are
57.10 onetime reductions.

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

57.12 Sec. 57. **EARLY EXPANSION.**

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

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

57.18 Sec. 58. **FISCAL AND ACTUARIAL ANALYSIS.**

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

57.24 Sec. 59. **REPEALER; TRANSFER.**

57.25 (a) Laws 2010, chapter 200, article 1, section 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8,
57.26 and 9, are repealed.

57.27 (b) Laws 2010, chapter 200, article 1, sections 18; and 19, are repealed.

57.28 (c) Minnesota Statutes 2008, section 256D.03, subdivisions 3a, 3b, 5, 6, 7, and 8,
57.29 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, are repealed.

57.30 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective 30 days after federal
57.31 approval of the amendments in this article to Minnesota Statutes, sections 256B.055,
57.32 subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later,

and all remaining unspent appropriations for the program established by Laws 2010, chapter 200, are transferred to the health care access fund. Paragraph (c) is effective 30 days after federal approval of the amendments in this article to Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivision 4, or January 1, 2011, whichever is later.

ARTICLE 3

CONTINUING CARE

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

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

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

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

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

(3) if the adjusted gross income is greater than 545 percent of federal poverty guidelines ~~and less than 675 percent of federal poverty guidelines~~, the parental contribution shall be ~~7.5~~ 12.5 percent of adjusted gross income~~;~~.

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

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

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

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

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

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

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

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

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

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

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

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

60.28 (2) the insurer denied insurance;

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

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

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

60.34 A parent who has requested a reduction in the contribution amount under this
60.35 paragraph shall submit proof in the form and manner prescribed by the commissioner or
60.36 county agency, including, but not limited to, the insurer's denial of insurance, the written

61.1 letter or complaint of the parents, court documents, and the written response of the insurer
61.2 approving insurance. The determinations of the commissioner or county agency under this
61.3 paragraph are not rules subject to chapter 14.

61.4 Sec. 2. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:
61.5 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
61.6 for a person who is employed and who:
61.7 (1) but for excess earnings or assets, meets the definition of disabled under the
61.8 supplemental security income program;
61.9 (2) is at least 16 but less than 65 years of age;
61.10 (3) meets the asset limits in paragraph (c); and
61.11 (4) ~~effective November 1, 2003,~~ pays a premium and other obligations under
61.12 paragraph (e).
61.13 Any spousal income or assets shall be disregarded for purposes of eligibility and premium
61.14 determinations.
61.15 (b) After the month of enrollment, a person enrolled in medical assistance under
61.16 this subdivision who:
61.17 (1) is temporarily unable to work and without receipt of earned income due to a
61.18 medical condition, as verified by a physician, may retain eligibility for up to four calendar
61.19 months; or
61.20 (2) effective January 1, 2004, loses employment for reasons not attributable to the
61.21 enrollee, may retain eligibility for up to four consecutive months after the month of job
61.22 loss. To receive a four-month extension, enrollees must verify the medical condition or
61.23 provide notification of job loss. All other eligibility requirements must be met and the
61.24 enrollee must pay all calculated premium costs for continued eligibility.
61.25 (c) For purposes of determining eligibility under this subdivision, a person's assets
61.26 must not exceed $20,000, excluding:
61.27 (1) all assets excluded under section 256B.056;
61.28 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
61.29 Keogh plans, and pension plans; and
61.30 (3) medical expense accounts set up through the person's employer.
61.31 (d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65
61.32 earned income disregard. To be eligible, a person applying for medical assistance under
61.33 this subdivision must have earned income above the disregard level.

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

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

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

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

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

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

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

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

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

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

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

63.17 <u>**EFFECTIVE DATE.** This section is effective January 1, 2011.</u>

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

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

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

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

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

Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing facility.** (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for ~~that resident~~ residents in the nursing facility where the resident currently resides, but in effect on June 30, 2010, and adjusted annually by any legislatively adopted percentage change in the elderly waiver services rates. That per diem shall be multiplied by 365 ~~and~~, divided by 12, ~~less~~ and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved

conversion rate ~~may~~ must be adjusted by ~~the greater of~~ any subsequent legislatively adopted home and community-based services percentage rate ~~increase or the average statewide percentage increase in nursing facility payment rates~~ adjustment. The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

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

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

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

Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

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

66.1 the health plan's participation is subsequently terminated for any reason, the person shall
66.2 be provided an opportunity to select a new health plan and shall have the right to change
66.3 health plans within the first 60 days of enrollment in the second health plan. Persons
66.4 required to participate in health plans under this section who fail to make a choice of
66.5 health plan shall not be randomly assigned to health plans under these demonstrations.
66.6 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
66.7 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
66.8 the commissioner may contract with managed care organizations, including counties, to
66.9 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
66.10 disabled persons only. For persons with a primary diagnosis of developmental disability,
66.11 serious and persistent mental illness, or serious emotional disturbance, the commissioner
66.12 must ensure that the county authority has approved the demonstration and contracting
66.13 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
66.14 commissioner shall not implement any demonstration project under this subdivision for
66.15 persons with a primary diagnosis of developmental disabilities, serious and persistent
66.16 mental illness, or serious emotional disturbance, without approval of the county board of
66.17 the county in which the demonstration is being implemented.

66.18 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
66.19 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
66.20 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
66.21 under this section projects for persons with developmental disabilities. The commissioner
66.22 may capitate payments for ICF/MR services, waivered services for developmental
66.23 disabilities, including case management services, day training and habilitation and
66.24 alternative active treatment services, and other services as approved by the state and by the
66.25 federal government. Case management and active treatment must be individualized and
66.26 developed in accordance with a person-centered plan. Costs under these projects may not
66.27 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
66.28 and until four years after the pilot project implementation date, subcontractor participation
66.29 in the long-term care developmental disability pilot is limited to a nonprofit long-term
66.30 care system providing ICF/MR services, home and community-based waiver services,
66.31 and in-home services to no more than 120 consumers with developmental disabilities in
66.32 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
66.33 prior to expansion of the developmental disability pilot project. This paragraph expires
66.34 four years after the implementation date of the pilot project.

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

67.1 representatives and senate and must involve representatives of affected disability groups
67.2 in the design of the demonstration projects.

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

67.7 (e) The commissioner, in consultation with the commissioners of commerce and
67.8 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
67.9 according to federal laws and regulations governing that program and state laws or rules
67.10 applicable to participating providers. ~~The process for approval of these programs shall~~
67.11 ~~begin only after the commissioner receives grant money in an amount sufficient to cover~~
67.12 ~~the state share of the administrative and actuarial costs to implement the programs during~~
67.13 ~~state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an~~
67.14 ~~account in the special revenue fund and are appropriated to the commissioner to be used~~
67.15 ~~solely for the purpose of PACE administrative and actuarial costs.~~ A PACE provider is
67.16 not required to be licensed or certified as a health plan company as defined in section
67.17 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
67.18 and found to be eligible for services under the elderly waiver or community alternatives
67.19 for disabled individuals or who are already eligible for Medicaid but meet level of
67.20 care criteria for receipt of waiver services may choose to enroll in the PACE program.
67.21 Medicare and Medicaid services will be provided according to this subdivision and
67.22 federal Medicare and Medicaid requirements governing PACE providers and programs.
67.23 PACE enrollees will receive Medicaid home and community-based services through the
67.24 PACE provider as an alternative to services for which they would otherwise be eligible
67.25 through home and community-based waiver programs and Medicaid State Plan Services.
67.26 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
67.27 costs that would have been incurred under fee-for-service or other relevant managed care
67.28 programs operated by the state.

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

68.1 under the fee-for-service program. Notwithstanding whether expansion occurs under
68.2 this paragraph, in determining MnDHO payment rates and risk adjustment methods for
68.3 contract years starting in 2012, the commissioner must consider the methods used to
68.4 determine county allocations for home and community-based program participants. If
68.5 necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs
68.6 for home and community-based services, the commissioner shall achieve the reduction by
68.7 maintaining the base rate for contract years 2010 and 2011 for services provided under the
68.8 community alternatives for disabled individuals waiver at the same level as for contract
68.9 year 2009. The commissioner may apply other reductions to MnDHO rates to implement
68.10 decreases in provider payment rates required by state law. In developing program
68.11 specifications for expansion of integrated programs, the commissioner shall involve and
68.12 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
68.13 including consultation on whether and how to include home and community-based waiver
68.14 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
68.15 of the house of representatives and senate committees with jurisdiction over health and
68.16 human services policy and finance by February 1, 2007.

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

68.21 Sec. 6. **CASE MANAGEMENT REFORM.**

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

68.24 (1) define the administrative and the service functions of case management and make
68.25 changes to improve the funding for administrative functions;

68.26 (2) standardize and simplify processes, standards, and timelines for administrative
68.27 functions of case management within the Department of Human Services, Disability
68.28 Services Division, including eligibility determinations, resource allocation, management
68.29 of dollars, provision for assignment of one case manager at a time per person, waiting lists,
68.30 quality assurance, host county concurrence requirements, county of financial responsibility
68.31 provisions, and waiver compliance; and

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

68.34 (b) In developing these recommendations, the commissioner shall consider the
68.35 recommendations of the 2007 Redesigning Case Management Services for Persons

69.1 with Disabilities report and consult with existing stakeholder groups, which include
69.2 representatives of counties, disability and senior advocacy groups, service providers, and
69.3 representatives of agencies which provide contracted case management.

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

69.5 Sec. 7. **[256.4825] REPORT REGARDING PROGRAMS AND SERVICES FOR**
69.6 **PEOPLE WITH DISABILITIES.**

69.7 The Minnesota State Council on Disability, the Minnesota Consortium for Citizens
69.8 with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of
69.9 each year, beginning in 2012, to the chairs and ranking minority members of the legislative
69.10 committees with jurisdiction over programs serving people with disabilities as provided in
69.11 this section. The report must describe the existing state policies and goals for programs
69.12 serving people with disabilities including, but not limited to, programs for employment,
69.13 transportation, housing, education, quality assurance, consumer direction, physical and
69.14 programmatic access, and health. The report must provide data and measurements to
69.15 assess the extent to which the policies and goals are being met. The commissioner of
69.16 human services and the commissioners of other state agencies administering programs for
69.17 people with disabilities shall cooperate with the Minnesota State Council on Disability,
69.18 the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and
69.19 provide those organizations with existing published information and reports that will assist
69.20 in the preparation of the report.

69.21 Sec. 8. **COMMISSIONER TO SEEK FEDERAL MATCH.**

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

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

ARTICLE 4

CHILDREN AND FAMILY SERVICES

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

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

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

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

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

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

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

(1) a licensed vehicle up to a loan value of less than or equal to ~~$15,000~~ $7,500. ~~If the assistance unit owns more than one licensed vehicle, the county agency shall determine the loan value of all additional vehicles and exclude the combined loan value of less than or equal to $7,500.~~ The county agency shall apply any excess loan value as if it were equity value to the asset limit described in this section~~,~~. If the assistance unit owns more than one licensed vehicle, the county agency shall determine the vehicle with the highest loan value and count only the loan value over $7,500, excluding: (i) the value of one vehicle per physically disabled person when the vehicle is needed to transport the disabled unit member; this exclusion does not apply to mentally disabled people; (ii) the value of special equipment for a disabled member of the assistance unit; and (iii) any vehicle used for long-distance travel, other than daily commuting, for the employment of a unit member.

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

71.1 would pay to purchase the vehicle. The county agency shall reimburse the applicant or
71.2 participant for the cost of a written statement that documents a lower loan value;
71.3 (2) the value of life insurance policies for members of the assistance unit;
71.4 (3) one burial plot per member of an assistance unit;
71.5 (4) the value of personal property needed to produce earned income, including
71.6 tools, implements, farm animals, inventory, business loans, business checking and
71.7 savings accounts used at least annually and used exclusively for the operation of a
71.8 self-employment business, and any motor vehicles if at least 50 percent of the vehicle's use
71.9 is to produce income and if the vehicles are essential for the self-employment business;
71.10 (5) the value of personal property not otherwise specified which is commonly
71.11 used by household members in day-to-day living such as clothing, necessary household
71.12 furniture, equipment, and other basic maintenance items essential for daily living;
71.13 (6) the value of real and personal property owned by a recipient of Supplemental
71.14 Security Income or Minnesota supplemental aid;
71.15 (7) the value of corrective payments, but only for the month in which the payment
71.16 is received and for the following month;
71.17 (8) a mobile home or other vehicle used by an applicant or participant as the
71.18 applicant's or participant's home;
71.19 (9) money in a separate escrow account that is needed to pay real estate taxes or
71.20 insurance and that is used for this purpose;
71.21 (10) money held in escrow to cover employee FICA, employee tax withholding,
71.22 sales tax withholding, employee worker compensation, business insurance, property rental,
71.23 property taxes, and other costs that are paid at least annually, but less often than monthly;
71.24 (11) monthly assistance payments for the current month's or short-term emergency
71.25 needs under section 256J.626, subdivision 2;
71.26 (12) the value of school loans, grants, or scholarships for the period they are
71.27 intended to cover;
71.28 (13) payments listed in section 256J.21, subdivision 2, clause (9), which are held
71.29 in escrow for a period not to exceed three months to replace or repair personal or real
71.30 property;
71.31 (14) income received in a budget month through the end of the payment month;
71.32 (15) savings from earned income of a minor child or a minor parent that are set aside
71.33 in a separate account designated specifically for future education or employment costs;
71.34 (16) the federal earned income credit, Minnesota working family credit, state and
71.35 federal income tax refunds, state homeowners and renters credits under chapter 290A,

72.1 property tax rebates and other federal or state tax rebates in the month received and the
72.2 following month;
72.3 (17) payments excluded under federal law as long as those payments are held in a
72.4 separate account from any nonexcluded funds;
72.5 (18) the assets of children ineligible to receive MFIP benefits because foster care or
72.6 adoption assistance payments are made on their behalf; and
72.7 (19) the assets of persons whose income is excluded under section 256J.21,
72.8 subdivision 2, clause (43).

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

72.10 Sec. 3. Minnesota Statutes 2008, section 256J.24, subdivision 10, is amended to read:
72.11 Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income
72.12 disregard to ensure that most participants do not lose eligibility for MFIP until their
72.13 income reaches at least ~~115~~ 110 percent of the federal poverty guidelines in effect ~~in~~
72.14 ~~October of each fiscal year~~ at the time of the adjustment. The adjustment to the disregard
72.15 shall be based on a household size of three, and the resulting earned income disregard
72.16 percentage must be applied to all household sizes. The adjustment under this subdivision
72.17 must be implemented ~~at the same time as the October food stamp or~~ whenever there is a
72.18 food support ~~cost-of-living~~ adjustment ~~is~~ reflected in the food portion of MFIP transitional
72.19 standard as required under subdivision 5a.

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

72.21 Sec. 4. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:
72.22 Subd. 3a. **Rental subsidies; unearned income.** (a) ~~Effective July 1, 2003,~~ The
72.23 county agency shall count ~~$50~~ $100 of the value of public and assisted rental subsidies
72.24 provided through the Department of Housing and Urban Development (HUD) as unearned
72.25 income to the cash portion of the MFIP grant. The full amount of the subsidy must be
72.26 counted as unearned income when the subsidy is less than ~~$50~~ $100. The income from
72.27 this subsidy shall be budgeted according to section 256J.34.
72.28 (b) The provisions of this subdivision shall not apply to an MFIP assistance unit
72.29 which includes a participant who is:
72.30 (1) age 60 or older;
72.31 (2) a caregiver who is suffering from an illness, injury, or incapacity that has been
72.32 certified by a qualified professional when the illness, injury, or incapacity is expected

73.1 to continue for more than 30 days and prevents the person from obtaining or retaining
73.2 employment; or

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

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

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

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

73.20 Sec. 5. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is
73.21 amended to read:

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

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

73.29 (2) a person who:

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

73.32 (ii) has an IQ below 80 who has been assessed by a vocational specialist or a county
73.33 agency to be employable, but the condition severely limits the person's ability to obtain or
73.34 maintain suitable employment. The determination of IQ level must be made by a qualified
73.35 professional. In the case of a non-English-speaking person: (A) the determination must

74.1 be made by a qualified professional with experience conducting culturally appropriate
74.2 assessments, whenever possible; (B) the county may accept reports that identify an
74.3 IQ range as opposed to a specific score; (C) these reports must include a statement of
74.4 confidence in the results;

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

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

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

74.20 (1) that a qualified professional has determined that the person's condition prevents
74.21 the person from working 20 or more hours per week; or

74.22 (2) for a person who meets the requirements of paragraph (a), clause (2), item (ii), or
74.23 clause (3), a qualified professional has determined the person's condition:

74.24 (i) significantly restricts the range of employment that the person is able to perform;
74.25 or

74.26 (ii) significantly interferes with the person's ability to obtain or maintain suitable
74.27 employment for 20 or more hours per week.

74.28 **ARTICLE 5**

74.29 **MISCELLANEOUS**

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

74.31 Subd. 2. **Staff; compensation.** The legislative auditor shall establish a Financial
74.32 Audits Division and a Program Evaluation Division to fulfill the duties prescribed in
74.33 this section. The legislative auditor shall establish a Legislative Budget Office Division
74.34 to fulfill the duties in section 3.98, subdivision 5. Each division may be supervised by a
74.35 deputy auditor, appointed by the legislative auditor, with the approval of the commission,

75.1 for a term coterminous with the legislative auditor's term. The deputy auditors may be
75.2 removed before the expiration of their terms only for cause. The legislative auditor
75.3 and deputy auditors may each appoint a confidential secretary to serve at pleasure.
75.4 The salaries and benefits of the legislative auditor, deputy auditors and confidential
75.5 secretaries shall be determined by the compensation plan approved by the Legislative
75.6 Coordinating Commission. The deputy auditors may perform and exercise the powers,
75.7 duties and responsibilities imposed by law on the legislative auditor when authorized by
75.8 the legislative auditor. The deputy auditors and the confidential secretaries serve in the
75.9 unclassified civil service, but all other employees of the legislative auditor are in the
75.10 classified civil service. Compensation for employees of the legislative auditor in the
75.11 classified service shall be governed by a plan prepared by the legislative auditor and
75.12 approved by the Legislative Coordinating Commission and the legislature under section
75.13 3.855, subdivision 3. While in office, a person appointed deputy for the Financial Audit
75.14 Division must hold an active license as a certified public accountant.

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

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

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

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

75.28 (1) concurring with the information provided;

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

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

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

75.32 (a) A health plan company that provides coverage under a health plan for cancer
75.33 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
75.34 amount for a prescribed, orally administered anticancer medication that is used to kill or

76.1 slow the growth of cancerous cells than what the health plan requires for an intravenously
76.2 administered or injected cancer medication that is provided, regardless of formulation or
76.3 benefit category determination by the health plan company.

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

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

76.11 (d) A plan offered by the commissioner of management and budget under section
76.12 43A.23 is deemed to be at parity and in compliance with this section.

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

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

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

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

76.23 (1) autism or autistic disorder;

76.24 (2) Asperger's syndrome; or

76.25 (3) pervasive developmental disorder - not otherwise specified.

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

76.28 (d) "Evidence-based," for purposes of this section only, is as described in subdivision
76.29 2, paragraph (c), clause (2).

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

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

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

77.1 (h) "Mental health professional" has the meaning given in section 245.4871,
77.2 subdivision 27, clauses (1) to (6).
77.3 (i) "Qualified mental health behavioral aide" means a mental health behavioral aide
77.4 as defined in section 256B.0943, subdivision 7.
77.5 (j) "Qualified mental health practitioner" means a mental health practitioner as
77.6 defined in section 245.4871, subdivision 26.
77.7 (k) "Statistically superior outcomes" means a research study in which the probability
77.8 that the results would be obtained under the null hypothesis is less than five percent.
77.9 Subd. 2. **Coverage required.** (a) For coverage requirements to apply, an individual
77.10 must have a diagnosis of autism spectrum disorder made through an evaluation of the
77.11 patient, completed within the six months prior to the start of treatment, which includes
77.12 all of the following:
77.13 (1) a complete medical and psychological evaluation performed by a licensed
77.14 physician and psychologist using empirically validated tools or tests that incorporate
77.15 measures for intellectual functioning, language development, adaptive skills, and
77.16 behavioral problems, which must include:
77.17 (i) a developmental history of the child, focusing on developmental milestones
77.18 and delays;
77.19 (ii) a family history, including whether there are other family members with an
77.20 autism spectrum disorder, developmental disability, fragile X syndrome, or tuberous
77.21 sclerosis;
77.22 (iii) a medical history, including signs of deterioration, seizure activity, brain injury,
77.23 and head circumference;
77.24 (iv) a physical examination completed within the past 12 months;
77.25 (v) an evaluation for intellectual functioning;
77.26 (vi) a lead screening for those children with a developmental disability; and
77.27 (vii) other evaluations and testing as indicated by the medical evaluation, which
77.28 may include neuropsychological testing, occupational therapy, physical therapy, family
77.29 functioning, genetic testing, imaging laboratory tests, and electrophysiological testing;
77.30 (2) a communication assessment conducted by a speech pathologist; and
77.31 (3) a comprehensive hearing test conducted by an audiologist with experience in
77.32 testing very young children.
77.33 (b) A health plan must provide coverage for the diagnosis, evaluation, assessment,
77.34 and medically necessary care of autism spectrum disorders that is evidence-based,
77.35 including but not limited to:

78.1 (1) neurodevelopmental and behavioral health treatments, instruction, and
78.2 management;
78.3 (2) applied behavior analysis and intensive early intervention services, including
78.4 service package models such as intensive early intervention behavior therapy services
78.5 and Lovaas therapy;
78.6 (3) speech therapy;
78.7 (4) occupational therapy;
78.8 (5) physical therapy; and
78.9 (6) prescription medications.
78.10 (c) Coverage required under this section shall include treatment that is in accordance
78.11 with:
78.12 (1) an individualized treatment plan prescribed by the insured's treating physician or
78.13 mental health professional as defined in this section; and
78.14 (2) medically and scientifically accepted evidence that meets the criteria of a
78.15 peer-reviewed, published study that is one of the following:
78.16 (i) a randomized study with adequate statistical power, including a sample size of
78.17 30 or more for each group, that shows statistically superior outcomes to a pill placebo
78.18 group, psychological placebo group, another treatment group, or a wait list control group,
78.19 or that is equivalent to another evidence-based treatment that meets the above standard
78.20 for the specified problem area; or
78.21 (ii) a series of at least three single-case design experiments with clear specification
78.22 of the subjects and with clear specification of the treatment approach that:
78.23 (A) use robust experimental designs;
78.24 (B) show statistically superior outcomes to pill placebo, psychological placebo,
78.25 or another treatment group; and
78.26 (C) either use a manualized approach or are conducted by at least two independent
78.27 investigators or teams; or
78.28 (3) where evidence meeting the standards of this subdivision does not exist for
78.29 the treatment of a diagnosed condition or for an individual matching the demographic
78.30 characteristics for which the evidence is valid, practice guidelines based on consensus
78.31 of Minnesota health care professionals knowledgeable in the treatment of individuals
78.32 with autism spectrum disorders.
78.33 (d) Early intensive behavior therapies that meet the criteria set forth in paragraphs
78.34 (b) and (c) must also meet the following best practices standards:
78.35 (1) the services must be prescribed by a mental health professional as an appropriate
78.36 treatment option for the individual child;

79.1 (2) regular reporting of services provided and the child's progress must be submitted
79.2 to the prescribing mental health professional;
79.3 (3) care must include appropriate parent or legal guardian education and
79.4 involvement;
79.5 (4) the medically prescribed treatment and frequency of services should be
79.6 coordinated between the school and provider for all children up to age 21; and
79.7 (5) services must be provided by a mental health professional or, as appropriate, a
79.8 board-certified behavior analyst, a qualified mental health practitioner, or a qualified
79.9 mental health behavioral aide.
79.10 (e) Providers under this section must work with the commissioner in implementing
79.11 evidence-based practices and, specifically for children under age 21, the Minnesota
79.12 Evidence-Based Practice Database of research-informed practice elements and specific
79.13 constituent practices.
79.14 (f) A health plan company may not refuse to renew or reissue, or otherwise terminate
79.15 or restrict coverage of an individual solely because the individual is diagnosed with an
79.16 autism spectrum disorder.
79.17 (g) A health plan company may request an updated treatment plan only once every
79.18 six months, unless the health plan company and the treating physician or mental health
79.19 professional agree that a more frequent review is necessary due to emerging circumstances.
79.20 Subd. 3. **Supervision, delegation of duties, and observation of qualified mental**
79.21 **health practitioner, board-certified behavior analyst, or mental health behavioral**
79.22 **aide.** A mental health professional who uses the services of a qualified mental health
79.23 practitioner, board-certified behavior analyst, or qualified mental health behavioral aide for
79.24 the purpose of assisting in the provision of services to patients who have autism spectrum
79.25 disorder is responsible for functions performed by these service providers. The qualified
79.26 mental health professional must maintain clinical supervision of services they provide
79.27 and accept full responsibility for their actions. The services provided must be medically
79.28 necessary and identified in the child's individual treatment plan. Service providers must
79.29 document their activities in written progress notes that reflect implementation of the
79.30 individual treatment plan.
79.31 Subd. 4. **State health care programs.** This section does not affect benefits
79.32 available under the medical assistance, MinnesotaCare, and general assistance medical
79.33 care programs, and the state employee group insurance plan offered under sections
79.34 43A.22 to 43A.30. These programs and the state employee group insurance plan must
79.35 maintain current levels of coverage, and section 256B.0644 shall continue to apply.
79.36 The commissioner shall monitor these services and report to the chairs of the house

80.1 of representatives and senate standing committees that have jurisdiction over health
80.2 and human services by February 1, 2011, whether there are gaps in the level of service
80.3 provided by these programs and the state employee group insurance plan, and the level of
80.4 service provided by private health plans following enactment of this section.

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

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

80.10 Sec. 5. Minnesota Statutes 2008, section 62J.38, is amended to read:

80.11 **62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.**

80.12 (a) The commissioner shall require group purchasers to submit detailed data on total
80.13 health care spending for each calendar year. Group purchasers shall submit data for the
80.14 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the
80.15 preceding calendar year.

80.16 (b) The commissioner shall require each group purchaser to submit data on revenue,
80.17 expenses, and member months, as applicable. Revenue data must distinguish between
80.18 premium revenue and revenue from other sources and must also include information
80.19 on the amount of revenue in reserves and changes in reserves. Expenditure data must
80.20 distinguish between costs incurred for patient care and administrative costs, including
80.21 amounts paid to contractors, subcontractors, and other entities for the purpose of managing
80.22 provider utilization or distributing provider payments. Patient care and administrative
80.23 costs must include only expenses incurred on behalf of health plan members and must
80.24 not include the cost of providing health care services for nonmembers at facilities owned
80.25 by the group purchaser or affiliate. Expenditure data must be provided separately
80.26 for the following categories and for other categories required by the commissioner:
80.27 physician services, dental services, other professional services, inpatient hospital services,
80.28 outpatient hospital services, emergency, pharmacy services and other nondurable medical
80.29 goods, mental health, and chemical dependency services, other expenditures, subscriber
80.30 liability, and administrative costs. Administrative costs must include costs for marketing;
80.31 advertising; overhead; salaries and benefits of central office staff who do not provide
80.32 direct patient care; underwriting; lobbying; claims processing; provider contracting and
80.33 credentialing; detection and prevention of payment for fraudulent or unjustified requests
80.34 for reimbursement or services; clinical quality assurance and other types of medical care

81.1 quality improvement efforts; concurrent or prospective utilization review as defined in
81.2 section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the
81.3 assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or
81.4 any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation
81.5 agreement with a hospital, clinic, or other health care provider. Capital costs and costs
81.6 incurred must be recorded according to standard accounting principles. The reports of
81.7 this data must also separately identify expenses for local, state, and federal taxes, fees,
81.8 and assessments. The commissioner may require each group purchaser to submit any
81.9 other data, including data in unaggregated form, for the purposes of developing spending
81.10 estimates, setting spending limits, and monitoring actual spending and costs. In addition to
81.11 reporting administrative costs incurred to acquire a hospital, clinic, or health care facility,
81.12 or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture,
81.13 integration, or affiliation agreement with a hospital, clinic, or other health care provider;
81.14 reports submitted under this section also must include the payments made during the
81.15 calendar year for these purposes. The commissioner shall make public, by group purchaser
81.16 data collected under this paragraph in accordance with section 62J.321, subdivision 5.
81.17 Workers' compensation insurance plans and automobile insurance plans are exempt from
81.18 complying with this paragraph as it relates to the submission of administrative costs.

81.19 (c) The commissioner may collect information on:

81.20 (1) premiums, benefit levels, managed care procedures, and other features of health
81.21 plan companies;

81.22 (2) prices, provider experience, and other information for services less commonly
81.23 covered by insurance or for which patients commonly face significant out-of-pocket
81.24 expenses; and

81.25 (3) information on health care services not provided through health plan companies,
81.26 including information on prices, costs, expenditures, and utilization.

81.27 (d) All group purchasers shall provide the required data using a uniform format and
81.28 uniform definitions, as prescribed by the commissioner.

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

81.30 (a) A health plan must cover private duty nursing services as provided under section
81.31 256B.0625, subdivision 7, for persons who are covered under the health plan and require
81.32 private duty nursing services.

81.33 (b) For purposes of this section, a period of private duty nursing services may
81.34 be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing
81.35 requirements that apply under the health plan. Cost-sharing requirements for private duty

82.1 nursing services must not place a greater financial burden on the insured or enrollee than
82.2 those requirements applied by the health plan to other similar services or benefits.

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

82.5 Sec. 7. Minnesota Statutes 2008, section 62Q.76, subdivision 1, is amended to read:
82.6 Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to ~~62Q.79~~ 62Q.791,
82.7 the terms ~~defined in this section~~ contract, health care provider, dental plan, dental
82.8 organization, dentist, and enrollee have the meanings given them in sections 62Q.733
82.9 and 62Q.76.

82.10 Sec. 8. **[62Q.791] CONTRACTS WITH DENTAL CARE PROVIDERS.**
82.11 (a) Notwithstanding any other provision of law, no contract of any dental
82.12 organization licensed under chapter 62C for provision of dental care services may:
82.13 (1) require, directly or indirectly, that a dentist or health care provider provide dental
82.14 care services to its enrollees at a fee set by the dental organization, unless the services
82.15 provided are covered dental care services for enrollees under the dental plan or contract; or
82.16 (2) prohibit, directly or indirectly, the dentist or health care provider from offering or
82.17 providing dental care services that are not covered dental care services under the dental
82.18 plan or contract, on terms and conditions acceptable to the enrollee and the dentist or
82.19 health care provider. For purposes of this section, "covered dental care services" means
82.20 dental care services that are expressly covered under the dental plan or contract, including
82.21 dental care services that are subject to contractual limitations such as deductibles,
82.22 co-payments, annual maximums, and waiting periods.
82.23 (b) When making payment or otherwise adjudicating any claim for dental care
82.24 services provided to an enrollee, a dental organization or dental plan must clearly identify
82.25 on an explanation of benefits form or other form of claim resolution the amount, if any,
82.26 that is the enrollee's responsibility to pay to the enrollee's dentist or health care provider.
82.27 (c) This section does not apply to any contract for the provision of dental care
82.28 services under any public program sponsored or funded by the state or federal government.

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

82.30 Sec. 9. **[245.6971] ADVISORY GROUP ON STATE-OPERATED SERVICES**
82.31 **REDESIGN.**

83.1 Subdivision 1. **Establishment.** The Advisory Group on State-Operated Services
83.2 Redesign is established to make recommendations to the commissioner of human services
83.3 and the legislature on the continuum of services needed to provide individuals with
83.4 complex conditions including mental illness and developmental disabilities access to
83.5 quality care and the appropriate level of care across the state to promote wellness, reduce
83.6 cost, and improve efficiency.

83.7 Subd. 2. **Duties.** The Advisory Group on State-Operated Services Redesign shall
83.8 make recommendations to the commissioner and the legislature no later than December
83.9 15, 2010, on the following:

83.10 (1) transformation needed to improve service delivery and provide a continuum of
83.11 care, such as transition of current facilities, closure of current facilities, or the development
83.12 of new models of care;

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

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

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

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

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

83.24 Subd. 3. **Membership.** The advisory group shall be composed of the following,
83.25 who will serve at the pleasure of their appointing authority:

83.26 (1) the commissioner of human services or the commissioner's designee, and two
83.27 additional representatives from the department;

83.28 (2) two legislators appointed by the speaker of the house, one from the minority
83.29 and one from the majority;

83.30 (3) two legislators appointed by the senate rules committee, one from the minority
83.31 and one from the majority;

83.32 (4) one representative appointed by AFSCME Council 5;

83.33 (5) one representative appointed by the ombudsman for mental health and
83.34 developmental disabilities;

83.35 (6) one representative appointed by the Minnesota Association of Professional
83.36 Employees;

84.1 (7) one representative appointed by the Minnesota Hospital Association;
84.2 (8) one representative appointed by the Minnesota Nurses Association;
84.3 (9) one representative appointed by NAMI-MN;
84.4 (10) one representative appointed by the Mental Health Association of Minnesota;
84.5 (11) one representative appointed by the Minnesota Association Of Community
84.6 Mental Health Programs;
84.7 (12) one representative appointed by the Minnesota Dental Association;
84.8 (13) three clients or client family members representing different populations
84.9 receiving services from state-operated services, who are appointed by the commissioner;
84.10 (14) one representative appointed by the chair of the state-operated services
84.11 governing board; and
84.12 (15) one representative appointed by the Minnesota Disability Law Center.
84.13 Subd. 4. **Administration.** The commissioner shall convene the first meeting of the
84.14 advisory group and shall provide administrative support and staff.
84.15 Subd. 5. **Recommendations.** The advisory group must report its recommendations
84.16 to the commissioner and to the legislature no later than December 15, 2010.
84.17 Subd. 6. **Expiration.** This section expires January 31, 2011.

84.18 Sec. 10. **[245.6972] LEGISLATIVE APPROVAL REQUIRED.**
84.19 The commissioner of human services shall not redesign or move state-operated
84.20 services programs without specific legislative approval. The commissioner may proceed
84.21 with redesign at the Mankato Crisis Center and the closure of the Community Behavioral
84.22 Health Hospital in Cold Spring.

84.23 Sec. 11. Minnesota Statutes 2009 Supplement, section 252.025, subdivision 7, is
84.24 amended to read:
84.25 Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop
84.26 by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have
84.27 developmental disabilities and exhibit severe behaviors which present a risk to public
84.28 safety. This program is statewide and must provide specialized residential services in
84.29 Cambridge and an array of community-based services with sufficient levels of care and a
84.30 sufficient number of specialists to ensure that individuals referred to the program receive
84.31 the appropriate care. The number of beds at the Cambridge facility may be reorganized
84.32 into two 16-bed facilities, one for individuals with developmental disabilities and one
84.33 for individuals with developmental disabilities and a co-occurring mental illness, with
84.34 the remaining beds converted into transitional intensive treatment foster homes.The

individuals working in the community-based services under this section are state employees supervised by the commissioner of human services. No layoffs shall occur as a result of restructuring under this section.

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

Sec. 12. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

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

Sec. 13. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

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

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

~~(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is~~

86.1 ~~divided by the amount of chemical dependency fund expenditures for entitled persons for~~
86.2 ~~all services to determine the proportion of exempt service expenditures for each county.~~
86.3 ~~(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt~~
86.4 ~~service expenditures to determine the adjusted prepaid plan months of eligibility for~~
86.5 ~~each county.~~
86.6 ~~(d) The adjusted prepaid plan months of eligibility is added to the number of~~
86.7 ~~restricted population fee for service months of eligibility for the Minnesota family~~
86.8 ~~investment program, general assistance, and medical assistance and divided by the county~~
86.9 ~~restricted population to determine county per capita months of covered service eligibility.~~
86.10 ~~(e) The number of adjusted prepaid plan months of eligibility for the state is added~~
86.11 ~~to the number of fee for service months of eligibility for the Minnesota family investment~~
86.12 ~~program, general assistance, and medical assistance for the state restricted population and~~
86.13 ~~divided by the state restricted population to determine state per capita months of covered~~
86.14 ~~service eligibility.~~
86.15 ~~(f) The county per capita months of covered service eligibility is divided by the~~
86.16 ~~state per capita months of covered service eligibility to determine the county welfare~~
86.17 ~~caseload factor.~~
86.18 ~~(g) The median married couple income for the most recent three-year period~~
86.19 ~~available for the state is divided by the median married couple income for the same period~~
86.20 ~~for each county to determine the income factor for each county.~~
86.21 ~~(h) The county restricted population is multiplied by the sum of the county welfare~~
86.22 ~~caseload factor and the county income factor to determine the adjusted population.~~
86.23 ~~(i) $15,000 shall be allocated to each county.~~
86.24 ~~(j) The remaining funds shall be allocated proportional to the county adjusted~~
86.25 ~~population.~~

86.26 Sec. 14. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:
86.27 Subd. 5. **Administrative adjustment.** The commissioner may make payments to
86.28 local agencies from money allocated under this section to support administrative activities
86.29 under sections 254B.03 and 254B.04. The administrative payment must not exceed
86.30 the lesser of (1) five percent of the first $50,000, four percent of the next $50,000, and
86.31 three percent of the remaining payments for services from the ~~allocation~~ special revenue
86.32 account according to subdivision 1; or (2) the local agency administrative payment for
86.33 the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in
86.34 the appropriation for this chapter.

Sec. 15. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

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

Sec. 16. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision to read:

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

Sec. 17. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

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

Sec. 18. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

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

88.12 Sec. 19. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:
88.13 Subd. 8. **Payments to improve services to American Indians.** The commissioner
88.14 may set rates for chemical dependency services to American Indians according to the
88.15 American Indian Health Improvement Act, Public Law 94-437, for eligible vendors.
88.16 These rates shall supersede rates set in county purchase of service agreements when
88.17 payments are made on behalf of clients eligible according to Public Law 94-437.

88.18 Sec. 20. **[254B.13] PILOT PROJECTS; CHEMICAL HEALTH CARE.**
88.19 Subdivision 1. **Authorization for pilot projects.** The commissioner of human
88.20 services may approve and implement pilot projects developed under the planning process
88.21 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
88.22 enhance coordination of the delivery of chemical health services required under section
88.23 254B.03.
88.24 Subd. 2. **Program design and implementation.** (a) The commissioner of
88.25 human services and counties participating in the pilot projects shall continue to work in
88.26 partnership to refine and implement the pilot projects initiated under Laws 2009, chapter
88.27 79, article 7, section 26.
88.28 (b) The commissioner and counties participating in the pilot projects shall
88.29 complete the planning phase by June 30, 2010, and, if approved by the commissioner for
88.30 implementation, enter into agreements governing the operation of the pilot projects with
88.31 implementation scheduled no earlier than July 1, 2010.
88.32 Subd. 3. **Program evaluation.** The commissioner of human services shall evaluate
88.33 pilot projects under this section and report the results of the evaluation to the legislative
88.34 committees with jurisdiction over chemical health by June 30, 2013. Evaluation of the

89.1 pilot projects must be based on outcome evaluation criteria negotiated with the projects
89.2 prior to implementation.

89.3 Subd. 4. **Notice of project discontinuation.** Each county's participation in the
89.4 pilot project may be discontinued for any reason by the county or the commissioner of
89.5 human services after 30 days' written notice to the other party. Any unspent funds held
89.6 for the exiting county's pro rata share in the special revenue fund under the authority
89.7 in subdivision 5, paragraph (c), shall be transferred to the general fund following
89.8 discontinuation of the pilot project.

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

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

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

89.16 (b) State expenditures for chemical dependency services and any other services
89.17 provided by or through the pilot projects must not be greater than chemical dependency
89.18 treatment fund expenditures expected in the absence of the pilot projects. The
89.19 commissioner may restructure the schedule of payments between the state and participating
89.20 counties under the local agency share and division of cost provisions under section
89.21 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the pilot projects.

89.22 (c) To the extent that state fiscal year expenditures within a pilot project region are
89.23 less than expected in the absence of the pilot projects, the commissioner may deposit
89.24 these unexpended funds in the special revenue fund and make these funds available for
89.25 expenditure by the pilot counties the following year. To the extent that treatment and pilot
89.26 project ancillary services expenditures within the pilot project exceed the amount expected
89.27 in the absence of the pilot projects, the pilot counties are responsible for the portion of
89.28 nontreatment expenditures in excess of otherwise expected expenditures.

89.29 (d) The commissioner may waive administrative rule requirements which are
89.30 incompatible with the implementation of the pilot project.

89.31 (e) The commissioner shall not approve or enter into any agreement related to pilot
89.32 projects authorized under this section which puts current or future federal funding at risk.

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

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

90.1 (2) ensure that no one is denied chemical dependency treatment services for which
90.2 they would otherwise be eligible under section 254A.03, subdivision 3; and
90.3 (3) provide the commissioner of human services with timely and pertinent
90.4 information as negotiated in agreements governing operation of the pilot projects.

90.5 Sec. 21. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision
90.6 to read:
90.7 Subd. 30. **Office of Health Care Inspector General.** (a) The commissioner shall
90.8 create within the Department of Human Services an Office of Health Care Inspector
90.9 General to enhance antifraud activities and to protect the integrity of the state health care
90.10 programs, as well as the health and welfare of the beneficiaries of those programs. The
90.11 Office of Health Care Inspector General must periodically report to the commissioner and
90.12 to the legislature program and management problems and recommendations to correct
90.13 them.
90.14 (b) The duties of the Office of Health Care Inspector General include, but are not
90.15 limited to:
90.16 (1) promoting economy, efficiency, and effectiveness through the elimination of
90.17 waste, fraud, and abuse;
90.18 (2) conducting and supervising audits, investigations, inspections, and evaluations
90.19 relating to the state health care programs under chapters 256B, 256D, and 256L;
90.20 (3) identifying weaknesses giving rise to opportunities for fraud and abuse in the
90.21 state health care programs and operations and making recommendations to prevent their
90.22 recurrence;
90.23 (4) leading and coordinating activities to prevent and detect fraud and abuse in the
90.24 state health care programs and operations;
90.25 (5) detecting wrongdoers and abusers of the state health care programs and
90.26 beneficiaries so appropriate remedies may be brought;
90.27 (6) keeping the commissioner and the legislature fully and currently informed about
90.28 problems and deficiencies in the administration of the state health care programs and
90.29 operations and about the need for and progress of corrective action;
90.30 (7) operating a toll-free hotline to permit individuals to call in suspected fraud,
90.31 waste, or abuse, referring the calls for appropriate action by the agency, and analyzing the
90.32 calls to identify trends and patterns of fraud and abuse needing attention;
90.33 (8) developing and reviewing legislative, regulatory, and program proposals to
90.34 reduce vulnerabilities to fraud, waste, and mismanagement; and

91.1 (9) recommending changes in program policies, regulations, and laws to improve
91.2 efficiency and effectiveness, and to prevent fraud, waste, abuse, and mismanagement.
91.3 (c) Beginning July 1, 2011, the commissioner, in consultation with the Office of
91.4 Health Care Inspector General, shall annually report to the legislature and the governor
91.5 new results from the two ongoing federal Medicaid audits. The commissioner shall report
91.6 (1) the most recent Medicaid Integrity Program (MIP) audit results, with any corrective
91.7 actions needed, and (2) certify the rate of errors determined for the state health care
91.8 programs under chapters 256B, 256D, and 256L, as determined from the most recent
91.9 Payment Error Rate Measurement (PERM) audit results for Minnesota. When the PERM
91.10 audit rate for Minnesota is greater than the national rate for the year or the MIP audit
91.11 determines the need for corrective action, the commissioner shall present a plan to the
91.12 legislature and the governor for the corrective actions and reduction of the error rate
91.13 in the next calendar year.

91.14 Sec. 22. Laws 2009, chapter 79, article 3, section 18, is amended to read:
91.15 Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED**
91.16 **MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE**
91.17 **ANOKA-METRO REGIONAL TREATMENT CENTER.**
91.18 ~~In consultation with community partners, the commissioner of human services~~ The
91.19 Advisory Group on State-Operated Services Redesign shall ~~develop~~ recommend an array
91.20 of community-based services to transform the current services now provided to patients
91.21 at the Anoka-Metro Regional Treatment Center. The community-based services may
91.22 be provided in facilities with 16 or fewer beds, and must provide the appropriate level
91.23 of care for the patients being admitted to the facilities. The planning for this transition
91.24 must be completed by October 1, ~~2009~~ 2010, with an initial report to the committee chairs
91.25 of health and human services by November 30, ~~2009~~ 2010, and a semiannual report on
91.26 progress until the transition is completed. ~~The commissioner of human services shall~~
91.27 ~~solicit interest from stakeholders and potential community partners.~~ The individuals
91.28 working in the community-based services facilities under this section are state employees
91.29 supervised by the commissioner of human services. No layoffs shall occur as a result of
91.30 restructuring under this section.

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

91.32 Sec. 23. **NONSUBMISSION OF HEALTH CARE CLAIM BY**
91.33 **CLEARINGHOUSE; SIGNIFICANT DISRUPTION.**

92.1 (a) A situation shall be considered a significant disruption to normal operations that
92.2 materially affects the provider's or facility's ability to conduct business in a normal manner
92.3 and to submit claims on a timely basis under Minnesota Statutes, section 62Q.75, if:
92.4 (1) a clearinghouse loses, or otherwise does not submit, a health care claim as
92.5 required by Minnesota Statutes, section 62J.536; and
92.6 (2) the provider or facility can substantiate that it submitted a complete claim to the
92.7 clearinghouse within provisions stated in contract or six months of the date of service,
92.8 whichever is less.
92.9 (b) This section expires January 1, 2012.

92.10 Sec. 24. **REPEALER.**
92.11 Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09,
92.12 subdivisions 4, 5, and 7, and Laws 2009, chapter 79, article 7, section 26, subdivision
92.13 3, are repealed.

92.14 Sec. 25. **EFFECTIVE DATE.**
92.15 Sections 12 to 17 and 24 are effective for claims paid on or after July 1, 2010.

92.16 **ARTICLE 6**
92.17 **DEPARTMENT OF HEALTH**

92.18 Section 1. Minnesota Statutes 2008, section 62D.08, is amended by adding a
92.19 subdivision to read:
92.20 Subd. 7. **Consistent administrative expenses and investment income reporting.**
92.21 (a) Every health maintenance organization must directly allocate administrative expenses
92.22 to specific lines of business or products when such information is available. Remaining
92.23 expenses that cannot be directly allocated must be allocated based on other methods, as
92.24 recommended by the Advisory Group on Administrative Expenses. Health maintenance
92.25 organizations must submit this information, including administrative expenses for dental
92.26 services, using the reporting template provided by the commissioner of health.
92.27 (b) Every health maintenance organization must allocate investment income based
92.28 on cumulative net income over time by business line or product and must submit this
92.29 information, including investment income for dental services, using the reporting template
92.30 provided by the commissioner of health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

93.32 (c) "Pharmaceutical electronic data intermediary" means any entity that provides
93.33 the infrastructure to connect computer systems or other electronic devices utilized
93.34 by prescribing practitioners with those used by pharmacies, health plans, third-party
93.35 administrators, and pharmacy benefit managers in order to facilitate the secure

94.1 transmission of electronic prescriptions, refill authorization requests, communications,
94.2 and other prescription-related information between such entities.
94.3 (d) "HITECH Act" means the Health Information Technology for Economic and
94.4 Clinical Health Act in division A, title XIII and division B, title IV of the American
94.5 Recovery and Reinvestment Act of 2009, including federal regulations adopted under
94.6 that act.
94.7 (e) "Interoperable electronic health record" means an electronic health record that
94.8 securely exchanges health information with another electronic health record system that
94.9 meets requirements specified in subdivision 3, and national requirements for certification
94.10 under the HITECH Act.
94.11 (f) "Qualified electronic health record" means an electronic record of health-related
94.12 information on an individual that includes patient demographic and clinical health
94.13 information and has the capacity to:
94.14 (1) provide clinical decision support;
94.15 (2) support physician order entry;
94.16 (3) capture and query information relevant to health care quality; and
94.17 (4) exchange electronic health information with, and integrate such information
94.18 from, other sources.

94.19 Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is
94.20 amended to read:
94.21 Subd. 3. **Interoperable electronic health record requirements.** To meet the
94.22 requirements of subdivision 1, hospitals and health care providers must meet the following
94.23 criteria when implementing an interoperable electronic health records system within their
94.24 hospital system or clinical practice setting.
94.25 (a) The electronic health record must be a qualified electronic health record.
94.26 (b) The electronic health record must be certified by the Office of the National
94.27 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and
94.28 health care providers ~~only~~ if a certified electronic health record product for the provider's
94.29 particular practice setting is available. This criterion shall be considered met if a hospital
94.30 or health care provider is using an electronic health records system that has been certified
94.31 within the last three years, even if a more current version of the system has been certified
94.32 within the three-year period.
94.33 (c) The electronic health record must meet the standards established according to
94.34 section 3004 of the HITECH Act as applicable.

95.1 (d) The electronic health record must have the ability to generate information on
95.2 clinical quality measures and other measures reported under sections 4101, 4102, and
95.3 4201 of the HITECH Act.

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

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

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

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

95.14 (1) evaluation and approval of the system as specified in section 16E.03, subdivisions
95.15 3 and 4;

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

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

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

95.21 Subdivision 1. **Definitions.** The following definitions apply to sections 62J.498 to
95.22 62J.4982:

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

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

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

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

95.31 (e) "Health data intermediary" means an entity that provides the infrastructure to
95.32 connect computer systems or other electronic devices used by health care providers,
95.33 laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit
95.34 managers to facilitate the secure transmission of health information, including

96.1 pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not
96.2 include health care providers engaged in a direct health information exchange.
96.3 (f) "Health information exchange" means the electronic transmission of
96.4 health-related information between organizations according to nationally recognized
96.5 standards.
96.6 (g) "Health information exchange service provider" means a health data intermediary
96.7 or health information organization that has been issued a certificate of authority by the
96.8 commissioner under section 62J.4981.
96.9 (h) "Health information organization" means an organization that oversees, governs,
96.10 and facilitates the exchange of health-related information among organizations according
96.11 to nationally recognized standards.
96.12 (i) "HITECH Act" means the Health Information Technology for Economic and
96.13 Clinical Health Act as defined in section 62J.495.
96.14 (j) "Major participating entity" means:
96.15 (1) a participating entity that receives compensation for services that is greater
96.16 than 30 percent of the health information organization's gross annual revenues from the
96.17 health information exchange service provider;
96.18 (2) a participating entity providing administrative, financial, or management services
96.19 to the health information organization, if the total payment for all services provided by the
96.20 participating entity exceeds three percent of the gross revenue of the health information
96.21 organization; and
96.22 (3) a participating entity that nominates or appoints 30 percent or more of the board
96.23 of directors of the health information organization.
96.24 (k) "Meaningful use" means use of certified electronic health record technology that
96.25 includes e-prescribing, and is connected in a manner that provides for the electronic
96.26 exchange of health information and used for the submission of clinical quality measures
96.27 as established by the Center for Medicare and Medicaid Services and the Minnesota
96.28 Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH
96.29 Act.
96.30 (l) "Meaningful use transaction" means an electronic transaction that a health care
96.31 provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare
96.32 penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.
96.33 (m) "Participating entity" means any of the following persons, health care providers,
96.34 companies, or other organizations with which a health information organization or health
96.35 data intermediary has contracts or other agreements for the provision of health information
96.36 exchange service providers:

97.1 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home
97.2 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise
97.3 licensed under the laws of this state or registered with the commissioner;
97.4 (2) a health care provider, and any other health care professional otherwise licensed
97.5 under the laws of this state or registered with the commissioner;
97.6 (3) a group, professional corporation, or other organization that provides the
97.7 services of individuals or entities identified in clause (2), including but not limited to a
97.8 medical clinic, a medical group, a home health care agency, an urgent care center, and
97.9 an emergent care center;
97.10 (4) a health plan as defined in section 62A.011, subdivision 3; and
97.11 (5) a state agency as defined in section 13.02, subdivision 17.
97.12 (n) "Reciprocal agreement" means an arrangement in which two or more health
97.13 information exchange service providers agree to share in-kind services and resources to
97.14 allow for the pass-through of meaningful use transactions.
97.15 (o) "State-certified health data intermediary" means a health data intermediary that:
97.16 (1) provides a subset of the meaningful use transaction capabilities necessary for
97.17 hospitals and providers to achieve meaningful use of electronic health records;
97.18 (2) is not exclusively engaged in the exchange of meaningful use transactions
97.19 covered by section 62J.536; and
97.20 (3) has been issued a certificate of authority to operate in Minnesota.
97.21 (p) "State-certified health information organization" means a nonprofit health
97.22 information organization that provides transaction capabilities necessary to fully support
97.23 clinical transactions required for meaningful use of electronic health records that has been
97.24 issued a certificate of authority to operate in Minnesota.
97.25 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall
97.26 protect the public interest on matters pertaining to health information exchange. The
97.27 commissioner shall:
97.28 (1) review and act on applications from health data intermediaries and health
97.29 information organizations for certificates of authority to operate in Minnesota;
97.30 (2) provide ongoing monitoring to ensure compliance with criteria established under
97.31 sections 62J.498 to 62J.4982;
97.32 (3) respond to public complaints related to health information exchange services;
97.33 (4) take enforcement actions as necessary, including the imposition of fines,
97.34 suspension, or revocation of certificates of authority as outlined in section 62J.4982;
97.35 (5) provide a biannual report on the status of health information exchange services
97.36 that includes but is not limited to:

98.1 (i) recommendations on actions necessary to ensure that health information exchange
98.2 services are adequate to meet the needs of Minnesota citizens and providers statewide;
98.3 (ii) recommendations on enforcement actions to ensure that health information
98.4 exchange service providers act in the public interest without causing disruption in health
98.5 information exchange services;
98.6 (iii) recommendations on updates to criteria for obtaining certificates of authority
98.7 under this section; and
98.8 (iv) recommendations on standard operating procedures for health information
98.9 exchange, including but not limited to the management of consumer preferences; and
98.10 (6) other duties necessary to protect the public interest.
98.11 (b) As part of the application review process for certification under paragraph (a),
98.12 prior to issuing a certificate of authority, the commissioner shall:
98.13 (1) hold public hearings that provide an adequate opportunity for participating
98.14 entities and consumers to provide feedback and recommendations on the application under
98.15 consideration. The commissioner shall make all portions of the application classified
98.16 as public data available to the public at least ten days in advance of the hearing. The
98.17 applicant shall participate in the hearing by presenting an application overview and
98.18 responding to questions from interested parties;
98.19 (2) make available all feedback and recommendations from the hearing available to
98.20 the public prior to issuing a certificate of authority; and
98.21 (3) consult with hospitals, physicians, and other professionals eligible to receive
98.22 meaningful use incentive payments or are subject to penalties as established in the
98.23 HITECH Act, and their respective statewide associations, prior to issuing a certificate of
98.24 authority.
98.25 (c)(1) When the commissioner is actively considering a suspension or revocation of
98.26 a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory
98.27 data that are collected, created, or maintained related to the suspension or revocation
98.28 are classified as confidential data on individuals and as protected nonpublic data in the
98.29 case of data not on individuals.
98.30 (2) The commissioner may disclose data classified as protected nonpublic or
98.31 confidential under this paragraph if disclosing the data will protect the health or safety of
98.32 patients.
98.33 (d) After the commissioner makes a final determination regarding a suspension or
98.34 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,
98.35 conclusions of law, and the specification of the final disciplinary action, are classified
98.36 as public data.

99.1 Sec. 7. **[62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
99.2 **INFORMATION EXCHANGE SERVICES.**

99.3 Subdivision 1. **Authority to require organizations to apply.** The commissioner
99.4 shall require an entity providing health information exchange services to apply for a
99.5 certificate of authority under this section. An applicant may continue to operate until
99.6 the commissioner acts on the application. If the application is denied, the applicant is
99.7 considered a health information organization whose certificate of authority has been
99.8 revoked under section 62J.4982, subdivision 2, paragraph (d).

99.9 Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health
99.10 data intermediary that provides health information exchange services for the transmission
99.11 of one or more clinical transactions necessary for hospitals, providers, or eligible
99.12 professionals to achieve meaningful use must be registered with the state and comply with
99.13 requirements established in this section.

99.14 (b) Notwithstanding any law to the contrary, any corporation organized to do so
99.15 may apply to the commissioner for a certificate of authority to establish and operate as
99.16 a health data intermediary in compliance with this section. No person shall establish or
99.17 operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers
99.18 to purchase or receive advance or periodic consideration in conjunction with a health
99.19 data intermediary contract unless the organization has a certificate of authority or has an
99.20 application under active consideration under this section.

99.21 (c) In issuing the certificate of authority, the commissioner shall determine whether
99.22 the applicant for the certificate of authority has demonstrated that the applicant meets
99.23 the following minimum criteria:

99.24 (1) can interoperate with at least one state-certified health information organization;

99.25 (2) can provide an option for Minnesota entities to connect to their services through
99.26 at least one state-certified health information organization;

99.27 (3) has a record locator service as defined in section 144.291, subdivision 2,
99.28 paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8,
99.29 when conducting meaningful use transactions; and

99.30 (4) holds reciprocal agreements with at least one state-certified health information
99.31 organization to enable access to record locator services to find patient data, and for the
99.32 transmission and receipt of meaningful use transactions consistent with the format and
99.33 content required by national standards established by Centers for Medicare and Medicaid
99.34 Services. Reciprocal agreements must meet the requirements established in subdivision 5.

99.35 Subd. 3. **Certificate of authority for health information organizations.**
99.36 (a) A health information organization that provides all electronic capabilities for the

100.1 transmission of clinical transactions necessary for meaningful use of electronic health
100.2 records must obtain a certificate of authority from the commissioner and demonstrate
100.3 compliance with the criteria in paragraph (c).

100.4 (b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do
100.5 so may apply for a certificate of authority to establish and operate a health information
100.6 organization under this section. No person shall establish or operate a health information
100.7 organization in this state, or sell or offer to sell, or solicit offers to purchase or receive
100.8 advance or periodic consideration in conjunction with a health information organization
100.9 or health information contract unless the organization has a certificate of authority under
100.10 this section.

100.11 (c) In issuing the certificate of authority, the commissioner shall determine whether
100.12 the applicant for the certificate of authority has demonstrated that the applicant meets
100.13 the following minimum criteria:

100.14 (1) the entity is a legally established, nonprofit organization;

100.15 (2) has appropriate insurance, including liability insurance, for the operation of the
100.16 health information organization is in place and sufficient to protect the interest of the
100.17 public and participating entities;

100.18 (3) has strategic and operational plans that clearly address how the organization will
100.19 expand technical capacity of the health information organization to support providers in
100.20 achieving meaningful use of electronic health records over time;

100.21 (4) the entity addresses the parameters to be used with participating entities and
100.22 other health information organizations for meaningful use transactions, compliance with
100.23 Minnesota law, and interstate health information exchange in trust agreements;

100.24 (5) the entity's board of directors is comprised of members that broadly represent the
100.25 health information organization's participating entities and consumers;

100.26 (6) the entity maintains a professional staff responsible to the board of directors with
100.27 the capacity to ensure accountability to the organization's mission;

100.28 (7) the entity is compliant with criteria established under the Health Information
100.29 Exchange Accreditation Program of the Electronic Healthcare Network Accreditation
100.30 Commission (EHNAC) or equivalent criteria established by the commissioner;

100.31 (8) the entity maintains a record locator service as defined in section 144.291,
100.32 subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293,
100.33 subdivision 8, when conducting meaningful use transactions;

100.34 (9) the organization demonstrates interoperability with all other state-certified health
100.35 information organizations using nationally recognized standards;

101.1 (10) the organization demonstrates compliance with all privacy and security
101.2 requirements required by state and federal law; and
101.3 (11) the organization uses financial policies and procedures consistent with generally
101.4 accepted accounting principles and has an independent audit of the organization's
101.5 financials on an annual basis.
101.6 (d) Health information organizations that have obtained a certificate of authority
101.7 must:
101.8 (1) meet the requirements established for connecting to the Nationwide Health
101.9 Information Network (NHIN) within the federally mandated timeline or within a time
101.10 frame established by the commissioner and published in the State Register. If the state
101.11 timeline for implementation varies from the federal timeline, the State Register notice
101.12 shall include an explanation for the variation;
101.13 (2) annually submit strategic and operational plans for review by the commissioner
101.14 that address:
101.15 (i) increasing adoption rates to include a sufficient number of participating entities to
101.16 achieve financial sustainability; and
101.17 (ii) progress in achieving objectives included in previously submitted strategic
101.18 and operational plans across the following domains: business and technical operations,
101.19 technical infrastructure, legal and policy issues, finance, and organizational governance;
101.20 (3) develop and maintain a business plan that addresses:
101.21 (i) plans for ensuring the necessary capacity to support meaningful use transactions;
101.22 (ii) approach for attaining financial sustainability, including public and private
101.23 financing strategies, and rate structures;
101.24 (iii) rates of adoption, utilization, and transaction volume, and mechanisms to
101.25 support health information exchange; and
101.26 (iv) an explanation of methods employed to address the needs of community clinics,
101.27 critical access hospitals, and free clinics in accessing health information exchange services;
101.28 (4) annually submit a rate plan outlining fee structures for health information
101.29 exchange services for approval by the commissioner. The commissioner shall approve the
101.30 rate plan if it:
101.31 (i) distributes costs equitably among users of health information services;
101.32 (ii) provides predictable costs for participating entities;
101.33 (iii) covers all costs associated with conducting the full range of meaningful use
101.34 clinical transactions, including access to health information retrieved through other
101.35 state-certified health information exchange service providers; and

102.1 (iv) provides for a predictable revenue stream for the health information organization
102.2 and generates sufficient resources to maintain operating costs and develop technical
102.3 infrastructure necessary to serve the public interest;
102.4 (5) enter into reciprocal agreements with all other state-certified health information
102.5 organizations to enable access to record locator services to find patient data, and
102.6 transmission and receipt of meaningful use transactions consistent with the format and
102.7 content required by national standards established by Centers for Medicare and Medicaid
102.8 Services. Reciprocal agreements must meet the requirements in subdivision 5; and
102.9 (6) comply with additional requirements for the certification or recertification of
102.10 health information organizations that may be established by the commissioner.
102.11 Subd. 4. **Application for certificate of authority for health information exchange**
102.12 **service providers.** (a) Each application for a certificate of authority shall be in a form
102.13 prescribed by the commissioner and verified by an officer or authorized representative of
102.14 the applicant. Each application shall include the following:
102.15 (1) a copy of the basic organizational document, if any, of the applicant and of
102.16 each major participating entity, such as the articles of incorporation, or other applicable
102.17 documents, and all amendments to it;
102.18 (2) a list of the names, addresses, and official positions of the following:
102.19 (i) all members of the board of directors and the principal officers and, if applicable,
102.20 shareholders of the applicant organization; and
102.21 (ii) all members of the board of directors and the principal officers of each major
102.22 participating entity and, if applicable, each shareholder beneficially owning more than ten
102.23 percent of any voting stock of the major participating entity;
102.24 (3) the name and address of each participating entity and the agreed-upon duration
102.25 of each contract or agreement if applicable;
102.26 (4) a copy of each standard agreement or contract intended to bind the participating
102.27 entities and the health information organization. Contractual provisions shall be consistent
102.28 with the purposes of this section in regard to the services to be performed under the
102.29 standard agreement or contract, the manner in which payment for services is determined,
102.30 the nature and extent of responsibilities to be retained by the health information
102.31 organization, and contractual termination provisions;
102.32 (5) a copy of each contract intended to bind major participating entities and the
102.33 health information organization. Contract information filed with the commissioner under
102.34 this section shall be nonpublic as defined in section 13.02, subdivision 9;
102.35 (6) a statement generally describing the health information organization, its health
102.36 information exchange contracts, facilities, and personnel, including a statement describing

103.1 the manner in which the applicant proposes to provide participants with comprehensive
103.2 health information exchange services;
103.3 (7) financial statements showing the applicant's assets, liabilities, and sources
103.4 of financial support, including a copy of the applicant's most recent certified financial
103.5 statement;
103.6 (8) strategic and operational plans that specifically address how the organization
103.7 will expand technical capacity of the health information organization to support providers
103.8 in achieving meaningful use of electronic health records over time, a description of
103.9 the proposed method of marketing the services, a schedule of proposed charges, and a
103.10 financial plan that includes a three-year projection of the expenses and income and other
103.11 sources of future capital;
103.12 (9) a statement reasonably describing the geographic area or areas to be served and
103.13 the type or types of participants to be served;
103.14 (10) a description of the complaint procedures to be used as required under this
103.15 section;
103.16 (11) a description of the mechanism by which participating entities will have an
103.17 opportunity to participate in matters of policy and operation;
103.18 (12) a copy of any pertinent agreements between the health information organization
103.19 and insurers, including liability insurers, demonstrating coverage is in place;
103.20 (13) a copy of the conflict of interest policy that applies to all members of the board
103.21 of directors and the principal officers of the health information organization; and
103.22 (14) other information as the commissioner may reasonably require to be provided.
103.23 (b) Thirty days after the receipt of the application for a certificate of authority,
103.24 the commissioner shall determine whether or not the application submitted meets the
103.25 requirements for completion in paragraph (a), and notify the applicant of any further
103.26 information required for the application to be processed.
103.27 (c) Ninety days after the receipt of a complete application for a certificate of
103.28 authority, the commissioner shall issue a certificate of authority to the applicant if the
103.29 commissioner determines that the applicant meets the minimum criteria requirements
103.30 of subdivision 2 for health data intermediaries or subdivision 3 for health information
103.31 organizations. If the commissioner determines that the applicant is not qualified, the
103.32 commissioner shall notify the applicant and specify the reasons for disqualification.
103.33 (d) Upon being granted a certificate of authority to operate as a health information
103.34 organization, the organization must operate in compliance with the provisions of this
103.35 section. Noncompliance may result in the imposition of a fine or the suspension or
103.36 revocation of the certificate of authority according to section 62J.4982.

104.1 Subd. 5. **Reciprocal agreements between health information exchange entities.**
104.2 (a) Reciprocal agreements between two health information organizations or between a
104.3 health information organization and a health data intermediary must include a fair and
104.4 equitable model for charges between the entities that:
104.5 (1) does not impede the secure transmission of transactions necessary to achieve
104.6 meaningful use;
104.7 (2) does not charge a fee for the exchange of meaningful use transactions transmitted
104.8 according to nationally recognized standards where no additional value-added service
104.9 is rendered to the sending or receiving health information organization or health data
104.10 intermediary either directly or on behalf of the client;
104.11 (3) is consistent with fair market value and proportionately reflects the value-added
104.12 services accessed as a result of the agreement; and
104.13 (4) prevents health care stakeholders from being charged multiple times for the
104.14 same service.
104.15 (b) Reciprocal agreements must include comparable quality of service standards that
104.16 ensure equitable levels of services.
104.17 (c) Reciprocal agreements are subject to review and approval by the commissioner.
104.18 (d) Nothing in this section precludes a state-certified health information organization
104.19 or state-certified health data intermediary from entering into contractual agreements for
104.20 the provision of value-added services beyond meaningful use.
104.21 (e) The commissioner of human services or health, when providing access to data or
104.22 services through a certified health information organization, must offer the same data or
104.23 services directly through any certified health information organization at the same pricing,
104.24 if the health information organization pays for all connection costs to the state data or
104.25 service. For all external connectivity to the respective agencies through existing or future
104.26 information exchange implementations, the respective agency shall establish the required
104.27 connectivity methods as well as protocol standards to be utilized.
104.28 Subd. 6. **State participation in health information exchange.** A state agency
104.29 that connects to a health information exchange service provider for the purpose of
104.30 exchanging meaningful use transactions must ensure that the contracted health information
104.31 exchange service provider has reciprocal agreements in place as required by this section.
104.32 The reciprocal agreements must provide equal access to information supplied by the
104.33 agency and necessary for meaningful use by the participating entities of the other health
104.34 information service providers.

104.35 Sec. 8. **[62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.**

105.1 Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any
105.2 violation of statute or rule applicable to a health information exchange service provider,
105.3 levy an administrative penalty in an amount up to $25,000 for each violation. In
105.4 determining the level of an administrative penalty, the commissioner shall consider the
105.5 following factors:
105.6 (1) the number of participating entities affected by the violation;
105.7 (2) the effect of the violation on participating entities' access to health information
105.8 exchange services;
105.9 (3) if only one participating entity is affected, the effect of the violation on the
105.10 patients of that entity;
105.11 (4) whether the violation is an isolated incident or part of a pattern of violations;
105.12 (5) the economic benefits derived by the health information organization or a health
105.13 data intermediary by virtue of the violation;
105.14 (6) whether the violation hindered or facilitated an individual's ability to obtain
105.15 health care;
105.16 (7) whether the violation was intentional;
105.17 (8) whether the violation was beyond the direct control of the health information
105.18 exchange service provider;
105.19 (9) any history of prior compliance with the provisions of this section, including
105.20 violations;
105.21 (10) whether and to what extent the health information exchange service provider
105.22 attempted to correct previous violations;
105.23 (11) how the health information exchange service provider responded to technical
105.24 assistance from the commissioner provided in the context of a compliance effort; and
105.25 (12) the financial condition of the health information exchange service provider
105.26 including, but not limited to, whether the health information exchange service provider
105.27 had financial difficulties that affected its ability to comply or whether the imposition of an
105.28 administrative monetary penalty would jeopardize the ability of the health information
105.29 exchange service provider to continue to deliver health information exchange services.
105.30 Reasonable notice in writing shall be given to the health information exchange
105.31 service provider of the intent to levy the penalty and the reasons for them. A health
105.32 information exchange service provider may have 15 days within which to contest whether
105.33 the finding of facts constitute a violation of this section and section 62J.4981, according to
105.34 the contested case and judicial review provisions of sections 14.57 to 14.69.
105.35 (b) If the commissioner has reason to believe that a violation of this section or
105.36 section 62J.4981 has occurred or is likely, the commissioner may confer with the persons

106.1 involved before commencing action under subdivision 2. The commissioner may notify
106.2 the health information exchange service provider and the representatives, or other persons
106.3 who appear to be involved in the suspected violation, to arrange a voluntary conference
106.4 with the alleged violators or their authorized representatives. The purpose of the
106.5 conference is to attempt to learn the facts about the suspected violation and if it appears
106.6 that a violation has occurred or is threatened, to find a way to correct or prevent it. The
106.7 conference is not governed by any formal procedural requirements and may be conducted
106.8 as the commissioner considers appropriate.

106.9 (c) The commissioner may issue an order directing a health information exchange
106.10 service provider or a representative of a health information exchange service provider to
106.11 cease and desist from engaging in any act or practice in violation of this section and
106.12 section 62J.4981.

106.13 (d) Within 20 days after service of the order to cease and desist, a health information
106.14 exchange service provider may contest whether the finding of facts constitutes a violation
106.15 of this section and section 62J.4981 according to the contested case and judicial review
106.16 provisions of sections 14.57 to 14.69.

106.17 (e) In the event of noncompliance with a cease and desist order issued under this
106.18 subdivision, the commissioner may institute a proceeding to obtain injunctive relief or
106.19 other appropriate relief in Ramsey County District Court.

106.20 Subd. 2. **Suspension or revocation of certificates of authority.** (a) The
106.21 commissioner may suspend or revoke a certificate of authority issued to a health
106.22 data intermediary or health information organization under section 62J.4981 if the
106.23 commissioner finds that:

106.24 (1) the health information exchange service provider is operating significantly
106.25 in contravention of its basic organizational document, or in a manner contrary to that
106.26 described in and reasonably inferred from any other information submitted under section
106.27 62J.4981, unless amendments to the submissions have been filed with and approved by
106.28 the commissioner;

106.29 (2) the health information exchange service provider is unable to fulfill its
106.30 obligations to furnish comprehensive health information exchange services as required
106.31 under its health information exchange contract;

106.32 (3) the health information exchange service provider is no longer financially solvent
106.33 or may not reasonably be expected to meet its obligations to participating entities;

106.34 (4) the health information exchange service provider has failed to implement the
106.35 complaint system in a manner designed to reasonably resolve valid complaints;

107.1 (5) the health information exchange service provider, or any person acting with its
107.2 sanction, has advertised or merchandised its services in an untrue, misleading, deceptive,
107.3 or unfair manner;

107.4 (6) the continued operation of the health information exchange service provider
107.5 would be hazardous to its participating entities or the patients served by the participating
107.6 entities; or

107.7 (7) the health information exchange service provider has otherwise failed to
107.8 substantially comply with section 62J.4981 or with any other statute or administrative
107.9 rule applicable to health information exchange service providers, or has submitted false
107.10 information in any report required under sections 62J.498 to 62J.4982.

107.11 (b) A certificate of authority shall be suspended or revoked only after meeting the
107.12 requirements of subdivision 3.

107.13 (c) If the certificate of authority of a health information exchange service provider is
107.14 suspended, the health information exchange service provider shall not, during the period
107.15 of suspension, enroll any additional participating entities, and shall not engage in any
107.16 advertising or solicitation.

107.17 (d) If the certificate of authority of a health information exchange service provider is
107.18 revoked, the organization shall proceed, immediately following the effective date of the
107.19 order of revocation, to wind up its affairs and shall conduct no further business except as
107.20 necessary to the orderly conclusion of the affairs of the organization. The organization
107.21 shall engage in no further advertising or solicitation. The commissioner may, by written
107.22 order, permit further operation of the organization as the commissioner finds to be in the
107.23 best interest of participating entities, to the end that participating entities will be given the
107.24 greatest practical opportunity to access continuing health information exchange services.

107.25 Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a)
107.26 When the commissioner has cause to believe that grounds for the denial, suspension,
107.27 or revocation of a certificate of authority exists, the commissioner shall notify the
107.28 health information exchange service provider in writing stating the grounds for denial,
107.29 suspension, or revocation and setting a time within 20 days for a hearing on the matter.

107.30 (b) After a hearing before the commissioner at which the health information
107.31 exchange service provider may respond to the grounds for denial, suspension, or
107.32 revocation, or upon the failure of the health information exchange service provider to
107.33 appear at the hearing, the commissioner shall take action as deemed necessary and shall
107.34 issue written findings that shall be mailed to the health information exchange service
107.35 provider.

108.1 (c) If suspension, revocation, or an administrative penalty is proposed according
108.2 to this section, the commissioner must deliver, or send by certified mail with return
108.3 receipt requested, to the health information exchange service provider written notice of
108.4 the commissioner's intent to impose a penalty. This notice of proposed determination
108.5 must include:

108.6 (1) a reference to the statutory basis for the penalty;

108.7 (2) a description of the findings of fact regarding the violations with respect to
108.8 which the penalty is proposed;

108.9 (3) the nature and amount of the proposed penalty;

108.10 (4) any circumstances described in subdivision 1, paragraph (a), that were considered
108.11 in determining the amount of the proposed penalty;

108.12 (5) instructions for responding to the notice, including a statement of the health
108.13 information exchange service provider's right to a contested case proceeding and a
108.14 statement that failure to request a contested case proceeding within 30 calendar days
108.15 permits the imposition of the proposed penalty; and

108.16 (6) the address to which the contested case proceeding request must be sent.

108.17 Subd. 4. **Coordination.** (a) To the extent possible when implementing sections
108.18 62J.498 to 62J.4982, the commissioner shall seek the advice of the Minnesota e-Health
108.19 Advisory Committee, in the review and update of criteria for the certification and
108.20 recertification of health information exchange service providers.

108.21 (b) By January 1, 2011, the commissioner shall report to the governor and the
108.22 chairs of the senate and house of representatives committees having jurisdiction over
108.23 health information policy issues on the status of the health information exchange in
108.24 Minnesota and provide recommendations on further action necessary to facilitate the
108.25 secure electronic movement of health information among health providers that will enable
108.26 Minnesota providers and hospitals to meet meaningful use exchange requirements.

108.27 Subd. 5. **Fees and monetary penalties.** (a) Every health information exchange
108.28 service provider subject to this section and section 62J.4981 shall be assessed fees as
108.29 follows:

108.30 (1) filing an application for certificate of authority to operate as a health information
108.31 organization, $10,500;

108.32 (2) filing an application for certificate of authority to operate as a health data
108.33 intermediary, $7,000;

108.34 (3) annual health information organization certificate fee, $14,000;

108.35 (4) annual health data intermediary certificate fee, $7,000; and

108.36 (5) fees for other filings, as specified by rule.

109.1 (b) Administrative monetary penalties imposed under this subdivision shall be
109.2 deposited into a revolving fund and are appropriated to the commissioner for the purposes
109.3 of sections 62J.498 to 62J.4982.

109.4 Sec. 9. Minnesota Statutes 2008, section 62Q.19, subdivision 1, is amended to read:
109.5 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
109.6 community providers. The criteria for essential community provider designation shall be
109.7 the following:
109.8 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
109.9 with medical care for uninsured persons and high-risk and special needs populations,
109.10 underserved, and other special needs populations; and
109.11 (2) a commitment to serve low-income and underserved populations by meeting the
109.12 following requirements:
109.13 (i) has nonprofit status in accordance with chapter 317A;
109.14 (ii) has tax exempt status in accordance with the Internal Revenue Service Code,
109.15 section 501(c)(3);
109.16 (iii) charges for services on a sliding fee schedule based on current poverty income
109.17 guidelines; and
109.18 (iv) does not restrict access or services because of a client's financial limitation;
109.19 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
109.20 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
109.21 government, an Indian health service unit, or a community health board as defined in
109.22 chapter 145A;
109.23 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
109.24 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
109.25 conditions; ~~or~~
109.26 (5) a sole community hospital. For these rural hospitals, the essential community
109.27 provider designation applies to all health services provided, including both inpatient and
109.28 outpatient services. For purposes of this section, "sole community hospital" means a
109.29 rural hospital that:
109.30 (i) is eligible to be classified as a sole community hospital according to Code
109.31 of Federal Regulations, title 42, section 412.92, or is located in a community with a
109.32 population of less than 5,000 and located more than 25 miles from a like hospital currently
109.33 providing acute short-term services;

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

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

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

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

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

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

110.15 Sec. 10. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

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

110.25 (b) In addition to any fee prescribed under subdivision 1, there shall be a
110.26 nonrefundable surcharge of $10 for each certified birth record. The local or state registrar
110.27 shall forward this amount to the commissioner of finance for deposit in the general fund
110.28 for the Minnesota Birth Defects Information System established under section 144.2215.
110.29 This surcharge shall not be charged under those circumstances in which no fee for a
110.30 certified birth record is permitted under subdivision 1, paragraph (a).

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

110.32 Sec. 11. **[144.615] BIRTH CENTERS.**

110.33 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
110.34 have the meanings given them.

111.1 (b) "Birth center" means a facility licensed for the primary purpose of performing
111.2 low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are
111.3 planned to occur away from the mother's usual residence following a low-risk pregnancy.
111.4 (c) "CABC" means the Commission for the Accreditation of Birth Centers.
111.5 (d) "Low-risk pregnancy" means a normal, uncomplicated prenatal course as
111.6 determined by documentation of adequate prenatal care and the anticipation of a normal
111.7 uncomplicated labor and birth, as defined by reasonable and generally accepted criteria
111.8 adopted by professional groups for maternal, fetal, and neonatal health care.
111.9 Subd. 2. **License required.** (a) Beginning January 1, 2011, no birth center shall be
111.10 established, operated, or maintained in the state without first obtaining a license from the
111.11 commissioner of health according to this section.
111.12 (b) A license issued under this section is not transferable or assignable and is subject
111.13 to suspension or revocation at any time for failure to comply with this section.
111.14 (c) A birth center licensed under this section shall not assert, represent, offer,
111.15 provide, or imply that the center is or may render care or services other than the services it
111.16 is permitted to render within the scope of the license or the accreditation issued.
111.17 (d) The license must be conspicuously posted in an area where patients are admitted.
111.18 Subd. 3. **Temporary license.** For new birth centers planning to begin operations
111.19 after January 1, 2011, the commissioner may issue a temporary license to the birth center
111.20 that is valid for a period of six months from the date of issuance. The birth center must
111.21 submit to the commissioner an application and applicable fee for licensure as required
111.22 under subdivision 4. The application must include the information required in subdivision
111.23 4, clauses (1) to (3) and (5) to (7), and documentation that the birth center has submitted
111.24 an application for accreditation to the CABC. Upon receipt of accreditation from the
111.25 CABC, the birth center must submit to the commissioner the information required in
111.26 subdivision 4, clause (4), and the applicable fee under subdivision 8. The commissioner
111.27 shall issue a new license.
111.28 Subd. 4. **Application.** An application for a license to operate a birth center and the
111.29 applicable fee under subdivision 8 must be submitted to the commissioner on a form
111.30 provided by the commissioner and must contain:
111.31 (1) the name of the applicant;
111.32 (2) the site location of the birth center;
111.33 (3) the name of the person in charge of the center;
111.34 (4) documentation that the accreditation described under subdivision 6 has been
111.35 issued, including the effective date and the expiration date of the accreditation, and the
111.36 date of the last site visit by the CABC;

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

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

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

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

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

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

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

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

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

112.25 (2) no abortions may be administered; and

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

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

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

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

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

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

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

113.1 (c) An application for renewal shall be submitted at least 60 days prior to expiration
113.2 of the license on forms prescribed by the commissioner of health.
113.3 Subd. 10. **Records.** All health records maintained on each client by a birth center
113.4 are subject to sections 144.292 to 144.298.
113.5 Subd. 11. **Report.** (a) The commissioner of health, in consultation with the
113.6 commissioner of human services and representatives of the licensed birth centers,
113.7 the American College of Obstetricians and Gynecologists, the American Academy
113.8 of Pediatrics, the Minnesota Hospital Association, and the Minnesota Ambulance
113.9 Association, shall evaluate the quality of care and outcomes for services provided in
113.10 licensed birth centers, including, but not limited to, the utilization of services provided at a
113.11 birth center, the outcomes of care provided to both mothers and newborns, and the numbers
113.12 of transfers to other health care facilities that are required and the reasons for the transfers.
113.13 The commissioner shall work with the birth centers to establish a process to gather and
113.14 analyze the data within protocols that protect the confidentiality of patient identification.
113.15 (b) The commissioner of health shall report the findings of the evaluation to the
113.16 legislature by January 15, 2014.

113.17 Sec. 12. Minnesota Statutes 2008, section 144.651, subdivision 2, is amended to read:
113.18 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person
113.19 who is admitted to an acute care inpatient facility for a continuous period longer than
113.20 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental
113.21 health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20,
113.22 "patient" also means a person who receives health care services at an outpatient surgical
113.23 center or at a birth center licensed under section 144.615. "Patient" also means a minor
113.24 who is admitted to a residential program as defined in section 253C.01. For purposes of
113.25 subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving
113.26 mental health treatment on an outpatient basis or in a community support program or other
113.27 community-based program. "Resident" means a person who is admitted to a nonacute care
113.28 facility including extended care facilities, nursing homes, and boarding care homes for
113.29 care required because of prolonged mental or physical illness or disability, recovery from
113.30 injury or disease, or advancing age. For purposes of all subdivisions except subdivisions
113.31 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board
113.32 and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, or a supervised
113.33 living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates
113.34 a rehabilitation program licensed under Minnesota Rules, parts 9530.4100 to 9530.4450.

114.1 Sec. 13. Minnesota Statutes 2008, section 144.9504, is amended by adding a
114.2 subdivision to read:
114.3 Subd. 12. **Blood lead level guidelines.** (a) By January 1, 2011, the commissioner
114.4 must revise clinical and case management guidelines to include recommendations
114.5 for protective health actions and follow-up services when a child's blood lead level
114.6 exceeds five micrograms of lead per deciliter of blood. The revised guidelines must be
114.7 implemented to the extent possible using available resources.
114.8 (b) In revising the clinical and case management guidelines for blood lead levels
114.9 greater than five micrograms of lead per deciliter of blood under this subdivision,
114.10 the commissioner of health must consult with a statewide organization representing
114.11 physicians, the public health department of Minneapolis and other public health
114.12 departments, and a nonprofit organization with expertise in lead abatement.

114.13 Sec. 14. Minnesota Statutes 2008, section 144A.51, subdivision 5, is amended to read:
114.14 Subd. 5. **Health facility.** "Health facility" means a facility or that part of a facility
114.15 which is required to be licensed pursuant to sections 144.50 to 144.58, 144.615, and a
114.16 facility or that part of a facility which is required to be licensed under any law of this state
114.17 which provides for the licensure of nursing homes.

114.18 Sec. 15. Minnesota Statutes 2008, section 144E.37, is amended to read:
114.19 **144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.**
114.20 The ~~board~~ commissioner of health shall establish a comprehensive advanced
114.21 life-support educational program to train rural medical personnel, including physicians,
114.22 physician assistants, nurses, and allied health care providers, in a team approach to
114.23 anticipate, recognize, and treat life-threatening emergencies before serious injury or
114.24 cardiac arrest occurs.
114.25 **EFFECTIVE DATE.** This section is effective July 1, 2010.

114.26 Sec. 16. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST**
114.27 **REDUCTION; REPORTING REQUIREMENTS.**
114.28 (a) Minnesota health plans and county-based purchasing plans may complete an
114.29 inventory of existing data collection and reporting requirements for health plans and
114.30 county-based purchasing plans and submit to the commissioners of health and human
114.31 services a list of data, documentation, and reports that:

115.1 (1) are collected from the same health plan or county-based purchasing plan more
115.2 than once;
115.3 (2) are collected directly from the health plan or county-based purchasing plan but
115.4 are available to the state agencies from other sources;
115.5 (3) are not currently being used by state agencies; or
115.6 (4) collect similar information more than once in different formats, at different
115.7 times, or by more than one state agency.
115.8 (b) The report to the commissioners may also identify the percentage of health
115.9 plan and county-based purchasing plan administrative time and expense attributed to
115.10 fulfilling reporting requirements and include recommendations regarding ways to reduce
115.11 duplicative reporting requirements.
115.12 (c) Upon receipt, the commissioners shall submit the inventory and recommendations
115.13 to the chairs of the appropriate legislative committees, along with their comments
115.14 and recommendations as to whether any action should be taken by the legislature to
115.15 establish a consolidated and streamlined reporting system under which data, reports, and
115.16 documentation are collected only once and only when needed for the state agencies to
115.17 fulfill their duties under law and applicable regulations.

115.18 Sec. 17. **APPLICATION PROCESS FOR HEALTH INFORMATION**
115.19 **EXCHANGE.**
115.20 To the extent that the commissioner of health applies for additional federal funding
115.21 to support the commissioner's responsibilities of developing and maintaining state level
115.22 health information exchange under section 3013 of the HITECH Act, the commissioner of
115.23 health shall ensure that applications are made through an open process that provides health
115.24 information exchange service providers equal opportunity to receive funding.

115.25 Sec. 18. **TRANSFER.**
115.26 The powers and duties of the Emergency Medical Services Regulatory Board with
115.27 respect to the comprehensive advanced life-support educational program under Minnesota
115.28 Statutes, section 144E.37, are transferred to the commissioner of health under Minnesota
115.29 Statutes, section 15.039.

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

115.31 Sec. 19. **REVISOR'S INSTRUCTION.**

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

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

116.5 ## ARTICLE 7

116.6 ## HEALTH CARE REFORM

116.7 Section 1. **[62E.20] RELATIONSHIP TO TEMPORARY FEDERAL HIGH-RISK**
116.8 **POOL.**

116.9 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
116.10 this subdivision have the meanings given.

116.11 (b) "Association" means the Minnesota Comprehensive Health Association.

116.12 (c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient
116.13 Protection and Affordable Care Act, Public Law 111-148, including any federal
116.14 regulations adopted under it.

116.15 (d) "Federal qualified high-risk pool" means an arrangement established by the
116.16 federal secretary of health and human services that meets the requirements of the federal
116.17 law.

116.18 Subd. 2. **Timing of this section.** This section applies beginning as of the date the
116.19 temporary federal qualified high risk health pool created under the federal law begins
116.20 to provide coverage in this state.

116.21 Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive
116.22 health association on its member insurers must comply with the maintenance of effort
116.23 requirement contained in paragraph (b), clause (3), of the federal law, to the extent that
116.24 requirement applies to assessments made by the association.

116.25 Subd. 4. **Coordination with federal law.** Upon the date a federal qualified high-risk
116.26 pool begins to provide coverage in this state, the comprehensive health association must
116.27 not enroll new enrollees, notwithstanding section 62E.14 or other law to the contrary. If
116.28 the lack of new enrollees would otherwise lead to noncompliance with subdivision 3, the
116.29 association shall reduce the premiums to levels below those otherwise required under
116.30 section 62E.08, to the extent necessary to comply with subdivision 3.

116.31 Subd. 5. **Coordination with state health care programs.** The commissioner of
116.32 human services, in consultation with the commissioner of commerce and the Minnesota
116.33 Comprehensive Health Association, shall coordinate enrollment between medical

117.1 assistance, MinnesotaCare, the federal qualified high-risk pool, and the Minnesota
117.2 Comprehensive Health Association, to ensure that:
117.3 (1) applicants for coverage through the federal qualified high-risk pool, or through
117.4 the Minnesota Comprehensive Health Association to the extent the association is enrolling
117.5 new members, are referred to the medical assistance or MinnesotaCare programs if they
117.6 are determined to be potentially eligible for coverage through those programs; and
117.7 (2) applicants for coverage under medical assistance or MinnesotaCare who are
117.8 determined not to be eligible for those programs are provided information about coverage
117.9 through the federal qualified high-risk pool and the Minnesota Comprehensive Health
117.10 Association.

117.11 Sec. 2. Minnesota Statutes 2008, section 62J.07, subdivision 2, is amended to read:
117.12 Subd. 2. **Membership.** The Legislative Commission on Health Care Access
117.13 consists of ~~five~~ seven members of the senate appointed under the rules of the senate and
117.14 ~~five~~ seven members of the house of representatives appointed under the rules of the house
117.15 of representatives. The Legislative Commission on Health Care Access must include ~~three~~
117.16 five members of the majority party and two members of the minority party in each house.

117.17 Sec. 3. Minnesota Statutes 2008, section 62J.07, is amended by adding a subdivision to
117.18 read:
117.19 Subd. 5. **Federal health care reform.** (a) The Legislative Commission on
117.20 Health Care Access shall analyze options and make recommendations regarding the
117.21 implementation of provisions of the Patient Protection and Affordable Health Care Act,
117.22 Public Law 111-148, and the health care reform provisions in the Health Care and
117.23 Education Reconciliation Act of 2010, Public Law 111-152, including:
117.24 (1) development of accountable care organizations;
117.25 (2) health insurance reform, including options related to coverage, purchasing,
117.26 exchange development, and coverage for high-risk individuals; and
117.27 (3) other provisions that will require changes in state law.
117.28 (b) Before finalizing and submitting federal applications for pilot projects authorized
117.29 under federal health care reform, the governor and state agencies shall seek review and
117.30 advice from the commission.
117.31 (c) The commission may create and make appointments to work groups to assist the
117.32 commission in its work. Work group members may include legislators, representatives
117.33 of businesses and nonprofit agencies impacted by federal health care reform, academic
117.34 experts, and consumer representatives.

118.1 Sec. 4. Minnesota Statutes 2008, section 62U.05, is amended to read:

118.2 **62U.05 PROVIDER PRICING FOR BASKETS OF CARE; ACCOUNTABLE**
118.3 **CARE ORGANIZATIONS.**

118.4 Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner
118.5 of health shall establish uniform definitions for baskets of care beginning with a minimum
118.6 of seven baskets of care. In selecting health conditions for which baskets of care should
118.7 be defined, the commissioner shall consider coronary artery and heart disease, diabetes,
118.8 asthma, and depression. In selecting health conditions, the commissioner shall also
118.9 consider the prevalence of the health conditions, the cost of treating the health conditions,
118.10 and the potential for innovations to reduce cost and improve quality.

118.11 (b) The commissioner shall convene one or more work groups to assist in
118.12 establishing these definitions. Each work group shall include members appointed by
118.13 statewide associations representing relevant health care providers and health plan
118.14 companies, and organizations that work to improve health care quality in Minnesota.

118.15 (c) To the extent possible, the baskets of care must incorporate a patient-directed,
118.16 decision-making support model.

118.17 (d) By January 1, 2012, the commissioner shall establish uniform definitions for the
118.18 total cost of providing all necessary services to a patient through an accountable care
118.19 organization meeting the standards specified in section 3022 of the Patient Protection
118.20 and Affordable Care Act, Public Law 111-148, and shall develop a standard method
118.21 and format for accountable care organizations to use for submitting package prices for
118.22 the total cost of care. This method must be published in the State Register and must be
118.23 made available to all providers.

118.24 Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may
118.25 establish package prices for the baskets of care defined under subdivision 1. Beginning
118.26 July 1, 2012, accountable care organizations may establish package prices for the total
118.27 cost of care defined under subdivision 1.

118.28 (b) Beginning January 1, 2010, no health care provider or group of providers that
118.29 has established a package price for a basket of care under this section, and beginning
118.30 July 1, 2012, no accountable care organization that has established a package price for
118.31 the total cost of care under this section, shall vary the payment amount that the provider
118.32 or organization accepts as full payment for a health care service based upon the identity of
118.33 the payer, upon a contractual relationship with a payer, upon the identity of the patient,
118.34 or upon whether the patient has coverage through a group purchaser. This paragraph
118.35 applies only to health care services provided to Minnesota residents or to non-Minnesota
118.36 residents who obtain health insurance through a Minnesota employer. This paragraph does

119.1 not apply to services paid for by Medicare, state public health care programs through
119.2 fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile
119.3 insurance. This paragraph does not affect the right of a provider to provide charity care
119.4 or care for a reduced price due to financial hardship of the patient or due to the patient
119.5 being a relative or friend of the provider.

119.6 Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall
119.7 establish quality measurements for the defined baskets of care by December 31, 2009.
119.8 The commissioner shall establish quality measures for the total cost of care for services
119.9 delivered through an accountable care organization by June 30, 2012. The commissioner
119.10 may contract with an organization that works to improve health care quality to make
119.11 recommendations about the use of existing measures or establishing new measures where
119.12 no measures currently exist.

119.13 (b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall
119.14 publish comparative price and quality information on the baskets of care in a manner
119.15 that is easily accessible and understandable to the public, as this information becomes
119.16 available. Beginning January 1, 2013, the commissioner or the commissioner's designee
119.17 shall publish comparative price and quality information on the total cost of care for
119.18 services delivered through an accountable care organization in a manner that is easily
119.19 accessible and understandable to the public, as this information becomes available.

119.20 Sec. 5. Minnesota Statutes 2008, section 256B.0754, is amended by adding a
119.21 subdivision to read:

119.22 Subd. 3. **Accountable care organizations.** By July 1, 2012, the commissioner of
119.23 human services shall deliver services to enrollees in state health care programs through
119.24 accountable care organizations, and shall provide incentive payments to accountable care
119.25 organizations that meet or exceed annual quality and performance targets. Accountable
119.26 care organizations and incentive payments must meet the standards specified in the Patient
119.27 Protection and Affordable Care Act, Public Law 111-148.

119.28 Sec. 6. **[256B.0756] COORDINATED CARE THROUGH A HEALTH HOME.**

119.29 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
119.30 medical assistance coverage of health home services for eligible individuals with chronic
119.31 conditions who select a designated provider, a team of health care professionals, or a
119.32 health team as the individual's health home.

119.33 (b) The commissioner shall implement this section in compliance with the
119.34 requirements of the state option to provide health homes for enrollees with chronic

120.1 conditions, as provided under the Patient Protection and Affordable Care Act, Public
120.2 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
120.3 provided in that act.

120.4 Subd. 2. **Eligible individual.** An individual is eligible for health home services
120.5 under this section if the individual is eligible for medical assistance under this chapter
120.6 and has at least:

120.7 (1) two chronic conditions;

120.8 (2) one chronic condition and is at risk of having a second chronic condition; or

120.9 (3) one serious and persistent mental health condition.

120.10 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
120.11 timely high-quality services that are provided by a health home. These services include:

120.12 (1) comprehensive care management;

120.13 (2) care coordination and health promotion;

120.14 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
120.15 to other settings;

120.16 (4) patient and family support, including authorized representatives;

120.17 (5) referral to community and social support services, if relevant; and

120.18 (6) use of health information technology to link services, as feasible and appropriate.

120.19 (b) The commissioner shall maximize the number and type of services
120.20 included in this subdivision to the extent permissible under federal law, including
120.21 physician, outpatient, mental health treatment, and rehabilitation services necessary for
120.22 comprehensive transitional care following hospitalization.

120.23 Subd. 4. **Health teams.** The commissioner shall establish health teams to support
120.24 the patient-centered health home and provide the services described in subdivision 3 to
120.25 individuals eligible under subdivision 2. The commissioner shall apply for grants or
120.26 contracts as provided under section 3502 of the Patient Protection and Affordable Care
120.27 Act to establish health teams and provide capitated payments to primary care providers.
120.28 For purposes of this section, "health teams" means community-based, interdisciplinary,
120.29 inter-professional teams of health care providers that support primary care practices.
120.30 These providers may include medical specialists, nurses, advanced practice registered
120.31 nurses, pharmacists, nutritionists, social workers, behavioral and mental health providers,
120.32 doctors of chiropractic, licensed complementary and alternative medicine practitioners,
120.33 and physician's assistants.

120.34 Subd. 5. **Payments.** The commissioner shall make payments to each health home
120.35 and each health team for the provision of health home services to each eligible individual
120.36 with chronic conditions that selects the health home as a provider.

121.1 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
121.2 the requirements and payment methods for health homes and health teams developed
121.3 under this section are consistent with the requirements and payment methods for health
121.4 care homes established under sections 256B.0751 and 256B.0753. The commissioner may
121.5 modify requirements and payment methods under sections 256B.0751 and 256B.0753 in
121.6 order to be consistent with federal health home requirements and payment methods.
121.7 Subd. 7. **State plan amendment.** The commissioner shall submit a state plan
121.8 amendment to implement this section to the federal Centers for Medicare and Medicaid
121.9 Services by January 1, 2011.

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

121.12 Sec. 7. **FEDERAL HEALTH CARE REFORM DEMONSTRATION PROJECTS**
121.13 **AND GRANTS.**
121.14 (a) The commissioner of human services shall seek to participate in the following
121.15 demonstration projects, or apply for the following grants, as described in the federal
121.16 Patient Protection and Affordable Care Act, Public Law 111-148:
121.17 (1) the demonstration project to evaluate integrated care around a hospitalization,
121.18 Public Law 111-148, section 2704;
121.19 (2) the Medicaid global payment system demonstration project, Public Law 111-148,
121.20 section 2705;
121.21 (3) the pediatric accountable care organization demonstration project, Public Law
121.22 111-148, section 2706;
121.23 (4) the Medicaid emergency psychiatric demonstration project, Public Law 111-148,
121.24 section 2707; and
121.25 (5) grants to provide incentives for prevention of chronic diseases in Medicaid,
121.26 Public Law 111-148, section 4108.
121.27 (b) The commissioner of human services shall report to the chairs and ranking
121.28 minority members of the house of representatives and senate committees or divisions with
121.29 jurisdiction over health care policy and finance on the status of the demonstration project
121.30 and grant applications. If the state is accepted as a demonstration project participant, or is
121.31 awarded a grant, the commissioner shall notify the chairs and ranking minority members
121.32 of those committees or divisions of any legislative changes necessary to implement the
121.33 demonstration projects or grants.

121.34 Sec. 8. **HEALTH CARE REFORM TASK FORCE.**

122.1 Subdivision 1. **Task force.** (a) The governor shall convene a Health Care
122.2 Reform Task Force to advise and assist the governor and the legislature regarding state
122.3 implementation of federal health care reform legislation. For purposes of this section,
122.4 "federal health care reform legislation" means the Patient Protection and Affordable Care
122.5 Act, Public Law 111-148, and the health care reform provisions in the Health Care and
122.6 Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:
122.7 (1) two legislators from the house of representatives appointed by the speaker and
122.8 two legislators from the senate appointed by the Subcommittee on Committees of the
122.9 Committee on Rules and Administration;
122.10 (2) two representatives appointed by the governor to represent the governor and
122.11 state agencies;
122.12 (3) three persons appointed by the governor who have demonstrated leadership in
122.13 health care organizations, health plan companies, or health care trade or professional
122.14 associations;
122.15 (4) three persons appointed by the governor who have demonstrated leadership in
122.16 employer and group purchaser activities related to health system improvement of whom at
122.17 least two must be from a labor organization; and
122.18 (5) five persons appointed by the governor who have demonstrated expertise in the
122.19 areas of health care financing, access, and quality.
122.20 The governor is exempt from the requirements of the open appointments process
122.21 for purposes of appointing task force members. Members shall be appointed for one-year
122.22 terms and may be reappointed.
122.23 (b) The Department of Health, Department of Human Services, and Department of
122.24 Commerce shall provide staff support to the task force. The task force may accept outside
122.25 resources to help support its efforts.
122.26 (c) Task force members must be appointed by July 1, 2010. The task force must hold
122.27 its first meeting by July 15, 2010.
122.28 Subd. 2. **Duties.** (a) By December 15, 2010, the task force shall develop and
122.29 present to the legislature and the governor a preliminary report and recommendations on
122.30 state implementation of federal health care reform legislation. The report must include
122.31 recommendations for state law and program changes necessary to comply with the federal
122.32 health care reform legislation, and also recommendations for implementing provisions of
122.33 the federal legislation that are optional for states. In developing recommendations, the task
122.34 force shall consider the extent to which an approach maximizes federal funding to the state.

123.1 (b) The task force, in consultation with the governor and the legislature, shall also
123.2 establish timelines and criteria for future reports on state implementation of the federal
123.3 health care reform legislation.

123.4 Sec. 9. **AMERICAN HEALTH BENEFIT EXCHANGE; PLANNING**
123.5 **PROVISIONS.**

123.6 Subdivision 1. **Federal planning grants.** The commissioners of commerce, health,
123.7 and human services shall jointly or separately apply to the federal secretary of health and
123.8 human services for one or more planning and establishment grants, including renewal
123.9 grants, authorized under section 1311 of the Patient Protection and Affordable Care Act,
123.10 Public Law 111-148, including any future amendments of that provision, relating to state
123.11 creation of American Health Benefit Exchanges.

123.12 Subd. 2. **Consideration of early creation and operation of exchange.** (a) The
123.13 commissioners referenced in subdivision 1 shall analyze the advantages and disadvantages
123.14 to the state of planning to have a state health insurance exchange, similar to an American
123.15 Health Benefit Exchange referenced in subdivision 1, begin prior to the federal deadline
123.16 of January 1, 2014.

123.17 (b) The commissioners shall provide a written report to the legislature on the results
123.18 of the analysis required under paragraph (a) no later than December 15, 2010. The written
123.19 report must comply with Minnesota Statutes, sections 3.195 and 3.197.

123.20 **ARTICLE 8**

123.21 **HUMAN SERVICES FORECAST ADJUSTMENTS**

123.22 Section 1. **SUMMARY OF APPROPRIATIONS; DEPARTMENT OF HUMAN**
123.23 **SERVICES FORECAST ADJUSTMENT.**

123.24 The dollar amounts shown are added to or if shown in parentheses, are subtracted
123.25 from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009,
123.26 chapter 173, article 2, from the general fund or any fund named to the Department of
123.27 Human Services for the purposes specified in this article, to be available for the fiscal
123.28 year indicated for each purpose. The figure "2010" used in this article means that the
123.29 appropriation or appropriations listed are available for the fiscal year ending June 30,
123.30 2010. The figure "2011" used in this article means that the appropriation or appropriations
123.31 listed are available for the fiscal year ending June 30, 2011.

123.32			**2010**		**2011**
123.33	General	$	(109,876,000)	$	(28,344,000)
123.34	Health Care Access		99,654,000		276,500,000

124.1	Federal TANF	(9,830,000)	15,133,000
124.2	**Total**	**$ (20,052,000)**	**$ 263,289,000**

124.3 Sec. 2. **COMMISSIONER OF HUMAN**
124.4 **SERVICES**

124.5	Subdivision 1. **Total Appropriation**	**$ (20,052,000)**	**$ 263,289,000**

124.6 Appropriations by Fund

		2010	2011
124.7		2010	2011
124.8	General	(109,876,000)	(28,344,000)
124.9	Health Care Access	99,654,000	276,500,000
124.10	Federal TANF	(9,830,000)	15,133,000

124.11 Subd. 2. **Revenue and Pass-Through**

124.12	Federal TANF	390,000	(251,000)

124.13 Subd. 3. **Children and Economic Assistance**
124.14 **Grants**

124.15	General Fund	4,489,000	(4,140,000)
124.16	Federal TANF	(10,220,000)	15,384,000

124.17 The amounts that may be spent from this
124.18 appropriation are as follows:

124.19 (a) **MFIP Grants**

124.20	General Fund	7,916,000	(14,481,000)
124.21	TANF Fund	(10,220,000)	15,384,000

124.22	(b) **MFIP Child Care Assistance Grants**	(7,832,000)	2,579,000
124.23	(c) **General Assistance Grants**	875,000	1,339,000
124.24	(d) **Minnesota Supplemental Aid Grants**	2,454,000	3,843,000
124.25	(e) **Group Residential Housing Grants**	1,076,000	2,580,000

124.26 Subd. 4. **Basic Health Care Grants**

124.27	General Fund	(62,770,000)	29,192,000
124.28	TANF Fund	99,654,000	276,500,000

124.29 The amounts that may be spent from this
124.30 appropriation are as follows:

124.31 (a) **MinnesotaCare Grants**

Health Care Access Fund	99,654,000	276,500,000		
(b) **Medical Assistance Basic Health Care – Families and Children**			1,165,000	24,146,000
(c) **Medical Assistance Basic Health Care – Elderly and Disabled**			(63,935,000)	5,046,000
Subd. 5. **Continuing Care Grants**			(51,595,000)	(53,396,000)

The amounts that may be spent from this appropriation are as follows:

(a) **Medical Assistance Long-Term Care Facilities**	(3,774,000)	(8,275,000)
(b) **Medical Assistance Long-Term Care Waivers**	(27,710,000)	(22,452,000)
(c) **Chemical Dependency Entitlement Grants**	(20,111,000)	(22,669,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the date following final enactment.

ARTICLE 9

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2010	**2011**	**Total**
General	$ (10,162,000)	$ (99,234,000)	$ (109,396,000)
State Government Special Revenue	(608,000)	(275,000)	(883,000)
Health Care Access	(1,094,000)	72,459,000	71,365,000
Federal TANF	-0-	27,918,000	27,918,000
Total	**$ (11,864,000)**	**$ (867,000)**	**$ (10,997,000)**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, article 13, as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available

126.1 for the fiscal years indicated for each purpose. The figures "2010" and "2011" used in
126.2 this article mean that the addition to or subtraction from the appropriation listed under
126.3 them is available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively.
126.4 Supplemental appropriations and reductions to appropriations for the fiscal year ending
126.5 June 30, 2010, are effective the day following final enactment unless a different effective
126.6 date is explicit.

126.7–126.10	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**

126.11 Sec. 3. **COMMISSIONER OF HUMAN**
126.12 **SERVICES**

126.13 Subdivision 1. **Total Appropriation**	**$ (9,467,000)**	**$ (5,084,000)**

126.14 Appropriations by Fund

126.15	2010	2011
126.16 General	(8,365,000)	(105,244,000)
126.17 State Government 126.18 Special Revenue	(8,000)	(16,000)
126.19 Health Care Access	(1,094,000)	72,259,000
126.20 Federal TANF	-0-	27,918,000

126.21 **Working Family Credit Expenditures to**
126.22 **be Claimed for TANF/MOE.** For fiscal year
126.23 2011, the commissioner may count $38,000
126.24 of working family credit expenditures as
126.25 TANF/MOE. Notwithstanding any provision
126.26 to the contrary, this rider expires June 30,
126.27 2013.

126.28 **TANF Financing and Maintenance of**
126.29 **Effort.** The commissioner of human
126.30 services, with the approval of the
126.31 commissioner of management and budget,
126.32 and after notification of the chairs of the
126.33 relevant senate budget division and house of
126.34 representatives finance division, may adjust
126.35 the amount of TANF transfers between the
126.36 MFIP transition year child care assistance
126.37 program and MFIP grant programs within the

127.1 fiscal year, and within the current biennium
127.2 and the biennium ending June 30, 2013,
127.3 to ensure that state and federal match and
127.4 maintenance of effort requirements are
127.5 met. These transfers and amounts must be
127.6 reported to the chairs of the senate and house
127.7 of representatives Finance Committees, the
127.8 senate Health and Human Services Budget
127.9 Division, the house of representatives Health
127.10 Care and Human Services Finance Division,
127.11 and Early Childhood Finance and Policy
127.12 Division by December 1 of each fiscal
127.13 year. Notwithstanding any provision to the
127.14 contrary, this rider expires June 30, 2013.

127.15 The appropriation reductions for each
127.16 purpose are shown in the following
127.17 subdivisions.

127.18 Subd. 2. **Agency Management; Financial** 127.19 **Operations**	(8,000)	(16,000)

127.20 This appropriation reduction is from the state
127.21 government special revenue fund.

127.22 Subd. 3. **Revenue and Pass-Through Revenue** 127.23 **Expenditures**	-0-	28,000,000

127.24 **TANF Funding for the Working Family**
127.25 **Tax Credit.** In addition to the amounts
127.26 specified in Minnesota Statutes, section
127.27 290.0671, subdivision 6, $18,722,000
127.28 of TANF funds in fiscal year 2010 and
127.29 $18,689,000 of TANF funds in fiscal year
127.30 2011 are appropriated to the commissioner
127.31 of human services to reimburse the cost of
127.32 the working family tax credit for eligible
127.33 families. Beginning January 1, 2011, the
127.34 commissioner shall reimburse the general
127.35 fund on a monthly basis according to a
127.36 schedule based on the pattern of working

128.1 family credit expenditures through June 20,
128.2 2011. This rider is effective upon enactment.

128.3 Subd. 4. **Children and Economic Assistance**
128.4 **Grants**

128.5 (a) **MFIP and Diversionary Work Program** 128.6 **Grants**	-0-	(2,033,000)

128.7 This appropriation reduces the general
128.8 fund appropriation by $5,691,000 and
128.9 increases the federal TANF appropriation by
128.10 $3,658,000.

128.11 (b) **Support Services Grants**	-0-	(7,646,000)

128.12 **Supported Work.** The fiscal year 2011
128.13 TANF appropriation to the commissioner of
128.14 human services for supported work for MFIP
128.15 recipients is reduced by $4,000,000. This
128.16 reduction is onetime.

128.17 **Base Adjustment.** The general fund base
128.18 shall be increased by $2,642,000 for fiscal
128.19 years 2012 and 2013.

128.20 (c) **MFIP Child Care Assistance Grants**	-0-	(38,000)

128.21 This appropriation reduces the general
128.22 fund appropriation by $4,000,000 and
128.23 increases the federal TANF appropriation by
128.24 $3,962,000.

128.25 (d) **Children and Community Services Grants**	-0-	(9,900,000)

128.26 **Children and Community Services Grant**
128.27 **Reduction.** The fiscal year 2011 general
128.28 fund appropriation to the commissioner
128.29 of human services for the children and
128.30 community services grants under Minnesota
128.31 Statutes, section 256M.40, is reduced by
128.32 $9,900,000. This reduction is ongoing and is
128.33 subtracted from the base.

128.34 (e) **Children's Mental Health Grants**	-0-	(8,028,000)

129.1 (1) The general fund appropriation for
129.2 respite care services for children with
129.3 severe emotional disturbance who are at
129.4 risk of out-of-home placement is reduced
129.5 by $1,024,000 for fiscal year 2011. This
129.6 reduction is onetime.

129.7 (2) The general fund appropriation for
129.8 children's early intervention services is
129.9 reduced by $1,024,000 for fiscal year 2011.
129.10 This reduction is onetime.

129.11 (3) The general fund appropriation for
129.12 children's capacity school-based services is
129.13 reduced by $4,777,000 for fiscal year 2011.

129.14 (4) The general fund appropriation for
129.15 children's mental health targeted case
129.16 management grants is reduced by $1,210,000
129.17 for fiscal year 2011.

129.18 Subd. 5. **Children and Economic Assistance**
129.19 **Management**

129.20 (a) **Children and Economic Assistance** 129.21 **Administration**	-0-	-0-

129.22 The general fund appropriation is reduced by
129.23 $172,000 in fiscal year 2010 and by $176,000
129.24 in fiscal year 2011.

129.25 The federal TANF appropriation is increased
129.26 by $172,000 in fiscal year 2010 and by
129.27 $176,000 in fiscal year 2011. The TANF
129.28 fund base shall be reduced by $700,000 in
129.29 fiscal years 2012 and 2013.

129.30 (b) **Children and Economic Assistance** 129.31 **Operations**	(1,580,000)	(1,692,000)

129.32 The general fund appropriation is reduced
129.33 by $1,408,000 in fiscal year 2010 and by
129.34 $1,534,000 in fiscal year 2011. The general

130.1 fund base is reduced by $26,000 in each of
130.2 fiscal years 2012 and 2013.

130.3 $74,000 in fiscal year 2011 is appropriated
130.4 from the health care access fund. This
130.5 appropriation is onetime.

130.6 The federal TANF appropriation is reduced
130.7 by $172,000 in fiscal year 2010 and by
130.8 $232,000 in fiscal year 2011.

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

130.10	(a) **MinnesotaCare Grants**	-0-	(67,549,000)

130.11 This appropriation reduction is from the
130.12 health care access fund.

130.13 130.14	(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	(1,108,000)
130.15 130.16	(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	(2,817,000)
130.17	(d) **General Assistance Medical Care Grants**	-0-	(52,614,000)

130.18 **Funding Reduction; Coordinated Care**
130.19 **Delivery Systems.** The appropriation for
130.20 payments to coordinated care delivery
130.21 systems in Laws 2010, chapter 200, article
130.22 2, section 2, subdivision 4, paragraph (d), is
130.23 reduced by $20,000,000 in fiscal year 2011.

130.24 130.25	(e) **Medical Assistance; Adults Without Children**	-0-	144,114,000

130.26 Of this appropriation, $142,768,000 is from
130.27 the health care access fund.

130.28	(f) **Other Health Care Grants**	-0-	(1,831,000)

130.29 Of this appropriation, the general fund is
130.30 increased by $19,000 and the health care
130.31 access fund appropriation is reduced by
130.32 $1,850,000. This appropriation is onetime.

131.1 **COBRA Carryforward.** Unexpended
131.2 funds appropriated in fiscal year 2010 for
131.3 COBRA grants under Laws 2009, chapter
131.4 79, article 5, section 78, do not cancel and
131.5 are available to the commissioner of human
131.6 services for fiscal year 2011 COBRA grant
131.7 expenditures. Up to $110,000 of the fiscal
131.8 year 2011 appropriation for COBRA grants
131.9 provided in Laws 2009, chapter 79, article
131.10 13, section 3, subdivision 6, may be used
131.11 by the commissioner of human services for
131.12 costs related to administration of the COBRA
131.13 grants.

131.14 **Transfer.** The commissioner shall transfer
131.15 $19,000 to the commissioner of commerce
131.16 for regulation of Minnesota Statutes, section
131.17 62A.3075.

131.18 Subd. 7. **Health Care Management**

131.19 (a) **Health Care Administration**	(2,853,000)	(4,783,000)

131.20 For fiscal year 2011 the health care access
131.21 fund appropriation is increased by $250,000
131.22 and the general fund appropriation is reduced
131.23 by $4,633,000.

131.24 **Reduction in Appropriation.** The base
131.25 funding under the current law forecast used
131.26 to calculate the state appropriation for the
131.27 medical assistance program is reduced by
131.28 one percent for the 2012-2013 biennium.
131.29 This reduction is subject to federal approval
131.30 of the intensive care management program
131.31 authorized under Minnesota Statutes, section
131.32 256B.0755, and is ongoing and shall apply
131.33 to future bienniums, or for as long as the
131.34 intensive care management program is

132.1 determined to be cost-effective by the
132.2 commissioner of human services.

132.3 **PACE Implementation Funding.** For fiscal
132.4 year 2011, $145,000 is appropriated from
132.5 the general fund to the commissioner of
132.6 human services to complete the actuarial and
132.7 administrative work necessary to begin the
132.8 operation of PACE under Minnesota Statutes,
132.9 section 256B.69, subdivision 23, paragraph
132.10 (e). Base level funding for this activity shall
132.11 be $130,000 in fiscal year 2012 and $0 in
132.12 fiscal year 2013.

132.13 **Minnesota Senior Health Options**
132.14 **Reimbursement.** Effective July 1, 2011,
132.15 federal administrative reimbursement
132.16 resulting from the Minnesota senior
132.17 health options project is appropriated
132.18 to the commissioner for this activity.
132.19 Notwithstanding any contrary provision, this
132.20 provision expires June 30, 2013.

132.21 **Health Care Inspector General.** $120,000
132.22 from the general fund in fiscal year 2011
132.23 is for the Office of Health Care Inspector
132.24 General, established under Minnesota
132.25 Statutes, section 256.01, subdivision 30.

132.26 **Fiscal and Actuarial Analysis.** $250,000
132.27 from the general fund is for the fiscal and
132.28 actuarial analysis of 2010 House File No.
132.29 135 and 2010 Senate File No. 118. This
132.30 appropriation is onetime.

132.31 **Utilization Review.** Effective July 1,
132.32 2011, federal administrative reimbursement
132.33 resulting from prior authorization and
132.34 inpatient admission certification by a
132.35 professional review organization shall be

133.1 dedicated to, and is appropriated to, the
133.2 commissioner for these activities. A portion
133.3 of these funds must be used for activities to
133.4 decrease unnecessary pharmaceutical costs
133.5 in medical assistance. Notwithstanding any
133.6 contrary provision, this provision expires
133.7 June 30, 2013.

133.8 **Base Adjustment.** The health care access
133.9 fund base is reduced by $50,000 in each of
133.10 fiscal years 2012 and 2013.

133.11 The general fund base is reduced by $416,000
133.12 in each of fiscal years 2012 and 2013.

133.13 (b) **Health Care Operations**

133.14 Appropriations by Fund

133.15 General	-0-	64,000
133.16 Health Care Access	(1,094,000)	(1,234,000)

133.17 **Base Adjustment.** The health care access
133.18 fund base for health care operations is
133.19 reduced by $1,272,000 in fiscal year 2012
133.20 and $1,337,000 in fiscal year 2013. The
133.21 general fund appropriation is onetime.

133.22 Subd. 8. **Continuing Care Grants**

133.23 (a) **Aging and Adult Services Grants** (154,000) (139,000)

133.24 This reduction is onetime and must not be
133.25 applied to the base.

133.26 **Community Service Development**
133.27 **Reduction.** The appropriation in Laws
133.28 2009, chapter 79, article 13, section 3,
133.29 subdivision 8, paragraph (a), for community
133.30 service development grants, as amended by
133.31 Laws 2009, chapter 173, article 2, section
133.32 1, subdivision 8, paragraph (a), is reduced
133.33 by $154,000 in fiscal year 2011. The
133.34 appropriation base is reduced by $139,000

134.1 for fiscal year 2012 and $0 for fiscal year
134.2 2013. Notwithstanding any law or rule to
134.3 the contrary, this provision expires June 30,
134.4 2012.

134.5 (b) **Medical Assistance Long-Term Care** 134.6 **Facilities Grants**	-0-	551,000
134.7 (c) **Medical Assistance Long-Term Care** 134.8 **Waivers and Home Care Grants**	-0-	(2,747,000)

134.9 **Manage Growth in Traumatic Brain**
134.10 **Injury and Community Alternatives for**
134.11 **Disabled Individuals' Waivers.** During
134.12 the fiscal year beginning July 1, 2010, the
134.13 commissioner shall allocate money for home
134.14 and community-based waiver programs
134.15 under Minnesota Statutes, section 256B.49,
134.16 to ensure a reduction in state spending that is
134.17 equivalent to limiting the caseload growth
134.18 of the traumatic brain injury waiver to six
134.19 allocations per month and the community
134.20 alternatives for disabled individuals waiver
134.21 to 60 allocations per month. The limits do not
134.22 apply: (1) when there is an approved plan for
134.23 nursing facility bed closures for individuals
134.24 under age 65 who require relocation due to
134.25 the bed closure; (2) to fiscal year 2009 waiver
134.26 allocations delayed due to unallotment; or (3)
134.27 to transfers authorized by the commissioner
134.28 from the personal care assistance program
134.29 of individuals having a home care rating of
134.30 CS, MT, or HL. Priorities for the allocation
134.31 of funds must be for individuals anticipated
134.32 to be discharged from institutional settings or
134.33 who are at imminent risk of a placement in
134.34 an institutional setting.

134.35 **Manage Growth in the Developmental**
134.36 **Disability (DD) Waiver.** The commissioner

135.1 shall manage the growth in the developmental
135.2 disability waiver by limiting the allocations
135.3 included in the November 2010 forecast to
135.4 six additional diversion allocations each
135.5 month for the calendar year that begins on
135.6 January 1, 2011. Additional allocations must
135.7 be made available for transfers authorized
135.8 by the commissioner from the personal care
135.9 assistance program of individuals having a
135.10 home care rating of CS, MT, or HL. This
135.11 provision is effective through December 31,
135.12 2011.

135.13 (d) **Adult Mental Health Grants**	(3,500,000)	(9,903,000)

135.14 **Compulsive Gambling Special Revenue**
135.15 **Account.** $149,000 for fiscal year 2010
135.16 and $27,000 for fiscal year 2011 from
135.17 the compulsive gambling special revenue
135.18 account established under Minnesota
135.19 Statutes, section 245.982, must be transferred
135.20 and deposited into the general fund by June
135.21 30 of each respective fiscal year.

135.22 **Compulsive Gambling Lottery Prize Fund**
135.23 **Appropriation.** The lottery prize fund
135.24 appropriation for compulsive gambling, is
135.25 reduced by $80,000 in fiscal year 2010 and
135.26 $79,000 in fiscal year 2011. This is a onetime
135.27 reduction.

135.28 **Adult Mental Health.** (1) The general
135.29 fund appropriation for adult mental health
135.30 evidence-based practices, including but not
135.31 limited to, assertive community treatment
135.32 and integrated dual diagnosis treatment
135.33 services, is reduced by $750,000 for fiscal
135.34 year 2011. This reduction is onetime.

136.1 (2) The general fund appropriation for
136.2 mental health grants to increase availability
136.3 of culturally specific adult mental health
136.4 services is reduced by $300,000 for fiscal
136.5 year 2011. This reduction is onetime.

136.6 (3) The general fund appropriation for
136.7 grants to community hospitals to provide
136.8 alternatives to residential treatment center
136.9 mental health programs is reduced by
136.10 $2,653,000 for fiscal year 2011. This
136.11 reduction is onetime.

136.12 (4) The general fund appropriation for grants
136.13 to counties for adult mental health services is
136.14 reduced by $6,200,000 for fiscal year 2011,
136.15 and $6,000,000 in each of fiscal years 2012
136.16 and 2013.

136.17 (5) Of the fiscal year 2010 general fund
136.18 appropriation for grants to counties for
136.19 housing with support services for adults
136.20 with serious and persistent mental illness,
136.21 $3,300,000 is canceled and returned to the
136.22 general fund.

136.23 (6) Of the fiscal year 2010 general
136.24 fund appropriation for additional crisis
136.25 intervention team training for law
136.26 enforcement, $200,000 is canceled and
136.27 returned to the general fund.

136.28	(e) **Chemical Dependency Entitlement Grants**	-0-	(3,986,000)
136.29 136.30	(f) **Chemical Dependency Nonentitlement Grants**	(389,000)	-0-

136.31 **Chemical Health.** Of the fiscal year 2010
136.32 general fund appropriation to Mother's First
136.33 and the Native American Program, $389,000
136.34 is canceled and returned to the general fund.

137.1 (g) **Other Continuing Care Grants** -0- 100,000

137.2 **Intermediate Care Facilities for the**
137.3 **Developmentally Disabled Payment Rates.**
137.4 $36,000 is appropriated from the general
137.5 fund in fiscal year 2011 and $4,000 in fiscal
137.6 year 2012 to increase payment rates for an
137.7 ICF/MR licensed for six beds and located in
137.8 Kandiyohi County to serve persons with high
137.9 behavioral needs. The payment rate increase
137.10 shall be effective for services provided from
137.11 July 1, 2010, through June 30, 2011. These
137.12 appropriations are onetime.

137.13 **Region 10 Quality Assurance Commission.**
137.14 $100,000 is appropriated from the general
137.15 fund in fiscal year 2011 to the commissioner
137.16 of human services for the purposes
137.17 of the Region 10 Quality Assurance
137.18 Commission under Minnesota Statutes,
137.19 section 256B.0951. This appropriation is
137.20 onetime.

137.21 Subd. 9. **Continuing Care Management** 111,000 101,000

137.22 **PACE Implementation Funding.** For fiscal
137.23 year 2011, $111,000 is appropriated from
137.24 the general fund to the commissioner of
137.25 human services to complete the actuarial
137.26 and administrative work necessary to begin
137.27 the operation of PACE under Minnesota
137.28 Statutes, section 256B.69, subdivision 23,
137.29 paragraph (e). Base level funding for this
137.30 activity shall be $101,000 in fiscal year 2012
137.31 and $0 in fiscal year 2013. For fiscal year
137.32 2013 and beyond, the commissioner must
137.33 work with stakeholders to develop financing
137.34 mechanisms to complete the actuarial
137.35 and administrative costs of PACE. The

138.1 commissioner shall inform the chairs and
138.2 ranking minority members of the legislative
138.3 committee with jurisdiction over health care
138.4 funding by January 15, 2011, on progress to
138.5 develop financing mechanisms.

138.6 Subd. 10. **State-Operated Services**

138.7 **Obsolete Laundry Depreciation Account.**
138.8 $669,000, or the balance, whichever is
138.9 greater, must be transferred from the
138.10 state-operated services laundry depreciation
138.11 account in the special revenue fund and
138.12 deposited into the general fund by June 30,
138.13 2010.

138.14 **State-operated Services Programs.** Of
138.15 the fiscal year 2011 appropriation for
138.16 the Minnesota sex offender program,
138.17 $12,600,000 is transferred to state-operated
138.18 services to maintain the METO program and
138.19 other residential adult mental health services.

138.20 Subd. 11. **Adult Mental Health Services**	-0-	12,600,000
138.21 Subd. 12. **Minnesota Sex Offender Services**	-0-	(12,600,000)

138.22 Subd. 13. **Contingent Appropriations**
138.23 **Reductions**

138.24 Upon enactment of the extension of
138.25 the enhanced federal medical assistance
138.26 percentage (FMAP) under Public Law 111-5
138.27 to June 30, 2011, that is contained in the
138.28 president's budget for federal fiscal year 2011
138.29 or contained in House Resolution 2847, the
138.30 federal "Jobs for Main Street Act of 2010," or
138.31 subsequent federal legislation, the reductions
138.32 identified in each clause shall be made to
138.33 the specified general fund appropriations
138.34 for fiscal year 2011. These contingent
138.35 reductions, if implemented, are in addition

139.1 to the reductions specified in subdivision 6,
139.2 paragraphs (a), (b), and (c), and subdivision
139.3 8, paragraphs (c) and (d), respectively.

		2010	2011
139.4	(1) MinnesotaCare Grants	-0-	(9,200,000)
139.5–139.6	(2) Medical Assistance Basic Health Care Grants - Families and Children	-0-	(109,662,500)
139.7–139.8	(3) Medical Assistance Basic Health Care Grants - Elderly and Disabled	-0-	(110,437,500)
139.9–139.10	(4) Medical Assistance Long-Term Care Facilities Grants	-0-	(51,925,000)
139.11–139.12	(5) Medical Assistance Long-Term Care Waivers and Home Care Grants	-0-	(115,475,000)

139.13 Sec. 4. **COMMISSIONER OF HEALTH**

		APPROPRIATIONS Available for the Year Ending June 30 2010	2011
139.18	Subdivision 1. **Total Appropriation**	$ (2,397,000)	$ 5,751,000

139.19 Appropriations by Fund

		2010	2011
139.21	General	(1,797,000)	5,810,000
139.22–139.23	State Government Special Revenue	(600,000)	(259,000)
139.24–139.25	Health Care Access Fund	-0-	200,000

		2010	2011
139.26	Subd. 2. **Community and Family Health**	-0-	100,000

139.27 **Grant for Memory Care Clinic.** $100,000
139.28 from the general fund in fiscal year 2011
139.29 is for a grant to a nonprofit, multispecialty
139.30 clinic located in the city of St. Cloud that
139.31 provides early identification, diagnosis, and
139.32 treatment of memory loss, and information
139.33 and support for family members who care for
139.34 persons with memory impairment. In order
139.35 to receive the grant, the clinic must certify to
139.36 the commissioner that it has a commitment

140.1 from a private foundation to provide a 50
140.2 percent match of the grant amount. This
140.3 appropriation is onetime.

140.4 **Statewide Health Improvement Program.**
140.5 $8,500,000 from the health care access
140.6 fund in fiscal year 2012 and $8,500,000 in
140.7 fiscal year 2013 is for the statewide health
140.8 improvement program under Minnesota
140.9 Statutes, section 145.986. These additions
140.10 are onetime.

140.11 Subd. 3. **Policy, Quality, and Compliance**

140.12 Appropriations by Fund

		2010	2011
140.13			
140.14	General	(1,797,000)	5,210,000
140.15 140.16	State Government Special Revenue	(600,000)	(268,000)
140.17 140.18	Health Care Access Fund	-0-	200,000

140.19 Of this appropriation, $74,000 in fiscal
140.20 year 2011 is to restore unallotments for the
140.21 Office of Unlicensed Complementary and
140.22 Alternative Health Care Practice.

140.23 **Health Care Reform.** Funds appropriated
140.24 in Laws 2008, chapter 358, article 5, section
140.25 4, subdivision 3, for health reform activities
140.26 to implement Laws 2008, chapter 358,
140.27 article 4, are available until expended.
140.28 Notwithstanding any contrary provision in
140.29 this article, this provision shall not expire.

140.30 **Health Care Reform Task Force.** $200,000
140.31 from the general fund is for expenses related
140.32 to the Health Care Reform Task Force
140.33 established under article 7, section 8.

140.34 **Autism Coverage Study.** $50,000 in
140.35 fiscal year 2011 is appropriated to the
140.36 commissioner of health to monitor the gaps

141.1 in the level of service provided by state
141.2 health programs, the state employee group
141.3 insurance plan, and private health plans for
141.4 autism spectrum disorder. This appropriation
141.5 is onetime.

141.6 **Rural Hospital Capital Improvement**
141.7 **Grants.** Of the general fund reductions in
141.8 fiscal year 2010, $1,755,000 is for the rural
141.9 hospital capital improvement grant program.

141.10 **Health Information Exchange Oversight.**
141.11 Of the state government special revenue fund
141.12 appropriations, $104,000 in fiscal year 2011
141.13 is for the duties required under Minnesota
141.14 Statutes, sections 62J.498 to 62J.4982.

141.15 **Birth Centers.** Of the state government
141.16 special revenue fund appropriations, $9,000
141.17 is for licensing birth centers under Minnesota
141.18 Statutes, section 144.651. Base funding shall
141.19 be $7,000 in fiscal year 2012 and $7,000 in
141.20 fiscal year 2013.

141.21 **Advisory Group on Administrative**
141.22 **Expenses.** Of the general fund appropriation,
141.23 $40,000 in fiscal year 2011 is for the advisory
141.24 group established under Minnesota Statutes,
141.25 section 62D.31.

141.26 **Community Clinic Grants.** Of this
141.27 appropriation, $2,500,000 in fiscal
141.28 year 2011 is for the commissioner to
141.29 provide community clinic grants under
141.30 Minnesota Statutes, section 145.9268. This
141.31 appropriation is onetime. In awarding grants
141.32 using this funding, the commissioner shall
141.33 give priority to proposals that seek to serve
141.34 medically underserved areas of the state that
141.35 are not served by a coordinated care delivery

142.1 system established under Minnesota Statutes,
142.2 section 256D.031, subdivision 6.

142.3 **Federally Qualified Health Center**
142.4 **Subsidies.** Of this appropriation, $2,500,000
142.5 in fiscal year 2011 is for the commissioner to
142.6 increase subsidies to federally qualified health
142.7 centers provided under Minnesota Statutes,
142.8 section 145.9269. This appropriation is
142.9 onetime. In awarding subsidies using this
142.10 funding, the commissioner shall give priority
142.11 to federally qualified health centers that serve
142.12 medically underserved areas of the state that
142.13 are not served by a coordinated care delivery
142.14 system established under Minnesota Statutes,
142.15 section 256D.031, subdivision 6.

142.16 **Base Level Adjustment.** The general fund
142.17 base is increased by $76,000 in each of fiscal
142.18 years 2012 and 2013. The state government
142.19 special revenue fund base is increased by
142.20 $97,000 in each of fiscal years 2012 and
142.21 2013.

142.22 Subd. 4. **Health Protection** -0- 500,000

142.23 **Birth Defects Information System.** Of
142.24 the general fund appropriation, $500,000 in
142.25 fiscal year 2011 is for the Minnesota Birth
142.26 Defects Information System established
142.27 under Minnesota Statutes, section 144.2215.

142.28 Sec. 5. **Office of the Legislative Auditor** **$** **-0-** **$** **200,000**

142.29 $200,000 or an amount equal to 90 percent
142.30 of the nonfederal administrative staff funds
142.31 expended by the commissioner of human
142.32 services related to the preparation and
142.33 drafting of fiscal notes during fiscal year
142.34 2009, is transferred from the Department

143.1 of Human Services to the Office of the
143.2 Legislative Auditor, and appropriated for
143.3 the fiscal year beginning July 1, 2011,
143.4 for completion of the duties described in
143.5 Minnesota Statutes, section 3.98.

143.6 Sec. 6. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by
143.7 Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

143.8 Subdivision 1. **Total Appropriation** **$ 5,225,451,000 $ 6,002,864,000**

143.9 Appropriations by Fund

	2010	2011
143.11 General	4,375,689,000	5,209,765,000
143.12 State Government 143.13 Special Revenue	565,000	565,000
143.14 Health Care Access	450,662,000	527,411,000
143.15 Federal TANF	286,770,000	263,458,000
143.16 Lottery Prize	1,665,000	1,665,000
143.17 Federal Fund	110,000,000	0

143.18 **Receipts for Systems Projects.**
143.19 Appropriations and federal receipts for
143.20 information systems projects for MAXIS,
143.21 PRISM, MMIS, and SSIS must be deposited
143.22 in the state system account authorized in
143.23 Minnesota Statutes, section 256.014. Money
143.24 appropriated for computer projects approved
143.25 by the Minnesota Office of Enterprise
143.26 Technology, funded by the legislature, and
143.27 approved by the commissioner of finance,
143.28 may be transferred from one project to
143.29 another and from development to operations
143.30 as the commissioner of human services
143.31 considers necessary, except that any transfers
143.32 to one project that exceed $1,000,000 or
143.33 multiple transfers to one project that exceed
143.34 $1,000,000 in total require the express
143.35 approval of the legislature. The preceding
143.36 requirement for legislative approval does not

144.1 apply to transfers made to establish a project's
144.2 initial operating budget each year; instead,
144.3 the requirements of section 11, subdivision
144.4 2, of this article apply to those transfers. Any
144.5 unexpended balance in the appropriation
144.6 for these projects does not cancel but is
144.7 available for ongoing development and
144.8 operations. Any computer project with a
144.9 total cost exceeding $1,000,000, including,
144.10 but not limited to, a replacement for the
144.11 proposed HealthMatch system, shall not be
144.12 commenced without the express approval of
144.13 the legislature.

144.14 **HealthMatch Systems Project.** In fiscal
144.15 year 2010, $3,054,000 shall be transferred
144.16 from the HealthMatch account in the state
144.17 systems account in the special revenue fund
144.18 to the general fund.

144.19 **Nonfederal Share Transfers.** The
144.20 nonfederal share of activities for which
144.21 federal administrative reimbursement is
144.22 appropriated to the commissioner may be
144.23 transferred to the special revenue fund.

144.24 **TANF Maintenance of Effort.**

144.25 (a) In order to meet the basic maintenance
144.26 of effort (MOE) requirements of the TANF
144.27 block grant specified under Code of Federal
144.28 Regulations, title 45, section 263.1, the
144.29 commissioner may only report nonfederal
144.30 money expended for allowable activities
144.31 listed in the following clauses as TANF/MOE
144.32 expenditures:

144.33 (1) MFIP cash, diversionary work program,
144.34 and food assistance benefits under Minnesota
144.35 Statutes, chapter 256J;

145.1 (2) the child care assistance programs
145.2 under Minnesota Statutes, sections 119B.03
145.3 and 119B.05, and county child care
145.4 administrative costs under Minnesota
145.5 Statutes, section 119B.15;

145.6 (3) state and county MFIP administrative
145.7 costs under Minnesota Statutes, chapters
145.8 256J and 256K;

145.9 (4) state, county, and tribal MFIP
145.10 employment services under Minnesota
145.11 Statutes, chapters 256J and 256K;

145.12 (5) expenditures made on behalf of
145.13 noncitizen MFIP recipients who qualify
145.14 for the medical assistance without federal
145.15 financial participation program under
145.16 Minnesota Statutes, section 256B.06,
145.17 subdivision 4, paragraphs (d), (e), and (j);
145.18 ~~and~~

145.19 (6) qualifying working family credit
145.20 expenditures under Minnesota Statutes,
145.21 section 290.0671~~.~~; and

145.22 (7) qualifying Minnesota education credit
145.23 expenditures under Minnesota Statutes,
145.24 section 290.0674.

145.25 (b) The commissioner shall ensure that
145.26 sufficient qualified nonfederal expenditures
145.27 are made each year to meet the state's
145.28 TANF/MOE requirements. For the activities
145.29 listed in paragraph (a), clauses (2) to
145.30 (6), the commissioner may only report
145.31 expenditures that are excluded from the
145.32 definition of assistance under Code of
145.33 Federal Regulations, title 45, section 260.31.

146.1 (c) For fiscal years beginning with state
146.2 fiscal year 2003, the commissioner shall
146.3 ensure that the maintenance of effort used
146.4 by the commissioner of finance for the
146.5 February and November forecasts required
146.6 under Minnesota Statutes, section 16A.103,
146.7 contains expenditures under paragraph (a),
146.8 clause (1), equal to at least 16 percent of
146.9 the total required under Code of Federal
146.10 Regulations, title 45, section 263.1.

146.11 (d) For the federal fiscal years beginning on
146.12 or after October 1, 2007, the commissioner
146.13 may not claim an amount of TANF/MOE in
146.14 excess of the 75 percent standard in Code
146.15 of Federal Regulations, title 45, section
146.16 263.1(a)(2), except:

146.17 (1) to the extent necessary to meet the 80
146.18 percent standard under Code of Federal
146.19 Regulations, title 45, section 263.1(a)(1),
146.20 if it is determined by the commissioner
146.21 that the state will not meet the TANF work
146.22 participation target rate for the current year;

146.23 (2) to provide any additional amounts
146.24 under Code of Federal Regulations, title 45,
146.25 section 264.5, that relate to replacement of
146.26 TANF funds due to the operation of TANF
146.27 penalties; and

146.28 (3) to provide any additional amounts that
146.29 may contribute to avoiding or reducing
146.30 TANF work participation penalties through
146.31 the operation of the excess MOE provisions
146.32 of Code of Federal Regulations, title 45,
146.33 section 261.43 (a)(2).

146.34 For the purposes of clauses (1) to (3),
146.35 the commissioner may supplement the

147.1 MOE claim with working family credit
147.2 expenditures to the extent such expenditures
147.3 or other qualified expenditures are otherwise
147.4 available after considering the expenditures
147.5 allowed in this section.

147.6 (e) Minnesota Statutes, section 256.011,
147.7 subdivision 3, which requires that federal
147.8 grants or aids secured or obtained under that
147.9 subdivision be used to reduce any direct
147.10 appropriations provided by law, do not apply
147.11 if the grants or aids are federal TANF funds.

147.12 (f) Notwithstanding any contrary provision
147.13 in this article, this provision expires June 30,
147.14 2013.

147.15 **Working Family Credit Expenditures as**
147.16 **TANF/MOE.** The commissioner may claim
147.17 as TANF/MOE up to $6,707,000 per year of
147.18 working family credit expenditures for fiscal
147.19 year 2010 through fiscal year 2011.

147.20 **Working Family Credit Expenditures**
147.21 **to be Claimed for TANF/MOE.** The
147.22 commissioner may count the following
147.23 amounts of working family credit expenditure
147.24 as TANF/MOE:

147.25 (1) fiscal year 2010, ~~$50,973,000~~
147.26 $50,897,000;

147.27 (2) fiscal year 2011, ~~$53,793,000~~
147.28 $54,243,000;

147.29 (3) fiscal year 2012, ~~$23,516,000~~
147.30 $23,345,000; and

147.31 (4) fiscal year 2013, ~~$16,808,000~~
147.32 $16,585,000.

147.33 Notwithstanding any contrary provision in
147.34 this article, this rider expires June 30, 2013.

148.1 **Food Stamps Employment and Training.**
148.2 (a) The commissioner shall apply for and
148.3 claim the maximum allowable federal
148.4 matching funds under United States Code,
148.5 title 7, section 2025, paragraph (h), for
148.6 state expenditures made on behalf of family
148.7 stabilization services participants voluntarily
148.8 engaged in food stamp employment and
148.9 training activities, where appropriate.

148.10 (b) Notwithstanding Minnesota Statutes,
148.11 sections 256D.051, subdivisions 1a, 6b,
148.12 and 6c, and 256J.626, federal food stamps
148.13 employment and training funds received
148.14 as reimbursement of MFIP consolidated
148.15 fund grant expenditures for diversionary
148.16 work program participants and child
148.17 care assistance program expenditures for
148.18 two-parent families must be deposited in the
148.19 general fund. The amount of funds must be
148.20 limited to $3,350,000 in fiscal year 2010
148.21 and $4,440,000 in fiscal years 2011 through
148.22 2013, contingent on approval by the federal
148.23 Food and Nutrition Service.

148.24 (c) Consistent with the receipt of these federal
148.25 funds, the commissioner may adjust the
148.26 level of working family credit expenditures
148.27 claimed as TANF maintenance of effort.
148.28 Notwithstanding any contrary provision in
148.29 this article, this rider expires June 30, 2013.

148.30 **ARRA Food Support Administration.**
148.31 The funds available for food support
148.32 administration under the American Recovery
148.33 and Reinvestment Act (ARRA) of 2009
148.34 are appropriated to the commissioner
148.35 to pay actual costs of implementing the

149.1 food support benefit increases, increased
149.2 eligibility determinations, and outreach. Of
149.3 these funds, 20 percent shall be allocated
149.4 to the commissioner and 80 percent shall
149.5 be allocated to counties. The commissioner
149.6 shall allocate the county portion based on
149.7 caseload. Reimbursement shall be based on
149.8 actual costs reported by counties through
149.9 existing processes. Tribal reimbursement
149.10 must be made from the state portion based
149.11 on a caseload factor equivalent to that of a
149.12 county.

149.13 **ARRA Food Support Benefit Increases.**
149.14 The funds provided for food support benefit
149.15 increases under the Supplemental Nutrition
149.16 Assistance Program provisions of the
149.17 American Recovery and Reinvestment Act
149.18 (ARRA) of 2009 must be used for benefit
149.19 increases beginning July 1, 2009.

149.20 **Emergency Fund for the TANF Program.**
149.21 TANF Emergency Contingency funds
149.22 available under the American Recovery
149.23 and Reinvestment Act of 2009 (Public Law
149.24 111-5) are appropriated to the commissioner.
149.25 The commissioner must request TANF
149.26 Emergency Contingency funds from the
149.27 Secretary of the Department of Health
149.28 and Human Services to the extent the
149.29 commissioner meets or expects to meet the
149.30 requirements of section 403(c) of the Social
149.31 Security Act. The commissioner must seek
149.32 to maximize such grants. The funds received
149.33 must be used as appropriated. Each county
149.34 must maintain the county's current level of
149.35 emergency assistance funding under the
149.36 MFIP consolidated fund and use the funds

150.1 under this paragraph to supplement existing
150.2 emergency assistance funding levels.

150.3 Sec. 7. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by
150.4 Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

150.5 Subd. 3. **Revenue and Pass-Through Revenue** 150.6 **Expenditures**	68,337,000	70,505,000

150.7 This appropriation is from the federal TANF
150.8 fund.

150.9 **TANF Transfer to Federal Child Care**
150.10 **and Development Fund.** The following
150.11 TANF fund amounts are appropriated to the
150.12 commissioner for the purposes of MFIP and
150.13 transition year child care under Minnesota
150.14 Statutes, section 119B.05:

150.15 (1) fiscal year 2010, ~~$6,531,000~~ $862,000;

150.16 (2) fiscal year 2011, ~~$10,241,000~~ $978,000;

150.17 (3) fiscal year 2012, ~~$10,826,000~~ $0; and

150.18 (4) fiscal year 2013, ~~$4,046,000~~ $0.

150.19 The commissioner shall authorize the
150.20 transfer of sufficient TANF funds to the
150.21 federal child care and development fund to
150.22 meet this appropriation and shall ensure that
150.23 all transferred funds are expended according
150.24 to federal child care and development fund
150.25 regulations.

150.26 Sec. 8. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by
150.27 Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

150.28 Subd. 4. **Children and Economic Assistance**
150.29 **Grants**

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

150.32 **(a) MFIP/DWP Grants**

151.1 Appropriations by Fund

151.2 General	63,205,000	89,033,000
151.3 Federal TANF	100,818,000	84,538,000

151.4 **(b) Support Services Grants**

151.5 Appropriations by Fund

151.6 General	8,715,000	12,498,000
151.7 Federal TANF	116,557,000	107,457,000

151.8 **MFIP Consolidated Fund.** The MFIP
151.9 consolidated fund TANF appropriation is
151.10 reduced by $1,854,000 in fiscal year 2010
151.11 and fiscal year 2011.

151.12 Notwithstanding Minnesota Statutes, section
151.13 256J.626, subdivision 8, paragraph (b), the
151.14 commissioner shall reduce proportionately
151.15 the reimbursement to counties for
151.16 administrative expenses.

151.17 **Subsidized Employment Funding Through**
151.18 **ARRA.** The commissioner is authorized to
151.19 apply for TANF emergency fund grants for
151.20 subsidized employment activities. Growth
151.21 in expenditures for subsidized employment
151.22 within the supported work program and the
151.23 MFIP consolidated fund over the amount
151.24 expended in the calendar quarters in the
151.25 TANF emergency fund base year shall be
151.26 used to leverage the TANF emergency fund
151.27 grants for subsidized employment and to
151.28 fund supported work. The commissioner
151.29 shall develop procedures to maximize
151.30 reimbursement of these expenditures over the
151.31 TANF emergency fund base year quarters,
151.32 and may contract directly with employers
151.33 and providers to maximize these TANF
151.34 emergency fund grants.

152.1 **Supported Work.** Of the TANF
152.2 appropriation, $4,700,000 in fiscal year 2010
152.3 and $4,700,000 in fiscal year 2011 are to the
152.4 commissioner for supported work for MFIP
152.5 recipients and is available until expended.
152.6 Supported work includes paid transitional
152.7 work experience and a continuum of
152.8 employment assistance, including outreach
152.9 and recruitment, program orientation
152.10 and intake, testing and assessment, job
152.11 development and marketing, preworksite
152.12 training, supported worksite experience,
152.13 job coaching, and postplacement follow-up,
152.14 in addition to extensive case management
152.15 and referral services. This is a onetime
152.16 appropriation.

152.17 **Base Adjustment.** The general fund base
152.18 is reduced by $3,783,000 in each of fiscal
152.19 years 2012 and 2013. The TANF fund base
152.20 is increased by $5,004,000 in each of fiscal
152.21 years 2012 and 2013.

152.22 **Integrated Services Program Funding.**
152.23 The TANF appropriation for integrated
152.24 services program funding is $1,250,000 in
152.25 fiscal year 2010 and $0 in fiscal year 2011
152.26 and the base for fiscal years 2012 and 2013
152.27 is $0.

152.28 **TANF Emergency Fund; Nonrecurrent**
152.29 **Short-Term Benefits.** (1) TANF emergency
152.30 contingency fund grants received due to
152.31 increases in expenditures for nonrecurrent
152.32 short-term benefits must be used to offset the
152.33 increase in these expenditures for counties
152.34 under the MFIP consolidated fund, under
152.35 Minnesota Statutes, section 256J.626,

153.1 and the diversionary work program. The
153.2 commissioner shall develop procedures
153.3 to maximize reimbursement of these
153.4 expenditures over the TANF emergency fund
153.5 base year quarters. Growth in expenditures
153.6 for the diversionary work program over the
153.7 amount expended in the calendar quarters in
153.8 the TANF emergency fund base year shall be
153.9 used to leverage these funds.

153.10 (2) To the extent that the commissioner
153.11 can claim eligible tax credit growth as
153.12 nonrecurrent short-term benefits, the
153.13 commissioner shall use those funds to
153.14 leverage the increased expenditures in clause
153.15 (1).

153.16 (3) TANF emergency funds for nonrecurrent
153.17 short-term benefits received in excess of the
153.18 amounts necessary for clauses (1) and (2)
153.19 shall be used to reimburse the general fund
153.20 for the costs of eligible tax credits in fiscal
153.21 year 2011. The amount of such funds shall
153.22 not exceed $28,000,000.

153.23	**(c) MFIP Child Care Assistance Grants**	61,171,000	65,214,000

153.24 **Acceleration of ARRA Child Care and**
153.25 **Development Fund Expenditure.** The
153.26 commissioner must liquidate all child care
153.27 and development money available under
153.28 the American Recovery and Reinvestment
153.29 Act (ARRA) of 2009, Public Law 111-5,
153.30 by September 30, 2010. In order to expend
153.31 those funds by September 30, 2010, the
153.32 commissioner may redesignate and expend
153.33 the ARRA child care and development funds
153.34 appropriated in fiscal year 2011 for purposes
153.35 under this section for related purposes that

154.1 will allow liquidation by September 30,
154.2 2010. Child care and development funds
154.3 otherwise available to the commissioner
154.4 for those related purposes shall be used to
154.5 fund the purposes from which the ARRA
154.6 child care and development funds had been
154.7 redesignated.

154.8 **School Readiness Service Agreements.**
154.9 $400,000 in fiscal year 2010 and $400,000
154.10 in fiscal year 2011 are from the federal
154.11 TANF fund to the commissioner of human
154.12 services consistent with federal regulations
154.13 for the purpose of school readiness service
154.14 agreements under Minnesota Statutes,
154.15 section 119B.231. This is a onetime
154.16 appropriation. Any unexpended balance the
154.17 first year is available in the second year.

154.18 **(d) Basic Sliding Fee Child Care Assistance** 154.19 **Grants**	40,100,000	45,092,000

154.20 **School Readiness Service Agreements.**
154.21 $257,000 in fiscal year 2010 and $257,000
154.22 in fiscal year 2011 are from the general
154.23 fund for the purpose of school readiness
154.24 service agreements under Minnesota
154.25 Statutes, section 119B.231. This is a onetime
154.26 appropriation. Any unexpended balance the
154.27 first year is available in the second year.

154.28 **Child Care Development Fund**
154.29 **Unexpended Balance.** In addition to
154.30 the amount provided in this section, the
154.31 commissioner shall expend $5,244,000 in
154.32 fiscal year 2010 from the federal child care
154.33 development fund unexpended balance
154.34 for basic sliding fee child care under
154.35 Minnesota Statutes, section 119B.03. The
154.36 commissioner shall ensure that all child

155.1 care and development funds are expended
155.2 according to the federal child care and
155.3 development fund regulations.

155.4 **Basic Sliding Fee.** $4,000,000 in fiscal year
155.5 2010 and $4,000,000 in fiscal year 2011 are
155.6 from the federal child care development
155.7 funds received from the American Recovery
155.8 and Reinvestment Act of 2009, Public
155.9 Law 111-5, to the commissioner of human
155.10 services consistent with federal regulations
155.11 for the purpose of basic sliding fee child care
155.12 assistance under Minnesota Statutes, section
155.13 119B.03. This is a onetime appropriation.
155.14 Any unexpended balance the first year is
155.15 available in the second year.

155.16 **Basic Sliding Fee Allocation for Calendar**
155.17 **Year 2010.** Notwithstanding Minnesota
155.18 Statutes, section 119B.03, subdivision 6,
155.19 in calendar year 2010, basic sliding fee
155.20 funds shall be distributed according to
155.21 this provision. Funds shall be allocated
155.22 first in amounts equal to each county's
155.23 guaranteed floor, according to Minnesota
155.24 Statutes, section 119B.03, subdivision 8,
155.25 with any remaining available funds allocated
155.26 according to the following formula:

155.27 (a) Up to one-fourth of the funds shall be
155.28 allocated in proportion to the number of
155.29 families participating in the transition year
155.30 child care program as reported during and
155.31 averaged over the most recent six months
155.32 completed at the time of the notice of
155.33 allocation. Funds in excess of the amount
155.34 necessary to serve all families in this category
155.35 shall be allocated according to paragraph (d).

156.1 (b) Up to three-fourths of the funds shall
156.2 be allocated in proportion to the average
156.3 of each county's most recent six months of
156.4 reported waiting list as defined in Minnesota
156.5 Statutes, section 119B.03, subdivision 2, and
156.6 the reinstatement list of those families whose
156.7 assistance was terminated with the approval
156.8 of the commissioner under Minnesota Rules,
156.9 part 3400.0183, subpart 1. Funds in excess
156.10 of the amount necessary to serve all families
156.11 in this category shall be allocated according
156.12 to paragraph (d).

156.13 (c) The amount necessary to serve all families
156.14 in paragraphs (a) and (b) shall be calculated
156.15 based on the basic sliding fee average cost of
156.16 care per family in the county with the highest
156.17 cost in the most recently completed calendar
156.18 year.

156.19 (d) Funds in excess of the amount necessary
156.20 to serve all families in paragraphs (a) and
156.21 (b) shall be allocated in proportion to each
156.22 county's total expenditures for the basic
156.23 sliding fee child care program reported
156.24 during the most recent fiscal year completed
156.25 at the time of the notice of allocation. To
156.26 the extent that funds are available, and
156.27 notwithstanding Minnesota Statutes, section
156.28 119B.03, subdivision 8, for the period
156.29 January 1, 2011, to December 31, 2011, each
156.30 county's guaranteed floor must be equal to its
156.31 original calendar year 2010 allocation.

156.32 **Base Adjustment.** The general fund base is
156.33 decreased by $257,000 in each of fiscal years
156.34 2012 and 2013.

156.35 **(e) Child Care Development Grants** 1,487,000 1,487,000

157.1 **Family, friends, and neighbor grants.**
157.2 $375,000 in fiscal year 2010 and $375,000
157.3 in fiscal year 2011 are from the child
157.4 care development fund required targeted
157.5 quality funds for quality expansion and
157.6 infant/toddler from the American Recovery
157.7 and Reinvestment Act of 2009, Public
157.8 Law 111-5, to the commissioner of human
157.9 services for family, friends, and neighbor
157.10 grants under Minnesota Statutes, section
157.11 119B.232. This appropriation may be used
157.12 on programs receiving family, friends, and
157.13 neighbor grant funds as of June 30, 2009,
157.14 or on new programs or projects. This is a
157.15 onetime appropriation. Any unexpended
157.16 balance the first year is available in the
157.17 second year.

157.18 **Voluntary quality rating system training,**
157.19 **coaching, consultation, and supports.**
157.20 $633,000 in fiscal year 2010 and $633,000
157.21 in fiscal year 2011 are from the federal child
157.22 care development fund required targeted
157.23 quality funds for quality expansion and
157.24 infant/toddler from the American Recovery
157.25 and Reinvestment Act of 2009, Public
157.26 Law 111-5, to the commissioner of human
157.27 services consistent with federal regulations
157.28 for the purpose of providing grants to provide
157.29 statewide child-care provider training,
157.30 coaching, consultation, and supports to
157.31 prepare for the voluntary Minnesota quality
157.32 rating system rating tool. This is a onetime
157.33 appropriation. Any unexpended balance the
157.34 first year is available in the second year.

157.35 **Voluntary quality rating system.** $184,000
157.36 in fiscal year 2010 and $1,200,000 in fiscal

158.1 year 2011 are from the federal child care
158.2 development fund required targeted funds for
158.3 quality expansion and infant/toddler from the
158.4 American Recovery and Reinvestment Act of
158.5 2009, Public Law 111-5, to the commissioner
158.6 of human services consistent with federal
158.7 regulations for the purpose of implementing
158.8 the voluntary Parent Aware quality star
158.9 rating system pilot in coordination with the
158.10 Minnesota Early Learning Foundation. The
158.11 appropriation for the first year is to complete
158.12 and promote the voluntary Parent Aware
158.13 quality rating system pilot program through
158.14 June 30, 2010, and the appropriation for
158.15 the second year is to continue the voluntary
158.16 Minnesota quality rating system pilot
158.17 through June 30, 2011. This is a onetime
158.18 appropriation. Any unexpended balance the
158.19 first year is available in the second year.

158.20 **(f) Child Support Enforcement Grants** 3,705,000 3,705,000

158.21 **(g) Children's Services Grants**

158.22	Appropriations by Fund		
158.23	General	48,333,000	50,498,000
158.24	Federal TANF	340,000	240,000

158.25 **Base Adjustment.** The general fund base is
158.26 decreased by $5,371,000 in fiscal year 2012
158.27 and decreased $5,371,000 in fiscal year 2013.

158.28 **Privatized Adoption Grants.** Federal
158.29 reimbursement for privatized adoption grant
158.30 and foster care recruitment grant expenditures
158.31 is appropriated to the commissioner for
158.32 adoption grants and foster care and adoption
158.33 administrative purposes.

158.34 **Adoption Assistance Incentive Grants.**
158.35 Federal funds available during fiscal year

159.1 2010 and fiscal year 2011 for the adoption
159.2 incentive grants are appropriated to the
159.3 commissioner for postadoption services
159.4 including parent support groups.

159.5 **Adoption Assistance and Relative Custody**
159.6 **Assistance.** The commissioner may transfer
159.7 unencumbered appropriation balances for
159.8 adoption assistance and relative custody
159.9 assistance between fiscal years and between
159.10 programs.

159.11 **(h) Children and Community Services Grants**	67,663,000	67,542,000

159.12 **Targeted Case Management Temporary**
159.13 **Funding Adjustment.** The commissioner
159.14 shall recover from each county and tribe
159.15 receiving a targeted case management
159.16 temporary funding payment in fiscal year
159.17 2008 an amount equal to that payment. The
159.18 commissioner shall recover one-half of the
159.19 funds by February 1, 2010, and the remainder
159.20 by February 1, 2011. At the commissioner's
159.21 discretion and at the request of a county
159.22 or tribe, the commissioner may revise
159.23 the payment schedule, but full payment
159.24 must not be delayed beyond May 1, 2011.
159.25 The commissioner may use the recovery
159.26 procedure under Minnesota Statutes, section
159.27 256.017, to recover the funds. Recovered
159.28 funds must be deposited into the general
159.29 fund.

159.30 **(i) General Assistance Grants**	48,215,000	48,608,000

159.31 **General Assistance Standard.** The
159.32 commissioner shall set the monthly standard
159.33 of assistance for general assistance units
159.34 consisting of an adult recipient who is
159.35 childless and unmarried or living apart

160.1 from parents or a legal guardian at $203.
160.2 The commissioner may reduce this amount
160.3 according to Laws 1997, chapter 85, article
160.4 3, section 54.

160.5 **Emergency General Assistance.** The
160.6 amount appropriated for emergency general
160.7 assistance funds is limited to no more
160.8 than $7,889,812 in fiscal year 2010 and
160.9 $7,889,812 in fiscal year 2011. Funds
160.10 to counties must be allocated by the
160.11 commissioner using the allocation method
160.12 specified in Minnesota Statutes, section
160.13 256D.06.

160.14 **(j) Minnesota Supplemental Aid Grants**	33,930,000	35,191,000

160.15 **Emergency Minnesota Supplemental**
160.16 **Aid Funds.** The amount appropriated for
160.17 emergency Minnesota supplemental aid
160.18 funds is limited to no more than $1,100,000
160.19 in fiscal year 2010 and $1,100,000 in fiscal
160.20 year 2011. Funds to counties must be
160.21 allocated by the commissioner using the
160.22 allocation method specified in Minnesota
160.23 Statutes, section 256D.46.

160.24 **(k) Group Residential Housing Grants**	111,778,000	114,034,000

160.25 **Group Residential Housing Costs**
160.26 **Refinanced.** (a) Effective July 1, 2011, the
160.27 commissioner shall increase the home and
160.28 community-based service rates and county
160.29 allocations provided to programs for persons
160.30 with disabilities established under section
160.31 1915(c) of the Social Security Act to the
160.32 extent that these programs will be paying
160.33 for the costs above the rate established
160.34 in Minnesota Statutes, section 256I.05,
160.35 subdivision 1.

161.1 (b) For persons receiving services under
161.2 Minnesota Statutes, section 245A.02, who
161.3 reside in licensed adult foster care beds
161.4 for which a difficulty of care payment
161.5 was being made under Minnesota Statutes,
161.6 section 256I.05, subdivision 1c, paragraph
161.7 (b), counties may request an exception to
161.8 the individual's service authorization not to
161.9 exceed the difference between the client's
161.10 monthly service expenditures plus the
161.11 amount of the difficulty of care payment.

161.12 **(l) Children's Mental Health Grants**	16,885,000	16,882,000

161.13 **Funding Usage.** Up to 75 percent of a fiscal
161.14 year's appropriation for children's mental
161.15 health grants may be used to fund allocations
161.16 in that portion of the fiscal year ending
161.17 December 31.

161.18 **(m) Other Children and Economic Assistance** 161.19 **Grants**	16,047,000	15,339,000

161.20 **Fraud Prevention Grants.** Of this
161.21 appropriation, $228,000 in fiscal year 2010
161.22 and $228,000 in fiscal year 2011 is to the
161.23 commissioner for fraud prevention grants to
161.24 counties.

161.25 **Homeless and Runaway Youth.** $218,000
161.26 in fiscal year 2010 is for the Runaway
161.27 and Homeless Youth Act under Minnesota
161.28 Statutes, section 256K.45. Funds shall be
161.29 spent in each area of the continuum of care
161.30 to ensure that programs are meeting the
161.31 greatest need. Any unexpended balance in
161.32 the first year is available in the second year.
161.33 Beginning July 1, 2011, the base is increased
161.34 by $119,000 each year.

162.1 **ARRA Homeless Youth Funds.** To the
162.2 extent permitted under federal law, the
162.3 commissioner shall designate $2,500,000
162.4 of the Homeless Prevention and Rapid
162.5 Re-Housing Program funds provided under
162.6 the American Recovery and Reinvestment
162.7 Act of 2009, Public Law 111-5, for agencies
162.8 providing homelessness prevention and rapid
162.9 rehousing services to youth.

162.10 **Supportive Housing Services.** $1,500,000
162.11 each year is for supportive services under
162.12 Minnesota Statutes, section 256K.26. This is
162.13 a onetime appropriation.

162.14 **Community Action Grants.** Community
162.15 action grants are reduced one time by
162.16 $1,794,000 each year. This reduction is due
162.17 to the availability of federal funds under the
162.18 American Recovery and Reinvestment Act.

162.19 **Base Adjustment.** The general fund base
162.20 is increased by $773,000 in fiscal year 2012
162.21 and $773,000 in fiscal year 2013.

162.22 **Federal ARRA Funds for Existing**
162.23 **Programs.** ~~(a)~~ (1) Federal funds received by
162.24 the commissioner for the emergency food
162.25 and shelter program from the American
162.26 Recovery and Reinvestment Act of 2009,
162.27 Public Law 111-5, but not previously
162.28 approved by the legislature are appropriated
162.29 to the commissioner for the purposes of the
162.30 grant program.

162.31 ~~(b)~~ (2) Federal funds received by the
162.32 commissioner for the emergency shelter
162.33 grant program including the Homelessness
162.34 Prevention and Rapid Re-Housing
162.35 Program from the American Recovery and

Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

~~(c)~~ (3) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

~~(d)~~ (4) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

~~(e)~~ (5) Federal funds received by the commissioner for the community services block grant program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

Long-Term Homeless Supportive Service Fund Appropriation. To the extent permitted under federal law, the commissioner shall designate $3,000,000 of the Homelessness Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law, 111-5, to the long-term homeless service fund under Minnesota Statutes, section 256K.26. This appropriation shall become available by July

164.1 1, 2009. This paragraph is effective the day
164.2 following final enactment.

164.3 Sec. 9. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by
164.4 Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

164.5 Subd. 8. **Continuing Care Grants**

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

164.8 **(a) Aging and Adult Services Grants**	13,499,000	15,805,000

164.9 **Base Adjustment.** The general fund base is
164.10 increased by $5,751,000 in fiscal year 2012
164.11 and $6,705,000 in fiscal year 2013.

164.12 **Information and Assistance**
164.13 **Reimbursement.** Federal administrative
164.14 reimbursement obtained from information
164.15 and assistance services provided by the
164.16 Senior LinkAge or Disability Linkage lines
164.17 to people who are identified as eligible for
164.18 medical assistance shall be appropriated to
164.19 the commissioner for this activity.

164.20 **Community Service Development Grant**
164.21 **Reduction.** Funding for community service
164.22 development grants must be reduced by
164.23 $260,000 for fiscal year 2010; $284,000 in
164.24 fiscal year 2011; $43,000 in fiscal year 2012;
164.25 and $43,000 in fiscal year 2013. Base level
164.26 funding shall be restored in fiscal year 2014.

164.27 **Community Service Development Grant**
164.28 **Community Initiative.** Funding for
164.29 community service development grants shall
164.30 be used to offset the cost of aging support
164.31 grants. Base level funding shall be restored
164.32 in fiscal year 2014.

165.1 **Senior Nutrition Use of Federal Funds.**
165.2 For fiscal year 2010, general fund grants
165.3 for home-delivered meals and congregate
165.4 dining shall be reduced by $500,000. The
165.5 commissioner must replace these general
165.6 fund reductions with equal amounts from
165.7 federal funding for senior nutrition from the
165.8 American Recovery and Reinvestment Act
165.9 of 2009.

165.10 **(b) Alternative Care Grants**	50,234,000	48,576,000

165.11 **Base Adjustment.** The general fund base is
165.12 decreased by $3,598,000 in fiscal year 2012
165.13 and $3,470,000 in fiscal year 2013.

165.14 **Alternative Care Transfer.** Any money
165.15 allocated to the alternative care program that
165.16 is not spent for the purposes indicated does
165.17 not cancel but must be transferred to the
165.18 medical assistance account.

165.19 **(c) Medical Assistance Grants; Long-Term** 165.20 **Care Facilities.**	367,444,000	419,749,000
165.21 **(d) Medical Assistance Long-Term Care** 165.22 **Waivers and Home Care Grants**	853,567,000	1,039,517,000

165.23 **Manage Growth in TBI and CADI**
165.24 **Waivers.** During the fiscal years beginning
165.25 on July 1, 2009, and July 1, 2010, the
165.26 commissioner shall allocate money for home
165.27 and community-based waiver programs
165.28 under Minnesota Statutes, section 256B.49,
165.29 to ensure a reduction in state spending that is
165.30 equivalent to limiting the caseload growth of
165.31 the TBI waiver to 12.5 allocations per month
165.32 each year of the biennium and the CADI
165.33 waiver to 95 allocations per month each year
165.34 of the biennium. Limits do not apply: (1)
165.35 when there is an approved plan for nursing

166.1 facility bed closures for individuals under
166.2 age 65 who require relocation due to the
166.3 bed closure; (2) to fiscal year 2009 waiver
166.4 allocations delayed due to unallotment; or (3)
166.5 to transfers authorized by the commissioner
166.6 from the personal care assistance program
166.7 of individuals having a home care rating
166.8 of "CS," "MT," or "HL." Priorities for the
166.9 allocation of funds must be for individuals
166.10 anticipated to be discharged from institutional
166.11 settings or who are at imminent risk of a
166.12 placement in an institutional setting.

166.13 **Manage Growth in ~~DD~~ Developmental**
166.14 **Disability Waiver.** The commissioner
166.15 shall manage the growth in the DD waiver
166.16 by limiting the allocations included in the
166.17 February 2009 forecast to 15 additional
166.18 diversion allocations each month for the
166.19 calendar years that begin on January 1, 2010,
166.20 and January 1, 2011. Additional allocations
166.21 must be made available for transfers
166.22 authorized by the commissioner from the
166.23 personal care program of individuals having
166.24 a home care rating of "CS," "MT," or "HL."

166.25 **Adjustment to Lead Agency Waiver**
166.26 **Allocations.** Prior to the availability of the
166.27 alternative license defined in Minnesota
166.28 Statutes, section 245A.11, subdivision 8,
166.29 the commissioner shall reduce lead agency
166.30 waiver allocations for the purposes of
166.31 implementing a moratorium on corporate
166.32 foster care.

166.33 **Alternatives to Personal Care Assistance**
166.34 **Services.** Base level funding of $3,237,000
166.35 in fiscal year 2012 and $4,856,000 in

167.1 fiscal year 2013 is to implement alternative
167.2 services to personal care assistance services
167.3 for persons with mental health and other
167.4 behavioral challenges who can benefit
167.5 from other services that more appropriately
167.6 meet their needs and assist them in living
167.7 independently in the community. These
167.8 services may include, but not be limited to, a
167.9 1915(i) state plan option.

167.10 **(e) Mental Health Grants**

167.11 Appropriations by Fund

167.12	General	77,739,000	77,739,000
167.13	Health Care Access	750,000	750,000
167.14	Lottery Prize	1,508,000	1,508,000

167.15 **Funding Usage.** Up to 75 percent of a fiscal
167.16 year's appropriation for adult mental health
167.17 grants may be used to fund allocations in that
167.18 portion of the fiscal year ending December
167.19 31.

167.20	**(f) Deaf and Hard-of-Hearing Grants**	1,930,000	1,917,000
167.21	**(g) Chemical Dependency Entitlement Grants**	111,303,000	122,822,000

167.22 **Payments for Substance Abuse Treatment.**
167.23 For services provided during fiscal years
167.24 2010 and 2011, county-negotiated rates
167.25 and provider claims to the consolidated
167.26 chemical dependency fund must not exceed
167.27 the lesser of: (1) rates charged for these
167.28 services on January 1, 2009; or (2) 160
167.29 percent of the average rate on January 1,
167.30 2009, for each group of vendors with similar
167.31 attributes. For services provided in fiscal
167.32 years 2012 and 2013, the statewide ~~average~~
167.33 ~~rates~~ aggregate payment under the new
167.34 rate methodology to be developed under
167.35 Minnesota Statutes, section 254B.12, must

168.1 not exceed the ~~average rates charged for~~
168.2 ~~these services on January 1, 2009, plus a~~
168.3 ~~state share increase of $3,787,000 for fiscal~~
168.4 ~~year 2012 and $5,023,000 for fiscal year~~
168.5 ~~2013~~ projected aggregate payment under
168.6 the rates in effect for fiscal year 2010 minus
168.7 1.25 percent. Notwithstanding any provision
168.8 to the contrary in this article, this provision
168.9 expires on June 30, 2013.

168.10 **Chemical Dependency Special Revenue**
168.11 **Account.** For fiscal year 2010, $750,000
168.12 must be transferred from the consolidated
168.13 chemical dependency treatment fund
168.14 administrative account and deposited into the
168.15 general fund.

168.16 **County CD Share of MA Costs for**
168.17 **ARRA Compliance.** Notwithstanding the
168.18 provisions of Minnesota Statutes, chapter
168.19 254B, for chemical dependency services
168.20 provided during the period October 1, 2008,
168.21 to December 31, 2010, and reimbursed by
168.22 medical assistance at the enhanced federal
168.23 matching rate provided under the American
168.24 Recovery and Reinvestment Act of 2009, the
168.25 county share is 30 percent of the nonfederal
168.26 share. This provision is effective the day
168.27 following final enactment.

168.28 **(h) Chemical Dependency Nonentitlement** 168.29 **Grants**	1,729,000	1,729,000
168.30 **(i) Other Continuing Care Grants**	19,201,000	17,528,000

168.31 **Base Adjustment.** The general fund base is
168.32 increased by $2,639,000 in fiscal year 2012
168.33 and increased by $3,854,000 in fiscal year
168.34 2013.

169.1 **Technology Grants.** $650,000 in fiscal
169.2 year 2010 and $1,000,000 in fiscal year
169.3 2011 are for technology grants, case
169.4 consultation, evaluation, and consumer
169.5 information grants related to developing and
169.6 supporting alternatives to shift-staff foster
169.7 care residential service models.

169.8 **Other Continuing Care Grants; HIV**
169.9 **Grants.** Money appropriated for the HIV
169.10 drug and insurance grant program in fiscal
169.11 year 2010 may be used in either year of the
169.12 biennium.

169.13 **Quality Assurance Commission.** Effective
169.14 July 1, 2009, state funding for the quality
169.15 assurance commission under Minnesota
169.16 Statutes, section 256B.0951, is canceled.

169.17 Sec. 10. **CANCELLATIONS.**

169.18 The remaining balance from Laws 2008, chapter 358, article 5, section 4, subdivision
169.19 3, appropriation for Section 125 employer incentives, is canceled.

169.20 Sec. 11. **TRANSFERS.**

169.21 The commissioner of management and budget shall transfer from the general fund to
169.22 the health care access fund $38,475,000 in fiscal year 2011, $14,758,000 in fiscal year
169.23 2012, and $35,058,000 in fiscal year 2013.

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

169.27 Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

169.28 All uncodified language contained in this article expires on June 30, 2011, unless a
169.29 different expiration date is explicit.

169.30 Sec. 13. **EFFECTIVE DATE.**

170.1 The provisions in this article are effective July 1, 2010, unless a different effective
170.2 date is explicit.

APPENDIX
Article locations in CEH2614-1

ARTICLE 1	DHS LICENSING	Page.Ln 2.4
ARTICLE 2	HEALTH CARE	Page.Ln 12.22
ARTICLE 3	CONTINUING CARE	Page.Ln 58.6
ARTICLE 4	CHILDREN AND FAMILY SERVICES	Page.Ln 70.1
ARTICLE 5	MISCELLANEOUS	Page.Ln 74.28
ARTICLE 6	DEPARTMENT OF HEALTH	Page.Ln 92.16
ARTICLE 7	HEALTH CARE REFORM	Page.Ln 116.5
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ARTICLE 9	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 125.17

254B.02 CHEMICAL DEPENDENCY ALLOCATION PROCESS.

Subd. 2. **County adjustment; maximum allocation.** The commissioner shall determine the state money used by each county in fiscal year 1986, using all state data sources. If available records do not provide specific chemical dependency expenditures for every county, the commissioner shall determine the amount of state money using estimates based on available data. In state fiscal year 1988, a county must not be allocated more than 150 percent of the state money spent by or on behalf of the county in fiscal year 1986 for chemical dependency treatment services eligible for payment under section 254B.05 but not including expenditures made for persons eligible for placement under section 254B.09, subdivision 6. The allocation maximums must be increased by 25 percent each year. After fiscal year 1992, there must be no allocation maximum. The commissioner shall reallocate the excess over the maximum to counties allocated less than the fiscal year 1986 state money, using the following process:

(a) The allocation is divided by 1986 state expenditures to determine percentage of prior expenditure, and counties are ranked by percentage of prior expenditure less expenditures for persons eligible for placement under section 254B.09, subdivision 6.

(b) The allocation of the lowest ranked county is raised to the same percentage of prior expenditure as the second lowest ranked county. The allocation of these two counties is then raised to the percentage of prior expenditures of the third lowest ranked county.

(c) The operations under paragraph (b) are repeated with each county by ranking until the money in excess of the allocation maximum has been allocated.

Subd. 3. **Reserve account.** The commissioner shall allocate money from the reserve account to counties that, during the current fiscal year, have met or exceeded the base level of expenditures for eligible chemical dependency services from local money. The commissioner shall establish the base level for fiscal year 1988 as the amount of local money used for eligible services in calendar year 1986. In later years, the base level must be increased in the same proportion as state appropriations to implement Laws 1986, chapter 394, sections 8 to 20, are increased. The base level must be decreased if the fund balance from which allocations are made under section 254B.02, subdivision 1, is decreased in later years. The local match rate for the reserve account is the same rate as applied to the initial allocation. Reserve account payments must not be included when calculating the county adjustments made according to subdivision 2. For counties providing medical assistance or general assistance medical care through managed care plans on January 1, 1996, the base year is fiscal year 1995. For counties beginning provision of managed care after January 1, 1996, the base year is the most recent fiscal year before enrollment in managed care begins. For counties providing managed care, the base level will be increased or decreased in proportion to changes in the fund balance from which allocations are made under subdivision 2, but will be additionally increased or decreased in proportion to the change in county adjusted population made in subdivision 1, paragraphs (b) and (c). Effective July 1, 2001, at the end of each biennium, any funds deposited in the reserve account funds in excess of those needed to meet obligations incurred under this section and sections 254B.06 and 254B.09 shall cancel to the general fund.

Subd. 4. **Allocation spending limits.** Money allocated according to subdivision 1 and section 254B.09, subdivision 4, is available for payments for up to two years. The commissioner shall deduct payments from the most recent year allocation in which money is available. Allocations under this section that are not used within two years must be reallocated to the reserve account for payments under subdivision 3. Allocations under section 254B.09, subdivision 4, that are not used within two years must be reallocated for payments under section 254B.09, subdivision 5.

254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL DEPENDENCY FUND.

Subd. 4. **Tribal allocation.** Eighty-five percent of the American Indian chemical dependency tribal account must be allocated to the federally recognized American Indian tribal governing bodies that have entered into an agreement under subdivision 2 as follows: $10,000 must be allocated to each governing body and the remainder must be allocated in direct proportion to the population of the reservation according to the most recently available estimates from the federal Bureau of Indian Affairs. When a tribal governing body has not entered into an agreement with the commissioner under subdivision 2, the county may use funds allocated to the reservation to pay for chemical dependency services for a current resident of the county and of the reservation.

Subd. 5. **Tribal reserve account.** The commissioner shall reserve 15 percent of the American Indian chemical dependency tribal account. The reserve must be allocated to those tribal units that have used all money allocated under subdivision 4 according to agreements made under subdivision 2 and to counties submitting invoices for American Indians under subdivision 1 when all money allocated under subdivision 4 has been used. An American Indian tribal governing body or a county submitting invoices under subdivision 1 may receive not more than 30 percent of the reserve account in a year. The commissioner may refuse to make reserve payments for persons not eligible under section 254B.04, subdivision 1, if the tribal governing body responsible for treatment placement has exhausted its allocation. Money must be allocated as invoices are received.

Subd. 7. **Nonreservation Indian account.** The nonreservation American Indian chemical dependency allocation must be held in reserve by the commissioner in an account for treatment of Indians not residing on lands of a reservation receiving money under subdivision 4. This money must be used to pay for services certified by county invoice to have been provided to an American Indian eligible recipient. Money allocated under this subdivision may be used for payments on behalf of American Indian county residents only if, in addition to other placement standards, the county certifies that the placement was appropriate to the cultural orientation of the client. Any funds for treatment of nonreservation Indians remaining at the end of a fiscal year shall be reallocated under section 254B.02.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial

months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(q) Effective July 1, 2003, general assistance medical care emergency services end.

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 5. **Certain county agencies to pay state for county share.** The county agencies that contract with the commissioner of human services for state administration of general assistance medical care payments shall make payment to the state for the county share of those payments in the manner described for medical assistance advances in section 256B.041, subdivision 5.

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a

pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the general assistance medical care rate minus the third party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.