A bill for an act

relating to state government finance; appropriating and transferring money and supplementing or reducing appropriations for the Departments of Health and Human Services, health-related boards, Emergency Medical Services Board, Council on Disabilities, omsbudsman for mental health and developmental disabilities, and omsbudsperson for families; establishing, regulating, or modifying health care services programs, continuing care services, children and family services, and Department of Health provisions; establishing a health information exchange; imposing fees and civil penalties; authorizing rulemaking; requiring reports; amending Minnesota Statutes 2008, sections 62J.04, subdivision 3; 62J.17, subdivision 4a; 62J.692, subdivision 4; 119B.011, subdivision 15; 119B.13, subdivision 1; 150A.22; 214.40, subdivision 7; 256.969, subdivision 27; 256B.0625, subdivision 39; 256B.0915, subdivision 3b; 256B.434, by adding a subdivision; 256B.48, subdivision 1; 256B.5012, by adding a subdivision; 256B.76, subdivision 4; 256D.045; 256D.05, subdivision 1; 256D.07; 256D.10; 256D.47; 256I.04, subdivision 1; 256J.13, subdivision 1; 256J.20, subdivision 3; 256J.21, subdivision 2; 256J.24, subdivisions 3, 4; 256J.28, by adding a subdivision; 256J.37, subdivisions 3a, 9; 256L.04, subdivision 7; 256L.05, subdivision 5; 256L.07, subdivision 1; 256L.12, subdivision 9; 256L.15, subdivision 2; 257.75, subdivision 7; 297F.10, subdivision 1; 517.08, subdivision 1c; Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3; 157.16, subdivision 3; 252.025, subdivision 7; 256.969, subdivisions 2b, 3a; 256B.0651, subdivision 1; 256B.0653, subdivisions 2, 6; 256B.0915, subdivision 3a; 256B.0947, subdivision 1; 256B.199; 256D.01, subdivision 1b; 256D.03, subdivision 4; 256D.44, subdivision 5; 256J.575, subdivision 3; 327.15, subdivision 3; Laws 2009, chapter 79, article 3, section 18; article 13, sections 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5, subdivision 8, as amended; proposing coding for new law in Minnesota Statutes, chapters 62J; 256D; repealing Minnesota Statutes 2008, sections 62J.17, subdivisions 1, 3, 5a, 6a, 8; 62J.321, subdivision 5a; 62J.381; 62J.41, subdivisions 1, 2; 256.742; 256.969, subdivision 26; 256.979, subdivision 8; 256D.06, subdivision 2; 256D.46; Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5; Minnesota Rules, parts 9500.1200; 9500.1202; 9500.1206, subparts 1, 1a, 2, 3, 4a, 4b, 5, 5a, 6, 6a, 6b, 7a, 7b, 8, 8a, 9, 9a, 9b, 11, 11a, 12, 12a, 12b, 12c, 12d, 12e, 12f, 12g, 12h, 12k, 13a, 14, 14a, 15, 15a, 15b, 15c, 15d, 16a, 17, 18, 18a, 18b, 18c, 18d, 19a, 19b, 21, 22a, 22b, 23, 23a, 24, 24a, 24b, 25, 25a, 25b, 25c, 25d, 25e, 25f, 26, 26b, 26c, 28a, 28b, 28c, 28d, 28e, 29, 29a, 29b, 30, 32, 32b, 32c, 32d, 32e, 32f, 33; 9500.1211; 9500.1213; 9500.1215; 9500.1219, subparts

1, 2, 3, 4; 9500.1221; 9500.1223, subparts 1, 2, 3, 5; 9500.1225; 9500.1226, subparts 1, 5, 6, 7, 8, 9; 9500.1231; 9500.1232, subpart 4; 9500.1233, subparts 1, 2, 3, 5; 9500.1237, subparts 1, 2, 4, 6; 9500.1239; 9500.1243; 9500.1245, subparts 1, 2, 3, 4, 5, 6, 7; 9500.1248, subpart 3; 9500.1250; 9500.1254, subparts 1, 2, 4, 5, 6, 7; 9500.1259, subparts 2, 3, 4; 9500.1261; 9500.1272.

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

ARTICLE 1

HEALTH CARE SERVICES

Section 1. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 2b, is amended to read:

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

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

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment

of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

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

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

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

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

Sec. 3. Minnesota Statutes 2008, section 256.969, subdivision 27, is amended to read:

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to

nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, subdivision 1. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, subdivision 1, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, subdivision 1, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, subdivision 1, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199, subdivision 1, when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199, subdivision 1, and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Sec. 4. Minnesota Statutes 2008, section 256B.0625, subdivision 39, is amended to read:

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631

of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay an $8.50 fee per dose for administration of the vaccine and for all other vaccines supplied at no cost by the federal government, including vaccines delivered in a pandemic situation to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Sec. 5. Minnesota Statutes 2009 Supplement, section 256B.0651, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of sections 256B.0651 to 256B.0656 and 256B.0659, the terms in paragraphs (b) to (g) have the meanings given.

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

(c) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person.

(d) "Home care services" means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; ~~physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy;~~ private duty nursing; and personal care assistance.

(e) "Home residence," effective January 1, 2010, means a residence owned or rented by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient except as allowed under sections 256B.0652, subdivision 10, and 256B.0654, subdivision 4.

(f) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(g) "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.

Sec. 6. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request.

~~(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.~~

~~(c)~~ (b) "Home health agency services" means services delivered in the recipient's home residence, except as specified in section 256B.0625, by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions.

~~(d)~~ (c) "Home health aide" means an employee of a home health agency who completes medically oriented tasks written in the plan of care for a recipient.

~~(e)~~ (d) "Home health agency" means a home care provider agency that is Medicare-certified.

~~(f) "Occupational therapy services" mean the services defined in Minnesota Rules, part 9505.0390.~~

~~(g) "Physical therapy services" mean the services defined in Minnesota Rules, part 9505.0390.~~

~~(h) "Respiratory therapy services" mean the services defined in chapter 147C and Minnesota Rules, part 4668.0003, subpart 37.~~

~~(i) "Speech-language pathology services" mean the services defined in Minnesota Rules, part 9505.0390.~~

~~(j)~~ (e) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

~~(k)~~ (f) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

~~(l)~~ (g) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

~~(m)~~ (h) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Sec. 7. Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; and

(4) home care therapies ~~provided in other settings such as a clinic, day program, or as an inpatient or when the recipient can access therapy outside of the recipient's residence~~.

Sec. 8. Minnesota Statutes 2009 Supplement, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Effective November 1, ~~2010~~ 2011, and subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Sec. 9. Minnesota Statutes 2009 Supplement, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

Subdivision 1. **Federal matching funds effective July 1, 2007.** (a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures

in paragraphs (b) and (c). These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27.

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds~~. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27~~; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

Subd. 2. **Federal matching funds; certain MinnesotaCare expenditures.** (a) Effective July 1, 2010, the commissioner shall apply for federal matching funds for MinnesotaCare expenditures for single adults and households with no children defined in

section 256L.04, subdivision 7, occurring on or after April 1, 2010. These funds shall be deposited as provided under section 16A.724, subdivision 3.

(b) The commissioner shall apply for federal matching funds under section 1923 of the Social Security Act for the expenditures in this section in the following sequence:

(1) general assistance medical care expenditures under subdivision 1, paragraph (c);

(2) MinnesotaCare expenditures for childless adults under paragraph (a); and

(3) certified public expenditures under subdivision 1, paragraph (b).

Subd. 3. **Extent of federal match.** The commissioner shall apply for federal matching funds under section 1923 of the Social Security Act for the expenditures in this section only to the extent that Minnesota's disproportionate share hospital allotment has not been exhausted by the payments for the medical assistance disproportionate population adjustments defined in section 256.969, subdivision 9, paragraph (b).

Sec. 10. 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~~ Dentists and dental clinics that operate with a mission to serve disproportionately large numbers of uninsured and underinsured individuals regardless of their ability to pay, may be designated as critical access dental providers. These providers are limited to:

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

(i) have nonprofit status as specified in chapter 317A;

(ii) have tax B exempt status as provided in Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to low-income, uninsured, high risk, underserved, or other special needs populations;

(iv) have professional staff familiar with cultural background of clients;

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

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

(vii) have free care available as needed;

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

(3) ~~whether the level of services provided by the dentist or dental clinic is critical to maintaining adequate levels of patient access within the service area.~~ state-operated dental clinics; and

(4) county-owned and operated hospital based dental clinics.

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

Sec. 11. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

~~(3) services provided by Medicare certified rehabilitation agencies;~~

~~(4)~~ (3) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

~~(5)~~ (4) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

~~(6)~~ (5) eyeglasses and eye examinations provided by a physician or optometrist;

~~(7)~~ (6) hearing aids;

~~(8)~~ (7) prosthetic devices;

~~(9)~~ (8) laboratory and X-ray services;

~~(10)~~ (9) physician's services;

~~(11)~~ (10) medical transportation except special transportation;

~~(12)~~ (11) chiropractic services as covered under the medical assistance program;

~~(13)~~ (12) podiatric services;

~~(14)~~ (13) dental services as covered under the medical assistance program;

~~(15)~~ (14) mental health services covered under chapter 256B;

~~(16)~~ (15) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

~~(17)~~ (16) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

~~(18)~~ (17) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

~~(19)~~ (18) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

~~(20)~~ (19) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

~~(21)~~ (20) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

~~(22)~~ (21) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

~~(23)~~ (22) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

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

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

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

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

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

(1) $25 for nonemergency visits to a hospital-based emergency room; and

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

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(i) General assistance medical care reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of the co-payments effective January 1, 2009.

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

(k) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

(u) Effective for services provided on or after July 1, 2009, total payment rates for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

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

(w) Effective January 1, 2011, rehabilitative and therapeutic services described in section 256B.0625, subdivisions 8, 8a, and 8b, provided in any outpatient setting are not covered under this subdivision.

Sec. 12. Minnesota Statutes 2008, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than ~~200~~ 75 percent of the federal poverty guidelines.

~~(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 250 percent of the federal poverty guidelines.~~

(b) Effective October 1, 2010, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 75 percent of the federal poverty guidelines.

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

Sec. 13. Minnesota Statutes 2008, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all~~: (1)~~ families ~~enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines;~~ and ~~(2)~~ single adults and households without children enrolled in the MinnesotaCare program ~~whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided~~ upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

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

Sec. 14. Minnesota Statutes 2008, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150

percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~200~~ 75 percent of the federal poverty guidelines ~~or 250 percent of the federal poverty guidelines on or after July 1, 2009~~, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

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

Sec. 15. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

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

section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

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

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

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

Sec. 16. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons.

~~Until June 30, 2009,~~ The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, ~~2009~~ 2011, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph ~~(d)~~ (a) with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4. ~~For purposes of paragraph (d), "minimum" means a monthly premium of $4.~~

~~(d) The following premium scale is established for individuals and families with gross family incomes of 300 percent of the federal poverty guidelines or less:~~

~~**Federal Poverty Guideline Range**~~	~~**Percent of Average Gross Monthly Income**~~
~~0-45%~~	~~minimum~~
~~46-54%~~	~~1.1%~~
~~55-81%~~	~~1.6%~~
~~82-109%~~	~~2.2%~~
~~110-136%~~	~~2.9%~~
~~137-164%~~	~~3.6%~~
~~165-191%~~	~~4.6%~~
~~192-219%~~	~~5.6%~~

~~220-248%~~ ~~6.5%~~

~~249-274%~~ ~~7.2%~~

~~275-300%~~ ~~8.0%~~

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

Sec. 17. **REPEALER.**

Minnesota Statutes 2008, section 256.969, subdivision 26, is repealed.

Minnesota Statutes 2009 Supplement, section 256B.0653, subdivision 5, is repealed.

ARTICLE 2

CONTINUING CARE

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0915, subdivision 3a, is amended to read:

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

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with (1) no dependencies in activities of daily living, (2) only one dependency in bathing, dressing, grooming, or walking, or (3) a dependency score of less than three if eating is the only dependency, shall be the lower of the case mix classification amount for case mix A as determined under paragraph (a) or the case mix classification amount for case mix A

effective on October 1, 2008, per month for all new participants enrolled in the program on or after July 1, 2009. This monthly limit shall be applied to all other participants who meet this criteria at reassessment.

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

Sec. 2. 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. 3. Minnesota Statutes 2008, section 256B.434, is amended by adding a subdivision to read:

Subd. 22. **Nursing facility rate reductions effective July 1, 2010.** Effective July 1, 2010, the commissioner shall decrease the operating payment rates of each nursing facility reimbursed under this section by 2.5 percent of the operating payment rate in effect on June 30, 2010.

Sec. 4. Minnesota Statutes 2008, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances:

(1) the nursing facility may :

~~(1)~~ (i) charge private paying residents a higher rate for a private room~~.~~; and

~~(2)~~ (ii) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner~~.~~;

(2) effective July 1, 2010, through September 30, 2011, nursing facilities may charge private paying residents rates up to two percent higher than the allowable payment rate determined by the commissioner for the RUG's group currently assigned to the resident;

(3) effective October 1, 2011, through September 30, 2012, nursing facilities may charge private paying residents rates up to four percent higher than the allowable payment rate determined by the commissioner for the RUG's group currently assigned to the resident; and

(4) effective October 1, 2012, through September 30, 2013, nursing facilities may charge private paying residents rates up to six percent higher than the allowable payment rate determined by the commissioner for the RUG's group currently assigned to the resident.

Nothing in this section precludes a nursing facility from charging a rate allowable under the facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

(b) Effective October 1, 2013, paragraph (a) no longer applies, except that special services, if offered, must be available to all residents of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility.

(c)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan. For residents on medical assistance, medical assistance payment according to the state plan must be accepted as payment in full for continued stay, except where otherwise provided for under statute;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

~~(c)~~ (d) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota Board of Pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

~~(d)~~ (e) Providing differential treatment on the basis of status with regard to public assistance.

~~(e)~~ (f) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance ~~or refusal to purchase special services~~. Discrimination in admissions ~~discrimination~~, services offered, or room assignment shall include, but is not limited to:

(1) basing admissions decisions upon ~~assurance by the applicant to the nursing facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek~~ information or assurances regarding current or future eligibility for public assistance for payment of nursing facility care ~~costs~~; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility is utilizing that information for any purpose prohibited by this paragraph.

~~(f)~~ (g) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney's fees or their equivalent.

~~(g)~~ (h) Refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

(i) For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 5. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **ICF/MR rate decreases effective July 1, 2010.** Effective July 1, 2010, the commissioner shall decrease the operating payment rate of each facility reimbursed under this section by 2.5 percent of the operating payment rates in effect on June 30, 2010. For each facility, the commissioner shall implement the rate reduction, based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate, in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.5012, subdivision 7.

Sec. 6. **COLA COMPENSATION REQUIREMENTS.**

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

Sec. 7. **PROVIDER RATE AND GRANT REDUCTIONS.**

(a) The commissioner of human services shall decrease grants, allocations, reimbursement rates, or rate limits, as applicable, by 2.5 percent effective July 1, 2010, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease and must be retroactive from the effective date of the rate decrease.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 3

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2008, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **Income.** "Income" means earned or unearned income received by all family members, including public assistance cash benefits and at-home infant child care subsidy payments, unless specifically excluded and child support and maintenance distributed to the family under section 256.741, subdivision 15. The following are excluded from income: funds used to pay for health insurance premiums for family members, ~~Supplemental Security Income,~~ scholarships, work-study income, and grants that cover costs or reimbursement for tuition, fees, books, and educational supplies; student loans for tuition, fees, books, supplies, and living expenses; state and federal earned income tax credits; assistance specifically excluded as income by law; in-kind income such as food support, energy assistance, foster care assistance, medical assistance, child care assistance, and housing subsidies; earned income of full-time or part-time students up to the age of 19, who have not earned a high school diploma or GED high school equivalency diploma including earnings from summer employment; grant awards under the family subsidy program; nonrecurring lump-sum income only to the extent that it is earmarked and used for the purpose for which it is paid; and any income assigned to the public authority according to section 256.741.

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

Sec. 2. Minnesota Statutes 2008, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) Beginning ~~July 1, 2006~~ March 1, 2011, the maximum rate paid for child care assistance in any county or multicounty region under the

child care fund shall be the rate for like-care arrangements in the county effective January 1, ~~2006~~ 2010, ~~increased~~ decreased by ~~six~~ five percent.

~~(b) Rate changes shall be implemented for services provided in September 2006 unless a participant eligibility redetermination or a new provider agreement is completed between July 1, 2006, and August 31, 2006.~~

~~As necessary, appropriate notice of adverse action must be made according to Minnesota Rules, part 3400.0185, subparts 3 and 4.~~

~~New cases approved on or after July 1, 2006, shall have the maximum rates under paragraph (a), implemented immediately.~~

~~(c)~~ (b) Every year, the commissioner shall survey rates charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in counties. When the commissioner determines that, using the commissioner's established protocol, the number of providers responding to the survey is too small to determine the 75th percentile rate for like-care arrangements in a county or multicounty region, the commissioner may establish the 75th percentile maximum rate based on like-care arrangements in a county, region, or category that the commissioner deems to be similar.

~~(d)~~ (c) A rate which includes a special needs rate paid under subdivision 3 or under a school readiness service agreement paid under section 119B.231, may be in excess of the maximum rate allowed under this subdivision.

~~(e)~~ (d) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

~~(f)~~ (e) When the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(g)~~ (f) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

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

Sec. 3. Minnesota Statutes 2009 Supplement, section 256D.01, subdivision 1b, is amended to read:

Subd. 1b. ~~**Rules**~~ **Personal needs allowance.** ~~The commissioner shall adopt rules to set standards of assistance and methods of calculating payment to conform with subdivision 1a. When a recipient is a resident of a licensed residential facility, except shelters for the homeless or shelters under section 611A.31, the recipient is not eligible for~~

~~a full general assistance standard.~~ The state standard of assistance for those recipients who have personal needs not otherwise provided for is the personal needs allowance authorized for medical assistance recipients under section 256B.35.

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

Sec. 4. Minnesota Statutes 2008, section 256D.045, is amended to read:

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. ~~The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2.~~ This provision applies to eligible children under the age of 18 effective July 1, 1997.

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

Sec. 5. Minnesota Statutes 2008, section 256D.05, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Each assistance unit with income and resources less than the standard of assistance established by the commissioner and with a member who is a resident of the state shall be eligible for and entitled to general assistance if the assistance unit is:

~~(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;~~

~~(2) a person whose presence in the home on a substantially continuous basis is required because of the professionally certified illness, injury, incapacity, or the age of another member of the household;~~

~~(3)~~ (1) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative; or

~~(4)~~ (2) a person who resides in a shelter facility described in ~~subdivision 3;~~ section 611A.31.

~~(5) a person not described in clause (1) or (3) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining employment;~~

~~(6) a person who has an application pending for, or is appealing termination of benefits from, the Social Security disability program or the program of supplemental security income for the aged, blind, and disabled, provided the person has a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;~~

~~(7) a person who is unable to obtain or retain employment because advanced age significantly affects the person's ability to seek or engage in substantial work;~~

~~(8) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;~~

~~(9) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan;~~

~~(10) a child under the age of 18 who is not living with a parent, stepparent, or legal custodian, and only if: the child is legally emancipated or living with an adult with the consent of an agency acting as a legal custodian; the child is at least 16 years of age and the general assistance grant is approved by the director of the county agency or a designated representative as a component of a social services case plan for the child; or the child is living with an adult with the consent of the child's legal custodian and the county agency. For purposes of this clause, "legally emancipated" means a person under the age of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of~~

~~the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv) is otherwise considered emancipated under Minnesota law, and for whom county social services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;~~

~~(11) a person who is eligible for displaced homemaker services, programs, or assistance under section 116L.96, but only if that person is enrolled as a full-time student;~~

~~(12) a person who lives more than four hours round-trip traveling time from any potential suitable employment;~~

~~(13) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day;~~

~~(14) a person over age 18 whose primary language is not English and who is attending high school at least half time; or~~

~~(15) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.~~

(b) As a condition of eligibility under paragraph (a), ~~clauses~~ clause (1), ~~(3), (5), (8), and (9),~~ the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision 5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) The burden of providing documentation for a county agency to use to verify eligibility for general assistance or for exemption from the food stamp employment and training program is upon the applicant or recipient. The county agency shall use documents already in its possession to verify eligibility, and shall help the applicant or recipient obtain other existing verification necessary to determine eligibility which the applicant or recipient does not have and is unable to obtain.

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

Sec. 6. Minnesota Statutes 2008, section 256D.07, is amended to read:

256D.07 TIME OF PAYMENT OF ASSISTANCE.

An applicant for general assistance or general assistance medical care authorized by section 256D.03, subdivision 3, shall be deemed eligible if the application and the verification of the statement on that application demonstrate that the applicant is within the eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of the commissioner. Any person requesting general assistance or general assistance medical care shall be permitted by the county agency to make an application for assistance as soon as administratively possible and in no event later than the fourth day following the date on which assistance is first requested, and no county agency shall require that a person requesting assistance appear at the offices of the county agency more than once prior to the date on which the person is permitted to make the application. The application shall be in writing in the manner and upon the form prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point." On the date that general assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, assistance for necessary transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2. ~~A person in need of emergency assistance shall be granted emergency assistance immediately, and necessary emergency assistance shall continue for up to 30 days following the date of application.~~ A determination of an applicant's eligibility for general assistance shall be made by the county agency as soon as the required verifications are received by the county agency and in no event later than 30 days following the date that the application is made. Any verifications required of the applicant shall be reasonable, and the commissioner shall by rule establish reasonable verifications. General assistance shall be granted to an eligible applicant without the necessity of first securing action by the board of the county agency. The first month's grant must be computed to cover the time period starting with the date a signed application form is received by the county agency or from the date that the applicant meets all eligibility factors, whichever occurs later.

If upon verification and due investigation it appears that the applicant provided false information and the false information materially affected the applicant's eligibility for general assistance or general assistance medical care provided pursuant to section 256D.03, subdivision 3, or the amount of the applicant's general assistance grant, the county agency may refer the matter to the county attorney. The county attorney may

commence a criminal prosecution or a civil action for the recovery of any general assistance wrongfully received, or both.

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

Sec. 7. Minnesota Statutes 2008, section 256D.10, is amended to read:

256D.10 ADMINISTRATIVE HEARING PRIOR TO ADVERSE ACTION.

No grant of general assistance except one made pursuant to section ~~256D.06, subdivision 2, or~~ 256D.08, subdivision 2, shall be reduced, terminated, or suspended unless the recipient receives notice and is afforded an opportunity to be heard prior to any action by the county agency.

Nothing herein shall deprive a recipient of the right to full administrative and judicial review of an order or determination of a county agency as provided for in section 256.045 subsequent to any action taken by a county agency after a prior hearing.

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

Sec. 8. Minnesota Statutes 2009 Supplement, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a ~~nursing home, a regional treatment center, or a group~~ licensed residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

~~(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.~~

~~(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.~~

~~(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.~~

~~(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.~~

~~(f)(1) Notwithstanding the language in this subdivision,~~ (b) An amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

~~(g)~~ (c) Notwithstanding this subdivision, to access housing and services as provided in paragraph ~~(f)~~ (b), the recipient may choose housing that may or may not be owned, operated, or controlled by the recipient's service provider if the housing is located in a multifamily building of six or more units. The maximum number of units that may be used by recipients of this program shall be 50 percent of the units in a building. The department shall develop an exception process to the 50 percent maximum. This paragraph expires on June 30, 2011.

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

Sec. 9. **[256D.441] SHORT-TERM AID PROGRAM.**

Subdivision 1. **Short-term aid program.** A grant of short-term aid shall, to the extent funds are available, be made to an eligible single adult, married couple, or family where the recipient requests temporary assistance not exceeding 30 days if (1) a crisis situation appears to exist under written criteria adopted by the county agency, (2) the individual or family is ineligible for MFIP or DWP and has not received a consolidated fund emergency grant within 12 months of application, and (3) the individual or family's annual net income is no greater than 200 percent of the federal poverty guidelines for the previous calendar year.

Subd. 2. **County to advise.** If an applicant or recipient relates facts to the county agency which may be sufficient to constitute a crisis situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for aid according to this subdivision. A short-term aid grant is available to a recipient not more than once in a 12-month period.

Subd. 3. **Limited funding.** (a) Funding for the short-term aid program is limited to the appropriation. Each fiscal year the commissioner shall allocate to counties the

money appropriated for short-term aid grants based on each county agency's average share of state's former emergency general assistance expenditures and any subsequent short-term aid expenditures for the immediate past three fiscal years as determined by the commissioner. The commissioner may reallocate any unspent amounts to other counties. No county shall be allocated less than $1,000 for the fiscal year.

(b) Any short-term aid expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

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

Sec. 10. Minnesota Statutes 2008, section 256D.47, is amended to read:

256D.47 PAYMENT METHODS.

Minnesota supplemental aid payments must be issued to the recipient, a protective payee, or a conservator or guardian of the recipient's estate in the form of county warrants immediately redeemable in cash, electronic benefits transfer, or by direct deposit into the recipient's account in a financial institution. Minnesota supplemental aid payments must be issued regularly on the first day of the month. The supplemental aid warrants must be mailed only to the address at which the recipient resides, unless another address has been approved in advance by the county agency. Vendor payments must not be issued by the county agency except for nonrecurring emergency need payments; at the request of the recipient; ~~for special needs, other than special diets;~~ or when the agency determines the need for protective payments exist.

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

Sec. 11. Minnesota Statutes 2008, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** (a) An individual is eligible for and entitled to a group residential housing payment to be made on the individual's behalf if the county agency has approved the individual's residence in a group residential housing setting and the individual meets the requirements in ~~paragraph (a) or (b)~~ this subdivision.

~~(a)~~ (b) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of the supplemental security income program, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver recipient under the provisions of sections

256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.

~~(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), and the individual's resources are less than the standards specified by section 256D.08, and the individual's countable income as determined under sections 256D.01 to 256D.21, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the county agency's agreement with the provider of group residential housing in which the individual resides.~~

(c) Each assistance unit with income and resources less than the standard of assistance for group residential housing established by the commissioner who is a resident of the state shall be eligible for and entitled to group residential housing if the assistance unit is a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative.

(d) As a condition of eligibility under paragraph (c), the recipient shall complete an interim assistance agreement and must apply for other maintenance benefits for which the individual may be eligible.

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

Sec. 12. Minnesota Statutes 2008, section 256J.13, subdivision 1, is amended to read:

Subdivision 1. **Minor child or pregnant woman.** The assistance unit must include at least one minor child or a pregnant woman. ~~If a minor child is a recipient of Supplemental Security Income or Minnesota supplemental aid, the assistance unit is eligible for MFIP, but the needs of the minor child receiving Supplemental Security Income or Minnesota supplemental aid must not be taken into account when the county agency determines the amount of the assistance payment to be paid to the assistance unit.~~

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

Sec. 13. 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)~~ (18) 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. 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, 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.

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

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

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

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

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

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

~~(7)~~ (6) the value of corrective payments, but only for the month in which the payment is received and for the following month;

~~(8)~~ (7) a mobile home or other vehicle used by an applicant or participant as the applicant's or participant's home;

~~(9)~~ (8) money in a separate escrow account that is needed to pay real estate taxes or insurance and that is used for this purpose;

~~(10)~~ (9) money held in escrow to cover employee FICA, employee tax withholding, sales tax withholding, employee worker compensation, business insurance, property rental, property taxes, and other costs that are paid at least annually, but less often than monthly;

~~(11)~~ (10) monthly assistance payments for the current month's or short-term emergency needs under section 256J.626, subdivision 2;

~~(12)~~ (11) the value of school loans, grants, or scholarships for the period they are intended to cover;

~~(13)~~ (12) payments listed in section 256J.21, subdivision 2, clause (9), which are held in escrow for a period not to exceed three months to replace or repair personal or real property;

~~(14)~~ (13) income received in a budget month through the end of the payment month;

~~(15)~~ (14) savings from earned income of a minor child or a minor parent that are set aside in a separate account designated specifically for future education or employment costs;

~~(16)~~ (15) the federal earned income credit, Minnesota working family credit, state and federal income tax refunds, state homeowners and renters credits under chapter 290A, property tax rebates and other federal or state tax rebates in the month received and the following month;

~~(17)~~ (16) payments excluded under federal law as long as those payments are held in a separate account from any nonexcluded funds;

~~(18)~~ (17) the assets of children ineligible to receive MFIP benefits because foster care or adoption assistance payments are made on their behalf; and

~~(19)~~ (18) the assets of persons whose income is excluded under section 256J.21, subdivision 2, clause (43).

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

Sec. 14. Minnesota Statutes 2008, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

~~(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient, except as described in section 256J.37, subdivision 3b;~~

~~(20) Minnesota supplemental aid, including retroactive payments;~~

~~(21)~~ (19) proceeds from the sale of real or personal property;

~~(22)~~ (20) state adoption assistance payments under section 259.67, and up to an equal amount of county adoption assistance payments;

~~(23)~~ (21) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds under section 256.476, and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

~~(24)~~ (22) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

~~(25)~~ (23) rent rebates;

~~(26)~~ (24) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

~~(27)~~ (25) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

~~(28)~~ (26) MFIP child care payments under section 119B.05;

~~(29)~~ (27) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

~~(30)~~ (28) income a participant receives related to shared living expenses;

~~(31)~~ (29) reverse mortgages;

~~(32)~~ (30) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

~~(33)~~ (31) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

~~(34)~~ (32) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

~~(35)~~ (33) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

~~(36)~~ (34) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

~~(37)~~ (35) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

~~(38)~~ (36) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

~~(39)~~ (37) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

~~(40)~~ (38) security and utility deposit refunds;

~~(41)~~ (39) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

~~(42)~~ (40) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

~~(43)~~ (41) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

~~(44)~~ (42) payments made to children eligible for relative custody assistance under section 257.85;

~~(45)~~ (43) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

~~(46)~~ (44) the principal portion of a contract for deed payment; and

~~(47)~~ (45) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC.

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

Sec. 15. Minnesota Statutes 2008, section 256J.24, subdivision 3, is amended to read:

Subd. 3. **Individuals who must be excluded from an assistance unit.** (a) The following individuals who are part of the assistance unit determined under subdivision 2 are ineligible to receive MFIP:

~~(1) individuals who are recipients of Supplemental Security Income or Minnesota supplemental aid;~~

~~(2)~~ (1) individuals disqualified from the food stamp or food support program or MFIP, until the disqualification ends;

~~(3)~~ (2) children on whose behalf federal, state or local foster care payments are made, except as provided in sections 256J.13, subdivision 2, and 256J.74, subdivision 2; and

~~(4)~~ (3) children receiving ongoing monthly adoption assistance payments under section 259.67.

(b) The exclusion of a person under this subdivision does not alter the mandatory assistance unit composition.

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

Sec. 16. Minnesota Statutes 2008, section 256J.24, subdivision 4, is amended to read:

Subd. 4. **Individuals who may elect to be included in the assistance unit.** (a) The minor child's eligible caregiver may choose to be in the assistance unit, if the caregiver is not required to be in the assistance unit under subdivision 2. If the eligible caregiver chooses to be in the assistance unit, that person's spouse must also be in the unit.

(b) Any minor child not related as a sibling, stepsibling, or adopted sibling to the minor child in the unit, but for whom there is an eligible caregiver may elect to be in the unit.

(c) A foster care provider of a minor child who is receiving federal, state, or local foster care maintenance payments may elect to receive MFIP if the provider meets the definition of caregiver under section 256J.08, subdivision 11. If the provider chooses to receive MFIP, the spouse of the provider must also be included in the assistance unit with the provider. The provider and spouse are eligible for assistance even if the only minor child living in the provider's home is receiving foster care maintenance payments.

(d) The adult caregiver or caregivers of a minor parent are eligible to be a separate assistance unit from the minor parent and the minor parent's child when:

(1) the adult caregiver or caregivers have no other minor children in the household;

(2) the minor parent and the minor parent's child are living together with the adult caregiver or caregivers; and

(3) the minor parent and the minor parent's child receive MFIP~~, or would be eligible to receive MFIP, if they were not receiving SSI benefits~~.

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

Sec. 17. Minnesota Statutes 2008, section 256J.28, is amended by adding a subdivision to read:

Subd. 6. **Choice of stand-alone food support for MFIP assistance units.** MFIP assistance units that receive no MFIP cash benefits may be eligible for more food support under the stand-alone food support program than they are receiving under the food portion of MFIP. County financial workers shall discuss the option of receiving stand-alone food support with participants at the time they lose their MFIP cash benefit. If requested by the participant, financial workers shall calculate the benefit the family would receive on stand-alone food support. Participants are not required to complete a food support application when MFIP is canceled but they must provide the necessary verifications to determine eligibility for the stand-alone food support program.

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

Sec. 18. Minnesota Statutes 2008, section 256J.37, subdivision 3a, is amended to read:

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

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

(1) age 60 or older;

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

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's

presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI or Retirement, Survivors, Disability Insurance (RSDI) recipient.

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

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

Sec. 19. Minnesota Statutes 2008, section 256J.37, subdivision 9, is amended to read:

Subd. 9. **Unearned income.** (a) The county agency must apply unearned income to the MFIP standard of need. When determining the amount of unearned income, the county agency must deduct the costs necessary to secure payments of unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

(b) The county agency must convert unearned income received on a periodic basis to monthly amounts by prorating the income over the number of months represented by the frequency of the payments. The county agency must begin counting the monthly amount in the month the periodic payment is received and budget it according to the assistance unit's budget cycle.

(c) The county agency must deduct the fees paid from SSI and Retirement, Survivors, Disability Insurance (RSDI) benefits to organizational representative payees.

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

Sec. 20. Minnesota Statutes 2009 Supplement, section 256J.575, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) The following MFIP participants are eligible for the services under this section:

(1) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3, except that it is not necessary for the participant to have reached or be approaching 60 months of eligibility for this section to apply;

(2) a participant who is applying for or receiving Supplemental Security Income or Social Security disability insurance;

(3) a participant who is a noncitizen who has been in the United States for 12 or fewer months; and

(4) a participant who is age 60 or older.

~~(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.~~

~~(c)~~ (b) A participant under paragraph (a), clause (3), must be provided with English as a second language opportunities and skills training for up to 12 months. After 12 months, the case manager and participant must determine whether the participant should continue with English as a second language classes or skills training, or both, and continue to receive family stabilization services.

~~(d)~~ (c) If a county agency or employment services provider has information that an MFIP participant may meet the eligibility criteria set forth in this subdivision, the county agency or employment services provider must assist the participant in obtaining the documentation necessary to determine eligibility.

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

Sec. 21. Minnesota Statutes 2008, section 257.75, subdivision 7, is amended to read:

Subd. 7. **Hospital and Department of Health ~~distribution of educational materials~~; recognition form.** Hospitals that provide obstetric services and the state registrar of vital statistics shall distribute the educational materials and recognition of parentage forms prepared by the commissioner of human services to new parents ~~and~~, shall assist parents in understanding the recognition of parentage form, including following the provisions for notice under subdivision 5, shall aid new parents in properly completing the recognition of parentage form, including providing notary services, and shall timely file the completed recognition of parentage form with the office of the state registrar of vital statistics. On and after January 1, 1994, hospitals may not distribute the declaration of parentage forms.

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

Sec. 22. Minnesota Statutes 2008, section 517.08, subdivision 1c, is amended to read:

Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected pursuant to subdivision 1b, paragraph (a), $25 must be retained by the county. The local registrar must pay $85 to the commissioner of management and budget to be deposited as follows:

(1) ~~$50~~ $55 in the general fund;

(2) $3 in the state government special revenue fund to be appropriated to the commissioner of public safety for parenting time centers under section 119A.37;

(3) $2 in the special revenue fund to be appropriated to the commissioner of health for developing and implementing the MN ENABL program under section 145.9255; and

(4) $25 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96~~; and~~.

~~(5) $5 in the special revenue fund is appropriated to the commissioner of human services for the Minnesota Healthy Marriage and Responsible Fatherhood Initiative under section 256.742.~~

(b) Of the $40 fee under subdivision 1b, paragraph (b), $25 must be retained by the county. The local registrar must pay $15 to the commissioner of management and budget to be deposited as follows:

(1) $5 as provided in paragraph (a), clauses (2) and (3); and

(2) $10 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96.

~~(c) The increase in the marriage license fee under paragraph (a) provided for in Laws 2004, chapter 273, and disbursement of the increase in that fee to the special fund for the Minnesota Healthy Marriage and Responsible Fatherhood Initiative under paragraph (a), clause (5), is contingent upon the receipt of federal funding under United States Code, title 42, section 1315, for purposes of the initiative.~~

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

Sec. 23. **REVISOR'S INSTRUCTION.**

The revisor of statutes, with the assistance of the Department of Human Services, shall prepare legislation for the 2011 legislative session that identifies additional laws or rules that require an amendment to effectuate the repeal of the general assistance program under Minnesota Statutes, sections 256D.01 to 256D.21 with the exception of provisions necessary to implement the personal needs allowance under sections 256D.01, subdivision

1b, and 256D.05, subdivision 1, paragraph (a), clauses (1) and (2). The legislation must include any cross-reference corrections, including corrections to punctuation and grammar, that are required as a result of the repeal.

Sec. 24. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256.742; and 256.979, subdivision 8, are repealed.

(b) Minnesota Statutes 2008, sections 256D.06, subdivision 2; and 256D.46, are repealed effective December 1, 2010.

(c) Minnesota Rules, parts 9500.1200; 9500.1202; 9500.1206, subparts 1, 1a, 2, 3, 4a, 4b, 5, 5a, 6, 6a, 6b, 7a, 7b, 8, 8a, 9, 9a, 9b, 11, 11a, 12, 12a, 12b, 12c, 12d, 12e, 12f, 12g, 12h, 12k, 13a, 14, 14a, 15, 15a, 15b, 15c, 15d, 16a, 17, 18, 18a, 18b, 18c, 18d, 19a, 19b, 21, 22a, 22b, 23, 23a, 24, 24a, 24b, 25, 25a, 25b, 25c, 25d, 25e, 25f, 26, 26b, 26c, 28a, 28b, 28c, 28d, 28e, 29, 29a, 29b, 30, 32, 32b, 32c, 32d, 32e, 32f, and 33; 9500.1211; 9500.1213; 9500.1215; 9500.1219, subparts 1, 2, 3, and 4; 9500.1221; 9500.1223, subparts 1, 2, 3, and 5; 9500.1225; 9500.1226, subparts 1, 5, 6, 7, 8, and 9; 9500.1231; 9500.1232, subpart 4; 9500.1233, subparts 1, 2, 3, and 5; 9500.1237, subparts 1, 2, 4, and 6; 9500.1239; 9500.1243; 9500.1245, subparts 1, 2, 3, 4, 5, 6, and 7; 9500.1248, subpart 3; 9500.1250; 9500.1254, subparts 1, 2, 4, 5, 6, and 7; 9500.1259, subparts 2, 3, and 4; 9500.1261; and 9500.1272, are repealed effective December 1, 2010.

ARTICLE 4

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2008, section 62J.04, subdivision 3, is amended to read:

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

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

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

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

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

(5) undertake health planning responsibilities;

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

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

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

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

Sec. 2. Minnesota Statutes 2008, section 62J.17, subdivision 4a, is amended to read:

Subd. 4a. **Expenditure reporting.** Each hospital, outpatient surgical center, and diagnostic imaging center~~, and physician clinic~~ shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

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

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

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

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

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

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

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

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

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

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

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

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

average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

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

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

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

(3) $1,800,000 to the Academic Health Center.

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

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

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

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

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

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

(g) Beginning in fiscal year 2011, the amounts distributed in paragraph (b) shall be reduced proportionally to achieve a state share reduction of $1,500,000.

Sec. 4. Minnesota Statutes 2008, section 150A.22, is amended to read:

150A.22 DONATED DENTAL SERVICES.

(a) Within available appropriations, the commissioner of health ~~shall~~ may contract with the Minnesota Dental Association, or another appropriate and qualified organization to develop and operate a donated dental services program to provide dental care to public program recipients and the uninsured through dentists who volunteer their services without compensation. As part of the contract, the commissioner shall include specific performance and outcome measures that the contracting organization must meet. The donated dental services program shall:

(1) establish a network of volunteer dentists, including dental specialties, to donate dental services to eligible individuals;

(2) establish a system to refer eligible individuals to the appropriate volunteer dentists; and

(3) develop and implement a public awareness campaign to educate eligible individuals about the availability of the program.

(b) Available funding for the program may be used for administrative or technical support. The organization contracting with the commissioner shall provide an annual report that accounts for funding appropriated to the program by the state, documents the number of individuals served by the program and the number of dentists participating as program providers, and provides data on meeting the specific performance and outcome measures identified by the commissioner.

Sec. 5. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is amended to read:

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

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

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

(d) In addition to the base fee in paragraph (b), each food and beverage service establishment, other than a special event food stand, and each hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual fee for each fee category, additional food service, or required additional inspection specified in this paragraph:

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

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

(ii) frozen pizza that is heated and served;

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

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

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

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

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

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

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

(iv) is a boarding establishment; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) Additional inspection fee, $360. "Additional inspection fee" means a fee to conduct the second inspection each year for elementary and secondary education facility

school lunch programs when required by the Richard B. Russell National School Lunch Act.

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

Service Area	Type	Fee
Food	limited food menu	$275
	small establishment	$400
	medium establishment	$450
	large food establishment	$500
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$350
Alcohol	beer or wine table service	$150
	alcohol service from bar	$250
Lodging	less than 25 rooms	$375
	25 to less than 100 rooms	$400
	100 rooms or more	$500
	less than five cabins	$350
	five to less than ten cabins	$400
	ten cabins or more	$450

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

Service Area	Type	Fee
Food	limited food menu	$250
	small establishment	$300
	medium establishment	$350
	large food establishment	$400
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250
	seasonal temporary food stand	$250
	mobile food unit	$250
Alcohol	beer or wine table service	$150
	alcohol service from bar	$250
Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300

100 rooms or more	$450
less than five cabins	$250
five to less than ten cabins	$350
ten cabins or more	$400

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

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

(1) camps with up to 99 campers, $325;

(2) camps with 100 to 199 campers, $550; and

(3) camps with 200 or more campers, $750.

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

Sec. 6. Minnesota Statutes 2008, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,220,000 for fiscal year 2006 and $22,250,000 for fiscal year 2007 and each year thereafter must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$8,553,000 for fiscal year 2006 and $8,550,000 for fiscal year 2007 and each year thereafter~~ The following amounts must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4~~; and~~:

(i) $8,553,000 in fiscal year 2006;

(ii) $8,550,000 in fiscal year 2007 through fiscal year 2009;

(iii) $7,550,000 in fiscal year 2010; and

(iv) $7,050,000 in fiscal year 2011 and each year thereafter; and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

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

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

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

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

(2) a recreational camping area with:

(i) 24 or less sites, $50;

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

(iii) 100 or more sites, $300.

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

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

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

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

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

(1) for initial construction of less than 25 sites, $375;

(2) for initial construction of 25 to 99 sites, $400; and

(3) for initial construction of 100 or more sites, $500.

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

(1) for expansion of less than 25 sites, $250;

(2) for expansion of 25 to 99 sites, $300; and

(3) for expansion of 100 or more sites, $450.

Sec. 8. **REPEALER.**

Minnesota Statutes 2008, sections 62J.17, subdivisions 1, 3, 5a, 6a, and 8; 62J.321, subdivision 5a; 62J.381; and 62J.41, subdivisions 1 and 2, are repealed.

ARTICLE 5

E-HEALTH TECHNOLOGY

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

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

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

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

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

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

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

(1) provide clinical decision support;

(2) support physician order entry;

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

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

Sec. 2. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is amended to read:

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

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

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

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

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

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

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

Sec. 3. **[62J.498] HEALTH INFORMATION EXCHANGE.**

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

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

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

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

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

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

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

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

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

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

(j) "Major participating entity" means:

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

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

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

(k) "Meaningful use" means use of certified electronic health record technology that includes e-prescribing, and is connected in a manner that provides for the electronic exchange of health information and used for the submission of clinical quality measures

as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

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

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

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

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

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

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

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

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

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

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

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

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

(p) "State-certified health information organization" means a nonprofit health information organization that provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall establish a Health Information Exchange Oversight Board. The board shall be charged

with advising the commissioner on regulatory action necessary to protect the public interest on matters pertaining to health information exchange. The board shall:

(1) review and recommend applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) work in consultation with the commissioner to provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) assist the commissioner's response to public complaints related to health information exchange services;

(4) make recommendations to the commissioner on enforcement actions including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biannual report to the commissioner on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences;

(6) other duties as assigned by the commissioner.

(b) The Health Information Exchange Oversight Board shall consist of seven members, including:

(1) two public members who do not have a material financial interest in health information exchange services; and

(2) five health care stakeholders who:

(i) are broadly representative of the Minnesota health care community;

(ii) reflect the geography of the state; and

(iii) have at least three years of practical experience in the use of electronic health records or health information exchange services immediately preceding appointment.

(c) Members of the Health Information Exchange Oversight Board shall not be employed by the Department of Health, but the board shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the board. The board shall meet at least quarterly. The commissioner may require more frequent

board meetings as needed. The compensation, terms, removal of members, and filling of vacancies on the board are governed by section 15.0575.

(d) The Health Information Exchange Oversight Board shall not be subject to chapter 13D when the board is considering contracts as described in section 62J.4981, subdivision 4, paragraph (a), clause (5).

(e) When the Health Information Exchange Oversight Board is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(f) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all Health Information Exchange Oversight Board minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

(g) The Health Information Exchange Oversight Board may make any data classified as protected nonpublic or confidential under this section accessible to an appropriate person or agency if the commissioner determines that failure to make the data accessible is likely to create a clear and present danger to public health or safety.

Sec. 4. **[62J.4981] CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.**

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

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

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers

to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

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

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

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

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

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

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization that provides all electronic transaction capabilities necessary to support clinical transactions necessary for meaningful use of electronic health records must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do so may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

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

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

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

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

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

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

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

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

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

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

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation;

(2) annually submit strategic and operational plans for review by the Health Information Exchange Oversight Board that address:

(i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and

(ii) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(3) develop and maintain a business plan that addresses:

(i) plans for ensuring the necessary capacity to support meaningful use transactions;

(ii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iii) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(iv) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(4) annually submit a rate plan outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:

(i) distributes costs equitably among users of health information services;

(ii) provides predictable costs for participating entities;

(iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and

(iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;

(5) enter into reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements in subdivision 5; and

(6) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner, in consultation with the Health Information Exchange Oversight Board.

Subd. 4. **Application for certificate of authority for health information exchange service providers.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following:

(1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a copy of each contract intended to bind major participating entities and the health information organization. The Health Information Exchange Oversight Board shall consider contract information provided under this section in a closed session as provided for in section 62J.498, subdivision 2, paragraph (c). Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;

(6) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;

(8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;

(9) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(10) a description of the complaint procedures to be used as required under this section;

(11) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(12) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(13) a copy of the conflict of interest policy that applies to all members of the board of directors and the principal officers of the health information organization; and

(14) other information as the commissioner may reasonably require to be provided.

(b) Thirty days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Ninety days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information exchange entities.** (a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of transactions necessary to achieve meaningful use;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements are subject to review and approval by the Health Information Exchange Oversight Board.

(c) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use.

Sec. 5. **[62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.**

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information exchange service provider, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization or a health data intermediary by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information exchange service provider;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information exchange service provider attempted to correct previous violations;

(11) how the health information exchange service provider responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information exchange service provider including, but not limited to, whether the health information exchange service provider had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information exchange service provider to continue to deliver health information exchange services.

Reasonable notice in writing to the health information exchange service provider shall be given of the intent to levy the penalty and the reasons for them. A health information exchange service provider may have 15 days within which to contest whether the finding of facts constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information exchange service provider and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information exchange service provider or a representative of a health information exchange service provider to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information exchange service provider may contest whether the finding of facts constitutes a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

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

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

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

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

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

(4) the health information exchange service provider has failed to implement a mechanism affording the participating entities an opportunity to participate in matters of policy and operation;

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

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

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

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

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

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

(d) If the certificate of authority of a health information exchange service provider is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written

order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

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

(b) After a hearing before the Health Information Exchange Oversight Board, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall consider the recommendations of the Health Information Exchange Oversight Board and take action as deemed necessary and shall issue written findings that shall be mailed to the health information exchange service provider.

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

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

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

(3) the amount of the proposed penalty;

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

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

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

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

(b) By January 1, 2011, the commissioner shall report to the governor and the legislature on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement

of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.

Subd. 5. **Expedited rulemaking.** The commissioner may use the expedited rulemaking process under section 14.389 to carry out the duties of sections 62J.498 to 62J.4982. The commissioner shall be exempt from section 14.125 for purposes of this section.

Subd. 6. **Fees and monetary penalties.** (a) Every health information exchange service provider subject to sections 62J.4981 and 62J.4982 shall be assessed fees as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $15,000;

(2) filing an application for certificate of authority to operate as a health data intermediary, $10,000;

(3) annual health information organization certificate fee, $20,000;

(4) annual health data intermediary certificate fee, $10,000; and

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

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

ARTICLE 6

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	$	(15,895,000)	$	(142,886,000)	$	(158,781,000)
State Government Special Revenue		(1,609,000)		(1,040,000)		(2,649,000)
Health Care Access		(1,525,000)		(156,840,000)		(158,365,000)
Federal TANF		-0-		28,000		28,000
Total	**$**	**(19,029,000)**	**$**	**(272,766,000)**	**$**	**(291,795,000)**

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

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

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

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**(14,921,000)**	**(259,768,000)**

Appropriations by Fund

	2010	2011
General	(13,819,000)	(142,253,000)
State Government Special Revenue	(8,000)	(16,000)
Health Care Access	(1,094,000)	(145,499,000)
Federal TANF	-0-	28,000,000

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2011, ...;

(2) fiscal year 2012, ...; and

(3) fiscal year 2013, ...;

Notwithstanding any provision to the contrary, this rider expires June 30, 2013.

TANF Financing and Maintenance of Effort. The commissioner of human services, with the approval of the commissioner of management and budget, and after notification of the chairs of the

relevant senate budget division and house of representatives finance division, may adjust the amount of TANF transfers between the MFIP transition year child care assistance program and MFIP grant programs within the fiscal year, and within the current biennium and the biennium ending June 30, 2013, to ensure that state and federal match and maintenance of effort requirements are met. These transfers and amounts shall be reported to the chairs of the senate and house of representatives Finance Committees, the senate Health and Human Services Budget Division, the house of representatives Health Care and Human Services Finance Division, and Early Childhood Finance and Policy Division by December 1 of each fiscal year. Notwithstanding any provision to the contrary, this provision expires June 30, 2013.

Special Revenue Fund Transfers.

(1) Notwithstanding any law to the contrary, the commissioner shall transfer $1,023,000 of the special revenue fund account balances to the general fund by June 30, 2010.

(2) The commissioner shall transfer $905,000 of the special revenue fund earnings in fiscal years 2012 and 2013 to the general fund by June 30, 2013. Notwithstanding any contrary provision, this provision shall not expire.

(3) The actual transfers made under this rider must be separately identified and reported as part of the quarterly reporting of transfers to the chairs of the relevant senate budget

division and house of representatives finance division.

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

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

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

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	172,000	49,580,000

TANF Funding for the Working Family Tax Credit. In addition to the amounts specified in Minnesota Statutes, section 290.0671, subdivision 6, $172,000 of TANF funds in fiscal year 2010 and $49,580,000 of TANF funds in fiscal year 2011 are appropriated to the commissioner of human services to reimburse the cost of the working family tax credit for eligible families. Beginning January 1, 2011, the commissioner shall reimburse the general fund on a monthly basis according to a schedule based on the pattern of working family credit expenditures through June 20, 2011.

TANF Transfer to Federal Child Care and Development Fund. The following additional TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2012, $5,000,000; and

(2) fiscal year 2013, $5,000,000.

The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

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

(a) **MFIP and Diversionary Work Program Grants**	-0-	(21,348,000)

This appropriation reduction is from the federal TANF fund.

(b) **Support Services Grants**	-0-	-0-
(c) **MFIP Child Care Assistance Grants**	-0-	(814,000)
(d) **Basic Sliding Fee Child Care Assistance Grants**	(5,000,000)	(5,876,000)

Basic Sliding Fee Allocation. For calendar year 2011, a county may terminate child care assistance for families already receiving assistance if the county basic sliding fee allocation is reduced below the county's allocation for calendar year 2010 by an amount that the county demonstrates cannot be absorbed without terminating assistance. The county must consult with and obtain approval from the commissioner before terminating assistance to families under this provision. If approved, the county must follow procedures outlined in Minnesota Rules, part 3400.0183, subpart 1, item B.

Base Adjustment. The general fund base is decreased by $3,302,000 in fiscal year 2012 and decreased by $3,553,000 in fiscal year 2013.

(e) **Child Support Enforcement Grants**	-0-	(300,000)

Minnesota Healthy Marriage and Responsible Fatherhood Initiative Fee. Notwithstanding Minnesota Statutes, section 517.08, the balance and the fee revenue available to the commissioner of human services for the healthy marriage and responsible fatherhood initiative in the state government special revenue fund must be transferred to and deposited into the general fund by June 30 of each fiscal year.

(f) **General Assistance Grants**	-0-	(21,294,000)
(g) **Minnesota Supplemental Aid Grants**	-0-	(452,000)
(h) **Group Residential Housing Grants**	-0-	(882,000)
(i) **Children's Mental Health Grants**	(200,000)	(1,410,000)
(j) **Other Children and Economic Assistance Grants**	-0-	5,592,000

Short-Term Aid Grants to Counties. Of the general fund appropriation, $6,000,000 in fiscal year 2011 is for short-term aid grants under Minnesota Statutes, section 256D.441. The base for this program is $11,000,000 in fiscal year 2012 and $11,000,000 in fiscal year 2013.

Subd. 5. **Children and Economic Assistance Management**

(a) **Children and Economic Assistance Administration**	(172,000)	(232,000)

This appropriation reduction is from the federal TANF fund.

(b) **Children and Economic Assistance Operations**	(1,408,000)	(1,491,000)

Suspension of Food Support Retailer Fees. Under the legislative approval requirement

in Laws 1998, chapter 407, article 6, section 116, the commissioner may eliminate the transaction payment to retailers for electronic benefits transfer (EBT) costs. By January 15, 2011, the commissioner shall make a report and recommendation to the house of representatives and senate finance committees with jurisdiction over the supplemental nutrition assistance program on whether to reinstitute the fee effective July 1, 2011. The report must include information on EBT usage trends and retailer fee costs.

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

(a) **MinnesotaCare Grants**	-0-	(140,979,000)

This appropriation reduction is from the health care access fund.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**	-0-	(27,635,000)

Medical Education Research Costs (MERC). In fiscal year 2011, the commissioner shall reduce the amount transferred to the medical education research fund under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), by $18,802,463, so as to provide no amount for general distribution under Minnesota Statutes, section 62J.692, subdivision 7, clause (5). This is a onetime reduction.

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**	-0-	(16,221,000)

(d) **Other Health Care Grants**

Minnesota COBRA Premium Subsidy. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel

and are available to the commissioner for fiscal year 2011 COBRA grant expenditures.

Subd. 7. **Health Care Management**

(a) **Health Care Administration**	(2,998,000)	(5,320,000)

Minnesota Senior Health Options Reimbursement. Effective July 1, 2011, federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity. Notwithstanding any contrary provision, this provision expires June 30, 2013.

Utilization Review. Effective July 1, 2011, federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to, and is appropriated to, the commissioner for these activities. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance. Notwithstanding any contrary provision, this provision expires June 30, 2013.

(b) **Health Care Operations**

Appropriations by Fund		
General	-0-	2,000
Health Care Access	(1,094,000)	(4,520,000)

Base Adjustment. The health care access fund base for health care operations is reduced by $1,451,000 in fiscal year 2012 and $1,581,000 in fiscal year 2013.

Subd. 8. **Continuing Care Grants**

(a) **Aging and Adult Services Grants**	-0-	(272,000)

Base Adjustment. The general fund base for aging and adult services grants is reduced by $268,000 in fiscal year 2012 and $291,000 in fiscal year 2013.

(b) **Alternative Care Grants**	-0-	(701,000)

Base Adjustment. The base for alternative care grants is reduced by $164,000 in fiscal year 2012 and $255,000 in fiscal year 2013.

(c) **Medical Assistance Long-Term Care Facilities Grants**	-0-	(9,911,000)
(d) **Medical Assistance Long-Term Care Waivers and Home Care Grants**	-0-	(23,636,000)

Manage Growth in Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waivers. During the fiscal year beginning July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to six allocations per month and the CADI waiver to 60 allocations per month. The limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or

who are at imminent risk of a placement in an institutional setting.

Manage Growth in the Developmental Disability (DD) Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the November 2010 forecast to six additional diversion allocations each month for the calendar year that begins on January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. This provision is effective through December 31, 2011.

(e) **Adult Mental Health Grants**	(3,700,000)	(200,000)

Compulsive Gambling Special Revenue Account. $149,000 for fiscal year 2010 and $27,000 for fiscal year 2011 from the compulsive gambling special revenue account established under Minnesota Statutes, section 245.982, must be transferred and deposited into the general fund by June 30 of each respective fiscal year.

Compulsive Gambling Lottery Prize Fund Appropriation. Of the lottery prize fund appropriation for compulsive gambling, $48,000 for fiscal year 2010 and $47,000 for fiscal year 2011 must be transferred and deposited into the general fund by June 30 of each respective fiscal year.

(f) **Deaf and Hard-of-Hearing Grants**	-0-	(37,000)

Base Adjustment. The general fund base for deaf and hard-of-hearing grants is reduced

by $12,000 in fiscal year 2012 and $9,000 in fiscal year 2013.

(g) **Chemical Dependency Entitlement Grants** -0- (5,300,000)

Consolidated Chemical Dependency Treatment Fund Balance. $4,800,000 must be transferred from the consolidated chemical dependency treatment fund and deposited into the general fund by June 30, 2010.

(h) **Chemical Dependency Nonentitlement Grants** (389,000) -0-

(i) **Other Continuing Care Grants** -0- (2,646,000)

HIV Grants. The general fund appropriation for the HIV drug and insurance grant program shall be reduced by $2,037,000 in fiscal year 2011 and increased by $2,037,000 in fiscal year 2013. These adjustments are onetime and must not be applied to the base. Notwithstanding any contrary provision, this provision expires June 30, 2013.

Base Adjustment. The general fund base is increased by $1,819,000 in fiscal year 2012 and is increased by $3,813,000 in fiscal year 2013.

Subd. 9. **Continuing Care Management** -0- 341,000

Provider Rate Reduction Evaluation. $341,000 is appropriated to the commissioner in fiscal year 2011 to monitor and report on changes in recipient access to continuing care services funded under Minnesota's Medicaid program resulting from rate reductions. The commissioner shall provide preliminary results of the monitoring to the house of representatives and senate committees and

divisions with jurisdiction over continuing care by February 15, 2011, and shall report updated results by December 31, 2012.

Base Adjustment. The general fund base for continuing care management is decreased by $79,000 in fiscal year 2012 and $79,000 in fiscal year 2013.

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

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010.

Adult Mental Health Services	48,000	(2,210,000)

Subd. 11. **Contingent Appropriations Reductions.**

Upon enactment of the extension of the enhanced federal medical assistance percentage (FMAP) under Public Law 111-5 to June 30, 2011, that is contained in the president's budget for federal fiscal year 2011 or contained in House Resolution 2847, the federal "Jobs for Main Street Act, 2010," or subsequent federal legislation, the reductions identified in each clause shall be made to the specified general fund appropriations

for fiscal year 2011. These contingent reductions, if implemented, are in addition to the reductions specified in subdivision 6, paragraphs (a), (b), and (c), and subdivision 8, paragraphs (c) and (d), respectively.

(1) MinnesotaCare Grants	-0-	(9,200,000)
(2) Medical Assistance Basic Health Care Grants - Families and Children	-0-	(109,662,500)
(3) Medical Assistance Basic Health Care Grants - Elderly and Disabled	-0-	(110,437,500)
(4) Medical Assistance Long-Term Care Facilities Grants	-0-	(51,925,000)
(5) Medical Assistance Long-Term Care Waivers and Home Care Grants	-0-	(115,475,000)

Sec. 4. **COMMISSIONER OF HEALTH**

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Subdivision 1. **Total Appropriation**	**$** (4,123,000)	**$** (12,349,000)

Appropriations by Fund

	2010	2011
General	(2,392,000)	(426,000)
State Government Special Revenue	(1,300,000)	(582,000)
Health Care Access	(431,000)	(11,341,000)

Subd. 2. **Community and Family Health**

Appropriations by Fund

	2010	2011
General	(221,000)	(121,000)
Health Care Access	(45,000)	(10,040,000)

Statewide Health Improvement Program.

Of the health care access fund reductions, $10,000,000 in fiscal year 2011 is for reductions to the statewide health

improvement program. This reduction is onetime.

Base Level Adjustment. The general fund base is reduced by $33,000 in fiscal year 2012 and by $33,000 in fiscal year 2013.

Subd. 3. **Policy, Quality and Compliance**

	Appropriations by Fund	
	2010	2011
General	(1,797,000)	-0-
State Government Special Revenue	(600,000)	(232,000)
Health Care Access	(386,000)	(1,301,000)

Health Care Reform. Funds appropriated in Laws 2008, chapter 358, article 5, section 4, subdivision 3, for health reform activities to implement Laws 2008, chapter 358, article 4, are available until expended. Notwithstanding any contrary provision in this article, this provision shall not expire.

Rural Hospital Capital Improvement Grants. Of the general fund reductions in fiscal year 2010, $1,755,000 is for the rural hospital capital improvement grant program.

Federally Qualified Health Centers. Of the health care access fund reductions, $1,000,000 in fiscal year 2011 is for the reduction of grants to federally qualified health centers. This is a onetime reduction.

Donated Dental Program Grants. Of the health care access fund reduction, $63,000 in fiscal year 2011 is for the elimination of grant funding to the donated dental service program.

Health Information Exchange Oversight. Of the state government special revenue fund

appropriations, $140,000 in fiscal year 2011 is for administrative support of the Health Information Exchange Oversight Board established in Minnesota Statutes, section 62J.498, subdivision 2.

Base Level Adjustment. The general fund base is decreased by $133,000 in fiscal year 2012 and $133,000 in fiscal year 2013. The health care access fund base is increased by $959,000 in fiscal year 2012 and $1,079,000 in fiscal year 2013. The state government special revenue fund base is increased by $367,000 in fiscal year 2012 and $362,000 in fiscal year 2013.

Subd. 4. **Health Protection**

Appropriations by Fund	2010	2011
General	(374,000)	(205,000)
State Government Special Revenue	(700,000)	(350,000)

Lead Base Grant Program. Of the general fund reduction, $25,000 in fiscal year 2010 and fiscal year 2011 is for the elimination of state funding for the temporary lead-safe housing base grant program.

Base Adjustment. The general fund base is decreased by $100,000 in fiscal year 2012 and $100,000 in fiscal year 2013. The state government special revenue fund is increased by $350,000 in fiscal year 2012 and $350,000 in fiscal year 2013.

Subd. 5. **Administrative Support Services** -0- (100,000)

Sec. 5. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ (290,000) $ (421,000)**

The appropriations and reductions in this section are from the state government special revenue fund.

In fiscal year 2010, $301,000 shall be transferred from the state government special revenue fund to the general fund. In fiscal year 2011, $441,000 shall be transferred from the state government special revenue fund to the general fund. These transfers are in addition to those made in Laws 2009, chapter 79, article 13, section 5, as amended by Laws 2009, chapter 173, article 2, section 3.

The reductions and transfers in this section are onetime in the fiscal year 2010-2011 biennium.

The appropriations and reductions for each purpose are shown in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	(9,000)	(14,000)
Subd. 3. **Board of Dentistry**	(21,000)	(31,000)
Subd. 4. **Board of Dietetic and Nutrition Practice**	(2,000)	(3,000)
Subd. 5. **Board of Marriage and Family Therapy**	(2,000)	(4,000)
Subd. 6. **Board of Medical Practice**	(73,000)	(112,000)
Subd. 7. **Board of Nursing**	(62,000)	(100,000)
Subd. 8. **Board of Nursing Home Administrators**	(36,000)	(31,000)
(a) **Administrative Services Unit-Operating Costs**	(11,000)	(16,000)
(b) **Administrative Services Unit-Retirement Costs**	(5,000)	-0-

(c) **Administrative Services Unit-Volunteer Health Care Provider Program**	(1,000)	(3,000)
(d) **Administrative Services Unit-Contested Cases and Other Legal Proceedings**	(15,000)	(6,000)
Subd. 9. **Board of Optometry**	(2,000)	(3,000)
Subd. 10. **Board of Pharmacy**	(28,000)	(42,000)
Subd. 11. **Board of Physical Therapy**	(6,000)	(9,000)
Subd. 12. **Board of Podiatry**	(1,000)	(2,000)
Subd. 13. **Board of Psychology**	(16,000)	(24,000)
Subd. 14. **Board of Social Work**	(18,000)	(28,000)
Subd. 15. **Board of Veterinary Medicine**	(4,000)	(6,000)
Subd. 16. **Board of Behavioral Health and Therapy**	(8,000)	(12,000)
Sec. 6. **EMERGENCY MEDICAL SERVICES BOARD**	432,000	(154,000)

Appropriations by Fund	2010	2011
General	445,000	(133,000)
State Government Special Revenue	(13,000)	(21,000)

(a) **Longevity Award and Incentive Program**	(19,000)	(19,000)
(b) **Health Professional Services Program**	(13,000)	(21,000)

This reduction is from the state government special revenue fund and is onetime in the 2010-2011 biennium.

$10,000 in fiscal year 2010 and $24,000 in fiscal year 2011 shall be transferred to the general fund from the portion of the emergency medical services relief account in the special revenue fund otherwise designated for distribution by the Emergency Medical Services Board under Minnesota Statutes, section 169.686, subdivision 3.

These transfers are onetime in the 2010-2011 biennium.

Sec. 7. **COUNCIL ON DISABILITY**	**$**	**(10,000)**	**$**	**(16,000)**
Sec. 8. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**(31,000)**	**$**	**(50,000)**
Sec. 9. **OMBUDSPERSON FOR FAMILIES**	**$**	**(4,000)**	**$**	**(8,000)**

Sec. 10. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds appropriated for this program, the administrative services unit must purchase medical professional liability insurance, if available, for a health care provider who is registered in accordance with subdivision 4 and who is not otherwise covered by a medical professional liability insurance policy or self-insured plan either personally or through another facility or employer. The administrative services unit is authorized to prorate payments or otherwise limit the number of participants in the program if the costs of the insurance for eligible providers exceed the funds appropriated for the program.

(b) Coverage purchased under this subdivision must be limited to the provision of health care services performed by the provider for which the provider does not receive direct monetary compensation.

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

Sec. 11. Minnesota Statutes 2009 Supplement, section 252.025, subdivision 7, is amended to read:

Subd. 7. **Minnesota extended treatment options.** The commissioner shall develop by July 1, 1997, the Minnesota extended treatment options to serve Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety. This program is statewide and must provide specialized residential services in Cambridge and an array of community-based services with sufficient levels of care and a sufficient number of specialists to ensure that individuals referred to the program receive the appropriate care. 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. Laws 2009, chapter 79, article 3, section 18, is amended to read:

Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE ANOKA-METRO REGIONAL TREATMENT CENTER.**

In consultation with community partners, the commissioner of human services shall develop an array of community-based services to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center. The community-based services may be provided in facilities with 16 or fewer beds, and must provide the appropriate level of care for the patients being admitted to the facilities. The planning for this transition must be completed by October 1, 2009, with an initial report to the committee chairs of health and human services by November 30, 2009, and a semiannual report on progress until the transition is completed. The commissioner of human services shall solicit interest from stakeholders and potential community partners. The individuals working in the community-based services facilities 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. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$** 5,225,451,000 **$** 6,002,864,000

Appropriations by Fund

	2010	2011
General	4,375,689,000	5,209,765,000
State Government Special Revenue	565,000	565,000
Health Care Access	450,662,000	527,411,000
Federal TANF	286,770,000	263,458,000
Lottery Prize	1,665,000	1,665,000
Federal Fund	110,000,000	0

Receipts for Systems Projects.

Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money

appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary, except that any transfers to one project that exceed $1,000,000 or multiple transfers to one project that exceed $1,000,000 in total require the express approval of the legislature. The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations. Any computer project with a total cost exceeding $1,000,000, including, but not limited to, a replacement for the proposed HealthMatch system, shall not be commenced without the express approval of the legislature.

HealthMatch Systems Project. In fiscal year 2010, $3,054,000 shall be transferred from the HealthMatch account in the state systems account in the special revenue fund to the general fund.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); ~~and~~

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671~~.~~; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures to the extent such expenditures or other qualified expenditures are otherwise available after considering the expenditures allowed in this section.

(e) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(f) Notwithstanding any contrary provision in this article, this provision expires June 30, 2013.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures for fiscal year 2010 through fiscal year 2011.

Working Family Credit Expenditures to be Claimed for TANF/MOE. The commissioner may count the following

amounts of working family credit expenditure as TANF/MOE:

(1) fiscal year 2010, ~~$50,973,000~~ $50,897,000;

(2) fiscal year 2011, ~~$53,793,000~~ $54,243,000;

(3) fiscal year 2012, ~~$23,516,000~~ $23,345,000; and

(4) fiscal year 2013, ~~$16,808,000~~ $16,585,000.

Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

Food Stamps Employment and Training.

(a) The commissioner shall apply for and claim the maximum allowable federal matching funds under United States Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family stabilization services participants voluntarily engaged in food stamp employment and training activities, where appropriate.

(b) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures for two-parent families must be deposited in the general fund. The amount of funds must be limited to $3,350,000 in fiscal year 2010 and $4,440,000 in fiscal years 2011 through

2013, contingent on approval by the federal Food and Nutrition Service.

(c) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

ARRA Food Support Administration. The funds available for food support administration under the American Recovery and Reinvestment Act (ARRA) of 2009 are appropriated to the commissioner to pay actual costs of implementing the food support benefit increases, increased eligibility determinations, and outreach. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion based on a caseload factor equivalent to that of a county.

ARRA Food Support Benefit Increases. The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Emergency Fund for the TANF Program. TANF Emergency Contingency funds

available under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) are appropriated to the commissioner. The commissioner must request TANF Emergency Contingency funds from the Secretary of the Department of Health and Human Services to the extent the commissioner meets or expects to meet the requirements of section 403(c) of the Social Security Act. The commissioner must seek to maximize such grants. The funds received must be used as appropriated. Each county must maintain the county's current level of emergency assistance funding under the MFIP consolidated fund and use the funds under this paragraph to supplement existing emergency assistance funding levels.

Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 3, is amended to read:

Subd. 3. **Revenue and Pass-Through Revenue Expenditures**	68,337,000	70,505,000

This appropriation is from the federal TANF fund.

TANF Transfer to Federal Child Care and Development Fund. The following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2010, ~~$6,531,000~~ $862,000;

(2) fiscal year 2011, ~~$10,241,000~~ $978,000;

(3) fiscal year 2012, ~~$10,826,000~~ $0; and

(4) fiscal year 2013, ~~$4,046,000~~ $0.

The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Sec. 15. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	63,205,000	89,033,000
Federal TANF	100,818,000	84,538,000

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	12,498,000
Federal TANF	116,557,000	107,457,000

MFIP Consolidated Fund. The MFIP consolidated fund TANF appropriation is reduced by $1,854,000 in fiscal year 2010 and fiscal year 2011.

Notwithstanding Minnesota Statutes, section 256J.626, subdivision 8, paragraph (b), the commissioner shall reduce proportionately the reimbursement to counties for administrative expenses.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth

in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

Supported Work. Of the TANF appropriation, $4,700,000 in fiscal year 2010 and $4,700,000 in fiscal year 2011 are to the commissioner for supported work for MFIP recipients and is available until expended. Supported work includes paid transitional work experience and a continuum of employment assistance, including outreach and recruitment, program orientation and intake, testing and assessment, job development and marketing, preworksite training, supported worksite experience, job coaching, and postplacement follow-up, in addition to extensive case management and referral services. This is a onetime appropriation.

Base Adjustment. The general fund base is reduced by $3,783,000 in each of fiscal years 2012 and 2013. The TANF fund base is increased by $5,004,000 in each of fiscal years 2012 and 2013.

Integrated Services Program Funding. The TANF appropriation for integrated services program funding is $1,250,000 in fiscal year 2010 and $0 in fiscal year 2011 and the base for fiscal years 2012 and 2013 is $0.

TANF Emergency Fund; Nonrecurrent Short-Term Benefits. (1) TANF emergency contingency fund grants received due to increases in expenditures for nonrecurrent short-term benefits must be used to offset the increase in these expenditures for counties under the MFIP consolidated fund, under Minnesota Statutes, section 256J.626, and the diversionary work program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters. Growth in expenditures for the diversionary work program over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage these funds.

(2) To the extent that the commissioner can claim eligible tax credit growth as nonrecurrent short-term benefits, the commissioner shall use those funds to leverage the increased expenditures in clause (1).

(3) TANF emergency funds for nonrecurrent short-term benefits received in excess of the amounts necessary for clauses (1) and (2) shall be used to reimburse the general fund for the costs of eligible tax credits in fiscal

year 2011. The amount of such funds shall not exceed $28,000,000.

(c) MFIP Child Care Assistance Grants 61,171,000 65,214,000

Acceleration of ARRA Child Care and Development Fund Expenditure. The commissioner must liquidate all child care and development money available under the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5, by September 30, 2010. In order to expend those funds by September 30, 2010, the commissioner may redesignate and expend the ARRA child care and development funds appropriated in fiscal year 2011 for purposes under this section for related purposes that will allow liquidation by September 30, 2010. Child care and development funds otherwise available to the commissioner for those related purposes shall be used to fund the purposes from which the ARRA child care and development funds had been redesignated.

School Readiness Service Agreements. $400,000 in fiscal year 2010 and $400,000 in fiscal year 2011 are from the federal TANF fund to the commissioner of human services consistent with federal regulations for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(d) Basic Sliding Fee Child Care Assistance Grants 40,100,000 45,092,000

School Readiness Service Agreements. $257,000 in fiscal year 2010 and $257,000 in fiscal year 2011 are from the general fund for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,244,000 in fiscal year 2010 from the federal child care development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

Basic Sliding Fee. $4,000,000 in fiscal year 2010 and $4,000,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of basic sliding fee child care assistance under Minnesota Statutes, section 119B.03. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Basic Sliding Fee Allocation for Calendar Year 2010. Notwithstanding Minnesota Statutes, section 119B.03, subdivision 6,

in calendar year 2010, basic sliding fee funds shall be distributed according to this provision. Funds shall be allocated first in amounts equal to each county's guaranteed floor, according to Minnesota Statutes, section 119B.03, subdivision 8, with any remaining available funds allocated according to the following formula:

(a) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(b) Up to three-fourths of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in Minnesota Statutes, section 119B.03, subdivision 2, and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(c) The amount necessary to serve all families in paragraphs (a) and (b) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

(d) Funds in excess of the amount necessary to serve all families in paragraphs (a) and (b) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation. To the extent that funds are available, and notwithstanding Minnesota Statutes, section 119B.03, subdivision 8, for the period January 1, 2011, to December 31, 2011, each county's guaranteed floor must be equal to its original calendar year 2010 allocation.

Base Adjustment. The general fund base is decreased by $257,000 in each of fiscal years 2012 and 2013.

(e) Child Care Development Grants	1,487,000	1,487,000

Family, friends, and neighbor grants. $375,000 in fiscal year 2010 and $375,000 in fiscal year 2011 are from the child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services for family, friends, and neighbor grants under Minnesota Statutes, section 119B.232. This appropriation may be used on programs receiving family, friends, and neighbor grant funds as of June 30, 2009, or on new programs or projects. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system training, coaching, consultation, and supports. $633,000 in fiscal year 2010 and $633,000 in fiscal year 2011 are from the federal child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of providing grants to provide statewide child-care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system rating tool. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system. $184,000 in fiscal year 2010 and $1,200,000 in fiscal year 2011 are from the federal child care development fund required targeted funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of implementing the voluntary Parent Aware quality star rating system pilot in coordination with the Minnesota Early Learning Foundation. The appropriation for the first year is to complete and promote the voluntary Parent Aware quality rating system pilot program through June 30, 2010, and the appropriation for the second year is to continue the voluntary Minnesota quality rating system pilot through June 30, 2011. This is a onetime

appropriation. Any unexpended balance the first year is available in the second year.

(f) Child Support Enforcement Grants	3,705,000	3,705,000

(g) Children's Services Grants

Appropriations by Fund		
General	48,333,000	50,498,000
Federal TANF	340,000	240,000

Base Adjustment. The general fund base is decreased by $5,371,000 in fiscal year 2012 and decreased $5,371,000 in fiscal year 2013.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for postadoption services including parent support groups.

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

(h) Children and Community Services Grants	67,663,000	67,542,000

Targeted Case Management Temporary Funding Adjustment. The commissioner shall recover from each county and tribe receiving a targeted case management temporary funding payment in fiscal year

2008 an amount equal to that payment. The commissioner shall recover one-half of the funds by February 1, 2010, and the remainder by February 1, 2011. At the commissioner's discretion and at the request of a county or tribe, the commissioner may revise the payment schedule, but full payment must not be delayed beyond May 1, 2011. The commissioner may use the recovery procedure under Minnesota Statutes, section 256.017, to recover the funds. Recovered funds must be deposited into the general fund.

(i) General Assistance Grants	48,215,000	48,608,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in fiscal year 2010 and $7,889,812 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants	33,930,000	35,191,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for

emergency Minnesota supplemental aid funds is limited to no more than $1,100,000 in fiscal year 2010 and $1,100,000 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(k) Group Residential Housing Grants 111,778,000 114,034,000

Group Residential Housing Costs Refinanced. (a) Effective July 1, 2011, the commissioner shall increase the home and community-based service rates and county allocations provided to programs for persons with disabilities established under section 1915(c) of the Social Security Act to the extent that these programs will be paying for the costs above the rate established in Minnesota Statutes, section 256I.05, subdivision 1.

(b) For persons receiving services under Minnesota Statutes, section 245A.02, who reside in licensed adult foster care beds for which a difficulty of care payment was being made under Minnesota Statutes, section 256I.05, subdivision 1c, paragraph (b), counties may request an exception to the individual's service authorization not to exceed the difference between the client's monthly service expenditures plus the amount of the difficulty of care payment.

(l) Children's Mental Health Grants 16,885,000 16,882,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations

in that portion of the fiscal year ending December 31.

(m) Other Children and Economic Assistance Grants 16,047,000 15,339,000

Fraud Prevention Grants. Of this appropriation, $228,000 in fiscal year 2010 and ~~$228,000~~ $379,000 in fiscal year 2011 is to the commissioner for fraud prevention grants to counties.

Homeless and Runaway Youth. $218,000 in fiscal year 2010 is for the Runaway and Homeless Youth Act under Minnesota Statutes, section 256K.45. Funds shall be spent in each area of the continuum of care to ensure that programs are meeting the greatest need. Any unexpended balance in the first year is available in the second year. Beginning July 1, 2011, the base is increased by $119,000 each year.

ARRA Homeless Youth Funds. To the extent permitted under federal law, the commissioner shall designate $2,500,000 of the Homeless Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, for agencies providing homelessness prevention and rapid rehousing services to youth.

Supportive Housing Services. $1,500,000 each year is for supportive services under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

Community Action Grants. Community action grants are reduced one time by $1,794,000 each year. This reduction is due

to the availability of federal funds under the American Recovery and Reinvestment Act.

Base Adjustment. The general fund base is increased by ~~$773,000~~ $903,000 in fiscal year 2012 and ~~$773,000~~ $413,000 in fiscal year 2013.

Federal ARRA Funds for Existing Programs. ~~(a)~~ (1) Federal funds received by the commissioner for the emergency food and shelter program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, but not previously approved by the legislature are appropriated to the commissioner for the purposes of the grant program.

~~(b)~~ (2) Federal funds received by the commissioner for the emergency shelter grant program including the Homelessness Prevention and Rapid Re-Housing Program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

~~(c)~~ (3) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

~~(d)~~ (4) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated

to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

~~(c)~~ (5) Federal funds received by the commissioner for the community services block grant program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

Long-Term Homeless Supportive Service Fund Appropriation. To the extent permitted under federal law, the commissioner shall designate $3,000,000 of the Homelessness Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law, 111-5, to the long-term homeless service fund under Minnesota Statutes, section 256K.26. This appropriation shall become available by July 1, 2009. This paragraph is effective the day following final enactment.

Sec. 16. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

Subd. 8. **Continuing Care Grants**

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

(a) Aging and Adult Services Grants	13,499,000	15,805,000

Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.

Information and Assistance Reimbursement. Federal administrative

reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

(b) Alternative Care Grants	50,234,000	48,576,000

Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does

not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month

for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver Allocations. Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

Alternatives to Personal Care Assistance Services. Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.

(e) Mental Health Grants

	Appropriations by Fund	
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that

portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants	1,930,000	1,917,000
(g) Chemical Dependency Entitlement Grants	111,303,000	122,822,000

Payments for Substance Abuse Treatment. For services provided during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of: (1) rates charged for these services on January 1, 2009; or (2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes. For services provided in fiscal years 2012 and 2013, the statewide ~~average rates~~ aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the ~~average rates charged for these services on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013~~ projected aggregate payment under the rates in effect for fiscal year 2010 minus 1.25 percent. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the

provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 17. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing Home Administrators**		1,211,000	1,023,000

Administrative Services Unit - Operating Costs. Of this appropriation, $524,000 in fiscal year 2010 and $526,000 in fiscal year 2011 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year 2010, $201,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $79,000 in fiscal year 2010 and $89,000 in fiscal year 2011 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2010 and $200,000 in fiscal year 2011 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section and for unforeseen

expenditures of an urgent nature. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years. The boards receiving funds under this section shall include these amounts when setting fees to cover their costs.

Sec. 18. **LOCAL SHARE PAYMENT MODIFICATION REQUIRED FOR EXTENSION OF ENHANCED FMAP.**

Upon federal enactment of an extension of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5 to June 30, 2011, effective from January 1, 2011, through June 30, 2011, the state shall reduce Hennepin County's monthly contribution to the nonfederal share of medical assistance costs to the percentage required on September 1, 2008, to meet federal requirements for enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5. Upon enactment of this extension of the enhanced FMAP, notwithstanding the requirements of Minnesota Statutes 2008, section 256B.19, subdivision 1c, paragraph (d), for the period beginning January 1, 2011, through June 30, 2011, Hennepin County's monthly payment under that provision is reduced to $434,688.

EFFECTIVE DATE. This section is effective upon federal enactment of an extension of enhanced FMAP from January 1, 2011, through June 30, 2011.

Sec. 19. **CAPITATION PAYMENTS.**

Upon federal enactment of an extension of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5 to June 30, 2011,

effective from January 1, 2011, through June 30, 2011, the commissioner of human services shall increase capitation payments made to the Metropolitan Health Plan under Minnesota Statutes, section 256B.19, subdivision 1c, paragraph (c), by $6,800,000. The increased amount includes federal matching funds.

EFFECTIVE DATE. This section is effective upon federal enactment of an extension of enhanced FMAP from January 1, 2011, through June 30, 2011.

Sec. 20. **COUNTY CHEMICAL DEPENDENCY SHARE OF MEDICAL ASSISTANCE COSTS REQUIRED FOR EXTENSION OF ENHANCED FMAP.**

Upon federal enactment of an extension of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5 to June 30, 2011, and notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period January 1, 2011, through June 20, 2011, and reimbursed by medical assistance at the enhanced FMAP rate, the county share is 30 percent of the nonfederal share.

EFFECTIVE DATE. This section is effective upon federal enactment of an extension of enhanced FMAP from January 1, 2011, through June 30, 2011.

Sec. 21. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2011, unless a different expiration date is explicit.

Sec. 22. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2010, unless a different effective date is explicit.

APPENDIX
Article locations in 10-6042

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ARTICLE 2	CONTINUING CARE	Page.Ln 21.8
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