SIXTY-FIRST DAY

St. Paul, Minnesota, Tuesday, February 9, 2010

The Senate met at 10:30 a.m. and was called to order by the President.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

Prayer was offered by the Chaplain, Rabbi Marcia Zimmerman.

The roll was called, and the following Senators answered to their names:

Anderson	Fobbe	Langseth	Pappas	Sieben
Berglin	Foley	Latz	Pariseau	Skoe
Betzold	Frederickson	Limmer	Parry	Skogen
Bonoff	Gerlach	Lourey	Pogemiller	Sparks
Carlson	Gimse	Lynch	Prettner Solon	Stumpf
Chaudhary	Hann	Marty	Rest	Tomassoni
Clark	Higgins	Metzen	Robling	Torres Ray
Cohen	Ingebrigtsen	Michel	Rosen	Vandeveer
Dahle	Johnson	Moua	Rummel	Vickerman
Dibble	Jungbauer	Murphy	Saltzman	Wiger
Dille	Kelash	Olseen	Saxhaug	
Doll	Koch	Olson, G.	Scheid	
Erickson Ropes	Koering	Olson, M.	Senjem	
Fischbach	Kubly	Ortman	Sheran	

The President declared a quorum present.

The reading of the Journal was dispensed with and the Journal, as printed and corrected, was approved.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time.

Senators Sheran and Erickson Ropes introduced–

S.F. No. 2477: A bill for an act relating to human services; modifying the medical assistance employed persons with disabilities program; changing asset limitation provisions; appropriating money; amending Minnesota Statutes 2008, sections 256B.056, subdivision 3; 256B.057, subdivision 9.

Referred to the Committee on Health, Housing and Family Security.

Senators Lourey, Chaudhary, Higgins, Tomassoni and Betzold introduced–

S.F. No. 2478: A bill for an act relating to corrections; requiring state and local jail and prison inmates to be housed in publicly owned and operated jails and prisons; prohibiting the state and counties from contracting with private prisons; prohibiting renewal of the Prairie Correctional Facility contract; amending Minnesota Statutes 2008, section 241.01, subdivision 3a; proposing coding for new law in Minnesota Statutes, chapters 243; 641.

Referred to the Committee on Judiciary.

Senators Limmer, Scheid, Murphy, Jungbauer and Foley introduced–

S.F. No. 2479: A bill for an act relating to highways; appropriating money to construct marked Trunk Highway 610, or elements thereof, in the city of Maple Grove; authorizing sale and issuance of trunk highway bonds.

Referred to the Committee on Finance.

Senator Stumpf introduced–

S.F. No. 2480: A bill for an act relating to tax increment financing; expanding the area of the state in which tourism facilities may be financed; authorizing certain expenditures by the city of East Grand Forks; amending Minnesota Statutes 2009 Supplement, section 469.174, subdivision 22.

Referred to the Committee on Taxes.

Senator Saltzman introduced–

S.F. No. 2481: A bill for an act relating to capital investment; appropriating money for HEAPR and capital improvements at Century College; authorizing the sale and issuance of state bonds.

Referred to the Committee on Finance.

Senator Wiger introduced–

S.F. No. 2482: A bill for an act relating to education; clarifying rulemaking authority of the Board of Teaching; amending Minnesota Statutes 2009 Supplement, section 122A.09, subdivision 4.

Referred to the Committee on Education.

Senator Olson, M. introduced–

S.F. No. 2483: A bill for an act relating to child protection; modifying provisions governing detention and release of runaway children; amending Minnesota Statutes 2009 Supplement, sections 260C.175, subdivision 1; 260C.176, subdivision 1; 260C.178, subdivision 1.

Referred to the Committee on Judiciary.

Senator Olson, M. introduced–

S.F. No. 2484: A bill for an act relating to game and fish; requiring rulemaking to allow spearing on Cass Lake.

Referred to the Committee on Environment and Natural Resources.

Senator Koering introduced–

S.F. No. 2485: A bill for an act relating to capital improvements; authorizing spending to acquire and better public land and buildings and other improvements of a capital nature with certain conditions; establishing new programs and terminating existing programs; authorizing the sale of state bonds; canceling and modifying previous appropriations; appropriating money; amending Minnesota Statutes 2008, sections 16A.105; 16A.66, subdivision 2; 403.275, subdivision 2; 462A.36, by adding subdivisions; Minnesota Statutes 2009 Supplement, section 16A.647, subdivisions 1, 5; Laws 2005, chapter 20, article 1, section 23, subdivision 12, as amended; Laws 2008, chapter 152, article 2, section 3, subdivision 2; Laws 2008, chapter 179, section 5, subdivision 4; Laws 2008, chapter 365, section 5, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 116J; repealing Minnesota Statutes 2008, sections 116J.431, subdivisions 3, 7, 8; 116J.435, subdivisions 1, 4, 5, 6, 7; Minnesota Statutes 2009 Supplement, sections 116J.431, subdivisions 1, 1a, 2, 4, 6; 116J.435, subdivisions 2, 3.

Referred to the Committee on Finance.

Senators Anderson, Rummel, Prettner Solon, Dibble and Doll introduced–

S.F. No. 2486: A resolution memorializing the United States Congress to adopt clean energy legislation that strengthens the nation's energy and economic security, advances clean energy development, creates jobs, addresses climate change, and preserves the authority of states to reduce emissions and promote renewable energy.

Referred to the Committee on Energy, Utilities, Technology and Communications.

Senator Saxhaug introduced–

S.F. No. 2487: A bill for an act relating to capital investment; appropriating money for the acquisition of conservation easements on private forest lands under the Minnesota forests for the future program; authorizing the sale and issuance of state bonds.

Referred to the Committee on Finance.

Senator Saxhaug introduced–

S.F. No. 2488: A bill for an act relating to state lands; authorizing conveyance of tax-forfeited lands bordering public waters.

Referred to the Committee on Environment and Natural Resources.

Senators Skoe, Skogen and Olson, M. introduced–

S.F. No. 2489: A bill for an act relating to capital investment; appropriating money for the Itasca Biological Station; authorizing the sale and issuance of state bonds.

Referred to the Committee on Finance.

Senators Dibble, Tomassoni, Metzen, Rosen and Scheid introduced–

S.F. No. 2490: A bill for an act relating to economic development; amending the definition of "green economy" to include the concept of "green chemistry"; amending Minnesota Statutes 2008, section 116J.437, subdivision 1.

Referred to the Committee on Business, Industry and Jobs.

Senator Kubly introduced–

S.F. No. 2491: A bill for an act relating to capital investment; appropriating money for a solar power installation grant program; authorizing the sale and issuance of state bonds; requiring a report; proposing coding for new law in Minnesota Statutes, chapter 216C.

Referred to the Committee on Finance.

Senators Moua, Betzold, Higgins, Dille and Foley introduced–

S.F. No. 2492: A bill for an act relating to dispute resolution; enacting the Uniform Collaborative Law Act proposed for adoption by the National Conference of Commissioners on Uniform State Laws; proposing coding for new law in Minnesota Statutes, chapter 572A.

Referred to the Committee on Judiciary.

Senators Moua, Limmer, Olseen, Scheid and Murphy introduced–

S.F. No. 2493: A bill for an act relating to crime; including use of scanning device and reencoder to acquire information from payment cards as identity theft; amending Minnesota Statutes 2008, section 609.527, subdivisions 1, 6, by adding a subdivision; Minnesota Statutes 2009 Supplement, section 388.23, subdivision 1.

Referred to the Committee on Judiciary.

Senators Saxhaug, Anderson, Stumpf and Bonoff introduced–

S.F. No. 2494: A resolution memorializing Congress and the Secretary of Agriculture to appropriate money and negotiate with the State of Minnesota on the sale and exchange of school trust lands.

Referred to the Committee on Environment and Natural Resources.

Senators Bonoff, Rest, Sieben, Stumpf and Rosen introduced–

S.F. No. 2495: A bill for an act relating to capital investment; appropriating money for a public schools fiber optic infrastructure grant program; establishing the grant program; authorizing the sale and issuance of state bonds; proposing coding for new law in Minnesota Statutes, chapter 126C.

Referred to the Committee on Finance.

Senators Rummel, Moua, Pogemiller and Rest introduced–

S.F. No. 2496: A bill for an act relating to state government; establishing the Legislative Commission for Policy Innovation and Research; proposing coding for new law in Minnesota Statutes, chapter 3.

Referred to the Committee on State and Local Government Operations and Oversight.

Senator Lourey introduced–

S.F. No. 2497: A bill for an act relating to state lands; authorizing public sale of certain tax-forfeited land that borders public water.

Referred to the Committee on Environment and Natural Resources.

Senator Lourey introduced–

S.F. No. 2498: A bill for an act relating to adoption; providing for adoption of an adult by a guardian; amending Minnesota Statutes 2008, section 259.241.

Referred to the Committee on Judiciary.

Senator Betzold introduced–

S.F. No. 2499: A bill for an act relating to retirement; Teachers Retirement Association; increasing member and employer contribution rates; temporarily suspending and temporarily reducing postretirement adjustment amounts; reducing interest on refunds; eliminating interest on reemployed annuitant earnings limitation account deferral amount payments; reducing deferred annuities augmentation rates; amending Minnesota Statutes 2008, sections 354.42, subdivision 3, by adding subdivisions; 356.47, subdivision 3; Minnesota Statutes 2009 Supplement, sections 354.42, subdivision 2; 354.47, subdivision 1; 354.49, subdivision 2; 354.55, subdivision 11; 356.415, subdivision 1, by adding a subdivision.

Referred to the Committee on State and Local Government Operations and Oversight.

Senator Jungbauer introduced–

S.F. No. 2500: A bill for an act relating to capital improvements; appropriating money for a water recycling treatment plant in the city of Ramsey; authorizing the sale and issuance of state bonds.

Referred to the Committee on Finance.

Senators Scheid, Moua, Higgins, Anderson and Olson, M. introduced–

S.F. No. 2501: A bill for an act relating to real estate; streamlining the process of connecting an owner facing a residential mortgage foreclosure with an authorized foreclosure prevention agency and with a person authorized to negotiate on behalf of the foreclosing lender; amending Minnesota Statutes 2008, section 580.021, subdivision 3; repealing Minnesota Statutes 2008, sections 580.021, subdivision 4; 580.022, subdivision 2.

Referred to the Committee on Commerce and Consumer Protection.

Senators Rest, Latz, Moua, Ingebrigtsen and Rosen introduced–

S.F. No. 2502: A bill for an act relating to public safety; appropriating money for public safety-related purposes.

Referred to the Committee on Finance.

Senators Murphy, Jungbauer, Lynch, Ingebrigtsen and Erickson Ropes introduced–

S.F. No. 2503: A bill for an act relating to crimes; providing penalty for careless driving resulting in death; amending Minnesota Statutes 2008, section 169.13, by adding a subdivision.

Referred to the Committee on Judiciary.

Senators Rosen and Fischbach introduced–

S.F. No. 2504: A bill for an act relating to human services; implementing governor's health care reform; creating interstate health insurance choice; creating a flexible benefit plan and repealing the small employer flexible benefits plan; creating primary provider care tiering for Minnesota health care programs; creating a MinnesotaCare modern benefit plan; authorizing rulemaking; amending Minnesota Statutes 2008, sections 256B.0754, by adding subdivisions; 256L.12, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62L; 256L; proposing coding for new law as Minnesota Statutes, chapter 62V; repealing Minnesota Statutes 2008, section 62L.056; Minnesota Statutes 2009 Supplement, section 256B.032.

Referred to the Committee on Health, Housing and Family Security.

Senators Bonoff, Clark, Rummel, Robling and Rest introduced–

S.F. No. 2505: A bill for an act relating to child care; appropriating money to provide statewide child care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system.

Referred to the Committee on Health, Housing and Family Security.

Senators Bonoff, Rest, Clark, Gerlach and Robling introduced–

S.F. No. 2506: A bill for an act relating to capital investment; requiring state agencies to track and report on the number of jobs created or retained as a result of capital project funding; amending Minnesota Statutes 2008, section 16A.633, by adding a subdivision.

Referred to the Committee on Finance.

MOTIONS AND RESOLUTIONS

Senator Bonoff moved that the name of Senator Latz be added as a co-author to S.F. No. 1017. The motion prevailed.

Senator Saltzman moved that the names of Senators Lynch and Bonoff be added as co-authors to S.F. No. 1882. The motion prevailed.

Senator Bonoff moved that the name of Senator Clark be added as a co-author to S.F. No. 2325. The motion prevailed.

Senator Bonoff moved that the name of Senator Saltzman be added as a co-author to S.F. No. 2341. The motion prevailed.

Senator Dibble moved that the name of Senator Higgins be added as a co-author to S.F. No. 2371. The motion prevailed.

Senator Murphy moved that the name of Senator Clark be added as a co-author to S.F. No. 2393. The motion prevailed.

Senator Vickerman moved that the name of Senator Erickson Ropes be added as a co-author to S.F. No. 2465. The motion prevailed.

Senator Vickerman moved that the names of Senators Fobbe, Clark and Erickson Ropes be added as co-authors to S.F. No. 2466. The motion prevailed.

Senator Dibble moved that S.F. No. 915 be taken from the table. The motion prevailed.

S.F. No. 915: A bill for an act relating to insurance; requiring school districts to obtain employee health coverage through the public employees insurance program; appropriating money; amending Minnesota Statutes 2008, sections 43A.316, subdivisions 9, 10, by adding subdivisions; 62E.02, subdivision 23; 62E.10, subdivision 1; 62E.11, subdivision 5; 297I.05, subdivision 5; 297I.15, subdivision 3.

Senator Dibble moved that S.F. No. 915 be re-referred to the Conference Committee as formerly constituted for further consideration. The motion prevailed.

RECESS

Senator Pogemiller moved that the Senate do now recess subject to the call of the President. The motion prevailed.

After a brief recess, the President called the Senate to order.

CALL OF THE SENATE

Senator Pogemiller imposed a call of the Senate. The Sergeant at Arms was instructed to bring in the absent members.

MOTIONS AND RESOLUTIONS - CONTINUED

Pursuant to Rule 26, Senator Pogemiller, Chair of the Committee on Rules and Administration, designated S.F. No. 2360 a Special Order to be heard immediately.

SPECIAL ORDER

S.F. No. 2360: A bill for an act relating to capital improvements; authorizing spending to acquire and better public land and buildings and other improvements of a capital nature with certain conditions; establishing new programs and modifying existing programs; authorizing the sale of state bonds; canceling and modifying previous appropriations; appropriating money; amending Minnesota Statutes 2008, sections 174.50, by adding a subdivision; 174.52, by adding a subdivision; 240A.09; Laws 2005, chapter 20, article 1, sections 19, subdivision 4; 23, subdivision 12, as amended; Laws 2006, chapter 258, sections 8, subdivision 4; 17, subdivision 5; Laws 2008, chapter 152, article 2, section 3, subdivision 2; Laws 2008, chapter 179, section 5, subdivision 4; proposing coding for new law in Minnesota Statutes, chapter 16B; repealing Laws 2009, chapter 93, article 1, section 45.

Senator Langseth moved to amend S.F. No. 2360 as follows:

Page 29, after line 11, insert:

"$550,000 is to design, construct, and equip accurate exclusive and nonexclusive standoff zones for State Capitol parking lots N and O, Senate parking lot B, the Centennial parking ramp, the Administration parking ramp, and Lots Q, C, and AA; and to provide vehicular security gates at each lot, access to which will be controlled by use of the employee's identification badge. This appropriation is part of phase 1 of Capitol campus security upgrades.

$200,000 is to modify selected existing pedestrian tunnel doors, or install new doors, to facilitate improved access control necessary to separate public from nonpublic tunnel segments and to install closed-circuit TV cameras in selected locations around the Capitol campus to address known blind spots. This appropriation is part of phase 1 of Capitol campus security upgrades.

$75,000 is to predesign renovation of the second and third floors of the Governor's residence on Summit Avenue in St. Paul."

The motion prevailed. So the amendment was adopted.

Senator Michel moved that S.F. No. 2360 be re-referred to the Committee on Capital Investment.

CALL OF THE SENATE

Senator Limmer imposed a call of the Senate for the balance of the proceedings on S.F. No. 2360. The Sergeant at Arms was instructed to bring in the absent members.

The question was taken on the adoption of the Michel motion.

The roll was called, and there were yeas 19 and nays 47, as follows:

Those who voted in the affirmative were:

Betzold	Gimse	Koch	Ortman	Rosen
Chaudhary	Hann	Limmer	Pariseau	Senjem
Fischbach	Ingebrigtsen	Michel	Parry	Vandeveer
Gerlach	Johnson	Olson, G.	Robling	

Those who voted in the negative were:

Anderson	Erickson Ropes	Latz	Pogemiller	Skogen
Berglin	Fobbe	Lourey	Prettner Solon	Sparks
Bonoff	Foley	Lynch	Rest	Stumpf
Carlson	Frederickson	Marty	Rummel	Tomassoni
Clark	Higgins	Metzen	Saltzman	Torres Ray
Cohen	Jungbauer	Moua	Saxhaug	Vickerman
Dahle	Kelash	Murphy	Scheid	Wiger
Dibble	Koering	Olseen	Sheran	
Dille	Kubly	Olson, M.	Sieben	
Doll	Langseth	Pappas	Skoe	

The motion did not prevail.

Senator Limmer moved to amend S.F. No. 2360 as follows:

Page 73, after line 15, insert:

"Sec. 39. **REPORT ON JOBS CREATED OR RETAINED.**

The commissioner of employment and economic development shall report to the house of representatives and senate committees with jurisdiction over capital investment on the jobs created or retained as a result of the projects funded in this act. The report must include, but is not limited to, the following information: the number and types of jobs for each project, whether new or retained, where the jobs were located, and pay ranges. The Board of Regents of the University of Minnesota, the Board of Trustees of the Minnesota State Colleges and Universities, and each agency appropriated money in this act shall collect and provide the information at the time and in the manner required by the commissioner of employment and economic development. The commissioner's report must be compiled using information supplied by each of the agencies appropriated money in this act. The report is due February 15, 2012."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 32 and nays 33, as follows:

Those who voted in the affirmative were:

Betzold	Fobbe	Jungbauer	Olson, G.	Saltzman
Bonoff	Frederickson	Koch	Olson, M.	Senjem
Chaudhary	Gerlach	Koering	Ortman	Vandeveer
Clark	Gimse	Kubly	Pariseau	Wiger
Dille	Hann	Limmer	Parry	
Doll	Ingebrigtsen	Metzen	Robling	
Fischbach	Johnson	Michel	Rosen	

Those who voted in the negative were:

Anderson	Foley	Moua	Rummel	Sparks
Berglin	Kelash	Murphy	Saxhaug	Stumpf
Carlson	Langseth	Olseen	Scheid	Tomassoni
Cohen	Latz	Pappas	Sheran	Torres Ray
Dahle	Lourey	Pogemiller	Sieben	Vickerman
Dibble	Lynch	Prettner Solon	Skoe	
Erickson Ropes	Marty	Rest	Skogen	

The motion did not prevail. So the amendment was not adopted.

Senator Robling moved to amend S.F. No. 2360 as follows:

Page 29, delete lines 27 to 30

Page 30, delete lines 1 to 16

Page 36, after line 28, insert:

"Subd. 3. **Local Road Improvement Fund Grants** 20,000,000

This appropriation is from the bond proceeds account in the state transportation fund as provided in Minnesota Statutes, section 174.50.

$10,000,000 is for construction and reconstruction of local roads with statewide or regional significance under Minnesota Statutes, section 174.52, subdivision 4.

$10,000,000 is for grants to counties to assist in paying the costs of rural road safety capital improvement projects on county state-aid highways under Minnesota Statutes, section 174.52, subdivision 4a."

Page 44, line 23, delete "(a)"

Page 44, delete line 34

Page 45, delete lines 1 to 35

Page 46, delete lines 1 to 10

Page 48, after line 25, insert:

"Subd. 3. **Minnesota Sex Offender Program Treatment Facilities - Moose Lake** 89,072,000

To complete design for and to construct, furnish, and equip an additional 400-bed secure residential facility and program and ancillary service facilities for the Minnesota sex offender treatment program at Moose Lake."

Page 52, delete subdivisions 5 to 7

Page 54, delete subdivision 10

Page 55, delete subdivisions 13 and 14

Page 56, delete lines 27 to 34

Page 57, delete lines 1 to 8

Page 57, line 9, delete "(c)"

Page 64, after line 30, insert:

"Subd. 26. **Minneapolis Planetarium.** $12,330,000 of the appropriation in Laws 2005, chapter 20, article 1, section 23, subdivision 16, paragraph (a), as amended by Laws 2008, chapter 179, section 58, and Laws 2009, chapter 93, article 1, section 30, for the Minnesota Planetarium is canceled. The bond sale authorization in Laws 2005, chapter 20, article 1, section 28, subdivision 1, as amended by Laws 2008, chapter 179, section 28, paragraph (d), is reduced by $12,330,000."

Correct the section totals, the appropriation summary, and the bond sale authorization

Renumber and reletter in sequence

Senator Langseth moved to amend the Robling amendment to S.F. No. 2360 as follows:

Page 1, delete lines 2 to 23 and insert:

"Page 48, line 20, delete "3,000,000" and insert "2,000,000""

Page 1, line 26, delete "89,072,000" and insert "1,000,000"

Page 1, delete lines 27 and 28 and insert "To design an additional 400-bed"

Page 1, delete lines 33 to 35

Page 2, delete lines 1 to 11

The question was taken on the adoption of the Langseth amendment to the Robling amendment.

The roll was called, and there were yeas 43 and nays 23, as follows:

Those who voted in the affirmative were:

Anderson	Erickson Ropes	Lynch	Pogemiller	Skogen
Berglin	Foley	Marty	Prettner Solon	Sparks
Betzold	Frederickson	Metzen	Rest	Stumpf
Carlson	Higgins	Moua	Rummel	Tomassoni
Clark	Kelash	Murphy	Saxhaug	Torres Ray
Cohen	Koering	Olson, G.	Scheid	Vickerman
Dahle	Kubly	Olson, M.	Sheran	Wiger
Dibble	Langseth	Pappas	Sieben	
Dille	Latz	Pariseau	Skoe	

Those who voted in the negative were:

Bonoff	Gerlach	Jungbauer	Olseen	Saltzman
Chaudhary	Gimse	Koch	Ortman	Senjem
Doll	Hann	Limmer	Parry	Vandeveer
Fischbach	Ingebrigtsen	Lourey	Robling	
Fobbe	Johnson	Michel	Rosen	

The motion prevailed. So the amendment to the amendment was adopted.

The question recurred on the Robling amendment, as amended.

The roll was called, and there were yeas 66 and nays 0, as follows:

Those who voted in the affirmative were:

Anderson	Fobbe	Langseth	Pappas	Sieben
Berglin	Foley	Latz	Pariseau	Skoe
Betzold	Frederickson	Limmer	Parry	Skogen
Bonoff	Gerlach	Lourey	Pogemiller	Sparks
Carlson	Gimse	Lynch	Prettner Solon	Stumpf
Chaudhary	Hann	Marty	Rest	Tomassoni
Clark	Higgins	Metzen	Robling	Torres Ray
Cohen	Ingebrigtsen	Michel	Rosen	Vandeveer
Dahle	Johnson	Moua	Rummel	Vickerman
Dibble	Jungbauer	Murphy	Saltzman	Wiger
Dille	Kelash	Olseen	Saxhaug	
Doll	Koch	Olson, G.	Scheid	
Erickson Ropes	Koering	Olson, M.	Senjem	
Fischbach	Kubly	Ortman	Sheran	

The motion prevailed. So the Robling amendment, as amended, was adopted.

Senator Jungbauer moved to amend S.F. No. 2360 as follows:

Page 41, line 3, after the period, insert "Before utilizing any part of this appropriation for final design or construction of a transit capital improvement project, the Metropolitan Council shall identify the sources for payment of anticipated project operating costs that remain after use of operating revenues and federal money. The Metropolitan Council shall submit to the legislative committees and divisions having jurisdiction over transportation policy and finance the proposed sources for payment of anticipated project operating costs before utilizing this appropriation."

Page 68, after line 22, insert:

"Sec. 33. Minnesota Statutes 2008, section 473.4051, is amended by adding a subdivision to read:

Subd. 4. **Operating costs.** On or before January 15, the council shall submit to the legislative committees and divisions having jurisdiction over transportation policy and finance an annual

statement listing each transit capital improvement project that is in final design or construction, or as to which an appropriation for final design or construction is requested by the council. With respect to each improvement listed, the council shall state the anticipated operating costs of the improvement and the sources of payment of those costs, including percentage contribution from each source.

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

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion prevailed. So the amendment was adopted.

Senator Gerlach moved to amend S.F. No. 2360 as follows:

Page 65, after line 25, insert:

"Sec. 29. Minnesota Statutes 2008, section 16B.35, subdivision 1, is amended to read:

Subdivision 1. **Percent of appropriations for art.** An appropriation for the construction or alteration of any state building may contain an amount not to exceed the lesser of $100,000 or one percent of the total appropriation for the building for the acquisition of works of art, excluding landscaping, which may be an integral part of the building or its grounds, attached to the building or grounds or capable of being displayed in other state buildings. Money used for this purpose is available only for the acquisition of works of art to be exhibited in areas of a building or its grounds accessible, on a regular basis, to members of the public. No more than ten percent of the total amount available each fiscal year under this subdivision may be used for administrative expenses, either by the commissioner of administration or by any other entity to whom the commissioner delegates administrative authority. For the purposes of this section "state building" means a building the construction or alteration of which is paid for wholly or in part by the state."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The motion did not prevail. So the amendment was not adopted.

Senator Hann moved to amend S.F. No. 2360 as follows:

Page 73, after line 15, insert:

"Sec. 39. **PREVAILING WAGE LAW SUSPENDED.**

The prevailing wage law, Minnesota Statutes, sections 177.41 to 177.44, does not apply to projects funded with money appropriated by this act."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 17 and nays 45, as follows:

Those who voted in the affirmative were:

Dille	Gimse	Jungbauer	Pariseau	Senjem
Fischbach	Hann	Koering	Parry	
Frederickson	Ingebrigtsen	Michel	Robling	
Gerlach	Johnson	Ortman	Rosen	

Those who voted in the negative were:

Anderson	Dibble	Latz	Pappas	Sieben
Berglin	Doll	Lourey	Pogemiller	Skoe
Betzold	Erickson Ropes	Lynch	Prettner Solon	Skogen
Bonoff	Fobbe	Marty	Rest	Sparks
Carlson	Foley	Metzen	Rummel	Stumpf
Chaudhary	Higgins	Moua	Saltzman	Tomassoni
Clark	Kelash	Murphy	Saxhaug	Torres Ray
Cohen	Kubly	Olseen	Scheid	Vickerman
Dahle	Langseth	Olson, M.	Sheran	Wiger

The motion did not prevail. So the amendment was not adopted.

Senator Rosen moved to amend S.F. No. 2360 as follows:

Page 50, after line 11, insert:

"Subd. 4. **Minnesota Correctional Facility - Oak Park Heights**

Exterior Intrusion Detection System Upgrade 3,529,000

To replace and improve the current perimeter detection system with a comprehensive system that will use current technology and provide essential components of effective and reliable escape detection at Minnesota's maximum security correctional facility, including, but not limited to, installation of a new sensor coil system, improved lighting, cameras, recording devices, and renovations of existing facilities required to accommodate the technology and functionality of the new system.

Subd. 5. **Minnesota Correctional Facility - Oak Park Heights**

Security System Upgrade 6,500,000

To replace and upgrade existing facility security systems and components with new fully integrated systems throughout the prison, including renovations of existing facilities required to accommodate the technology and functionality of the new

systems."

Page 64, after line 30, insert:

"Subd. 26. **Minneapolis Planetarium.** $10,029,000 of the appropriation in Laws 2005, chapter 20, article 1, section 23, subdivision 16, paragraph (a), as amended by Laws 2008, chapter 179, section 58, and Laws 2009, chapter 93, article 1, section 30, for the Minnesota Planetarium is canceled. The bond sale authorization in Laws 2005, chapter 20, article 1, section 28, subdivision 1, as amended by Laws 2008, chapter 179, section 28, paragraph (d), is reduced by $10,029,000."

Correct the section total, the appropriation summary, and the bond sale authorization

Renumber the subdivisions in sequence and correct the internal references

Amend the title accordingly

The question was taken on the adoption of the amendment.

The roll was called, and there were yeas 29 and nays 37, as follows:

Those who voted in the affirmative were:

Bonoff	Fobbe	Johnson	Olson, G.	Rummel
Chaudhary	Frederickson	Jungbauer	Ortman	Saltzman
Clark	Gerlach	Koch	Pariseau	Senjem
Dille	Gimse	Koering	Parry	Sheran
Erickson Ropes	Hann	Limmer	Robling	Vandeveer
Fischbach	Ingebrigtsen	Michel	Rosen	

Those who voted in the negative were:

Anderson	Foley	Marty	Prettner Solon	Stumpf
Berglin	Higgins	Metzen	Rest	Tomassoni
Betzold	Kelash	Moua	Saxhaug	Torres Ray
Carlson	Kubly	Murphy	Scheid	Vickerman
Cohen	Langseth	Olseen	Sieben	Wiger
Dahle	Latz	Olson, M.	Skoe	
Dibble	Lourey	Pappas	Skogen	
Doll	Lynch	Pogemiller	Sparks	

The motion did not prevail. So the amendment was not adopted.

Senator Chaudhary moved to amend S.F. No. 2360 as follows:

Page 73, after line 15, insert:

"Sec. 39. **EMPLOYING MINNESOTA RESIDENTS.**

To the extent possible, an employer carrying out a project funded by an appropriation in this act must ensure that at least 90 percent of the people employed by that employer on the project have resided in Minnesota for at least 90 days immediately preceding commencement of construction of the project."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator Limmer moved to amend the Chaudhary amendment to S.F. No. 2360 as follows:

Page 1, line 6, delete "have resided in" and insert "be a permanent citizen of"

The question was taken on the adoption of the Limmer amendment to the Chaudhary amendment.

The roll was called, and there were yeas 21 and nays 44, as follows:

Those who voted in the affirmative were:

Dille	Hann	Koering	Pariseau	Vandeveer
Fischbach	Ingebrigtsen	Limmer	Parry	
Frederickson	Johnson	Michel	Robling	
Gerlach	Jungbauer	Olson, G.	Rosen	
Gimse	Koch	Ortman	Senjem	

Those who voted in the negative were:

Anderson	Dibble	Lourey	Pogemiller	Skoe
Berglin	Doll	Lynch	Prettner Solon	Skogen
Betzold	Erickson Ropes	Marty	Rest	Sparks
Bonoff	Foley	Metzen	Rummel	Stumpf
Carlson	Higgins	Moua	Saltzman	Tomassoni
Chaudhary	Kelash	Murphy	Saxhaug	Torres Ray
Clark	Kubly	Olseen	Scheid	Vickerman
Cohen	Langseth	Olson, M.	Sheran	Wiger
Dahle	Latz	Pappas	Sieben	

The motion did not prevail. So the amendment to the amendment was not adopted.

The question was taken on the adoption of the Chaudhary amendment.

The roll was called, and there were yeas 18 and nays 45, as follows:

Those who voted in the affirmative were:

Bonoff	Ingebrigtsen	Olseen	Rest	Vandeveer
Chaudhary	Kelash	Olson, M.	Saltzman	Wiger
Fobbe	Koch	Pariseau	Scheid	
Higgins	Kubly	Parry	Sieben	

Those who voted in the negative were:

Anderson	Doll	Koering	Moua	Senjem
Berglin	Erickson Ropes	Langseth	Olson, G.	Sheran
Betzold	Fischbach	Latz	Ortman	Skoe
Carlson	Foley	Limmer	Pogemiller	Skogen
Clark	Frederickson	Lourey	Prettner Solon	Sparks
Cohen	Gerlach	Lynch	Robling	Stumpf
Dahle	Hann	Marty	Rosen	Tomassoni
Dibble	Johnson	Metzen	Rummel	Torres Ray
Dille	Jungbauer	Michel	Saxhaug	Vickerman

The motion did not prevail. So the amendment was not adopted.

S.F. No. 2360 was read the third time, as amended, and placed on its final passage.

The question was taken on the passage of the bill, as amended.

The roll was called, and there were yeas 52 and nays 14, as follows:

Those who voted in the affirmative were:

Anderson	Berglin	Betzold	Bonoff	Carlson

Clark	Higgins	Marty	Prettner Solon	Skogen
Cohen	Ingebrigtsen	Metzen	Rest	Sparks
Dahle	Jungbauer	Moua	Rummel	Stumpf
Dibble	Kelash	Murphy	Saltzman	Tomassoni
Dille	Koering	Olseen	Saxhaug	Torres Ray
Erickson Ropes	Kubly	Olson, G.	Scheid	Vickerman
Fobbe	Langseth	Olson, M.	Senjem	Wiger
Foley	Latz	Pappas	Sheran	
Frederickson	Lourey	Pariseau	Sieben	
Gimse	Lynch	Pogemiller	Skoe	

Those who voted in the negative were:

Chaudhary	Gerlach	Koch	Ortman	Rosen
Doll	Hann	Limmer	Parry	Vandeveer
Fischbach	Johnson	Michel	Robling	

So the bill, as amended, was passed and its title was agreed to.

Senator Pogemiller moved that S.F. No. 2360 be laid on the table. The motion prevailed.

MOTIONS AND RESOLUTIONS - CONTINUED

Without objection, remaining on the Order of Business of Motions and Resolutions, the Senate reverted to the Orders of Business of Reports of Committees and Second Reading of Senate Bills.

REPORTS OF COMMITTEES

Senator Pogemiller moved that the Committee Report at the Desk be now adopted. The motion prevailed.

Senator Cohen from the Committee on Finance, to which was referred

S.F. No. 2168: A bill for an act relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2, 3; 256.969, subdivisions 21, 26, 27; 256B.0625, subdivisions 13f, 20, by adding a subdivision; 256B.69, by adding a subdivision; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a, 30; 256B.195, subdivision 3; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D.

Reports the same back with the recommendation that the bill be amended as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

HEALTH CARE PROGRAM MODIFICATIONS

Section 1. **[245.4862] MENTAL HEALTH URGENT CARE AND PSYCHIATRIC CONSULTATION.**

Subdivision 1. **Mental health urgent care and psychiatric consultation.** The commissioner shall include mental health urgent care and psychiatric consultation services as part of, but not limited to, the redesign of six community-based behavioral health hospitals and the Anoka-Metro Regional Treatment Center. These services must not duplicate existing services in the region, and must be implemented as specified in subdivisions 3 to 7.

Subd. 2. **Definitions.** For purposes of this section:

(a) Mental health urgent care includes:

(1) initial mental health screening;

(2) mobile crisis assessment and intervention;

(3) rapid access to psychiatry, including psychiatric evaluation, initial treatment, and short-term psychiatry;

(4) nonhospital crisis stabilization residential beds; and

(5) health care navigator services which include, but are not limited to, assisting uninsured individuals in obtaining health care coverage.

(b) Psychiatric consultation services includes psychiatric consultation to primary care practitioners.

Subd. 3. **Rapid access to psychiatry.** The commissioner shall develop rapid access to psychiatric services based on the following criteria:

(1) the individuals who receive the psychiatric services must be at risk of hospitalization and otherwise unable to receive timely services;

(2) where clinically appropriate, the service may be provided via interactive video where the service is provided in conjunction with an emergency room, a local crisis service, or a primary care or behavioral care practitioner; and

(3) the commissioner may integrate rapid access to psychiatry with the psychiatric consultation services in subdivision 4.

Subd. 4. **Collaborative psychiatric consultation.** (a) The commissioner shall establish a collaborative psychiatric consultation service based on the following criteria:

(1) the service may be available via telephone, interactive video, e-mail, or other means of communication to emergency rooms, local crisis services, mental health professionals, and primary care practitioners, including pediatricians;

(2) the service shall be provided by a multidisciplinary team including, at a minimum, a child and adolescent psychiatrist, an adult psychiatrist, and a licensed clinical social worker;

(3) the service shall include a triage-level assessment to determine the most appropriate response to each request, including appropriate referrals to other mental health professionals, as well as provision of rapid psychiatric access when other appropriate services are not available;

(4) the first priority for this service is to provide the consultations required under section

256B.0625, subdivision 13j; and

(5) the service must encourage use of cognitive and behavioral therapies and other evidence-based treatments in addition to or in place of medication, where appropriate.

(b) The commissioner shall appoint an interdisciplinary work group to establish appropriate medication and psychotherapy protocols to guide the consultative process, including consultation with the Drug Utilization Review Board as provided in section 256B.0625, subdivision 13j.

Subd. 5. **Phased availability.** (a) The commissioner may phase in the availability of mental health urgent care services based on the limits of appropriations and the commissioner's determination of level of need and cost-effectiveness.

(b) For subdivisions 3 and 4, the first phase must focus on adults in Hennepin and Ramsey Counties and children statewide who are affected by section 256B.0625, subdivision 13j, and must include tracking of costs for the services provided and associated impacts on utilization of inpatient, emergency room, and other services.

Subd. 6. **Limited appropriations.** The commissioner shall maximize use of available health care coverage for the services provided under this section. The commissioner's responsibility to provide these services for individuals without health care coverage must not exceed the appropriations for this section.

Subd. 7. **Flexible implementation.** To implement this section, the commissioner shall select the structure and funding method that is the most cost-effective for each county or group of counties. This may include grants, contracts, direct provision by state-operated services, and public-private partnerships. Where feasible, the commissioner shall make any grants under this section a part of the integrated adult mental health initiative grants under section 245.4661.

Sec. 2. Minnesota Statutes 2008, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective March 1, 2010, to September 30, 2010, the surcharge under paragraph (b) is increased to 3.95 percent. Effective October 1, 2010, to June 30, 2011, the surcharge under paragraph (b) is increased to 3.06 percent. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (b) shall be deposited in the account established in section 256D.032.

(d) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

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

Sec. 3. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) Effective March 1, 2010, to June 30, 2011: (1) the surcharge under paragraph (a) is increased to 4.0 percent; and (2) each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to 4.0 percent of the total premium revenues of the plan, as reported to the commissioner of health, according to the payment schedule in subdivision 4. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (a) shall be deposited in the account established in section 256D.032.

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

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

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

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

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

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

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

~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new corporation's

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

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

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

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

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

Sec. 4. 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~~ six 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~~ July 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. 5. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay

over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for

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

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, ~~2010~~ 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, ~~2010~~ 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, ~~2010~~ 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, ~~2010~~ 2011, to reflect this reduction.

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

(i) In order to offset the ratable reductions provided for in this subdivision, the total payment rate for medical assistance fee-for-service admissions occurring on or after March 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by 14 percent from the current statutory rates if the hospital is located in Hennepin or Ramsey County and 18 percent from the current statutory rates for all other Minnesota hospitals. For purposes of this paragraph, medical assistance does not include general assistance medical care. This increase shall be paid from the account established in section 256D.032. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

Sec. 6. Minnesota Statutes 2008, section 256.969, subdivision 21, is amended to read:

Subd. 21. **Mental health or chemical dependency admissions; rates.** (a) Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or

chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

(b) In order to ensure adequate access for the provision of mental health services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, payment rates for medical assistance admissions occurring on or after March 1, 2010, to June 30, 2011, at a Minnesota private, not-for-profit hospital above the 75th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521 to 523 admissions paid by medical assistance for admissions occurring in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than a total of $40,000,000, including state and federal shares. This increase shall be paid from the account established in section 256D.032. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

Sec. 7. Minnesota Statutes 2008, section 256.969, subdivision 26, is amended to read:

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

(2) 371 cesarean section without complicating diagnosis;

(3) 372 vaginal delivery with complicating diagnosis;

(4) 373 vaginal delivery without complicating diagnosis;

(5) 386 extreme immaturity and respiratory distress syndrome, neonate;

(6) 388 full-term neonates with other problems;

(7) 390 prematurity without major problems;

(8) 391 normal newborn;

(9) 385 neonate, died or transferred to another acute care facility;

(10) 425 acute adjustment reaction and psychosocial dysfunction;

(11) 430 psychoses;

(12) 431 childhood mental disorders; and

(13) 164-167 appendectomy.

For medical assistance admissions occurring on or after March 1, 2010, to June 30, 2011, the payment rate under paragraph (a), clause (2), shall be increased to 100 percent from 90 percent, after application of the rate increase in subdivision 3a, paragraph (i). This increase shall be paid from the account established in section 256D.032. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

Sec. 8. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

Subd. 26a. **Psychiatric and burn services payment adjustment on or after July 1, 2010.** (a) For admissions occurring on or after July 1, 2010, the commissioner shall increase the total payment for medical assistance fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at any hospital that is a nonstate public Minnesota hospital and a Level I trauma center. The rate increases shall be established for each hospital by the commissioner at a level that uses each hospital's voluntary payments under paragraph (c) as the nonfederal share. For purposes of this subdivision, medical assistance does not include general assistance medical care. Payments to managed care health plans shall not be increased for payments under this subdivision.

(b) The rate increases provided in paragraph (a) apply to the following diagnosis-related groups or subgroups, or any subsequent designations of such groups or subgroups: 424 to 431, 433, 504 to 511, 521, and 523. These increases are only available to the extent that revenue is available from the counties under paragraph (c) for the nonfederal share.

(c) Effective July 15, 2010, in addition to any payment otherwise required under sections 256B.19, 256B.195, 256B.196, and 256B.199, the following government entities may make the following voluntary payments to the commissioner on an annual basis:

(1) Hennepin County, $7,000,000; and

(2) Ramsey County, $3,500,000.

The amounts in this paragraph shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, including payments under subdivision 9.

(d) The commissioner may adjust the intergovernmental transfers under paragraph (c) and the payments under paragraph (a) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limits imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act regarding increased local share.

(e) This section shall be implemented upon federal approval, retroactive to July 1, 2010, for services provided on or after that date.

Sec. 9. 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, except that Hennepin County Medical Center and Regions Hospital shall not receive a payment under this subdivision;

(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, paragraphs (a) to (d). 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, paragraphs (a) to (d), 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. Effective for federal disproportionate share hospital funds earned on general assistance medical care payments for services rendered on or after March 1, 2010, to June 30, 2011, the amount of the three percent ratable reduction required under this paragraph shall be deposited in the account established in section 256D.032.

(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, paragraphs (a) to (d), 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, paragraphs (a) to (d), adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199, paragraphs (a) to (d), 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, paragraphs (a) to (d), and payments under this section.

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

EFFECTIVE DATE. This section is effective for services rendered on or after March 1, 2010.

Sec. 10. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

(e) In order to ensure adequate access for the provision of maternity services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, and notwithstanding paragraph (a), payment rates for medical assistance admissions occurring from March 1, 2010, to June 30, 2011, at a private, not-for-profit hospital above the 65th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 370 to 373 and 391 admissions paid by medical assistance for admissions provided in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than a total of $35,000,000, including state and federal shares. This increase shall be paid from the account established in section 256D.032. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

Sec. 11. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Rate increase for hospitals in cities of the third class and fourth class.** Effective for services rendered on or after March 1, 2010, to June 30, 2011, payment rates for medical assistance admissions, excluding general assistance medical care admissions, at Minnesota hospitals with fewer than 500 medical assistance admissions during fiscal year 2008 and located in cities of the third class or of the fourth class, as defined in section 410.01, shall be increased by 27 percent. This increase shall be paid from the account established in section 256D.032. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from

the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

Sec. 13. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13j. **Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications.** (a) The commissioner, in consultation with the Drug Utilization Review Board established in subdivision 13i and actively practicing pediatric mental health professionals,

must:

(1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

(2) identify situations where a collaborative psychiatric consultation and prior authorization should be required before the initiation or continuation of drug therapy in pediatric patients including, but not limited to, high-dose regimens, off-label use of prescription medication, a patient's young age, and lack of coordination among multiple prescribing providers; and

(3) track prescriptive practices and the use of psychotropic medications in children with the goal of reducing the use of medication, where appropriate.

(b) Effective July 1, 2011, the commissioner shall require prior authorization and a collaborative psychiatric consultation before an atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medication meeting the criteria identified in paragraph (a), clause (2), is eligible for payment. A collaborative psychiatric consultation must be completed before the identified medications are eligible for payment unless:

(1) the patient has already been stabilized on the medication regimen; or

(2) the prescriber indicates that the child is in crisis.

If clause (1) or (2) applies, the collaborative psychiatric consultation must be completed within 90 days for payment to continue.

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 4.

Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.195, subdivision 3, is amended to read:

Subd. 3. **Payments to certain safety net providers.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated annually:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions Hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates. The allocation in paragraph (b), clause (1), item (ii), to increase hospital payments under section 256.969, subdivision 26, shall not limit payments under that section.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

(1) if the payments under subdivision 5 are approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments; or

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

(f) For federal fiscal years 2010 and 2011, payments under this subdivision shall be made at no

less than the federal fiscal year 2009 level.

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

Sec. 15. Minnesota Statutes 2009 Supplement, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians affiliated with Hennepin County Medical Center and Regions Hospital equal to the difference between the established medical assistance payment for physician services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians of Hennepin Faculty Associates and HealthPartners.

(c) Beginning January 1, 2010, Hennepin County and Ramsey County ~~shall~~ may make monthly voluntary intergovernmental transfers to the commissioner in ~~the following~~ amounts~~: $133,333 by~~ not to exceed $12,000,000 per year from Hennepin County and ~~$100,000 by~~ $6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to ~~Metropolitan Health Plan and HealthPartners by~~ any licensed health plan under contract with the medical assistance program that makes payments to Hennepin County Medical Center or Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level

cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its Minnesota health care program payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

(d) The commissioner shall inform Hennepin County and Ramsey County on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (c), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(e) The payments in paragraphs (a) to (c) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

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

Sec. 16. Minnesota Statutes 2009 Supplement, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).

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

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, and 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.

(e) Effective July 15, 2010, in addition to any payment otherwise required under sections 256B.19, 256B.195, and 256B.196, the following government entities may make the following voluntary payments to the commissioner on an annual basis:

(1) Hennepin County, $6,200,000; and

(2) Ramsey County, $4,000,000.

(f) The sums in paragraph (e) shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(g) Effective July 15, 2010, the commissioner shall make the following Medicaid disproportionate share hospital payments to the hospitals on a monthly basis:

(1) to Hennepin County Medical Center, the amount of the transfer under paragraph (e), clause (1), plus any federal matching funds available to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions Hospital, the amount of the transfer under paragraph (e), clause (2), plus any federal matching funds available to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(h) Effective July 15, 2010, after making the payments provided in paragraph (g), the commissioner shall make the increased payments provided in section 256.969, subdivision 26a.

(i) The commissioner shall make the payments under paragraphs (g) and (h) prior to making any other payments under this section, section 256.969, subdivision 27, or 256B.195.

(j) The commissioner may adjust the intergovernmental transfers under paragraph (e) and the payments under paragraph (g) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limitations imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act regarding increased local share.

(k) This section shall be implemented upon federal approval of the rate increase and a federal determination that the increased transfers do not violate the restriction in the American Resource and Recovery Act regarding the local share, retroactive to admissions occurring on or after July 15, 2010.

Sec. 17. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5k. **Temporary rate modifications.** For services rendered effective May 1, 2010, to June 30, 2011, the total payment made to managed care plans under the medical assistance program and under MinnesotaCare for families with children shall be increased by 4.61 percent. This increase shall be paid from the account established in section 256D.032.

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

Sec. 18. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility

requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal. This paragraph does not apply to applicants and recipients who are exempt under paragraph (f).

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

If an enrollee meets one of the categories described in this paragraph, the commissioner shall not require the enrollee to enroll in MinnesotaCare.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social

Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV,

Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(q) Effective July 1, 2003, general assistance medical care emergency services end.

(r) For the period beginning March 1, 2010, and ending July 1, 2011, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated.

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

Sec. 19. Minnesota Statutes 2008, section 256D.03, subdivision 3a, is amended to read:

Subd. 3a. **Claims; assignment of benefits.** (a) Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

(b) Effective for general assistance medical care services rendered on or after March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under this subdivision shall be deposited in or credited to the account established in section 256D.032.

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

Sec. 20. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined

cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

(b) Effective for all premiums due on or after June 30, 1997, general assistance medical care does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. General assistance medical care shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

(c) Effective for general assistance medical care services rendered on or after March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under this subdivision shall be deposited in or credited to the account established in section 256D.032.

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

Sec. 21. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of $1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify their assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

(b) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without approval or acquiescence of the United States Citizenship and Immigration Services.

(c) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources is ineligible for general assistance medical care.

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

Subd. 3. **Transitional MinnesotaCare.** (a) Except as provided in paragraph (c), effective March 1, 2010, all applicants and recipients who meet the eligibility requirements in subdivision 1, paragraph (a), clause (2), and who are not described in subdivision 2 shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, immediately following approval of general assistance medical care.

(b) If all other eligibility requirements of this subdivision are met, general assistance medical care may be paid for individuals identified in paragraph (a) for a temporary period beginning the date of application. Eligibility for general assistance medical care shall continue until enrollment in MinnesotaCare is completed. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to the applicant or recipient. Once enrolled in MinnesotaCare, the MinnesotaCare-covered services as described in section 256L.03 shall apply for the remainder of the six-month general assistance medical care eligibility period until their six-month renewal.

(c) This subdivision does not apply if the applicant or recipient:

(1) has applied for and is awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) is homeless as defined by United States Code, title 42, section 11301, et seq.;

(3) is classified as an end-stage renal disease beneficiary in the Medicare program;

(4) receives treatment funded in section 254B.02; or

(5) fails to meet the requirements of section 256L.09, subdivision 2.

Applicants and recipients who meet any one of these criteria shall remain eligible for general assistance medical care and shall not be required to enroll in MinnesotaCare.

(d) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required in paragraph (a), an individual must complete a new application.

Subd. 4. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(d) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV,

Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

Subd. 5. **General assistance medical care; services.** (a) General assistance medical care covers:

(1) inpatient hospital services within the limitations described in subdivision 10;

(2) outpatient hospital services;

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

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

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

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

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

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

(18) 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) 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: (i) the service is otherwise covered under this chapter as a physician service, (ii) 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 (iii) 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) 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) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

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

(23) 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.

(b) Sex reassignment surgery is not covered under this section.

(c) Drug coverage is covered in accordance with section 256D.03, subdivision 4, paragraph (d).

(d) The following co-payments shall apply for services provided:

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

(2) $3 per brand-name 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.

(e) 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. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the $7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

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

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 6. **Coordinated care delivery option.** (a) A county or group of counties may elect to provide health care services to individuals who are eligible for general assistance medical care under this section and who reside within the county or counties through a coordinated care delivery option. The health care services provided by the county must include the services described in subdivision 5 with the exception of outpatient prescription drug coverage but including drugs administered in an outpatient setting. Counties that elect to provide health care services through this option must ensure that the requirements of this subdivision are met. Upon electing to provide services through this option, the county accepts the financial risk of the delivery of the health care services described in this subdivision to general assistance medical care recipients residing in the county for the period beginning July 1, 2010, and ending July 1, 2011, for the fixed payments described in subdivision 10.

(b) A county that elects to provide services through this option must provide to the commissioner the following:

(1) the names of the county or counties that are electing to provide services through the county care delivery option; and

(2) the geographic area to be served.

(c) The county may contract with a managed care plan, an integrated delivery system, a physician-hospital organization, or an academic health center to administer the delivery of services through this option. Any county providing general assistance medical care services through a county-based purchasing plan in accordance with section 256B.692 may continue to provide services through the county-based purchasing plan. Payments to the county-based purchasing plan for the period beginning July 1, 2010, and ending July 1, 2011, shall be paid according to subdivision 10.

(d) A county must demonstrate the ability to:

(1) provide the covered services required under this subdivision to recipients residing within the county;

(2) provide a system for advocacy, consumer protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

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

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

(e) The commissioner may require the county to provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services.

(f) A county that elects to provide services through this option shall be considered to be a prepaid health plan for purposes of section 256.045.

(g) The state shall not be liable for the payment of any cost or obligation incurred by the county or a participating provider.

Subd. 7. **Health care home designation.** The commissioner or a county may require a recipient to designate a primary care provider or a primary care clinic that is certified as a health care home under section 256B.0751.

Subd. 8. **Payments; fee-for-service rate for the period between March 1, 2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010, and before July 1, 2010, the payment rates for all covered services provided to general assistance medical care recipients, with the exception of outpatient prescription drug coverage, shall be 50 percent of the general assistance medical care payment rate in effect on February 28, 2010.

(b) Outpatient prescription drug coverage provided on or after March 1, 2010, and before July 1, 2010, shall be paid on a fee-for-service basis in accordance with section 256B.0625, subdivision 13e.

Subd. 9. **Payments; fee-for-service rates for the period between July 1, 2010, and July 1, 2011.** (a) Effective for services provided on or after July 1, 2010, and before July 1, 2011, to general

assistance medical care recipients residing in counties that are not served through the coordinated care delivery option, payments shall be made by the commissioner to providers at rates described in this subdivision.

(b) For inpatient hospital admissions provided on or after July 1, 2010, and before July 1, 2011, the payment rate shall be:

(1) 69 percent of the general assistance medical care rate in effect on February 28, 2010, if the inpatient hospital services were provided in a hospital where the fee-for-service inpatient and outpatient hospital general assistance medical care payments to the hospital for admissions provided in calendar year 2007 totaled $1,000,000 or more or the hospital's fee-for-service inpatient and outpatient hospital general assistance medical care payments received for calendar year 2007 admissions was one percent or more of the hospital's net patient revenue received for services provided in calendar year 2007; or

(2) 60 percent of the general assistance medical care rate in effect on February 28, 2010, if the inpatient hospital services were provided by a hospital that does not meet the criteria described in clause (1).

(c) Effective for services other than inpatient hospital services and outpatient prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011, the payment rate shall begin at 50 percent of the general assistance medical care rate in effect on February 28, 2010.

(d) Outpatient prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011, shall be paid on a fee-for-service basis in accordance with section 256B.0625, subdivision 13e.

(e) The commissioner may adjust the rates paid under paragraphs (b) and (c) on a quarterly basis to ensure that the total aggregate amount paid out for services provided on a fee-for-service basis beginning March 1, 2010, and ending June 30, 2011, does not exceed the appropriation from the general assistance medical care account established in section 256D.032 for the general assistance medical care program.

Subd. 10. **Payments; rate setting for the coordinated care delivery option.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after July 1, 2010, and before July 1, 2011, to recipients residing in counties that have elected to provide services through the coordinated care delivery option, the commissioner shall establish quarterly prospective fixed payments to the county. The payments must not exceed 60 percent of the county's general assistance medical care county allocation amount as determined in paragraph (b). These payments must not be used by the county to pay MinnesotaCare premiums for general assistance medical care recipients or MinnesotaCare enrollees.

(b) For each county that elects to provide services in accordance with subdivision 7, the commissioner shall determine a general assistance medical care county allocation amount that equals the total general assistance medical care payments made for recipients residing within the county in fiscal year 2009 for all covered general assistance medical care services with the exception of outpatient prescription drug coverage.

(c) Outpatient prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011, shall be paid on a fee-for-service basis according to section 256B.0625, subdivision 13e.

EFFECTIVE DATE. This section is effective for services rendered on or after March 1, 2010, and before July 1, 2011.

Sec. 22. **[256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

The general assistance medical care account is created in the special revenue fund. Money deposited into the account is subject to appropriation by the legislature.

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

Sec. 23. Minnesota Statutes 2008, section 256D.06, subdivision 7, is amended to read:

Subd. 7. **SSI conversions and back claims.** (a) The commissioner of human services shall contract with agencies or organizations capable of ensuring that clients who are presently receiving assistance under sections 256D.01 to 256D.21, and who may be eligible for benefits under the federal Supplemental Security Income program, apply and, when eligible, are converted to the federal income assistance program and made eligible for health care benefits under the medical assistance program. The commissioner shall ensure that money owing to the state under interim assistance agreements is collected.

(b) The commissioner shall also directly or through contract implement procedures for collecting federal Medicare and medical assistance funds for which clients converted to SSI are retroactively eligible.

(c) The commissioner shall contract with agencies to ensure implementation of this section. County contracts with providers for residential services shall include the requirement that providers screen residents who may be eligible for federal benefits and provide that information to the local agency. The commissioner shall modify the MAXIS computer system to provide information on clients who have been on general assistance for two years or longer. The list of clients shall be provided to local services for screening under this section.

(d) Effective for general assistance medical care services rendered on or after March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under this subdivision shall be deposited in or credited to the account established in section 256D.032.

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

Sec. 24. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

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

Sec. 25. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has

been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, is the first day of the month following the last day of general assistance medical care coverage.

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

Sec. 26. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month

beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

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

Sec. 27. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

Subd. 6. **Exception for certain adults.** Single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, are eligible without meeting the requirements of this section until renewal.

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

Sec. 28. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

Subd. 4. **Exception for transitioned adults.** County agencies shall pay premiums for single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, until six-month renewal. The county agency has the option of continuing to pay premiums for these enrollees.

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

Sec. 29. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

Subd. 7. **Exception for certain adults.** Single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, are exempt from the requirements of this section until renewal.

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

Sec. 30. **DRUG REBATE PROGRAM.**

The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph (cc), and 256D.03. The rebate revenues collected under the drug rebate program for persons eligible for the general assistance medical care program shall be deposited in the general assistance medical care account in the special revenue fund established under Minnesota Statutes, section 256D.032.

EFFECTIVE DATE. This section is effective March 1, 2010, and expires June 30, 2011.

Sec. 31. **PROVIDER PARTICIPATION.**

For purposes of Minnesota Statutes, section 256B.0644, the reference to the general assistance medical care program shall include the temporary general assistance medical care program established under Minnesota Statutes, section 256D.031. In meeting the requirements of Minnesota Statutes, section 256B.0644, a provider must accept new patients regardless of the Minnesota health care program the patient is enrolled in and may not refuse to accept patients enrolled in one Minnesota health care program and continue to accept patients enrolled in other Minnesota health care programs.

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

Sec. 32. **TEMPORARY SUSPENSION.**

(a) For the period beginning March 1, 2010, to June 30, 2011, the commissioner of human services shall not implement or administer Minnesota Statutes 2008, section 256D.03, subdivisions 6 and 9; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4; or Minnesota Statutes 2008, section 256B.692; and Minnesota Statutes 2009 Supplement, section 256B.69, as they apply to the general assistance medical care program unless specifically continued in Minnesota Statutes, section 256D.031.

(b) Notwithstanding paragraph (a), outpatient prescription drug coverage shall continue to be provided under Minnesota Statutes, section 256D.03.

EFFECTIVE DATE. This section is effective March 1, 2010, and expires July 1, 2011.

Sec. 33. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION ASSESSMENT MODIFICATION; TRANSFER.**

Subdivision 1. **Minnesota Comprehensive Health Association assessment modification.** For the purpose of the annual assessment allocation required in Minnesota Statutes, section 62E.11, the Minnesota Comprehensive Health Association shall credit $21,875,000 to HealthPartners' assessment for calendar year 2010 and $13,125,000 to HealthPartners' assessment for calendar year 2011, upon receipt by the association of the transfers specified in subdivision 2.

Subd. 2. **Transfer.** $21,875,000 shall be transferred in fiscal year 2011 and $13,125,000 in fiscal year 2012 from the general assistance medical care account established in Minnesota Statutes, section 256D.032, to the commissioner of commerce for disbursement upon receipt to the Minnesota Comprehensive Health Association, to compensate for the loss in the association's assessments created by the credits specified in subdivision 1.

ARTICLE 2

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

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, as amended by Laws 2009, chapter 173, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named 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 appropriations listed under them are available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively. "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium" is fiscal years 2010 and 2011. Supplemental appropriations and reductions for the fiscal year ending June 30, 2010, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year	
	2010	**2011**

	Ending June 30 2010	2011

Sec. 2. **HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**(82,741,000)**	**$** **165,372,000**

Appropriations by Fund	2010	2011
General	(62,256,000)	(34,110,000)
Health Care Access	(68,568,000)	(185,157,000)
Special Revenue	48,053,000	384,639,000

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

Subd. 2. **Children and Economic Assistance Grants**	-0-	(14,121,000)

The commissioner shall reduce the amount allocated to children and community services grants by $14,121,000. This is a onetime reduction in fiscal year 2011. The commissioner shall transfer $14,121,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

Subd. 3. **Children and Economic Assistance Management**

Children and Economic Assistance Operations

Appropriations by Fund		
Special Revenue	29,000	-0-

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

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

(a) MinnesotaCare Grants	(68,128,000)	(179,051,000)

Appropriations by Fund		
Health Care Access	(68,568,000)	(185,157,000)

Special Revenue	440,000	6,106,000		
(b) Medical Assistance Basic Health Care Grants - Families and Children			3,074,000	53,875,000
	Appropriations by Fund			
General	-0-	(4,070,000)		
Special Revenue	3,074,000	57,945,000		
(c) Medical Assistance Basic Health Care Grants - Elderly and Disabled			2,325,000	41,314,000
	Appropriations by Fund			
General	-0-	(6,470,000)		
Special Revenue	2,325,000	47,784,000		
(d) General Assistance Medical Care Grants			(20,083,000)	266,945,000
	Appropriations by Fund			
General	(60,406,000)	-0-		
Special Revenue	40,323,000	266,945,000		

For general assistance medical care grants under Minnesota Statutes, section 256D.031. The commissioner shall transfer $60,406,000 on March 1, 2010, from the general fund to the fund established in Minnesota Statutes, section 256D.032. Any unexpended amount not used for general assistance medical care expenditures incurred before March 1, 2010, does not cancel and shall be transferred to the fund established in Minnesota Statutes, section 256D.032, by January 1, 2011.

Subd. 5. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) Health Care Administration

	Appropriations by Fund	
General	(825,000)	(2,425,000)
Special Revenue	825,000	2,784,000

$825,000 in fiscal year 2010 and $2,475,000 in fiscal year 2011 from the special revenue fund are for administration of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation and accounting, the commissioner may transfer these amounts to the general fund. The commissioner shall transfer $825,000 in fiscal year 2010 and $2,475,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

(b) Health Care Operations

	Appropriations by Fund	
General	(1,025,000)	(3,075,000)
Special Revenue	1,067,000	3,075,000

$1,025,000 in fiscal year 2010 and $3,075,000 in fiscal year 2011 from the special revenue fund are for operations of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation and accounting, the commissioner may transfer these amounts to the general fund. The commissioner shall transfer $1,025,000 in fiscal year 2010 and $3,075,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

Subd. 6. **Continuing Care Grants**

Mental Health Grants	-0-	(5,000,000)

The commissioner shall reduce the amount allocated to adult mental health grants by $5,000,000. This is a onetime reduction in fiscal year 2011. The commissioner shall transfer $5,000,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

Subd. 7. **Continuing Care Management**	-0-	1,051,000

Subd. 8. **Transfers**

(a) From March 1, 2010, until June 30, 2011, the commissioner may transfer amounts appropriated from the account created in Minnesota Statutes, section 256D.032, to the general fund to pay the hospital rate increases under Minnesota Statutes, section 256.969, from the medical assistance account.

(b) From May 1, 2010, until June 30, 2011, the commissioner may transfer amounts appropriated from the account created in Minnesota Statutes, section 256D.032, to the general fund or the health care access fund to pay the managed care plan rate increases under Minnesota Statutes, section 256B.69, subdivision 5k, from the medical assistance account.

EFFECTIVE DATE. This article is effective March 1, 2010."

Delete the title and insert:

"A bill for an act relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2, 3; 256.969, subdivisions 21, 26, 27, by adding subdivisions; 256B.0625, subdivision 13f, by adding a subdivision; 256B.69, by adding a subdivision; 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a, 30; 256B.195, subdivision 3; 256B.196, subdivision 2; 256B.199; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D."

And when so amended the bill do pass. Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. No. 2168 was read the second time.

Senator Pogemiller moved that the Senate revert to the Order of Business of Introduction and First Reading of Senate Bills. The motion prevailed.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bill was read the first time.

Senators Vickerman, Clark, Senjem, Erickson Ropes and Fobbe introduced–

S.F. No. 2507: A resolution relating to payment of the Federal Respite Leave Benefit for members of the 1st of the 34th Brigade of the Minnesota National Guard who served in Iraq during the Troop Surge of 2007.

Referred to the Committee on Agriculture and Veterans.

MEMBERS EXCUSED

Senator Bakk was excused from the Session of today.

ADJOURNMENT

Senator Pogemiller moved that the Senate do now adjourn until 8:30 a.m., Thursday, February 11, 2010. The motion prevailed.

Peter S. Wattson, Secretary of the Senate (Legislative)