NINETY-SIXTH DAY

St. Paul, Minnesota, Tuesday, May 4, 2010

The Senate met at 8:45 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, Pastor Gary Dreier.

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

Anderson	Fischbach	Kubly	Ortman	Sheran
Bakk	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	

The President declared a quorum present.

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

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.

EXECUTIVE AND OFFICIAL COMMUNICATIONS

The following communication was received.

April 30, 2010

The Honorable James P. Metzen
President of the Senate

Dear Senator Metzen:

Pursuant to Minnesota Statutes 116V.01, Subdivision 2, the Chair of the Senate Committee with jurisdiction over agriculture finance, or his designee, is to serve on the Board of Directors of the Agricultural Utilization Research Institute. It is my pleasure to appoint Senator Dan Skogen to serve as my designee on the AURI Board.

Sincerely,
Senator Jim Vickerman

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following Senate Files, herewith returned: S.F. Nos. 2493, 2226 and 2990.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 184: A bill for an act relating to higher education; authorizing data matching; modifying institution eligibility; establishing award procedures; establishing scholarship priorities; establishing powers and duties; modifying security requirements; regulating the use of certain revenues; providing for refunds; defining terms; making technical corrections; amending Minnesota Statutes 2008, sections 136A.101, subdivision 10; 136A.126, subdivision 1, by adding a subdivision; 136A.127, subdivision 6, by adding subdivisions; 136A.15, subdivision 6; 136A.16, subdivision 14; 136A.62, subdivision 3; 136A.645; 136A.646; 136A.65, by adding a subdivision; 136F.581, by adding a subdivision; 141.25, subdivisions 7, 13, by adding a subdivision; 141.251, subdivision 2; 141.28, subdivision 2; Minnesota Statutes 2009 Supplement, sections 136A.01, subdivision 2; 136A.101, subdivision 4; 136A.127, subdivisions 2, 4; 299A.45, subdivision 1; 340A.404, subdivision 4a; Laws 2009, chapter 95, article 2, section 40; Laws 2010, chapter 215, article 2, sections 4, subdivision 3; 6; proposing coding for new law in Minnesota Statutes, chapters 136A; 137.

Senate File No. 184 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Senator Pappas moved that the Senate do not concur in the amendments by the House to S.F. No. 184, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House refuses to concur in the Senate amendments to House File No. 3386:

H.F. No. 3386: A bill for an act relating to real property; requiring performance guidelines for certain residential contracts; modifying statutory warranties; requiring notice and opportunity to repair; providing for dispute resolution procedures; requiring a report; amending Minnesota Statutes 2008, sections 302A.781, subdivision 4; 326B.809; 327A.01, by adding a subdivision; 327A.02, subdivision 4, by adding subdivisions; 327A.03; proposing coding for new law in Minnesota Statutes, chapter 327A.

The House respectfully requests that a Conference Committee of 3 members be appointed thereon.

Swails, Obermueller and Hoppe have been appointed as such committee on the part of the House.

House File No. 3386 is herewith transmitted to the Senate with the request that the Senate appoint a like committee.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 3, 2010

Senator Saltzman moved that the Senate accede to the request of the House for a Conference Committee on H.F. No. 3386, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce the passage by the House of the following Senate File, AS AMENDED by the House, in which amendments the concurrence of the Senate is respectfully requested:

S.F. No. 2756: A bill for an act relating to transportation; allowing escort drivers of overdimensional loads to control traffic; directing commissioner of public safety to establish escort driver training and certification program; amending Minnesota Statutes 2008, sections 169.06, subdivision 4; 169.86, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 299D.

Senate File No. 2756 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Senator Kelash moved that the Senate do not concur in the amendments by the House to S.F. No. 2756, and that a Conference Committee of 3 members be appointed by the Subcommittee on Conference Committees on the part of the Senate, to act with a like Conference Committee appointed on the part of the House. The motion prevailed.

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 3 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2427: A bill for an act relating to property held in trust; clarifying status of certain distributions; changing certain relationship and inheritance provisions; providing for emergency and temporary conservators; amending Minnesota Statutes 2008, sections 501B.64, subdivision 3; 524.1-201; 524.2-114; Minnesota Statutes 2009 Supplement, section 524.5-409; proposing coding for new law in Minnesota Statutes, chapter 524.

There has been appointed as such committee on the part of the House:

Hortman, Davnie and Loon.

Senate File No. 2427 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 3 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2737: A bill for an act relating to state government; changing certain pesticide control provisions; authorizing waiver of a fee; providing for control of bovine tuberculosis; eliminating the native grasses and wildflower seed production and incentive program; authorizing ownership of agricultural land by certain nonprofit corporations; requiring tree care and tree trimming company registration; regulating certain sale and distribution of firewood; authorizing individuals and entities to take certain easements in agricultural land; allowing a temporary lien for livestock production inputs for 45 days following a mediation request requiring reports; clarifying the role of the commissioner and Department of Veterans Affairs in providing certain resources for the county veterans service offices; modifying a residency requirement for purposes of eligibility for higher educational benefits for the surviving spouse and children of a deceased veteran who dies as a result of military service; repealing authorization for a license plate; repealing a requirement that the Department of Veterans Affairs report on the status of a construction project priority listing; appropriating money; amending Minnesota Statutes 2008, sections 3.737, subdivision 4; 17.03, by adding a subdivision; 18B.31, subdivision 5; 18B.36, subdivision 1; 18B.37, subdivision

4; 18G.07; 28A.082, subdivision 1; 35.244, subdivisions 1, 2; 197.60, subdivision 1; 197.601; 197.605; 197.606; 197.609, subdivisions 1, 2; 197.75, subdivision 1; 239.092; 239.093; 500.221, subdivisions 2, 4; 500.24, subdivision 2; 514.965, subdivision 2; 514.966, subdivision 6, by adding a subdivision; Minnesota Statutes 2009 Supplement, sections 3.737, subdivision 1; 18B.316, subdivision 10; Laws 2008, chapter 296, article 1, section 25; proposing coding for new law in Minnesota Statutes, chapters 17; 38; repealing Minnesota Statutes 2008, sections 17.231; 168.1251; 343.26; Laws 2009, chapter 94, article 3, section 23.

There has been appointed as such committee on the part of the House:

Juhnke, Koenen and Magnus.

Senate File No. 2737 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Mr. President:

I have the honor to announce that the House has acceded to the request of the Senate for the appointment of a Conference Committee, consisting of 3 members of the House, on the amendments adopted by the House to the following Senate File:

S.F. No. 2790: A bill for an act relating to public safety; modifying provisions related to certain juvenile records; authorizing the expungement of certain juvenile records; authorizing the commissioner of human services to grant set asides or variances for certain individuals disqualified from licensure because of an offense committed as a juvenile; requiring chemical use screen of juvenile offenders; changing penalties and prohibitions related to using or brandishing replica firearms and BB guns on school property; requiring the revisor of statutes to publish a table in Minnesota Statutes containing cross-references to collateral sanctions imposed on juveniles as a result of an adjudication of delinquency; clarifying detention placement options for extended jurisdiction juveniles pending revocation hearings; modifying certain provisions regarding juvenile delinquency to include stays of adjudication of delinquency; extending the duration of the continuance period allowed in a juvenile delinquency matter; amending Minnesota Statutes 2008, sections 121A.23, subdivision 1; 241.31, subdivision 1; 242.32, subdivision 2; 260B.125, subdivision 4; 260B.130, subdivision 5; 260B.157, subdivision 1; 260B.171, subdivision 5; 260B.176, subdivision 2; 260B.198, subdivision 7; 299C.105, subdivision 1; 299C.61, subdivision 8a; 609.117, subdivision 1; 609.344, subdivision 1; 609.66, subdivision 1d; 609A.02, subdivisions 2, 3; 609A.03, subdivisions 1, 2, 4, 5, 5a, 7; 624.713, subdivision 3; Minnesota Statutes 2009 Supplement, sections 245C.24, subdivision 2; 624.713, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 609A.

There has been appointed as such committee on the part of the House:

Lesch, Hilstrom and Abeler.

Senate File No. 2790 is herewith returned to the Senate.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Returned May 3, 2010

Mr. President:

I have the honor to announce the passage by the House of the following House Files, herewith transmitted: H.F. Nos. 910 and 2612.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 3, 2010

FIRST READING OF HOUSE BILLS

The following bills were read the first time.

H.F. No. 910: A bill for an act relating to notaries public; modifying fees; regulating commissions and notarial stamps and seals; providing clarifications; providing for the accommodations of physical limitations; amending Minnesota Statutes 2008, sections 358.028; 358.09; 358.15; 358.47; 358.48; 359.01, subdivision 2; 359.02; 359.03, subdivisions 1, 2, 3, 4; 359.061; 359.12; Minnesota Statutes 2009 Supplement, sections 357.021, subdivision 2; 359.01, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 359; repealing Minnesota Statutes 2008, section 359.05.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 214, now on the Calendar.

H.F. No. 2612: A bill for an act relating to civil commitment; clarifying civil commitment venue; amending Minnesota Statutes 2008, sections 253B.02, by adding a subdivision; 253B.045, subdivision 2; 253B.05, subdivision 3; 253B.064, subdivision 1; 253B.07, subdivisions 1, 2, 2d; 253B.185, subdivision 1; 253B.20, subdivision 4; 253B.23, subdivision 1, by adding a subdivision; Minnesota Statutes 2009 Supplement, section 253B.10, subdivision 3.

Referred to the Committee on Rules and Administration for comparison with S.F. No. 2186, now on General Orders.

REPORTS OF COMMITTEES

Senator Vickerman from the Committee on Agriculture and Veterans, to which was referred the following appointment:

DEPARTMENT OF VETERANS AFFAIRS
COMMISSIONER
Michael Pugliese

Reports the same back with the recommendation that the appointment be confirmed.

Senator Pogemiller moved that the foregoing committee report be laid on the table. The motion prevailed.

Senator Vickerman from the Committee on Agriculture and Veterans, to which were referred the following appointments:

MINNESOTA RURAL FINANCE AUTHORITY
Marcus Knisely
Sander Ludeman
Susan Meyer
Howard Swenson

Reports the same back with the recommendation that the appointments be confirmed.

Senator Pogemiller moved that the foregoing committee report be laid on the table. The motion prevailed.

INTRODUCTION AND FIRST READING OF SENATE BILLS

The following bills were read the first time.

Senator Chaudhary introduced–

S.F. No. 3400: A bill for an act relating to traffic regulations; regulating engine braking on trunk highways; amending Minnesota Statutes 2008, sections 169.011, by adding a subdivision; 169.67, by adding a subdivision.

Referred to the Committee on Transportation.

Senator Sparks introduced–

S.F. No. 3401: A bill for an act relating to veterans; requiring a health study of the health effects of wind turbine movement on certain veterans.

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

Senators Scheid, Wiger, Bonoff, Frederickson and Fobbe introduced–

S.F. No. 3402: A bill for an act relating to tobacco; tobacco control and preventing tobacco use; modernizing definitions of tobacco, tobacco products, and tobacco-related devices; modifying promotional and self-service distribution rules; subjecting sale of tobacco-related devices to municipal licensing; prescribing criminal penalties; amending Minnesota Statutes 2008, sections 297F.01, subdivision 19; 325F.77, subdivision 4; 461.12, subdivisions 1, as amended, 2, 3, 4, 5, 6; 461.18, subdivision 1; 609.685, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 609.

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

Senator Stumpf introduced–

S.F. No. 3403: A bill for an act relating to natural resources; requiring the commissioner of natural resources to implement management strategies for deer in the bovine tuberculosis

management zone.

Referred to the Committee on Environment and Natural Resources.

Senators Stumpf, Skoe and Bakk introduced–

S.F. No. 3404: A bill for an act relating to natural resources; prohibiting the commissioner of natural resources from surveying and adjusting boundaries of certain lands; proposing coding for new law in Minnesota Statutes, chapter 84.

Referred to the Committee on Environment and Natural Resources.

Senators Stumpf and Rest introduced–

S.F. No. 3405: A bill for an act relating to taxation; increasing revenue for certain education finance and early education programs; amending Minnesota Statutes 2008, sections 124D.135, subdivision 1; 124D.4531, subdivision 1; 126C.40, subdivision 1; Minnesota Statutes 2009 Supplement, sections 124D.135, subdivision 3; 126C.41, subdivision 2; 126C.44.

Referred to the Committee on Finance.

MOTIONS AND RESOLUTIONS

Senator Saltzman moved that the name of Senator Latz be added as a co-author to S.F. No. 2476. The motion prevailed.

Senator Wiger moved that the name of Senator Lourey be added as a co-author to S.F. No. 2636. The motion prevailed.

Senator Saltzman moved that the name of Senator Vandeveer be added as a co-author to S.F. No. 2752. The motion prevailed.

Senator Sparks introduced –

Senate Resolution No. 190: A Senate resolution congratulating Nick Peterson of Eden Prairie, Minnesota, for receiving the Eagle Award.

Referred to the Committee on Rules and Administration.

Senator Murphy introduced –

Senate Resolution No. 191: A Senate resolution congratulating Austin M. Knott of Red Wing, Minnesota, for receiving the Eagle Award.

Referred to the Committee on Rules and Administration.

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.

APPOINTMENTS

Senator Pogemiller from the Subcommittee on Conference Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

S.F. No. 184: Senators Pappas, Robling and Latz.

Senator Pogemiller moved that the foregoing appointments be approved. 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

Senator Rest moved that the names of Senators Gerlach and Sieben be added as co-authors to S.F. No. 3398. The motion prevailed.

Remaining on the Order of Business of Motions and Resolutions, Senator Pogemiller moved that the Senate take up the General Orders Calendar. The motion prevailed.

SUSPENSION OF RULES

Senator Pogemiller moved that Rule 22.3 be suspended as to the lie-over requirement on General Orders. The motion prevailed.

GENERAL ORDERS

The Senate resolved itself into a Committee of the Whole, with Senator Metzen in the chair.

After some time spent therein, the committee arose, and Senator Metzen reported that the committee had considered the following:

S.F. Nos. 3246 and 3379, which the committee recommends to pass.

S.F. No. 2496, which the committee recommends to pass with the following amendment offered by Senator Rummel:

Page 1, line 9, delete "the chair of the Committee on"

Page 1, line 10, delete "Finance and"

The motion prevailed. So the amendment was adopted.

S.F. No. 2634, which the committee reports progress, subject to the following motions:

Senator Latz moved to amend S.F. No. 2634 as follows:

Page 9, delete section 15 and insert:

"Sec. 15. Minnesota Statutes 2008, section 609.5315, subdivision 5, is amended to read:

Subd. 5. **Distribution of money.** The money or proceeds from the sale of forfeited property, after payment of seizure, storage, forfeiture, and sale expenses, and satisfaction of valid liens against the property, must be distributed as follows:

(1) ~~70~~ 65 percent of the money or proceeds must be forwarded to the ~~appropriate agency for deposit as a supplement to the agency's operating fund or similar fund for use in law enforcement~~ commissioner of public safety and are appropriated to the commissioner for grants awarded under sections 299A.641 and 299C.065 and for grants to local law enforcement agencies to purchase or replace in-car camera systems;

(2) 20 percent of the money or proceeds must be forwarded to the ~~county attorney or other prosecuting agency that handled the forfeiture for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes~~ commissioner of public safety and are appropriated to the commissioner for grants to local prosecutorial offices to reimburse those offices for costs incurred related to forfeitures; and

(3) the remaining ~~ten~~ 15 percent of the money or proceeds must be forwarded within 60 days after resolution of the forfeiture to the state treasury and credited to the general fund. Any local police relief association organized under chapter 423 which received or was entitled to receive the proceeds of any sale made under this section before the effective date of Laws 1988, chapter 665, sections 1 to 17, shall continue to receive and retain the proceeds of these sales.

The commissioner of public safety may not use the source of the forfeiture proceeds as a factor in awarding grants under this section."

Amend the title accordingly

Senator Latz moved to amend the Latz amendment to S.F. No. 2634 as follows:

Page 1, after line 24, insert:

"Up to 2.5 percent of the money appropriated to the commissioner of public safety in clauses (1) and (2) may be used by the department to administer the authorized grants."

The question was taken on the adoption of the Latz amendment to the Latz amendment.

The roll was called, and there were yeas 14 and nays 46, as follows:

Those who voted in the affirmative were:

Anderson Berglin Betzold Carlson Cohen

Dahle	Doll	Latz	Prettner Solon	Sieben
Dibble	Higgins	Olson, M.	Rummel	

Those who voted in the negative were:

Bonoff	Ingebrigtsen	Metzen	Rest	Stumpf
Chaudhary	Jungbauer	Michel	Robling	Tomassoni
Dille	Kelash	Moua	Rosen	Torres Ray
Erickson Ropes	Koch	Olseen	Saltzman	Vandeveer
Fischbach	Koering	Olson, G.	Saxhaug	Vickerman
Fobbe	Kubly	Ortman	Senjem	Wiger
Foley	Langseth	Pappas	Sheran	
Frederickson	Limmer	Pariseau	Skoe	
Gerlach	Lourey	Parry	Skogen	
Hann	Lynch	Pogemiller	Sparks	

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

Senator Latz withdrew his first amendment.

S.F. No. 2634 was then progressed.

On motion of Senator Pogemiller, the report of the Committee of the Whole, as kept by the Secretary, was adopted.

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.

APPOINTMENTS

Senator Pogemiller from the Subcommittee on Conference Committees recommends that the following Senators be and they hereby are appointed as a Conference Committee on:

H.F. No. 3386: Senators Saltzman, Scheid and Limmer.

Senator Pogemiller moved that the foregoing appointments be approved. 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.

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, Second Reading of Senate Bills and Second Reading of House Bills.

REPORTS OF COMMITTEES

SUSPENSION OF RULES

Senator Pogemiller moved that Joint Rule 2.03 be suspended as it relates to the Committee Report on S.F. No. 2337. The motion prevailed.

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

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

S.F. No. 3043: A bill for an act relating to commerce; requiring a certain appraisal fee disclosure; providing for the licensing and regulation of appraisal management companies; reducing the size of the Real Estate Appraiser Advisory Board; amending Minnesota Statutes 2008, sections 82B.05, subdivision 5, by adding a subdivision; 82B.06; Minnesota Statutes 2009 Supplement, section 82B.05, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 47; proposing coding for new law as Minnesota Statutes, chapter 82C.

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

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2009 Supplement, section 82B.05, subdivision 1, is amended to read:

Subdivision 1. **Members.** The Real Estate Appraiser Advisory Board consists of ~~15~~ nine members appointed by the commissioner of commerce. ~~Three of the~~ Two members must be public members ~~must be public members, four~~, one member must be ~~consumers~~ a consumer of appraisal services, ~~and eight~~ three must be ~~real estate appraisers of whom not less than two members must be trainee real property appraisers, licensed real property appraisers, or~~ certified residential real property appraisers, ~~not less than two members~~ and three must be certified general real property appraisers, and not less than one ~~member~~ of those members must be certified by the Appraisal Qualification Board of the Appraisal Foundation to teach the Uniform Standards of Professional Appraisal Practice. Three members must live or work outside of the seven-county metropolitan area. The board is governed by section 15.0575.

Sec. 2. Minnesota Statutes 2008, section 82B.05, subdivision 5, is amended to read:

Subd. 5. **Conduct of meetings.** Places of regular board meetings must be decided by the vote of members. Written notice must be given to each member of the time and place of each meeting of the board at least ten days before the scheduled date of regular board meetings. The board shall establish procedures for emergency board meetings and other operational procedures, subject to the approval of the commissioner.

The members of the board shall elect a chair from among the members to preside at board meetings.

A quorum of the board is ~~eight~~ five members.

The board shall meet at least once every six months as determined by a majority vote of the members or a call of the commissioner. The chair of the board may call a meeting at any other time, subject to the notice requirements of this section.

Sec. 3. Minnesota Statutes 2008, section 82B.05, is amended by adding a subdivision to read:

Subd. 7. **Enforcement reports.** The commissioner shall, on a regular basis, provide the board with the commissioner's enforcement reports.

Sec. 4. Minnesota Statutes 2008, section 82B.06, is amended to read:

82B.06 POWERS OF THE BOARD.

The board shall make recommendations to the commissioner as the commissioner requests or at the board's own initiative on:

(1) rules with respect to each category of licensed real estate appraiser, the type of educational experience, appraisal experience, and equivalent experience that will meet the requirements of this chapter;

(2) examination specifications for each category of licensed real estate appraiser, to assist in providing or obtaining appropriate examination questions and answers, and procedures for grading examinations;

(3) rules with respect to each category of licensed real estate appraiser, the continuing education requirements for the renewal of licensing that will meet the requirements provided in this chapter;

(4) periodic review of the standards for the development and communication of real estate appraisals provided in this chapter and rules explaining and interpreting the standards; ~~and~~

(5) development of standards and procedures for processing the determination of appraiser violations of this chapter and USPAP; and

(6) other matters necessary in carrying out the provisions of this chapter.

Sec. 5. **[82C.01] TITLE.**

This chapter shall be known as the Minnesota Appraisal Management Company Licensing and Regulation Act.

Sec. 6. **[82C.02] DEFINITIONS.**

Subdivision 1. **Terms.** As used in this chapter, the terms in this section have the meanings given them.

Subd. 2. **Appraisal.** In conformance with the Uniform Standards of Professional Appraisal Practice (USPAP), "appraisal" is defined as: (noun) the act or process of developing an opinion of value; an opinion of value; (adjective) of or pertaining to appraising and related functions such as appraisal practice or appraisal services. For purposes of this chapter, all appraisals or assignments that are referred to involve one to four unit single-family properties.

Subd. 3. **Appraisal assignment.** "Appraisal assignment" means an engagement for which an appraiser is employed or retained to act, as a disinterested third party in giving an unbiased analysis,

opinion, or conclusion relating to the nature, quality, value, or utility of named interests in, or aspects of, identified real estate.

Subd. 4. **Appraisal management company.** "Appraisal management company" means a corporation, partnership, sole proprietorship, subsidiary, unit, or other business entity that directly or indirectly performs the following appraisal management services:

(1) administers networks of independent contractors and/or employee appraisers to perform residential real estate appraisal assignments for clients;

(2) receives requests for residential real estate appraisal services from clients and, for a fee paid by the client, enters into an agreement with one or more independent appraisers to perform the real estate appraisal services contained in the request; or

(3) serves as a third-party broker of appraisal management services between clients and appraisers.

Subd. 5. **Appraisal management services.** "Appraisal management services" means the process of directly or indirectly performing any of the following functions on behalf of a lender, financial institution, client, or any other person to:

(1) administer an appraiser panel;

(2) recruit, qualify, verify licensing or certification, and negotiate fees and service level expectations with persons who are part of an appraiser panel;

(3) receive an order for an appraisal from one person, and deliver the order for the appraisal to an appraiser that is part of an appraiser panel for completion;

(4) track and determine the status of orders for appraisals;

(5) conduct quality control of a completed appraisal prior to the delivery of the appraisal to the person that ordered the appraisal; or

(6) provide a completed appraisal performed by an appraiser to one or more clients.

Subd. 6. **Appraiser.** "Appraiser" means a person who is expected to perform valuation services competently and in a manner that is independent, impartial, and objective, and who is licensed under chapter 82B.

Subd. 7. **Appraiser panel.** "Appraiser panel" means a network of licensed or certified appraisers who are independent contractors to the appraisal management company that have:

(1) responded to an invitation, request, or solicitation from an appraisal management company, in any form, to perform appraisals for persons that have ordered appraisals through the appraisal management company, or to perform appraisals for the appraisal management company directly, on a periodic basis, as requested and assigned by the appraisal management company; and

(2) been selected and approved by an appraisal management company to perform appraisals for any client of the appraisal management company that has ordered an appraisal through the appraisal management company, or to perform appraisals for the appraisal management company directly, on a periodic basis, as assigned by the appraisal management company.

Subd. 8. **Appraisal review.** "Appraisal review" means the act of developing and communicating an opinion about the quality of another appraiser's work that was performed as part of an appraisal assignment, except that an examination of an appraisal for grammatical, typographical, or other similar errors that do not make a substantive valuation change shall not be an appraisal review.

Subd. 9. **Client.** "Client" means any person or entity that contracts with, or otherwise enters into an agreement with, an appraisal management company for the performance of real estate appraisal services or appraisal management services. For purposes of this chapter, the appraisal management company is the party engaging the independent appraiser and can be the appraiser's client. However, this does not preclude an appraisal management company from acting as a duly authorized agent for a lender.

Subd. 10. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 11. **Controlling person.** "Controlling person" means:

(1) any owner, officer, or director of an appraisal management company seeking to offer appraisal management services in this state;

(2) an individual employed, appointed, or authorized by an appraisal management company that has the authority to enter into a contractual relationship with other persons for the performance of appraisal management services and has the authority to enter into agreements with appraisers for the performance of appraisals;

(3) an individual who possesses, directly or indirectly, the power to direct or cause the direction of the management or policies of an appraisal management company; or

(4) an individual who enters into:

(i) contractual relationships with clients for the performance of appraisal management services; and

(ii) agreements with employed and independent appraisers for the performance of real estate appraisal services.

Subd. 12. **Employee.** "Employee" means an individual who is treated as an employee for purposes of compliance with federal income tax laws.

Subd. 13. **Person.** "Person" means a natural person, firm, partnership, limited liability partnership, corporation, association, limited liability company, or other form of business organization and the officers, directors, employees, or agents of that person.

Subd. 14. **USPAP.** "USPAP" means the Uniform Standards of Professional Appraisal Practice as established by the Appraisal Foundation. State and federal regulatory authorities enforce the content of the current or applicable edition of USPAP.

Sec. 7. **[82C.03] LICENSING.**

Subdivision 1. **Requirement.** It is unlawful for a person, corporation, partnership, sole proprietorship, subsidiary, unit, or other business entity to directly or indirectly engage or attempt to engage in business as an appraisal management company, to directly or indirectly engage or attempt to perform appraisal management services, or to advertise or hold itself out as engaging

in or conducting business as an appraisal management company without first obtaining a license issued by the commissioner under the provisions of this chapter.

Subd. 2. **Owner requirements.** (a) An appraisal management company applying to the commissioner for a license in this state may not be more than ten percent owned by any person that is currently subject to any cease and desist order or injunctive order that would preclude involvement with an appraisal management company, or that has ever:

(1) voluntarily surrendered in lieu of disciplinary action an appraiser certification, registration, or license or an appraisal management company license;

(2) been the subject of a final order revoking or denying an appraiser certification, registration, or license or an appraisal management company license; or

(3) a final order barring involvement in any industry or profession issued by this or another state or federal regulatory agency.

(b) A person that owns more than ten percent of an appraisal management company in this state shall:

(1) be of good moral character, as determined by the commissioner;

(2) submit to a background investigation, as determined by the commissioner; and

(3) certify to the commissioner that the person has never been the subject of an order of certificate, registration or license suspension, revocation, or denial; cease and desist order; injunctive order; or order barring involvement in an industry or profession issued by this or another state or federal regulatory agency.

Subd. 3. **Designated controlling person requirements.** (a) **Designation.** Each appraisal management company applying to the commissioner for a license in this state shall designate a controlling person that will be the main contact for all communication between the commissioner and the appraisal management company.

(b) **Requirements.** In order to serve as a designated controlling person of an appraisal management company, a person must:

(1) certify to the commissioner that the person is not currently subject to any cease and desist order or injunctive order that would preclude involvement with an appraisal management company, and has never been the subject of an order suspending, revoking, or denying a certification, registration, or license for real estate services, or a final order barring involvement in any industry or profession issued by this or another state or federal regulatory agency;

(2) be of good moral character, as determined by the commissioner; and

(3) submit to a background investigation, as determined by the commissioner.

Subd. 4. **Application for license.** Application for an appraisal management company license must be submitted on a form prescribed by the commissioner.

Subd. 5. **Minimum information.** The application must, at a minimum, include the following information:

(1) the name of the entity seeking registration;

(2) the business address or addresses of the entity seeking registration;

(3) telephone contact and e-mail information of the entity seeking registration;

(4) if the entity is not a corporation that is domiciled in this state, the name and contact information for the company's agent for service of process in this state;

(5) the name, address, and contact information for an individual or corporation, partnership, limited liability company, association, or other business entity that owns ten percent or more of the appraisal management company;

(6) the name, address, and contact information for a controlling person or persons;

(7) a certification that the entity has a system and process in place to verify that a person being added to the employment or appraiser panel of the appraisal management company for appraisal services within this state holds an active appraisal license in this state pursuant to chapter 82B if a license is required to perform appraisals;

(8) a certification that the entity has a system in place to review the work of all employed and independent appraisers that are performing real estate appraisal services for the appraisal management company on a periodic basis to verify that the real estate appraisal assignments are being conducted in accordance with USPAP and chapter 82B;

(9) a certification that the entity maintains a detailed record of each service request that it receives and the independent appraiser that performs the real estate appraisal services for the appraisal management company, pursuant to section 82C.13;

(10) a certification that the employees of the appraisal management company will be appropriately trained and familiar with the appraisal process;

(11) a certification that the appraisal management company has a system and process in place to verify that a person being added to the appraiser panel of the appraisal management company holds a license in good standing in this state pursuant to chapter 82B; and

(12) an irrevocable Uniform Consent to Service of Process, pursuant to section 82C.07.

Subd. 6. **Effective date of license.** Initial licenses issued under this chapter are effective upon issuance and remain valid, subject to denial, suspension, or revocation under this chapter, until the following August 31.

Sec. 8. **[82C.04] TERM OF LICENSE.**

Initial licenses issued under this chapter are valid for a period not to exceed two years. Each initial license must expire on August 31 of the expiration year assigned by the commissioner.

Sec. 9. **[82C.045] FEE DISCLOSURE.**

(a) An appraisal management company shall separately state to the client the fees paid to an appraiser for appraisal services and the fees charged by the appraisal management company for services associated with the management of the appraisal process, including procurement of the appraiser's services.

(b) Appraisers shall not be prohibited by the appraisal management company, client, or other third party from disclosing the fee paid to the appraiser for the performance of the appraisal in the appraisal report.

Sec. 10. **[82C.05] LICENSE RENEWAL.**

Subdivision 1. **Term.** Licenses renewed under this chapter are valid for a period of 24 months.

Subd. 2. **Timely renewal.** (a) Application for timely renewal of a license is considered timely filed if received by the commissioner before the date of the license expiration.

(b) An application for renewal is considered properly filed if made upon a form prescribed by the commissioner, accompanied by fees prescribed by this chapter, and containing any information the commissioner requires.

(c) A licensee failing to make timely application for renewal of the license is unlicensed until the renewal license has been issued by the commissioner and is received by the licensee.

Subd. 3. **Contents of renewal application.** Application for the renewal of an existing license must contain the information specified in section 82C.03. However, only the requested information having changed from the most recent prior application need be submitted.

Subd. 4. **Cancellation.** A licensee ceasing an activity or activities regulated by this chapter and desiring to no longer be licensed shall so inform the commissioner in writing and, at the same time, surrender the license and all other symbols or indicia of licensure.

Sec. 11. **[82C.06] EXEMPTIONS.**

This chapter does not apply to:

(1) a person that exclusively employs appraisers on an employer and employee basis for the performance of appraisals, and:

(i) the employer is responsible for ensuring that the appraisals are performed by employees in accordance with USPAP; and

(ii) the employer accepts all liability associated with the performance of the appraisal by the employee;

(2) a department or unit within a financial institution that is subject to direct regulation by an agency of the United States government, or to regulation by an agency of this state, that receives a request for the performance of an appraisal from one employee of the financial institution, and another employee of the same financial institution assigns the request for the appraisal to an appraiser that is an independent contractor to the institution, except that an appraisal management company that is a wholly owned subsidiary of a financial institution shall not be considered a department or unit within a financial institution to which the provisions of this chapter do not apply;

(3) a person that enters into an agreement, whether written or otherwise, with an appraiser for the performance of an appraisal, and upon the completion of the appraisal, the report of the appraiser performing the appraisal is signed by both the appraiser who completed the appraisal and the appraiser who requested the completion of the appraisal, except that an appraisal management company may not avoid the requirements of this chapter by requiring that an employee of the

appraisal management company that is an appraiser to sign an appraisal that is completed by an appraiser that is part of the appraisal panel of the appraisal management company; or

(4) any governmental agency performing appraisals on behalf of that level of government or any agency performing ad valorem tax appraisals for county assessors.

Sec. 12. **[82C.07] CONSENT TO SERVICE OF PROCESS.**

Each entity applying for a license as an appraisal management company in this state shall complete an irrevocable Uniform Consent to Service of Process as prescribed by the commissioner.

Sec. 13. **[82C.08] LICENSING FEES.**

Subdivision 1. **Establishment and retention.** The fees shall be retained by the commissioner for the sole purpose of administering this licensing and regulation program.

Subd. 2. **Amounts.** (a) Each application for initial licensure shall be accompanied by a fee of $5,000.

(b) Each application for renewal of the license must be received prior to the two-year expiration period with the renewal fee of $2,500.

Subd. 3. **Forfeiture.** All fees are nonrefundable except that an overpayment of a fee must be refunded upon proper application.

Sec. 14. **[82C.09] INVESTIGATIONS AND SUBPOENAS.**

The commissioner has under this chapter the same powers with respect to section 45.027, including the authority to impose a civil penalty not to exceed $10,000 per violation.

Sec. 15. **[82C.10] EMPLOYEE REQUIREMENTS.**

An employee of the appraisal management company that has the responsibility to review the work of employed and independent appraisers where the subject properties are located within this state, which include the reviewer's opinion of value or concurrence with the original appraiser's value, must be licensed according to chapter 82B and perform the review assignments in compliance with USPAP and chapter 82B. This requirement does not apply to employees who review appraisals for completeness and compliance in connection with an appraisal management company's internal quality control processes, but who do not perform appraisal reviews that are subject to Standard 3 of USPAP.

Sec. 16. **[82C.11] LIMITATIONS.**

An appraisal management company licensed in this state pursuant to this chapter may enter into contracts or agreements for appraisal assignments in this state only with an employee or independent appraiser holding an active Minnesota real estate appraiser license pursuant to chapter 82B.

Sec. 17. **[82C.12] ADHERENCE TO STANDARDS.**

An appraisal management company must have a system in place to review the work of all employed and independent appraisers that are performing real estate appraisal assignments for the appraisal management company on a periodic basis to verify that the real estate appraisal services are being conducted in accordance with USPAP and chapter 82B. An appraisal management

company is required to make referrals directly to state appraiser regulatory authorities when a state licensed or certified appraiser violates USPAP, applicable state law, or engages in other unethical or unprofessional conduct.

Sec. 18. **[82C.13] RECORD KEEPING.**

An appraisal management company must maintain a detailed record of each service request that it receives and the employee appraiser or independent appraiser that performs the appraisal assignment for the appraisal management company.

Records must be kept for a period of at least five years after the appraisal assignment request is sent to the independent appraiser or completion of the appraisal report, whichever period expires later.

Sec. 19. **[82C.14] APPRAISER INDEPENDENCE; PROHIBITIONS.**

(a) It is unlawful for any employee, director, officer, or agent of an appraisal management company licensed in this state pursuant to this chapter to influence or attempt to influence the development, reporting, or review of an appraisal through coercion, extortion, collusion, compensation, inducement, intimidation, or bribery, including but not limited to:

(1) withholding or threatening to withhold timely payment for an appraisal;

(2) withholding or threatening to withhold future business or assignments for an employed or independent appraiser, or demoting or terminating or threatening to demote or terminate an employed or independent appraiser;

(3) expressly or impliedly promising future business, assignments, promotions, or increased compensation for an employed or independent appraiser;

(4) conditioning the request for an appraisal assignment on the payment of an appraisal fee or salary or bonus on the opinion, conclusion, or valuation to be reached, or on a preliminary estimate or opinion requested from an employed or independent appraiser;

(5) requesting that an employed or independent appraiser provide an estimated, predetermined, or desired valuation in an appraisal report, or provide estimated values or comparable sales at any time prior to the completion of an appraisal assignment;

(6) providing to an employed or independent appraiser an anticipated, estimated, encouraged, or desired value for a subject property or a proposed or target amount to be loaned to the borrower, except that a copy of the sales contract for purchase transactions may be provided;

(7) providing to an employed or independent appraiser, or any entity or person related to the appraiser, stock, or other financial or nonfinancial benefits;

(8) allowing the removal of an employed or independent appraiser from a list of qualified appraisers used by any entity, without prior written notice to the appraiser, which notice must include documented evidence of the appraiser's violation of USPAP or chapter 82B, substandard performance, or otherwise improper or unprofessional behavior;

(9) request or require any employed or independent appraiser to provide the appraisal management company or any of its employees, or any of its clients, with the appraiser's digital

signature;

(10) alter, amend, or change an appraisal report submitted by an appraiser, to include removing or applying a signature, adding or deleting information from the appraisal report;

(11) require the appraiser to collect the fee from a borrower, homeowner, or other person;

(12) require an appraiser to sign any indemnification agreement that would require the appraiser to defend and hold harmless the appraisal management company or any of its agents or employees for any liability, damage, losses, or claims arising out of the services performed by the appraisal management company or its agents, employees, or independent contractors and not the services performed by the appraiser;

(13) use an appraiser directly selected or referred by any member of a loan production staff for an individual assignment; or

(14) any other act or practice that impairs or attempts to impair an appraiser's independence, objectivity, or impartiality.

(b) Nothing in paragraph (a) prohibits the appraisal management company from requesting that an independent appraiser:

(1) consider additional appropriate property information;

(2) provide further detail, substantiation, or explanation for the appraiser's value conclusion; or

(3) correct objective factual errors in an appraisal report.

Sec. 20. **[82C.15] ADJUDICATION OF DISPUTES BETWEEN AN APPRAISAL MANAGEMENT COMPANY AND AN INDEPENDENT APPRAISER.**

Except within the first 30 days after an independent appraiser is first added to the appraiser panel of an appraisal management company, an appraisal management company may not remove an appraiser from its appraiser panel, or otherwise refuse to assign requests for real estate appraisal services to an independent appraiser without:

(1) notifying the appraiser in writing of the reasons why the appraiser is being removed from the appraiser panel or is not receiving appraisal requests from the appraisal management company;

(2) if the appraiser is being removed from the panel for illegal conduct, having determined that the appraiser has violated USPAP or chapter 82B, taking into account the nature of the alleged conduct or violation; and

(3) providing an opportunity for the appraiser to respond and appeal the notification of the appraisal management company.

Sec. 21. **[82C.16] DENIAL, SUSPENSION, REVOCATION OF LICENSES.**

Subdivision 1. **Powers of commissioner.** The commissioner may by order take any or all of the following actions:

(1) bar a person from serving as an officer, director, partner, controlling person, or any similar role at an appraisal management company, if such person has ever been the subject of a final

order suspending, revoking, or denying a certification, registration or license as a realtor, broker, or appraiser, or a final order barring involvement in any industry or profession issued by this or another state or federal regulatory agency;

(2) deny, suspend, or revoke an appraisal management company license;

(3) censure an appraisal management company license; and

(4) impose a civil penalty as provided for in section 45.027.

(b) In order to take the action in paragraph (a), the commissioner must find:

(1) that the order is in the public interest; and

(2) that an officer, director, partner, employee, agent, controlling person or persons, or any person occupying a similar status or performing similar functions, has:

(i) violated any provision of this chapter;

(ii) filed an application for a license that is incomplete in any material respect or contains a statement that, in light of the circumstances under which it is made, is false or misleading with respect to a material fact;

(iii) failed to maintain compliance with the affirmations made under section 80C.03, subdivision 5;

(iv) violated a standard of conduct or engaged in a fraudulent, coercive, deceptive, or dishonest act or practice, whether or not the act or practice involves the appraisal management company;

(v) engaged in an act or practice, whether or not the act or practice involves the business of appraisal management, appraisal assignments, or real estate mortgage related practices, that demonstrates untrustworthiness, financial irresponsibility, or incompetence;

(vi) pled guilty, with or without explicitly admitting guilt, pled nolo contendere, or been convicted of a felony, gross misdemeanor, or a misdemeanor involving moral turpitude;

(vii) paid a civil penalty or been the subject of disciplinary action by the commissioner, or an order of suspension or revocation, cease and desist order, or injunction order, or an order barring involvement in an industry or profession issued by this or any other state or federal regulatory agency or government-sponsored enterprise, or by the secretary of Housing and Urban Development;

(viii) been found by a court of competent jurisdiction to have engaged in conduct evidencing gross negligence, fraud, misrepresentation, or deceit;

(ix) refused to cooperate with an investigation or examination by the commissioner;

(x) failed to pay any fee or assessment imposed by the commissioner; or

(xi) failed to comply with state and federal tax obligations.

Subd. 2. **Orders of the commissioner.** To begin a proceeding under this section, the commissioner shall issue an order requiring the subject of the proceeding to show cause why action should not be taken against the licensee according to this section. The order must be calculated to give reasonable notice of the time and place for the hearing and must state the reasons for

entry of the order. The commissioner may by order summarily suspend a license pending a final determination of an order to show cause. If a license is summarily suspended, pending final determination of an order to show cause, a hearing on the merits must be held within 30 days of the issuance of the order of summary suspension. All hearings must be conducted under chapter 14. After the hearing, the commissioner shall enter an order disposing of the matter as the facts require. If the subject of the order fails to appear at a hearing after having been duly notified of it, the subject is considered in default, and the proceeding may be determined against the subject of the order upon consideration of the order to show cause, the allegations of which may be considered to be true.

Subd. 3. **Actions against lapsed license.** If a license lapses, is surrendered, withdrawn, terminated, or otherwise becomes ineffective, the commissioner may institute a proceeding under this subdivision within two years after the license was last effective and enter a revocation or suspension order as of the last date which the license was in effect, and may impose a civil penalty as provided for in this section or section 45.027.

Sec. 22. **APPROPRIATION.**

$223,000 is appropriated from the general fund to the commissioner of commerce to license appraisal management companies under this act, to be available until June 30, 2011."

Delete the title and insert:

"A bill for an act relating to commerce; reducing the size of the Real Estate Appraiser Advisory Board; providing for the licensing and regulation of appraisal management companies; appropriating money; amending Minnesota Statutes 2008, sections 82B.05, subdivision 5, by adding a subdivision; 82B.06; Minnesota Statutes 2009 Supplement, section 82B.05, subdivision 1; proposing coding for new law as Minnesota Statutes, chapter 82C."

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

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

S.F. No. 3318: A bill for an act relating to state government; changing provisions in the energy improvement financing program; amending Minnesota Statutes 2008, section 16B.322, subdivisions 4, 5; Minnesota Statutes 2009 Supplement, section 16B.322, subdivisions 4a, 4b, 4c.

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

Page 1, after line 6, insert:

"Section 1. Minnesota Statutes 2008, section 16B.24, subdivision 3, is amended to read:

Subd. 3. **Disposal of old buildings.** (a) Upon request from the head of an agency with control of a state-owned building with an estimated market value of less than $50,000, as determined by the commissioner, the commissioner may sell, demolish, or otherwise dispose of the building if the commissioner determines that the building is no longer used or is a fire or safety hazard.

~~The commissioner,~~ (b) Upon request of the head of an agency ~~which has~~ with control of a state-owned building ~~which is no longer used or which is a fire or safety hazard, shall,~~ with an estimated market value of $50,000 or more, as determined by the commissioner, the commissioner

may sell, demolish, or otherwise dispose of the building after determining that the building is no longer used or is a fire or safety hazard and obtaining approval of the chairs of the senate Finance Committee and house of representatives Ways and Means Committee~~, sell, wreck, or otherwise dispose of the building~~.

(c) In the event a sale is made under this subdivision, the proceeds shall be deposited in the ~~proper~~ account ~~or in the general fund~~ provided by law. If there is no requirement in law specifying how proceeds must be deposited other than section 16A.72, the proceeds must be deposited in the account from which the appropriation to acquire or construct the building was made. If the account from which the appropriation was made cannot be identified or has been terminated, the proceeds shall be deposited in the general fund."

Page 3, after line 17, insert:

"Sec. 7. Minnesota Statutes 2008, section 79.34, subdivision 1, is amended to read:

Subdivision 1. **Conditions requiring membership.** The nonprofit association known as the Workers' Compensation Reinsurance Association may be incorporated under chapter 317A with all the powers of a corporation formed under that chapter, except that if the provisions of that chapter are inconsistent with sections 79.34 to 79.40, sections 79.34 to 79.40 govern. Each insurer as defined by section 79.01, subdivision 2, shall, as a condition of its authority to transact workers' compensation insurance in this state, be a member of the reinsurance association and is bound by the plan of operation of the reinsurance association; provided, that all affiliated insurers within a holding company system as defined in chapter 60D are considered a single entity for purposes of the exercise of all rights and duties of membership in the reinsurance association. Each self-insurer approved under section 176.181 and each political subdivision that self-insures shall, as a condition of its authority to self-insure workers' compensation liability in this state, be a member of the reinsurance association and is bound by its plan of operation; provided that:

(1) all affiliated companies within a holding company system, as determined by the commissioner of labor and industry in a manner consistent with the standards and definitions in chapter 60D, are considered a single entity for purposes of the exercise of all rights and duties of membership in the reinsurance association; and

(2) all group self-insurers granted authority to self-insure pursuant to section 176.181 are considered single entities for purposes of the exercise of all the rights and duties of membership in the reinsurance association. As a condition of its authority to self-insure workers' compensation liability, and for losses incurred after December 31, 1983, the state is a member of the reinsurance association and is bound by its plan of operation. The commissioner of ~~management and budget~~ administration represents the state in the exercise of all the rights and duties of membership in the reinsurance association. The amounts necessary to pay the state's premiums required for coverage by the Workers' Compensation Reinsurance Association are appropriated from the general fund to the commissioner of ~~management and budget~~ administration. The University of Minnesota shall pay its portion of workers' compensation reinsurance premiums directly to the Workers' Compensation Reinsurance Association. For the purposes of this section, "state" means the administrative branch of state government, the legislative branch, the judicial branch, the University of Minnesota, and any other entity whose workers' compensation liability is paid from the state revolving fund. The commissioner of management and budget may calculate, prorate, and charge a department or agency the portion of premiums paid to the reinsurance association for

employees who are paid wholly or in part by federal funds, dedicated funds, or special revenue funds. The reinsurance association is not a state agency. Actions of the reinsurance association and its board of directors and actions of the commissioner of labor and industry with respect to the reinsurance association are not subject to chapters 13 and 15. All property owned by the association is exempt from taxation. The reinsurance association is not obligated to make any payments or pay any assessments to any funds or pools established pursuant to this chapter or chapter 176 or any other law.

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

Renumber the sections in sequence

Amend the title as follows:

Page 1, line 2, after "government;" insert "imposing a threshold value before notification of certain legislators is required for disposal of certain state-owned buildings;"

Page 1, line 3, after "program;" insert "clarifying responsibility for administration of the state's responsibilities as a member of the workers' compensation reinsurance association;"

Amend the title numbers accordingly

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

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

H.F. No. 3056: A bill for an act relating to health; modifying provider peer grouping timelines and system; amending Minnesota Statutes 2008, sections 62U.04, subdivisions 3, 9; 256B.0754, subdivision 2; repealing Minnesota Statutes 2009 Supplement, section 256B.032.

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

Delete everything after the enacting clause and insert:

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

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) ~~Beginning June 1~~ By no later than October 15, 2010, the commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider

shall have ~~21~~ 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(c) By no later than January 1, 2011, the commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use, condition-specific quality of care, and the condition-specific results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:

(1) clearly indicate the reason they believe the data used to calculate the peer group system results are not accurate;

(2) provide evidence and documentation to support the reason that data was not accurate; and

(3) cooperate with the commissioner, including allowing the commissioner access to data necessary and relevant to resolving the dispute.

If a provider does not meet the requirements of this paragraph, a provider's appeal shall be considered withdrawn. The commissioner shall not publish results for a specific provider under paragraph (e) or (f) while that provider has an unresolved appeal.

~~(d)~~ (e) Beginning ~~September 1, 2010~~ January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing information under paragraph (e) or (f), the commissioner shall ensure the scientific validity and reliability of the results according to the standards described in paragraph (h). If additional time is needed to establish the scientific validity and reliability of the results, the commissioner may delay the dissemination of data to providers under paragraph (b) or (c), or the publication of information under paragraph (e) or (f). If the delay is more than 60 days, the commissioner shall report in writing to the Legislative Commission on Health Care Access the following information:

(1) the reason for the delay;

(2) the actions being taken to resolve the delay and establish the scientific validity and reliability of the results; and

(3) the new dates by which the results shall be disseminated.

If there is a delay under this paragraph, the commissioner must disseminate the information to providers under paragraph (b) or (c) at least 90 days before publishing results under paragraph (e) or (f).

(h) The commissioner's assurance of valid and reliable clinic and hospital peer grouping performance results shall include, at a minimum, the following:

(1) use of the best available evidence, research, and methodologies; and

(2) establishment of an explicit minimum reliability threshold developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

In achieving these thresholds, the commissioner shall not aggregate clinics that are not part of the same system or practice group. The commissioner shall consult with and solicit feedback from representatives of physician clinics and hospitals during the peer grouping data analysis process to obtain input on the methodological options prior to final analysis and on the design, development, and testing of provider reports.

Sec. 2. Minnesota Statutes 2008, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** (a) By ~~January 1, 2011~~ no later than 12 months after the commissioner publishes the information in subdivision 3, paragraph (e):

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

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

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

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

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

Sec. 3. Minnesota Statutes 2008, section 256B.0754, subdivision 2, is amended to read:

Subd. 2. **Payment reform.** By ~~January 1, 2011~~ no later than 12 months after the commissioner of health publishes the information in section 62U.04, subdivision 3, paragraph (e), the commissioner

of human services shall use the information and methods developed under section 62U.04 to establish a payment system that:

(1) rewards high-quality, low-cost providers;

(2) creates enrollee incentives to receive care from high-quality, low-cost providers; and

(3) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another.

Sec. 4. **PAYMENT REFORM IMPLEMENTATION REPORT.**

By April 1, 2011, the commissioner of human services shall report to the chairs of the senate Health and Human Services Budget Division and the house of representatives Health Care and Human Services Finance Division recommendations for implementing the payment reform in Minnesota Statutes, section 256B.0754, subdivision 2. The recommendations shall include:

(1) legislative changes needed to fully implement this payment reform; and

(2) an analysis of the fiscal impact of implementing this payment reform.

Sec. 5. **REPEALER.**

Minnesota Statutes 2009 Supplement, section 256B.032, is repealed."

Amend the title as follows:

Page 1, line 2, before "provider" insert "the"

Amend the title numbers accordingly

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

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

S.F. No. 3028: A bill for an act relating to education; providing for prekindergarten through grade 12 education, including general education, education excellence, special programs, facilities and technology, libraries, nutrition, accounting, early childhood education, and state agencies; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2008, sections 120A.41; 120B.128; 122A.14, by adding a subdivision; 122A.18, subdivisions 1, 2; 122A.23, subdivision 2; 122A.40, subdivision 5, by adding a subdivision; 122A.41, subdivisions 2, 4; 123B.75, subdivision 5; 123B.77, subdivision 1a; 126C.10, subdivision 2a; 127A.441; 127A.45, subdivisions 2, 3, 13, by adding a subdivision; Minnesota Statutes 2009 Supplement, sections 16A.152, subdivision 2; 122A.09, subdivision 4; 122A.40, subdivisions 6, 8; 122A.41, subdivisions 3, 5; 124D.10, subdivision 13; Laws 2009, chapter 96, article 1, section 24; article 2, section 67; article 3, section 21; article 4, section 12; article 5, section 13; article 6, section 11; article 7, sections 3, subdivision 2; 5; proposing coding for new law in Minnesota Statutes, chapter 127A.

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

Delete everything after the enacting clause and insert:

"Section 1. Laws 2009, chapter 96, article 2, section 67, subdivision 5, is amended to read:

Subd. 5. **Magnet school grants.** For magnet school and program grants under Minnesota Statutes section 124D.88:

$	750,000	.....	2010
$	~~750,000~~ 709,000	.....	2011

Sec. 2. Laws 2009, chapter 96, article 2, section 67, subdivision 11, is amended to read:

Subd. 11. **Statewide testing and reporting system.** For the statewide testing and reporting system under Minnesota Statutes, section 120B.30:

$	15,150,000	.....	2010
$	~~15,150,000~~ 13,150,000	.....	2011

None of the amounts appropriated under this subdivision shall be used for contract costs associated with hand-scoring of constructed-response items of the Minnesota Comprehensive Assessment-Series II in reading, science, and mathematics, with the exception of mathematics grades 3 to 8 of the 2009-2010 school year. Any balance in the first year does not cancel but is available in the second year. Any amount generated as a result of the savings from foregoing hand-scoring shall be, to the extent possible, redirected into the development of computerized statewide testing. The base for fiscal year 2012 is $17,150,000 and $13,550,000 for fiscal year 2013 and later.

Sec. 3. Laws 2009, chapter 96, article 2, section 67, subdivision 12, is amended to read:

Subd. 12. **Examination fees; teacher training and support programs.** (a) For students' advanced placement and international baccalaureate examination fees under Minnesota Statutes, section 120B.13, subdivision 3, and the training and related costs for teachers and other interested educators under Minnesota Statutes, section 120B.13, subdivision 1:

$	4,500,000	.....	2010
$	~~4,500,000~~ 4,000,000	.....	2011

(b) The advanced placement program shall receive 75 percent of the appropriation each year and the international baccalaureate program shall receive 25 percent of the appropriation each year. The department, in consultation with representatives of the advanced placement and international baccalaureate programs selected by the Advanced Placement Advisory Council and IBMN, respectively, shall determine the amounts of the expenditures each year for examination fees and training and support programs for each program.

(c) Notwithstanding Minnesota Statutes, section 120B.13, subdivision 1, at least $500,000 ~~each year~~ in fiscal year 2010 and $472,000 in fiscal year 2011 is for teachers to attend subject matter summer training programs and follow-up support workshops approved by the advanced placement or international baccalaureate programs. The commissioner shall determine the payment process and the amount of the subsidy.

(d) The commissioner shall pay all examination fees for all students of low-income families

under Minnesota Statutes, section 120B.13, subdivision 3, and to the extent of available appropriations shall also pay examination fees for students sitting for an advanced placement examination, international baccalaureate examination, or both.

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $4,253,000.

Sec. 4. Laws 2009, chapter 96, article 2, section 67, subdivision 13, is amended to read:

Subd. 13. **Concurrent enrollment programs.** For concurrent enrollment programs under Minnesota Statutes, section 124D.091:

$	2,000,000	.....	2010
$	~~2,000,000~~ 1,610,000	.....	2011

If the appropriation is insufficient, the commissioner must proportionately reduce the aid payment to each district.

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $1,890,000.

Sec. 5. Laws 2009, chapter 96, article 2, section 67, subdivision 14, is amended to read:

Subd. 14. **Collaborative urban educator.** For the collaborative urban educator grant program:

$	528,000	.....	2010
$	~~528,000~~ 499,000	.....	2011

$210,000 in fiscal year 2010 and $199,000 in fiscal year 2011 is for the Southeast Asian teacher program at Concordia University, St. Paul; $159,000 in fiscal year 2010 and $150,000 in fiscal year 2011 is for the collaborative urban educator program at the University of St. Thomas; and $159,000 in fiscal year 2010 and $150,000 in fiscal year 2011 is for the Center for Excellence in Urban Teaching at Hamline University. Grant recipients must collaborate with urban and nonurban school districts. Any balance in the first year does not cancel but is available in the second year.

Sec. 6. Laws 2009, chapter 96, article 2, section 67, subdivision 16, is amended to read:

Subd. 16. **Student organizations.** For student organizations:

$	725,000	.....	2010
$	~~725,000~~ 601,000	.....	2011

$40,000 each year is for student organizations serving health occupations.

$38,000 each year is for student organizations serving service occupations.

$88,000 each year is for student organizations serving trade and industry occupations.

$84,000 each year is for student organizations serving business occupations.

$131,000 each year is for student organizations serving agriculture occupations.

$125,000 each year is for student organizations serving family and consumer science occupations.

$95,000 each year is for student organizations serving marketing occupations.

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $685,000.

Sec. 7. Laws 2009, chapter 96, article 2, section 67, subdivision 17, is amended to read:

Subd. 17. **Education Planning and Assessment System (EPAS) program.** For the Educational Planning and Assessment System (EPAS) program under Minnesota Statutes, section 120B.128:

$	829,000	.....	2010
$	~~829,000~~ -0-	.....	2011

Any balance in the first year does not cancel but is available in the second year.

Sec. 8. Laws 2009, chapter 96, article 4, section 12, subdivision 5, is amended to read:

Subd. 5. **Equity in telecommunications access.** For equity in telecommunications access:

$	3,750,000	.....	2010
$	~~3,750,000~~ 2,088,000	.....	2011

If the appropriation amount is insufficient, the commissioner shall reduce the reimbursement rate in Minnesota Statutes, section 125B.26, subdivisions 4 and 5, and the revenue for fiscal years 2010 and 2011 shall be prorated.

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $3,544,000.

Sec. 9. Laws 2009, chapter 96, article 5, section 13, subdivision 8, is amended to read:

Subd. 8. **Electronic library for Minnesota.** For statewide licenses to online databases selected in cooperation with the Minnesota Office of Higher Education for school media centers, public libraries, state government agency libraries, and public or private college or university libraries:

$	900,000	.....	2010
$	~~900,000~~ 610,000	.....	2011

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $851,000.

Sec. 10. Laws 2009, chapter 96, article 6, section 11, subdivision 5, is amended to read:

Subd. 5. **Head Start program.** For Head Start programs under Minnesota Statutes, section 119A.52:

$	20,100,000	.....	2010
$	~~20,100,000~~ 18,755,000	.....	2011

Any balance in the first year does not cancel but is available in the second year. The base for fiscal year 2012 and later is $18,995,000.

Sec. 11. Laws 2009, chapter 96, article 7, section 3, subdivision 2, is amended to read:

Subd. 2. **Department.** (a) For the Department of Education:

$	~~20,943,000~~ 20,571,000	.....	2010
$	~~20,943,000~~ 20,340,000	.....	2011

Any balance in the first year does not cancel but is available in the second year.

(b) $260,000 each year is for the Minnesota Children's Museum.

(c) $41,000 each year is for the Minnesota Academy of Science.

(d) ~~$632,000 each year~~ $621,000 in fiscal year 2010 and $618,000 in fiscal year 2011 is for the Board of Teaching. Any balance in the first year does not cancel but is available in the second year.

(e) ~~$171,000 each year~~ $168,000 in fiscal year 2010 and $166,000 in fiscal year 2011 is for the Board of School Administrators. Any balance in the first year does not cancel but is available in the second year.

(f) $40,000 each year is for an early hearing loss intervention coordinator under Minnesota Statutes, section 125A.63, subdivision 5. If the department expends federal funds to employ a hearing loss coordinator under Minnesota Statutes, section 125A.63, subdivision 5, then the appropriation under this paragraph is reallocated for purposes of employing a world languages coordinator.

(g) $50,000 each year is for the Duluth Children's Museum.

(h) None of the amounts appropriated under this subdivision may be used for Minnesota's Washington, D.C., office.

(i) The expenditures of federal grants and aids as shown in the biennial budget document and its supplements are approved and appropriated and shall be spent as indicated. The commissioner must provide, to the K-12 Education Finance Division in the house of representatives and the E-12 Budget Division in the senate, details about the distribution of state incentive grants, education technology state grants, teacher incentive funds, and statewide data system funds as outlined in the supplemental federal funds submission dated March 25, 2009.

(j) The base for fiscal year 2012 and later is $19,876,000.

(k) $24,000 in fiscal year 2010 and $23,000 in fiscal year 2011 shall be transferred from the department's special revenue fund to the general fund.

Sec. 12. Laws 2009, chapter 96, article 7, section 5, is amended to read:

Sec. 5. **APPROPRIATIONS; PERPICH CENTER FOR ARTS EDUCATION.**

The sums indicated in this section are appropriated from the general fund to the Perpich Center for Arts Education for the fiscal years designated:

$	~~7,087,000~~ 6,949,000	.....	2010
$	~~7,087,000~~ 6,867,000	.....	2011

Any balance in the first year does not cancel but is available in the second year.

The base for fiscal year 2012 and later is $6,867,000.

$19,000 in fiscal year 2010 and $11,000 in fiscal year 2011 shall be transferred from the Perpich Center's special revenue fund to the general fund.

Sec. 13. **STATEWIDE TESTING AND REPORTING SYSTEM; CONTRACTOR CASH FLOW.**

Of the base amount established under section 2, for the statewide testing and reporting system in fiscal year 2012 only, $2,000,000 is for payments to the statewide testing contractor for services provided by the contractor in fiscal year 2011. The commissioner shall work with the contractor to adjust the state's testing and reporting system contract to reflect this adjustment to the state's scheduled payments."

Delete the title and insert:

"A bill for an act relating to education finance; reducing appropriations for education grants; reducing administrative appropriations; amending Laws 2009, chapter 96, article 2, section 67, subdivisions 5, 11, 12, 13, 14, 16, 17; article 4, section 12, subdivision 5; article 5, section 13, subdivision 8; article 6, section 11, subdivision 5; article 7, sections 3, subdivision 2; 5."

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

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

S.F. No. 3064: A bill for an act relating to education finance; providing funding for the Northwestern Online College in the high school program.

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

Delete everything after the enacting clause and insert:

"Section 1. **FUND TRANSFERS.**

Subdivision 1. **Anoka-Hennepin.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 11, Anoka-Hennepin, may permanently transfer up to $400,000 from its debt redemption fund to its undesignated general fund balance without making a levy reduction.

Subd. 2. **Elk River.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 728, Elk River, may permanently transfer up to $500,000 from its debt redemption fund to its undesignated general fund balance without making a levy reduction.

Subd. 3. **Hayfield.** Notwithstanding Minnesota Statutes, section 123B.79 or 123B.80, on June 30, 2010, Independent School District No. 203, Hayfield, may permanently transfer up to $75,000 from its reserved for operating capital account to its undesignated general fund balance without making a levy reduction.

Subd. 4. **Kenyon-Wanamingo.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 2172, Kenyon-Wanamingo, may permanently transfer up to $55,000 from its debt redemption fund to its undesignated general fund balance without making a levy reduction.

Subd. 5. **Madelia.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 837, Madelia, may permanently transfer up to $350,000 from its debt redemption fund to its reserved for operating capital account without making a levy reduction.

Subd. 6. **Rochester.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 535, Rochester, may permanently transfer up to $400,000 from its debt redemption fund to its undesignated general fund balance without making a levy reduction.

Subd. 7. **St. Louis Park.** Notwithstanding Minnesota Statutes, sections 123B.79, 123B.80, and 475.61, subdivision 4, on June 30, 2010, Independent School District No. 283, St. Louis Park, may permanently transfer up to $225,000 from its reserved for operating capital account to its undesignated general fund balance without making a levy reduction. Any funds transferred under this subdivision must be used to pay for the costs directly associated with closing the Cedar Manor Elementary School, including moving and storage costs.

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

Delete the title and insert:

"A bill for an act relating to education finance; permitting fund transfers for certain school districts."

And when so amended the bill do pass and be re-referred to the Committee on Taxes. Amendments adopted. Report adopted.

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

S.F. No. 3063: A bill for an act relating to education finance; adjusting the career and technical levy formula; amending Minnesota Statutes 2008, section 124D.4531, subdivision 1.

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

Delete everything after the enacting clause and insert:

"Section 1. Laws 1999, chapter 241, article 4, section 25, is amended to read:

Sec. 25. **ALTERNATIVE FACILITIES REVENUE PROGRAM.**

Subdivision 1. **[INDEPENDENT SCHOOL DISTRICT NO. 622, NORTH ST. PAUL-MAPLEWOOD-OAKDALE.]** Independent school district No. 622, North St. Paul-Maplewood-Oakdale, is eligible for the alternative facilities revenue program under Minnesota Statutes, section 123B.59, for the purposes of financing school facilities in the district.

Subd. 2. **Stillwater.** Independent school district No. 834, Stillwater, is eligible for the alternative facilities revenue program under Minnesota Statutes, section 123B.59, for the purposes of financing school facilities in the district.

Subd. 3. **Independent School District No. 284, Wayzata.** Independent School District No. 284, Wayzata, is eligible for the alternative facilities revenue program under Minnesota Statutes, section 123B.59, for the purposes of financing school facilities in the district.

EFFECTIVE DATE. This section is effective for revenue for fiscal year 2013 and later.

Sec. 2. Laws 2009, chapter 96, article 4, section 12, subdivision 4, is amended to read:

Subd. 4. **Alternative facilities bonding aid.** For alternative facilities bonding aid, according to Minnesota Statutes, section 123B.59, subdivision 1:

$	19,287,000	.....	2010
$	~~19,287,000~~ 12,383,000	.....	2011

The 2010 appropriation includes $1,928,000 for 2009 and $17,359,000 for 2010.

The 2011 appropriation includes $1,928,000 for 2010 and ~~$17,359,000~~ $10,455,000 for 2011.

Sec. 3. **ALTERNATIVE FACILITIES AID REDUCTION.**

Notwithstanding Minnesota Statutes, section 123B.59, subdivisions 6 and 7, for fiscal year 2011 only, a school district that has authority to issue general obligations bonds without voter approval, other than authority according to Minnesota Statutes, section 123B.59 or 475.51, and is not eligible for equity revenue under Minnesota Statutes, section 126C.10, subdivision 24, paragraph (a), clause (2), is eligible for aid for bonding debt service equal to the amount computed under Minnesota Statutes, section 123B.59, subdivision 6, for the district's bonding debt service costs in fiscal year 2011 times 0.5. In addition to levy authority granted under Minnesota Statutes, section 123B.59, for taxes payable in 2011 only, a school district that previously received aid that was eliminated under this section may levy an equal amount in taxes payable in 2011 and recognize that revenue in fiscal year 2011."

Delete the title and insert:

"A bill for an act relating to education finance; adjusting the alternative facilities bonding and levy program to eliminate aid for certain districts; allowing Independent School District No. 284, Wayzata, to participate in alternative facilities bonding and levy program in fiscal year 2013 and later; amending Laws 1999, chapter 241, article 4, section 25; Laws 2009, chapter 96, article 4,

section 12, subdivision 4."

And when so amended the bill do pass and be re-referred to the Committee on Taxes. Amendments adopted. Report adopted.

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

S.F. No. 2337: A bill for an act relating to human services; establishing an intensive care management program for medical assistance enrollees; reducing funding for the medical assistance program; requiring a request for proposals; requiring a report; appropriating money; amending Laws 2009, chapter 79, article 13, section 3, subdivision 6, as amended; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. 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 July 1, 2010, the surcharge under paragraph (b) is increased to 2.63 percent.

(d) Effective October 1, 2011, the surcharge under paragraph (c) is reduced to 2.30 percent.

(e) 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 July 1, 2010.

Sec. 2. 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 October 1, 2010, in addition to the surcharge under paragraph (a), each health maintenance organization shall pay to the commissioner a surcharge equal to 0.85 percent of total premium revenues and each county-based purchasing plan authorized under section 256B.692 shall

pay to the commissioner a surcharge equal to 1.45 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 shall be deposited in the health care access fund established in section 16A.724.

(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 July 1, 2010.

Sec. 3. 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~~ 24 months of the rebased period beginning January 1, 2011, rates shall not be rebased ~~at 74.25 percent of the full value of the rebasing percentage change. From April 1, 2011, to March 31, 2012, rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change~~. Effective ~~April 1, 2012~~ January 1, 2013, 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.

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

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

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or

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

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

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

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

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

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made to

hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

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

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

(i) In 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 July 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by five percent from the current statutory rates. Effective July 1, 2011, the rate increase under this paragraph shall be reduced to 0.63 percent. 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.

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

Sec. 5. 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 July 1, 2010, 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 $10,000,000 each fiscal year, including state and federal shares. 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.

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

Sec. 6. 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.

(c) For medical assistance admissions occurring on or after July 1, 2010, the payment rate under paragraph (a), clause (2), shall be increased to 100 percent from 90 percent. 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.

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

Sec. 7. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Hospital payment adjustment after June 30, 2010.** (a) For medical assistance admissions occurring on or after July 1, 2010, to March 31, 2011, the commissioner shall increase rates at Minnesota private, not-for-profit hospitals as follows:

(1) for a hospital with total admissions reimbursed by government payers equal to or greater than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 437 percent;

(2) for a hospital with total admissions reimbursed by government payers equal to or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 349.6 percent; and

(3) for a hospital with total admissions reimbursed by government payers of less than 40 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 262.2 percent.

(b) For medical assistance admissions occurring on or after April 1, 2011, the commissioner shall increase rates at Minnesota private, not-for-profit hospitals as follows:

(1) for a hospital with total admissions reimbursed by government payers equal to or greater than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 145 percent;

(2) for a hospital with total admissions reimbursed by government payers equal to or greater than 40 percent but less than 50 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 116 percent; and

(3) for a hospital with total admissions reimbursed by government payers of less than 40 percent, payment rates for inpatient hospital services shall be increased for each admission by $250 multiplied by 87 percent.

(c) For purposes of paragraphs (a) and (b), "government payers" means Medicare, medical assistance, MinnesotaCare, and general assistance medical care.

(d) For medical assistance admissions occurring on or after July 1, 2010, to March 31, 2011, the commissioner shall increase rates for inpatient hospital services at Minnesota hospitals by $850 for each admission. For medical assistance admissions occurring on or after April 1, 2011, the payment under this paragraph shall be reduced to $320 per admission.

(e) For purposes of this subdivision, 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 subdivision. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments.

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

Sec. 8. Minnesota Statutes 2008, section 256B.04, subdivision 14a, is amended to read:

Subd. 14a. **Level of need determination.** Nonemergency medical transportation level of need determinations must be performed by a physician, a registered nurse working under direct supervision of a physician, a physician's assistant, a nurse practitioner, a licensed practical nurse, or a discharge planner. Nonemergency medical transportation level of need determinations must not be performed more than ~~semiannually~~ annually on any individual, unless the individual's circumstances have sufficiently changed so as to require a new level of need determination. Individuals residing in licensed nursing facilities are exempt from a level of need determination and are eligible for special transportation services until the individual no longer resides in a licensed nursing facility. If a person authorized by this subdivision to perform a level of need determination determines that an individual requires stretcher transportation, the individual is presumed to maintain that level of need until otherwise determined by a person authorized to perform a level of need determination, or for six months, whichever is sooner.

Sec. 9. Minnesota Statutes 2008, section 256B.055, is amended by adding a subdivision to read:

Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a person who:

(1) is over the age of 21 and under the age of 65;

(2) resides in a household with no children;

(3) is not pregnant; and

(4) is not eligible under any other subdivision of this section.

(b) Beginning October 1, 2010, persons who are eligible for medical assistance under this subdivision are not eligible for long-term care services.

(c) Paragraph (b) does not apply to persons who meet the descriptions under section 1937(a)(2), subparagraph (B), of the Social Security Act. For purposes of this paragraph, "medically frail" shall be defined as requiring assistance and being determined dependent in at least two activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (b).

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

Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The

accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of supplemental security income may have an income up to the supplemental security income standard in effect on that date.

(b) To be eligible for medical assistance, families and children may have an income up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996, AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16, 1996, shall be increased by three percent.

(c) Effective July 1, 2002, to be eligible for medical assistance, families and children may have an income up to 100 percent of the federal poverty guidelines for the family size.

(d) Effective June 1, 2010, to be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 75 percent of federal poverty guidelines for the family size.

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

income to the recipient.

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

Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking four or more prescriptions to treat or prevent two or more chronic medical conditions, or a recipient with a drug therapy problem that is identified or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued under chapter 151;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have

developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, excluding long-term care and group homes, if the service is ordered by the provider-directed care coordination team; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

EFFECTIVE DATE. This section is effective retroactive to March 23, 2010.

Sec. 14. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) Nursery care services provided by a birth center shall be paid the lower of billed charges or 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

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

Sec. 15. Minnesota Statutes 2008, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital-based emergency room; and

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009, and before January 1, 2011:

(1) $6 for nonemergency visits to a hospital-based emergency room;

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

(3) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly co-payments must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on co-payments.

(c) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2011:

(1) $3.50 for nonemergency visits to a hospital-based emergency room;

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

(3) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly co-payments must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit in co-payments.

(d) Recipients of medical assistance are responsible for all co-payments in this subdivision.

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

Sec. 16. Minnesota Statutes 2008, section 256B.0631, subdivision 3, is amended to read:

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum or the $7 per month maximum effective January 1, 2009, for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent co-payment limit.

(b) The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans and county-based purchasing plans shall not be increased ~~as a result of the removal of the co-payments effective January 1, 2009~~:

(1) as a result of the removal of the co-payments effective January 1, 2009; or

(2) as a result of the reduction of the co-payments effective January 1, 2011.

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

Sec. 17. Minnesota Statutes 2008, section 256B.0753, is amended by adding a subdivision to read:

Subd. 4. **Consistency with federal reform efforts.** The commissioner may modify provisions

of the care coordination payment system in order to be consistent with Public Law 111-14, section 2703.

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

Sec. 18. **[256B.0755] HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.**

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provides services to a specified patient population for an agreed upon total cost of care payment. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting total cost of care to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems if they are willing and able to be held accountable for the total cost of care and quality and performance standards established by the commissioner;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage and authorize projects that involve close partnerships between the health care delivery system and counties and nonprofit agencies that provide services to patients enrolled with the health care delivery system, including social services, public health, mental health, community-based services, and continuing care; and

(7) encourage and authorize projects established by community hospitals, clinics, and other providers in rural communities.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the health care delivery system;

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

(3) in cooperation with counties, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

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

(d) A health care delivery system may be formed by a county, an integrated delivery system or network, a physician-hospital organization, an academic center, a county-based purchasing plan, a managed care plan, or other entity. A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for health care delivery systems.

Subd. 2. **Enrollment.** (a) Initially, individuals eligible for medical assistance under section 256B.055, subdivision 15, shall be eligible for enrollment in a health care delivery system.

(b) Eligible applicants and recipients may enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system is available, the applicant or recipient shall be allowed to choose among the available delivery systems. The commissioner may assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care and the cost of care provided to its enrollees.

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, and rural clinics to the extent practicable.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark to be paid for services provided to the recipients enrolled in a health care delivery system. The commissioner shall establish a payment arrangement with the health care delivery system to provide these services during the specified time period at a cost that is equal to or less than 97 percent of the forecasted total cost of care for the enrollee population using predetermined payments for the recipients enrolled in the health care delivery system rather than fee-for-service methods that pay for units of service. The actual amount to be paid may be negotiated, but may not exceed 97 percent of the forecasted cost.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

Subd. 5. **Hennepin and Ramsey Counties Pilot Program.** (a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including the Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

(e) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall explore the expansion of the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects.

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

Sec. 19. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with

the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing ~~plan's payment rate~~ plan payments under section 256B.692 for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009.

~~(g)~~ (h) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold four percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(h)~~ (i) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(i)~~ (j) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(j)~~ (k) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and prepaid general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(k)~~ (l) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

~~(l)~~ (m) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

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

Sec. 20. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5k. **Rate modifications.** For services rendered on or after October 1, 2010, the total payment made to managed care plans and county-based purchasing plans under the medical assistance program shall be increased by 1.28 percent. This increase shall be paid from the health

care access fund established in section 16A.724.

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

Sec. 21. Minnesota Statutes 2009 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent over the rates in effect on June 30, 2009. Effective for services rendered on or after July 1, 2011, payment rates for physician and professional services shall be reduced an additional 1.5 percent for the medical assistance and general assistance medical care programs. ~~This reduction does~~ These reductions do not apply to office or other outpatient visits, preventive medicine visits ~~and~~, or family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. ~~This reduction does~~ These reductions do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective ~~October 1, 2009~~ July 1, 2011, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the additional payment reduction described in this paragraph.

(d) Effective for services rendered on or after October 1, 2010, payment rates for physician and professional services billed by physicians employed by and clinics owned by a nonprofit health maintenance organization shall be increased by 25 percent. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12, shall reflect the payment increase described in this paragraph.

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

Sec. 22. Minnesota Statutes 2008, section 256B.76, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

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

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

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

Sec. 23. Minnesota Statutes 2008, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the ~~health plan companies~~ managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental

providers as approved by the commissioner. ~~In determining which dentists and dental clinics shall be deemed critical access dental providers, the commissioner shall review:~~

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

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

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

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

(vii) have free care available as needed;

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

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

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare; and

(5) a dental clinic associated with an oral health or dental education program operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system.

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

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

Sec. 24. Minnesota Statutes 2009 Supplement, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, prior to third-party liability and spenddown calculation. Effective for services provided on or after July 1, 2011, payment rates shall be reduced an additional 1.5 percent for the medical assistance and general assistance medical care programs. Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after ~~October 1, 2009~~ July 1, 2011, to reflect this additional reduction.

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

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

Sec. 25. Minnesota Statutes 2009 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the

$10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

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

Sec. 26. Minnesota Statutes 2008, section 256L.12, subdivision 9, is amended to read:

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

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

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

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

(d) Effective for services rendered on or after January 1, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room

utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009.

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

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

Sec. 27. Minnesota Statutes 2008, section 256L.12, is amended by adding a subdivision to read:

Subd. 9c. **Rate setting; increase effective October 1, 2010.** For services rendered on or after October 1, 2010, the total payment made to managed care plans and county-based purchasing plans under MinnesotaCare for families with children shall be increased by 1.28 percent.

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

Sec. 28. Laws 2009, chapter 79, article 5, section 75, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance coverage.** The commissioner of human services shall establish a demonstration project to provide additional medical assistance coverage for a maximum of 200 American Indian children in Minneapolis, St. Paul, and Duluth who are burdened by health disparities associated with the cumulative health impact of toxic environmental exposures. Under this demonstration project, the additional medical assistance coverage for this population must include, but is not limited to, home environmental assessments for triggers of asthma, and in-home asthma education on the proper medical management of asthma by a certified asthma educator or public health nurse with asthma management training, and is limited to two visits per child. The first home visit payment rate must be based on a rate commensurate with a first-time visit rate and follow-up visit rate. Coverage also includes the following durable medical equipment: high efficiency particulate air (HEPA) cleaners, HEPA vacuum cleaners, allergy bed and pillow encasements, high filtration filters for forced air gas furnaces, and dehumidifiers with medical tubing to connect the appliance to a floor drain, if the listed item is ~~medically necessary~~ useful to reduce asthma symptoms. Provision of these items of durable medical equipment must be preceded by a home environmental assessment for triggers of asthma and in-home asthma education on the proper medical management of asthma by a Certified Asthma Educator or public health nurse with asthma management training.

Sec. 29. Laws 2009, chapter 79, article 5, section 78, subdivision 5, is amended to read:

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

Sec. 30. Laws 2009, chapter 79, article 13, section 3, subdivision 6, is amended to read:

Subd. 6. **Basic Health Care Grants**

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

(a) MinnesotaCare Grants	391,915,000	485,448,000

This appropriation is from the health care access fund.

(b) MA Basic Health Care Grants - Families and Children	751,988,000	973,088,000

Medical Education Research Costs (MERC). Of these funds, the commissioner of human services shall transfer $38,000,000 in fiscal year 2010 to the medical education research fund. These funds must restore the fiscal year 2009 unallotment of the transfers under Minnesota Statutes, section 256B.69, subdivision 5c, paragraph (a), for the July 1, 2008, through June 30, 2009, period.

Newborn Screening Fee. Of the general fund appropriation, $34,000 in fiscal year 2011 is to the commissioner for the hospital reimbursement increase described under Minnesota Statutes, section 256.969, subdivision 28.

Local Share Payment Modification Required for ARRA Compliance. Effective from July 1, 2009, to December 31, 2010, Hennepin County's monthly contribution to the nonfederal share of medical assistance costs must be reduced to the percentage required on September 1, 2008, to meet federal requirements for enhanced federal match under the American Reinvestment and Recovery Act (ARRA) of 2009. Notwithstanding the requirements of Minnesota Statutes, section 256B.19, subdivision 1c, paragraph (d), for the period beginning July 1, 2009, to December 31, 2010, Hennepin County's monthly payment under that provision is reduced to $434,688.

Capitation Payments. Effective from July 1, 2009, to December 31, 2010, notwithstanding the provisions of Minnesota Statutes 2008, section 256B.19, subdivision 1c, paragraph (c), the commissioner shall increase capitation payments made to the Metropolitan Health Plan under Minnesota Statutes 2008, section 256B.69, by $6,800,000 to recognize higher than average medical education costs. The increased amount includes federal matching funds.

Use of Savings. Any savings derived from implementation of the prohibition in Minnesota Statutes, section 256B.032, on the enrollment of low-quality, high-cost health care providers as vendors of state health care program services shall be used to offset on a pro rata basis the reimbursement reductions for basic care services in Minnesota Statutes, section 256B.766.

(c) MA Basic Health Care Grants - Elderly and Disabled	970,183,000	1,142,310,000

Minnesota Disability Health Options. Notwithstanding Minnesota Statutes, section 256B.69, subdivision 5a, paragraph (b), for the period beginning July 1, 2009, to June 30, 2011, the monthly enrollment of persons receiving home and community-based waivered services under Minnesota Disability Health Options shall not exceed 1,000. If the budget neutrality provision in Minnesota Statutes, section 256B.69, subdivision 23, paragraph (f), is reached prior to June 30, 2013, the commissioner may waive this monthly enrollment requirement.

Hospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for Minnesota health care program enrollees must be delayed as follows: for fiscal year 2011, payments in the month of June equal to $15,937,000 must be included in the first payment of fiscal year 2012 and for fiscal year

2013, payments in the month of June equal to $6,666,000 must be included in the first payment of fiscal year 2014. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires December 31, 2014.

Nonhospital Fee-for-Service Payment Delay. Payments from the Medicaid Management Information System that would otherwise have been made for nonhospital acute care services for Minnesota health care program enrollees must be delayed as follows: payments in the month of June equal to $23,438,000 for fiscal year 2011 must be included in the first payment for fiscal year 2012, and payments in the month of June equal to $27,156,000 for fiscal year 2013 must be included in the first payment for fiscal year 2014. This payment delay must not include nursing facilities, intermediate care facilities for persons with developmental disabilities, home and community-based services, prepaid health plans, personal care provider organizations, and home health agencies. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires December 31, 2014.

(d) General Assistance Medical Care Grants 345,223,000 *381,081,000*

*** (The preceding text "381,081,000" was indicated as vetoed by the governor. It was reconsidered and not approved by the legislature, May 17, 2009.)**

(e) Other Health Care Grants

	Appropriations by Fund	
General	295,000	295,000
Health Care Access	23,533,000	~~7,080,000~~ 5,252,000

Base Adjustment. The health care access fund base is reduced to $190,000 in each of

fiscal years 2012 and 2013.

Sec. 31. **PREPAID HEALTH PLAN RATES.**

In negotiating the prepaid health plan contract rates for services rendered on or after January 1, 2011, the commissioner of human services shall take into consideration and the rates shall reflect the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

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

Sec. 32. **SPECIAL TRANSPORTATION SERVICES.**

The commissioner of human services shall ensure that effective October 1, 2010, to avoid conflicts of interest, all contracts for level of need assessments under Minnesota Statutes, section 256B.04, subdivision 14a, require that the contractor have no financial interest in the provision of medical transportation services other than performing level of need assessments.

Sec. 33. **STATE PLAN AMENDMENT; FEDERAL APPROVAL.**

(a) The commissioner of human services shall submit a Medicaid state plan amendment to receive federal fund participation for adults without children whose income is equal to or less than 75 percent of federal poverty guidelines in accordance with the Patient Protection and Affordable Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The effective date of the state plan amendment shall be June 1, 2010.

(b) The commissioner of human services shall submit an amendment to the MinnesotaCare health care reform waiver to include in the waiver single adults and households without children.

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

Sec. 34. **UPPER PAYMENT LIMIT REPORT.**

Each January 15, beginning in 2011, the commissioner of human services shall report the following information to the chairs of the house of representatives and senate finance committees and divisions with responsibility for human services appropriations:

(1) the estimated room within the Medicare hospital upper payment limit for the federal year beginning on October 1 of the year the report is made;

(2) the amount of a rate increase under Minnesota Statutes, section 256.969, subdivision 3a, paragraph (i), that would increase medical assistance hospital spending to the upper payment limit; and

(3) the amount of a surcharge increase under Minnesota Statutes, section 256.9657, subdivision 2, needed to generate the state share of the potential rate increase under clause (2).

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

Sec. 35. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall edit Minnesota Statutes and Minnesota Rules to remove references to the general assistance medical care program and references to Minnesota Statutes, section 256D.03, subdivision 3, or Minnesota Statutes, chapter 256D, as it pertains to general assistance medical care and make other changes as may be necessary to remove references to the general assistance medical care program. The revisor may consult with the Department of Human Services when making editing decisions on the removal of these references.

Sec. 36. **REPEALER.**

(a) Minnesota Statutes 2008, section 256D.03, subdivisions 3, 3a, 5, 6, 7, and 8, are repealed June 1, 2010.

(b) Laws 2010, chapter 200, article 1, sections 12; 18; and 19, are repealed June 1, 2010.

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

ARTICLE 2

CONTINUING CARE

Section 1. Minnesota Statutes 2008, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; ~~and~~

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

Sec. 2. Minnesota Statutes 2008, section 144D.03, is amended by adding a subdivision to read:

Subd. 3. **Certificate of transitional consultation.** A housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line that transition to housing with services consultation under section 256B.0911, subdivision 3c, has been completed. The housing with services establishment shall maintain copies of contracts and certificates for audit for a period of three years.

Sec. 3. Minnesota Statutes 2008, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 4. **[144D.08] UNIFORM CONSUMER INFORMATION GUIDE.**

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06.

Sec. 5. **[144D.09] TERMINATION OF LEASE.**

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including the address and phone number along with a statement of how to request problem-solving assistance.

Sec. 6. Minnesota Statutes 2008, section 144G.06, is amended to read:

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in section 144G.01, that includes information about services offered by that provider, which services may be covered by Medicare, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 7. Minnesota Statutes 2008, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is ~~reduced~~ changed, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that the number of beds ~~have been delicensed~~ has been changed. The nursing home must notify the commissioner of health in writing when the number of beds ~~are delicensed~~ is changed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the ~~15th~~ third of the month, the invoice for the second following month must be ~~reduced~~ changed to recognize the ~~delicensing~~ change in the number of beds. ~~Beds on layaway status continue to be subject to the surcharge.~~ The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) Effective July 15, 2010, the surcharge under paragraph (d) shall be increased to $3,400.

(f) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph ~~(d)~~ (e) based on the commissioner's determination of a permissible surcharge.

~~(f)~~ (g) Between A~~pril 1, 2002, and August 15, 2004~~ July 1, 2010, and June 30, 2011, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431, subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

Sec. 8. Minnesota Statutes 2008, section 256.9657, subdivision 3a, is amended to read:

Subd. 3a. **ICF/MR license surcharge.** (a) Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health

must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

(b) Effective July 1, 2010, the surcharge under paragraph (a) is increased to $4,037 per licensed bed.

Sec. 9. Minnesota Statutes 2009 Supplement, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must provide long-term care options counseling by assisting older adults, caregivers, and providers in accessing information and options counseling about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options;

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health;

(9) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall

provide information ~~to the commissioner of human services that is consistent with information required by the commissioner of health under section 144G.06, the Uniform Consumer Information Guide~~ that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs; and

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability.

Sec. 10. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to ~~310~~ 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting.

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

Sec. 11. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments ~~offering or providing assisted living under chapter 144G~~ shall inform all prospective residents of the ~~availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident~~ requirement to contact the Senior LinkAge Line for long-term care options counseling and transitional consultation. The Senior LinkAge Line shall provide a certificate to the prospective resident and also send a copy of the certificate to the housing with services establishment that the prospective resident chooses, verifying that consultation has been provided. The housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line. The housing with services establishment shall maintain copies of contracts and certificates for audit for a period of three years. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units~~, and the Area Agencies on Aging~~ under section 144D.03, subdivision 3, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; ~~and~~

(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals who are at highest risk of nursing facility placement or as needed for determining eligibility; and

(4) a prospective resident does not include a person moving from the community to housing with services during nonworking hours when:

(i) the move is based on a recent precipitating event that precludes the person from living safely in the community, such as sustaining an injury or the caregiver's inability to provide needed care; and

(ii) the Senior LinkAge Line is contacted on the first working day following the nonworking day move to the registered housing with services.

Sec. 12. Minnesota Statutes 2008, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3i. **Rate reduction for customized living and 24-hour customized living services.** (a) Effective July 1, 2010, the commissioner shall reduce service component rates and service rate limits for customized living services and 24-hour customized living services, from the rates in effect on June 30, 2010, by five percent.

(b) To implement the rate reductions in this subdivision, capitation rates paid by the commissioner to managed care organizations under section 256B.69 shall reflect a ten percent reduction for the specified services for the period January 1, 2011, to June 30, 2011, and a five percent reduction for those services on and after July 1, 2011.

Sec. 13. Minnesota Statutes 2008, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to ~~$8.86~~ $10.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to ~~$8.86~~ $10.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under sections 256B.436 and 256B.437, subdivision 6. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

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

Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55, is amended to read:

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. ~~For the rate year beginning October 1, 2009, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434. For rate years beginning October 1, 2010; October 1, 2011; and October 1, 2012,~~ For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment

of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

EFFECTIVE DATE. This section is effective retroactive to October 1, 2009.

Sec. 15. Minnesota Statutes 2008, section 256B.49, is amended by adding a subdivision to read:

Subd. 23. **Living arrangements.** The commissioner shall not place a limit, without express legislative approval, on the number of adult recipients of home and community-based waivered services receiving assisted living plus services or customized living services who may reside in one building, regardless of adult recipient age. Limits in effect on May 1, 2001, on the number of recipients who may reside in one living unit shall remain in effect, regardless of the number of units in a building. The commissioner shall not deny medical assistance enrollment based on building capacity to an otherwise-qualified provider of waivered services.

Sec. 16. Minnesota Statutes 2008, section 256B.5012, is amended by adding a subdivision to read:

Subd. 9. **Rate increase effective June 1, 2010.** For rate periods beginning on or after June 1, 2010, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $8.74 per day. The increase shall not be subject to any annual percentage increase.

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

Sec. 17. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for

ICF/MR services, waivered services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until four years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

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

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

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO

programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods ~~for contract years starting in 2012,~~ the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract ~~years~~ year 2010 ~~and 2011~~ for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective December 31, 2010, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans ~~for further expansion of~~ to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance ~~by February 1, 2007~~ prior to implementation.

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

Sec. 18. **REVISOR'S INSTRUCTION.**

The revisor shall edit Minnesota Statutes, section 256B.0917, subdivision 14, to be effective July 1, 2011.

ARTICLE 3

CHILDREN AND FAMILY SERVICES; DEPARTMENT OF HUMAN SERVICES LICENSING

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

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

(b) The fair hearing is the only administrative appeal of the final agency determination for purposes of appeal by the disqualified individual. The disqualified individual does not have the

right to challenge the accuracy and completeness of data under section 13.04.

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

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

(e) Notwithstanding paragraph (c), if the commissioner does not ~~set aside~~ rescind a disqualification of an individual who was disqualified based on both a preponderance of evidence and a conviction or admission, the individual may request a fair hearing under section 256.045, unless the disqualifications are deemed conclusive under section 245C.29. The scope of the hearing conducted under section 256.045 with regard to the disqualification based on a conviction or admission shall be limited solely to whether the individual poses a risk of harm, according to section 256.045, subdivision 3b. In this case, the reconsideration decision under section 245C.22 is not the final agency decision for purposes of appeal by the disqualified individual.

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

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

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

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

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

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

(b) If the commissioner does not ~~set aside~~ rescind a disqualification that is based on a maltreatment determination, the scope of the contested case hearing must include the maltreatment

determination and the disqualification. In such cases, a fair hearing must not be conducted under section 256.045.

(c) If the commissioner does not rescind a disqualification that is based on a preponderance of evidence that the individual committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, the scope of the contested case hearing must include the disqualification decision. In such cases, a fair hearing must not be conducted under section 256.045.

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

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

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

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

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

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

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

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

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

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

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a

Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, which has not been ~~set aside~~ rescinded under sections 245C.22 and 245C.23, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit; or

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

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

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care

payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256D.0515, is amended to read:

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

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

~~(1)~~ their gross income ~~meets the federal Food Stamp requirements under United States Code, title 7, section 2014(c); and~~

~~(2) they have financial resources, excluding vehicles, of less than $7,000~~ is equal to or less than 165 percent of the federal poverty guidelines for the same family size.

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

Sec. 6. Minnesota Statutes 2008, section 256J.24, subdivision 6, is amended to read:

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident

has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth; ~~or~~

(5) the child is the mother's first child subsequent to a pregnancy that did not result in a live birth; or

(6) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

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

Sec. 7. Minnesota Statutes 2009 Supplement, section 256J.425, subdivision 3, is amended to read:

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

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

(2) a person who:

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

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

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

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

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

(b) For purposes of this ~~section~~ chapter, "severely limits the person's ability to obtain or maintain suitable employment" means: (1) that a qualified professional has determined that the person's condition prevents the person from working 20 or more hours per week; or (2) for a person who meets the requirements of paragraph (a), clause (2), item (ii), or paragraph (a), clause (3), of this subdivision, a qualified professional has determined: (i) the person's condition significantly restricts the range of employment that the person is able to perform; or (ii) significantly interferes with the person's ability to obtain or maintain employment for 20 or more hours per week.

Sec. 8. Minnesota Statutes 2008, section 626.556, subdivision 10i, is amended to read:

Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative reconsideration is not applicable in family assessments since no determination concerning maltreatment is made. For investigations, except as provided under paragraph (e), an individual or facility that the commissioner of human services, a local social service agency, or the commissioner of education determines has maltreated a child, an interested person acting on behalf of the child, regardless of the determination, who contests the investigating agency's final determination regarding maltreatment, may request the investigating agency to reconsider its final determination regarding maltreatment. The request for reconsideration must be submitted in writing to the investigating agency within 15 calendar days after receipt of notice of the final determination regarding maltreatment or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the parent or guardian of the child. If mailed, the request for reconsideration must be postmarked and sent to the investigating agency within 15 calendar days of the individual's or facility's receipt of the final determination. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 15 calendar days after the individual's or facility's receipt of the final determination. Effective January 1, 2002, an individual who was determined to have maltreated a child under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must be submitted within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment

determination and the disqualification must be postmarked and sent to the investigating agency within 30 calendar days of the individual's receipt of the maltreatment determination and notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the investigating agency within 30 calendar days after the individual's receipt of the notice of disqualification.

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

(c) If, as a result of a reconsideration or review, the investigating agency changes the final determination of maltreatment, that agency shall notify the parties specified in subdivisions 10b, 10d, and 10f.

(d) Except as provided under paragraph (f), if an individual or facility contests the investigating agency's final determination regarding maltreatment by requesting a fair hearing under section 256.045, the commissioner of human services shall assure that the hearing is conducted and a decision is reached within 90 days of receipt of the request for a hearing. The time for action on the decision may be extended for as many days as the hearing is postponed or the record is held open for the benefit of either party.

(e) ~~Effective January 1, 2002,~~ If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and requested reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or the disqualification is not ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

(f) ~~Effective January 1, 2002,~~ If a maltreatment determination or a disqualification based on serious or recurring maltreatment is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, the license holder has the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and licensing sanction or denial of a license. In such

cases, a fair hearing regarding the maltreatment determination and disqualification shall not be conducted under section 256.045. Except for family child care and child foster care, reconsideration of a maltreatment determination as provided under this subdivision, and reconsideration of a disqualification as provided under section 245C.22, shall also not be conducted when:

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

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

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

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

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

(g) For purposes of this subdivision, "interested person acting on behalf of the child" means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been determined to be the perpetrator of the maltreatment.

Sec. 9. Minnesota Statutes 2008, section 626.557, subdivision 9d, is amended to read:

Subd. 9d. **Administrative reconsideration; review panel.** (a) Except as provided under paragraph (e), any individual or facility which a lead agency determines has maltreated a vulnerable adult, or the vulnerable adult or an interested person acting on behalf of the vulnerable adult, regardless of the lead agency's determination, who contests the lead agency's final disposition of an allegation of maltreatment, may request the lead agency to reconsider its final disposition. The request for reconsideration must be submitted in writing to the lead agency within 15 calendar days after receipt of notice of final disposition or, if the request is made by an interested person who is not entitled to notice, within 15 days after receipt of the notice by the vulnerable adult or the vulnerable adult's legal guardian. If mailed, the request for reconsideration must be postmarked and sent to the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. If the request for reconsideration is made by personal service, it must be received by the lead agency within 15 calendar days of the individual's or facility's receipt of the final disposition. An individual who was determined to have maltreated a vulnerable adult under this section and who was disqualified on the basis of serious or recurring maltreatment under sections 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and the disqualification. The request for reconsideration of the maltreatment determination and the disqualification must

be submitted in writing within 30 calendar days of the individual's receipt of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request for reconsideration of the maltreatment determination and the disqualification must be postmarked and sent to the lead agency within 30 calendar days of the individual's receipt of the notice of disqualification. If the request for reconsideration is made by personal service, it must be received by the lead agency within 30 calendar days after the individual's receipt of the notice of disqualification.

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

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

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

(e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis of a determination of maltreatment, which was serious or recurring, and the individual has requested reconsideration of the maltreatment determination under paragraph (a) and reconsideration of the disqualification under sections 245C.21 to 245C.27, reconsideration of the maltreatment determination and requested reconsideration of the disqualification shall be consolidated into a single reconsideration. If reconsideration of the maltreatment determination is denied or if the disqualification is not ~~set aside~~ rescinded under sections 245C.21 to 245C.27, the individual may request a fair hearing under section 256.045. If an individual requests a fair hearing on the maltreatment determination and the disqualification, the scope of the fair hearing shall include both the maltreatment determination and the disqualification.

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

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

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

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

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

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

(g) Until August 1, 2002, an individual or facility that was determined by the commissioner of human services or the commissioner of health to be responsible for neglect under section 626.5572, subdivision 17, after October 1, 1995, and before August 1, 2001, that believes that the finding of neglect does not meet an amended definition of neglect may request a reconsideration of the determination of neglect. The commissioner of human services or the commissioner of health shall mail a notice to the last known address of individuals who are eligible to seek this reconsideration. The request for reconsideration must state how the established findings no longer meet the elements of the definition of neglect. The commissioner shall review the request for reconsideration and make a determination within 15 calendar days. The commissioner's decision on this reconsideration is the final agency action.

(1) For purposes of compliance with the data destruction schedule under subdivision 12b, paragraph (d), when a finding of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, the date of the original finding of a substantiated maltreatment must be used to calculate the destruction date.

(2) For purposes of any background studies under chapter 245C, when a determination of substantiated maltreatment has been changed as a result of a reconsideration under this paragraph, any prior disqualification of the individual under chapter 245C that was based on this determination of maltreatment shall be rescinded, and for future background studies under chapter 245C the commissioner must not use the previous determination of substantiated maltreatment as a basis for disqualification or as a basis for referring the individual's maltreatment history to a health-related licensing board under section 245C.31.

ARTICLE 4

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2008, section 62D.08, is amended by adding a subdivision to read:

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information using the reporting template provided by the commissioner of health.

EFFECTIVE DATE. This section is effective January 1, 2013.

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

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

Subd. 2. **Membership.** (a) The advisory group shall be chaired by the commissioner of health and shall consist of ten members as follows:

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

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

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

(4) three members appointed by the commissioner of health to represent health maintenance organizations and county-based purchasing plans;

(5) three members appointed by the commissioner of health to represent:

(i) hospitals;

(ii) physicians; and

(iii) other health care providers; and

(6) one member appointed by the commissioner of health to represent consumers.

(b) The appointments required under this subdivision shall be completed by November 1, 2010.

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

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

February 15, 2012.

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

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

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

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

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

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

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

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

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

(3) $1,800,000 to the Academic Health Center. $150,000 of the funds distributed to the Academic Health Center under this paragraph shall be used for a program to assist foreign-trained physicians to successfully compete for family medicine residency programs at the University of Minnesota.

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

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited

through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

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

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

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

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

Sec. 4. Minnesota Statutes 2008, section 144.226, subdivision 3, is amended to read:

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

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The local or state registrar shall forward this amount to the commissioner of management and budget for deposit in the general fund. This surcharge shall not be charged under those circumstances in which no fee for a certified birth record is permitted under subdivision 1, paragraph (a).

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

Sec. 5. Minnesota Statutes 2008, section 144E.37, is amended to read:

144E.37 COMPREHENSIVE ADVANCED LIFE SUPPORT.

The ~~board~~ commissioner of health shall establish a comprehensive advanced life-support educational program to train rural medical personnel, including physicians, physician assistants, nurses, and allied health care providers, in a team approach to anticipate, recognize, and treat life-threatening emergencies before serious injury or cardiac arrest occurs.

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

Sec. 6. Minnesota Statutes 2009 Supplement, section 157.16, subdivision 3, is amended to read:

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

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

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

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

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

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

(ii) frozen pizza that is heated and served;

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

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

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

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

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

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

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

(iv) is a boarding establishment; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Area	**Type**	**Fee**
Food	limited food menu	$250
	small establishment	$300
	medium establishment	$350
	large food establishment	$400
	additional food service	$150
Transient food service	food cart	$250
	seasonal permanent food stand	$250

	seasonal temporary food stand	$250
	mobile food unit	$250
Alcohol	beer or wine table service	$150
	alcohol service from bar	$250
Lodging	less than 25 rooms	$250
	25 to less than 100 rooms	$300
	100 rooms or more	$450
	less than five cabins	$250
	five to less than ten cabins	$350
	ten cabins or more	$400

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

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

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

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

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

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

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

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

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

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

(2) a recreational camping area with:

(i) 24 or less sites, $50;

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

(iii) 100 or more sites, $300.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 8. **HEALTH PLAN AND COUNTY ADMINISTRATIVE COST REDUCTION; REPORTING REQUIREMENTS.**

(a) Minnesota health plans and county-based purchasing plans may complete an inventory of existing data collection and reporting requirements for health plans and county-based purchasing plans and submit to the commissioners of health and human services a list of data, documentation, and reports that:

(1) are collected from the same health plan or county-based purchasing plan more than once;

(2) are collected directly from the health plan or county-based purchasing plan but are available to the state agencies from other sources;

(3) are not currently being used by state agencies; or

(4) collect similar information more than once in different formats, at different times, or by more than one state agency.

(b) The report to the commissioners may also identify the percentage of health plan and

county-based purchasing plan administrative time and expense attributed to fulfilling reporting requirements, and include recommendations regarding ways to reduce duplicative reporting requirements.

(c) Upon receipt, the commissioners shall submit the inventory and recommendations to the chairs of the appropriate legislative committees, along with their comments and recommendations as to whether any action should be taken by the legislature to establish a consolidated and streamlined reporting system under which data, reports, and documentation are collected only once, and only when needed for the state agencies to fulfill their duties under law and applicable regulations.

Sec. 9. **TRANSFER.**

The powers and duties of the Emergency Medical Services Regulatory Board with respect to the comprehensive advanced life-support educational program under Minnesota Statutes, section 144E.37, are transferred to the commissioner of health under Minnesota Statutes, section 15.039.

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

Sec. 10. **REVISOR'S INSTRUCTION.**

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

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

ARTICLE 5

GENERAL ASSISTANCE MEDICAL CARE AMENDMENTS

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

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

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

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

(1) the provider accepts new medical assistance, general assistance medical care, and

MinnesotaCare patients;

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

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

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

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

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

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

Sec. 2. Minnesota Statutes 2008, section 256B.69, subdivision 27, is amended to read:

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

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

Sec. 3. Minnesota Statutes 2008, section 256B.692, subdivision 1, is amended to read:

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

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

Sec. 4. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, as amended by Laws 2010, chapter 200, article 1, section 11, is amended to read:

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2008, section 256L.12, subdivision 5, is amended to read:

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance ~~or general assistance medical care~~ will remain in the same managed care plan if the managed care plan has a contract for that population. ~~Effective January 1, 1998,~~ MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare ~~and general assistance medical care~~

~~programs~~ program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

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

Sec. 6. Laws 2010, chapter 200, article 1, section 12, the effective date, is amended to read:

EFFECTIVE DATE. This section, except for subdivision 4, is effective for services rendered on or after April 1, 2010. Subdivision 4 of this section is effective June 1, 2010.

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

Sec. 7. Laws 2010, chapter 200, article 1, section 12, subdivision 7, is amended to read:

Subd. 7. **Payments; rate setting for the hospital coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date~~. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and University of Minnesota Medical Center, Fairview, shall be weighted at 110 percent of the actual amount.~~ as follows:

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

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

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

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

The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

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

this paragraph at a rate negotiated between the hospital and the nonhospital provider.

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

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

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

Sec. 8. Laws 2010, chapter 200, article 1, section 16, is amended by adding an effective date to read:

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

Sec. 9. Laws 2010, chapter 200, article 1, section 21, is amended to read:

Sec. 21. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; and 256D.03, subdivision 9, are repealed effective April 1, 2010.

(b) Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is repealed effective ~~April~~ June 1, 2010.

(c) Minnesota Statutes 2008, section 256B.195, subdivisions 4 and 5, are repealed effective for federal fiscal year 2010.

(d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and 3, are repealed effective for federal fiscal year 2010.

(e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision 4; and 256L.17, subdivision 7, are repealed ~~January 1, 2011~~ June 1, 2010.

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

Sec. 10. Laws 2010, chapter 200, article 2, section 2, subdivision 1, is amended to read:

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

Appropriations by Fund	2010	2011
General	34,807,000	118,493,000
Health Care Access	(42,792,000)	(211,621,000)

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

Special Revenue Fund Transfers.

(a) The commissioner shall transfer the

following amounts from special revenue fund balances to the general fund by June 30 of each respective fiscal year: $410,000 for fiscal year 2010, and $412,000 for fiscal year 2011.

(b) Actual transfers made under paragraph (a) must be separately identified and reported as part of the quarterly reporting of transfers to the chairs of the relevant senate budget division and house finance division.

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

Sec. 11. Laws 2010, chapter 200, article 2, section 2, subdivision 5, is amended to read:

Subd. 5. **Health Care Management**

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

Health Care Administration.	(2,998,000)	(5,270,000)

Base Adjustment. The general fund base for health care administration is reduced by ~~$182,000~~ $36,000 in fiscal year 2012 and ~~$182,000~~ $36,000 in fiscal year 2013.

Sec. 12. Laws 2010, chapter 200, article 2, section 2, subdivision 8, is amended to read:

Subd. 8. **Transfers**

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

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

Compulsive Gambling ~~Special Revenue~~ Administration. The lottery prize fund appropriation for compulsive gambling administration is reduced by $6,000 for fiscal year 2010 and $4,000 for fiscal year 2011 ~~must be transferred from the lottery prize fund appropriation for compulsive gambling administration to the general fund by June~~

~~30 of each respective fiscal year~~. These are onetime reductions.

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

ARTICLE 6

MISCELLANEOUS

Section 1. **[62Q.545] COVERAGE OF PRIVATE DUTY NURSING SERVICES.**

(a) Private duty nursing services, as provided under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4, shall be covered under a health plan for persons who are concurrently covered by both the health plan and enrolled in medical assistance under chapter 256B.

(b) For purposes of this section, a period of private duty nursing services may be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing requirements that apply under the health plan. Cost-sharing requirements for private duty nursing services must not place a greater financial burden on the insured or enrollee than those requirements applied by the health plan to other similar services or benefits. Nothing in this section is intended to prevent a health plan company from requiring prior authorization by the health plan company for such services as required by section 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions of the health plan.

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

Sec. 2. **[137.32] MINNESOTA COUPLES ON THE BRINK PROJECT.**

Subdivision 1. **Establishment.** Within the limits of available appropriations, the Board of Regents of the University of Minnesota is requested to develop and implement a Minnesota couples on the brink project, as provided for in this section. The regents may administer the project with federal grants, state appropriations, and in-kind services received for this purpose.

Subd. 2. **Purpose.** The purpose of the project is to develop, evaluate, and disseminate best practices for promoting successful reconciliation between married persons who are considering or have commenced a marriage dissolution proceeding and who choose to pursue reconciliation.

Subd. 3. **Implementation.** The regents shall:

(1) enter into contracts or manage a grant process for implementation of the project; and

(2) develop and implement an evaluation component for the project.

Sec. 3. Minnesota Statutes 2009 Supplement, section 150A.106, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) In order to be certified by the board to practice as an advanced dental therapist, a person must:

(1) complete a dental therapy education program;

(2) pass an examination to demonstrate competency under the dental therapy scope of practice;

(3) be licensed as a dental therapist;

(4) complete 2,000 hours of dental therapy clinical practice under direct or indirect supervision;

(5) graduate from a master's advanced dental therapy education program;

(6) pass a board-approved certification examination to demonstrate competency under the advanced scope of practice; and

(7) submit an application for certification as prescribed by the board.

(b) A dental therapy educational program may offer a combined dental therapy and advanced dental therapy program if the combined program was in existence on April 1, 2010. The combined program is exempt from board approval if the requirement of section 150A.06, subdivision 1d, paragraph (b) is met. A graduate of a combined program satisfies the requirements of paragraph (a), clauses (1) and (5), if the degree upon graduation is a master's degree and the board shall issue a dental therapy license and an advanced practice certification to a graduate of a combined program if the other licensure and certification requirements are satisfied. As part of the combined program, the clinical practice requirements in paragraph (a), clause (4), may be commenced before a dental therapy license is granted.

Sec. 4. Minnesota Statutes 2009 Supplement, section 150A.06, subdivision 1d, is amended to read:

Subd. 1d. **Dental therapists.** (a) A person of good moral character who has graduated with a baccalaureate degree or a master's degree from a dental therapy education program that has been approved by the board or accredited by the American Dental Association Commission on Dental Accreditation or another board-approved national accreditation organization may apply for licensure.

(b) Notwithstanding paragraph (a), a dental therapy education program in existence on April 1, 2010, is exempt from the requirement of board approval and applicants who have graduated from the program shall be licensed if the requirements of paragraph (c) are satisfied. Programs identified in this paragraph must become accredited within two years after the establishment of a recognized national accreditation program for dental therapists.

(c) The applicant must submit an application and fee as prescribed by the board and a diploma or certificate from a dental therapy education program. Prior to being licensed, the applicant must pass a comprehensive, competency-based clinical examination that is approved by the board and administered independently of an institution providing dental therapy education. The applicant must also pass an examination testing the applicant's knowledge of the Minnesota laws and rules relating to the practice of dentistry. An applicant who has failed the clinical examination twice is ineligible to retake the clinical examination until further education and training are obtained as specified by the board. A separate, nonrefundable fee may be charged for each time a person applies. An applicant who passes the examination in compliance with subdivision 2b, abides by professional ethical conduct requirements, and meets all the other requirements of the board shall be licensed as a dental therapist.

Sec. 5. Minnesota Statutes 2008, section 152.126, as amended by Laws 2009, chapter 79, article

11, sections 9, 10, and 11, is amended to read:

152.126 ~~SCHEDULE II AND III~~ CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC REPORTING SYSTEM.

Subdivision 1. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) "Board" means the Minnesota State Board of Pharmacy established under chapter 151.

(b) "Controlled substances" means those substances listed in section 152.02, subdivisions 3 to 5, and those substances defined by the board pursuant to section 152.02, subdivisions 7, 8, and 12.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does not include a licensed hospital pharmacy that distributes controlled substances for inpatient hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

(e) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or interfere with the legitimate prescribing of controlled substances for pain. No prescriber shall be subject to disciplinary action by a health-related licensing board for prescribing a controlled substance according to the provisions of section 152.125.

Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish by January 1, 2010, an electronic system for reporting the information required under subdivision 4 for all controlled substances dispensed within the state.

(b) The board may contract with a vendor for the purpose of obtaining technical assistance in the design, implementation, operation, and maintenance of the electronic reporting system.

Subd. 3. **Prescription Electronic Reporting Advisory Committee.** (a) The board shall convene an advisory committee. The committee must include at least one representative of:

(1) the Department of Health;

(2) the Department of Human Services;

(3) each health-related licensing board that licenses prescribers;

(4) a professional medical association, which may include an association of pain management and chemical dependency specialists;

(5) a professional pharmacy association;

(6) a professional nursing association;

(7) a professional dental association;

(8) a consumer privacy or security advocate; and

(9) a consumer or patient rights organization.

(b) The advisory committee shall advise the board on the development and operation of the electronic reporting system, including, but not limited to:

(1) technical standards for electronic prescription drug reporting;

(2) proper analysis and interpretation of prescription monitoring data; and

(3) an evaluation process for the program.

~~(c) The Board of Pharmacy, after consultation with the advisory committee, shall present recommendations and draft legislation on the issues addressed by the advisory committee under paragraph (b), to the legislature by December 15, 2007.~~

Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the following data to the board or its designated vendor, subject to the notice required under paragraph (d):

(1) name of the prescriber;

(2) national provider identifier of the prescriber;

(3) name of the dispenser;

(4) national provider identifier of the dispenser;

(5) prescription number;

(6) name of the patient for whom the prescription was written;

(7) address of the patient for whom the prescription was written;

(8) date of birth of the patient for whom the prescription was written;

(9) date the prescription was written;

(10) date the prescription was filled;

(11) name and strength of the controlled substance;

(12) quantity of controlled substance prescribed;

(13) quantity of controlled substance dispensed; and

(14) number of days supply.

(b) The dispenser must submit the required information by a procedure and in a format established by the board. The board may allow dispensers to omit data listed in this subdivision or may require the submission of data not listed in this subdivision provided the omission or submission is necessary for the purpose of complying with the electronic reporting or data transmission standards of the American Society for Automation in Pharmacy, the National Council

on Prescription Drug Programs, or other relevant national standard-setting body.

(c) A dispenser is not required to submit this data for those controlled substance prescriptions dispensed for:

(1) individuals residing in licensed skilled nursing or intermediate care facilities;

(2) individuals receiving assisted living services under chapter 144G or through a medical assistance home and community-based waiver;

(3) individuals receiving medication intravenously;

(4) individuals receiving hospice and other palliative or end-of-life care; and

(5) individuals receiving services from a home care provider regulated under chapter 144A.

(d) A dispenser must not submit data under this subdivision unless a conspicuous notice of the reporting requirements of this section is given to the patient for whom the prescription was written.

Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database of the data reported under subdivision 4. The board shall maintain data that could identify an individual prescriber or dispenser in encrypted form. The database may be used by permissible users identified under subdivision 6 for the identification of:

(1) individuals receiving prescriptions for controlled substances from prescribers who subsequently obtain controlled substances from dispensers in quantities or with a frequency inconsistent with generally recognized standards of use for those controlled substances, including standards accepted by national and international pain management associations; and

(2) individuals presenting forged or otherwise false or altered prescriptions for controlled substances to dispensers.

(b) No permissible user identified under subdivision 6 may access the database for the sole purpose of identifying prescribers of controlled substances for unusual or excessive prescribing patterns without a valid search warrant or court order.

(c) No personnel of a state or federal occupational licensing board or agency may access the database for the purpose of obtaining information to be used to initiate or substantiate a disciplinary action against a prescriber.

(d) Data reported under subdivision 4 shall be retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from ~~the date~~ the last day of the month during which the data was received.

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is prescribing or considering prescribing any controlled substance and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(4) personnel of the board specifically assigned to conduct a bona fide investigation of a specific licensee;

(5) personnel of the board engaged in the collection of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(6) authorized personnel of a vendor under contract with the board who are engaged in the design, implementation, operation, and maintenance of the electronic reporting system as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities;

(7) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant; and

(8) personnel of the medical assistance program assigned to use the data collected under this section to identify recipients whose usage of controlled substances may warrant restriction to a single primary care physician, a single outpatient pharmacy, or a single hospital.

For purposes of clause (3), access by an individual includes persons in the definition of an individual under section 13.02.

(c) Any permissible user identified in paragraph (b), who directly accesses the data electronically, shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(d) The board shall not release data submitted under this section unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(e) The board shall not release the name of a prescriber without the written consent of the

prescriber or a valid search warrant or court order. The board shall provide a mechanism for a prescriber to submit to the board a signed consent authorizing the release of the prescriber's name when data containing the prescriber's name is requested.

(f) The board shall maintain a log of all persons who access the data and shall ensure that any permissible user complies with paragraph (c) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

Subd. 7. **Disciplinary action.** (a) A dispenser who knowingly fails to submit data to the board as required under this section is subject to disciplinary action by the appropriate health-related licensing board.

(b) A prescriber or dispenser authorized to access the data who knowingly discloses the data in violation of state or federal laws relating to the privacy of health care data shall be subject to disciplinary action by the appropriate health-related licensing board, and appropriate civil penalties.

Subd. 8. **Evaluation and reporting.** (a) The board shall evaluate the prescription electronic reporting system to determine if the system is negatively impacting appropriate prescribing practices of controlled substances. The board may contract with a vendor to design and conduct the evaluation.

(b) The board shall submit the evaluation of the system to the legislature by ~~January~~ July 15, 2011.

Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A pharmacist, prescriber, or other dispenser making a report to the program in good faith under this section is immune from any civil, criminal, or administrative liability, which might otherwise be incurred or imposed as a result of the report, or on the basis that the pharmacist or prescriber did or did not seek or obtain or use information from the program.

(b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser to obtain information about a patient from the program, and the pharmacist, prescriber, or other dispenser, if acting in good faith, is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit charitable foundations, the federal government, and other sources to fund the enhancement and ongoing operations of the prescription electronic reporting system established under this section. Any funds received shall be appropriated to the board for this purpose. The board may not expend funds to enhance the program in a way that conflicts with this section without seeking approval from the legislature.

(b) The administrative services unit for the health-related licensing boards shall apportion between the Board of Medical Practice, the Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of Optometry, and the Board of Pharmacy an amount to be paid through fees by each respective board. The amount apportioned to each board shall equal each board's share of the annual appropriation to the Board of Pharmacy from the state government special revenue fund for operating the prescription electronic reporting system under this section. Each board's apportioned share shall be based on the number of prescribers or dispensers that each

board identified in this paragraph licenses as a percentage of the total number of prescribers and dispensers licensed collectively by these boards. Each respective board may adjust the fees that the boards are required to collect to compensate for the amount apportioned to each board by the administrative services unit.

Sec. 6. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision to read:

Subd. 8. **State-operated services account.** The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

Sec. 7. Minnesota Statutes 2008, section 254B.01, subdivision 2, is amended to read:

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

Sec. 8. Minnesota Statutes 2008, section 254B.02, subdivision 1, is amended to read:

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

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

~~(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.~~

~~(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.~~

~~(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.~~

~~(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.~~

~~(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.~~

~~(g) The median married couple income for the most recent three year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.~~

~~(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.~~

~~(i) $15,000 shall be allocated to each county.~~

~~(j) The remaining funds shall be allocated proportional to the county adjusted population~~ in the special revenue account must be used according to the requirements in this chapter.

Sec. 9. Minnesota Statutes 2008, section 254B.02, subdivision 5, is amended to read:

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

Sec. 10. Minnesota Statutes 2008, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03, subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~15~~ 16.14 percent of the cost of chemical dependency services, including those services provided to persons eligible for medical assistance under chapter 256B and general assistance medical care under chapter 256D. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section. ~~Fifteen~~ 16.14 percent of any state collections from private or third-party pay, less 15 percent ~~of~~ for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section. ~~If all funds allocated according to section 254B.02 are exhausted by a county and the county has met or exceeded the base level of expenditures under section 254B.02, subdivision 3, the county shall pay the state for 15 percent of the costs paid by the state under this~~

~~section. The commissioner may refuse to pay state funds for services to persons not eligible under section 254B.04, subdivision 1, if the county financially responsible for the persons has exhausted its allocation.~~

Sec. 11. Minnesota Statutes 2008, section 254B.03, is amended by adding a subdivision to read:

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

Sec. 12. Minnesota Statutes 2008, section 254B.05, subdivision 4, is amended to read:

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

Sec. 13. Minnesota Statutes 2008, section 254B.06, subdivision 2, is amended to read:

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

Sec. 14. Minnesota Statutes 2008, section 254B.09, subdivision 8, is amended to read:

Subd. 8. **Payments to improve services to American Indians.** The commissioner may set rates for chemical dependency services to American Indians according to the American Indian Health Improvement Act, Public Law 94-437, for eligible vendors. These rates shall supersede rates set in county purchase of service agreements when payments are made on behalf of clients eligible according to Public Law 94-437.

Sec. 15. Minnesota Statutes 2009 Supplement, section 517.08, subdivision 1b, is amended to read:

Subd. 1b. **Term of license; fee; premarital education.** (a) The local registrar shall examine upon oath the parties applying for a license relative to the legality of the contemplated marriage. If one party is unable to appear in person, the party appearing may complete the absent applicant's information. The local registrar shall provide a copy of the marriage application to the party who is unable to appear, who must verify the accuracy of the party's information in a notarized statement.

The marriage license must not be released until the verification statement has been received by the local registrar. If at the expiration of a five-day period, on being satisfied that there is no legal impediment to it, including the restriction contained in section 259.13, the local registrar shall issue the license, containing the full names of the parties before and after marriage, and county and state of residence, with the county seal attached, and make a record of the date of issuance. The license shall be valid for a period of six months. Except as provided in paragraph (c), the local registrar shall collect from the applicant a fee of ~~$110~~ $115 for administering the oath, issuing, recording, and filing all papers required, and preparing and transmitting to the state registrar of vital statistics the reports of marriage required by this section. If the license should not be used within the period of six months due to illness or other extenuating circumstances, it may be surrendered to the local registrar for cancellation, and in that case a new license shall issue upon request of the parties of the original license without fee. A local registrar who knowingly issues or signs a marriage license in any manner other than as provided in this section shall pay to the parties aggrieved an amount not to exceed $1,000.

(b) In case of emergency or extraordinary circumstances, a judge of the district court of the county in which the application is made may authorize the license to be issued at any time before expiration of the five-day period required under paragraph (a). A waiver of the five-day waiting period must be in the following form:

STATE OF MINNESOTA, COUNTY OF ..... (insert county name)

APPLICATION FOR WAIVER OF MARRIAGE LICENSE WAITING PERIOD:

..... (legal names of the applicants)

Represent and state as follows:

That on ..... (date of application) the applicants applied to the local registrar of the above-named county for a license to marry.

That it is necessary that the license be issued before the expiration of five days from the date of the application by reason of the following: (insert reason for requesting waiver of waiting period)

.....

.....

.....

WHEREAS, the applicants request that the judge waive the required five-day waiting period and the local registrar be authorized and directed to issue the marriage license immediately.

Date: .....

.....

.....

(Signatures of applicants)

Acknowledged before me on this ..... day of ..... .

.....

NOTARY PUBLIC

COURT ORDER AND AUTHORIZATION:

STATE OF MINNESOTA, COUNTY OF ..... (insert county name)

After reviewing the above application, I am satisfied that an emergency or extraordinary circumstance exists that justifies the issuance of the marriage license before the expiration of five days from the date of the application. IT IS HEREBY ORDERED that the local registrar is authorized and directed to issue the license forthwith.

.....

..... (judge of district court)

..... (date).

(c) The marriage license fee for parties who have completed at least 12 hours of premarital education is $40. In order to qualify for the reduced license fee, the parties must submit at the time of applying for the marriage license a signed, dated, and notarized statement from the person who provided the premarital education on their letterhead confirming that it was received. The premarital education must be provided by a licensed or ordained minister or the minister's designee, a person authorized to solemnize marriages under section 517.18, or a person authorized to practice marriage and family therapy under section 148B.33. The education must include the use of a premarital inventory and the teaching of communication and conflict management skills.

(d) The statement from the person who provided the premarital education under paragraph (b) must be in the following form:

"I, ... (name of educator), confirm that ..... (names of both parties) received at least 12 hours of premarital education that included the use of a premarital inventory and the teaching of communication and conflict management skills. I am a licensed or ordained minister, a person authorized to solemnize marriages under Minnesota Statutes, section 517.18, or a person licensed to practice marriage and family therapy under Minnesota Statutes, section 148B.33."

The names of the parties in the educator's statement must be identical to the legal names of the parties as they appear in the marriage license application. Notwithstanding section 138.17, the educator's statement must be retained for seven years, after which time it may be destroyed.

(e) If section 259.13 applies to the request for a marriage license, the local registrar shall grant the marriage license without the requested name change. Alternatively, the local registrar may delay the granting of the marriage license until the party with the conviction:

(1) certifies under oath that 30 days have passed since service of the notice for a name change upon the prosecuting authority and, if applicable, the attorney general and no objection has been filed under section 259.13; or

(2) provides a certified copy of the court order granting it. The parties seeking the marriage license shall have the right to choose to have the license granted without the name change or to delay its granting pending further action on the name change request.

Sec. 16. Minnesota Statutes 2008, section 517.08, subdivision 1c, as amended by Laws 2010, chapter 200, article 1, section 17, is amended to read:

Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected pursuant to subdivision 1b, paragraph (a), $25 must be retained by the county. The local registrar must pay ~~$85~~ $90 to the commissioner of management and budget to be deposited as follows:

(1) $55 in the general fund;

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

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

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

(5) $5 in the special revenue fund, which is appropriated to the Board of Regents of the University of Minnesota for the Minnesota couples on the brink project under section 137.32.

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

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

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

Sec. 17. Laws 2009, chapter 79, article 3, section 18, is amended to read:

Sec. 18. **REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE ANOKA-METRO REGIONAL TREATMENT CENTER.**

In consultation with community partners, the commissioner of human services shall develop an array of community-based services in the metro area to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center. The community-based services may be ~~provided in facilities with 16 or fewer beds, and must provide the appropriate level of care for the patients being admitted to the facilities~~ established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers, and community partnerships, and must be staffed by state employees. The planning for this transition must be completed by October 1, ~~2009~~ 2010, with ~~an initial~~ a report detailing the transition plan, services that will be provided, including incorporating peer specialists where appropriate, the location of the services, and the number of patients that will be served, to the committee chairs of health and human services by November 30, ~~2009~~ 2010~~, and a semiannual report on progress until the transition is completed~~. The commissioner of human services shall ~~solicit interest from~~ make a genuine effort to engage stakeholders and potential community partners in the process. The individuals ~~working in~~ employed by the community-based services ~~facilities~~ under this section are state employees supervised by the commissioner of human services. No

layoffs shall occur as a result of restructuring under this section. Savings generated as a result of transitioning patients from the Anoka-Metro Regional Treatment Center to community-based services may be used to fund supportive housing staffed by state employees.

Sec. 18. **CASE MANAGEMENT RECOMMENDATIONS.**

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

(1) define the administrative and the service functions of case management for persons with disabilities and make changes to improve the funding for administrative functions;

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

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

In developing these recommendations, the commissioner of human services shall consider the recommendations of the 2007 Redesigning Case Management Services for Persons with Disabilities Report and consult with existing stakeholder groups, which include representatives of counties, disability and senior advocacy groups, service providers, and representatives of agencies that provide contacted case management.

This provision is effective the day following final enactment.

Sec. 19. **VETERINARY PRACTICE AND CONTROLLED SUBSTANCE ABUSE STUDY.**

The Board of Pharmacy, in consultation with the Prescription Electronic Reporting Advisory Committee and the Board of Veterinary Medical Practice, shall study the issue of the diversion of controlled substances from veterinary practice and report to the chairs and ranking minority members of the senate health and human services policy and finance division and the house of representatives health care and human services policy and finance division by December 15, 2011, on recommendations to include veterinarians in the prescription electronic reporting system in Minnesota Statutes, section 152.126.

Sec. 20. **REPEALER.**

Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, and 4; and 254B.09, subdivisions 4, 5, and 7, are repealed.

ARTICLE 7

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

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

	2010	2011	Total
General	$ 3,503,000	$ 243,587,000	$ 247,090,000
State Government Special Revenue	113,000	624,000	737,000
Health Care Access	998,000	27,534,000	28,532,000
Federal TANF	11,464,000	14,986,000	26,450,000
Special Revenue	-0-	93,000	93,000
Total	**$ 16,078,000**	**$ 286,824,000**	**$ 302,902,000**

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

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

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 18,167,000**	**$ 290,442,000**

Appropriations by Fund	2010	2011
General	5,705,000	247,961,000
Health Care Access	998,000	27,495,000
Federal TANF	11,464,000	14,986,000

The appropriations for each purpose are

shown in the following subdivisions.

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

TANF Funding for the Working Family Tax Credit. In addition to the amounts specified in Minnesota Statutes, section 290.0671, subdivision 6, $18,964,000 of TANF funds in fiscal year 2010 are appropriated to the commissioner to reimburse the general fund for the cost of the working family tax credit for eligible families. With respect to the amounts appropriated for fiscal year 2010, the commissioner shall reimburse the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

TANF Transfer to Federal Child Care and Development Fund. Of the TANF appropriation in fiscal year 2011, $12,500,000 is to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05. The commissioner shall authorize the transfer

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

Special Revenue Fund Transfers. (a) The commissioner shall transfer the following amounts from special revenue fund balances to the general fund by June 30 of each respective fiscal year: $613,000 in fiscal year 2010, and $493,000 in fiscal year 2011. This provision is effective the day following final enactment.

(b) The actual transfers made under paragraph (a) must be separately identified and reported as part of the quarterly reporting of transfers to the chairs of the relevant senate budget division and house of representatives finance division.

Supplemental Nutrition Assistance Program Enhanced Administrative Funding. The funds available for administration of the Supplemental Nutrition Assistance Program under the Department of Defense Appropriations Act of 2010, Public Law 111-118, are appropriated to the commissioner to pay the actual costs of providing for increased eligibility determinations, caseload-related costs, timely application processing, and quality control. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on recent caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion, based on a caseload factor equivalent to that of a county.

Subd. 2. **Agency Management**

(a) **Financial Operations**	-0-	103,000

Base Adjustment. The general fund base is decreased by $3,292,000 in fiscal year 2012 and $3,292,000 in fiscal year 2013.

(b) **Legal and Regulatory Operations** -0- (286,000)

Moratorium of Premium Payments. For fiscal year 2011, there shall be a moratorium on payments made by the commissioner to the Minnesota Joint Underwriting Association for personal injury liability insurance for providers under Minnesota Statutes, section 245.814. Notwithstanding Minnesota Statutes, section 62I.16, the Minnesota Joint Underwriting Association shall continue to insure the providers under Minnesota Statutes, section 245.814. In fiscal year 2011, the amount of the general fund appropriation allocated to payments under Minnesota Statutes, section 245.814, is reduced by $400,000. This is a onetime reduction in fiscal year 2011.

Base Adjustment. The general fund base is increased by $382,000 in fiscal year 2012 and $382,000 in fiscal year 2013.

(c) **Management Operations** -0- (114,000)

Base Adjustment. The general fund base is increased by $18,000 in fiscal year 2012 and $18,000 in fiscal year 2013.

Subd. 3. **Revenue and Pass-Through Revenue Expenditures** 11,464,000 20,000,000

These appropriations are from the federal TANF fund.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall carry over and expend in fiscal year 2011 $7,500,000 of the TANF funds transferred in fiscal year 2010 that reflect the child care and development fund unexpended balance for the basic sliding fee child care assistance program under Minnesota Statutes, section 119B.03. The

commissioner shall ensure that all funds are expended according to the federal child care and development fund regulations relating to the TANF transfers.

Base Adjustment. The general fund base is increased by $7,500,000 in fiscal year 2012 and $7,500,000 in fiscal year 2013.

TANF Transfer Correction. Notwithstanding any provisions of Laws 2009, chapter 79, article 13, section 3, subdivision 3, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 3, the following TANF fund amounts are appropriated to the commissioner for the purposes of MFIP and transition year child care under Minnesota Statutes, section 119B.05:

(1) fiscal year 2010, $862,000;

(2) fiscal year 2011, $978,000;

(3) fiscal year 2012, $0; and

(4) fiscal year 2013, $0.

Notwithstanding any contrary provision in this article, this paragraph expires on June 30, 2013.

Subd. 4. **Economic Support Grants**

(a) **Support Services Grants**	-0-	-0-

Base Adjustment. The federal TANF fund base is decreased by $5,004,000 in fiscal year 2012 and $5,004,000 in fiscal year 2013.

(b) **MFIP Child Care Assistance Grants**	-0-	433,000

Base Adjustment. The general fund base is increased by $94,000 in fiscal year 2012 and $24,000 in fiscal year 2013.

(c) **Basic Sliding Fee Child Care Assistance Grants**

	Appropriations by Fund	
General	-0-	(7,500,000)

Federal TANF		-0-		(5,014,000)

Base Adjustment. The general fund base is increased by $2,699,000 in fiscal year 2012 and $2,699,000 in fiscal year 2013. The federal TANF fund base is increased by $5,014,000 in fiscal year 2012 and $5,014,000 in fiscal year 2013.

(d) **Child and Community Services Grants**	-0-	(10,700,000)

This is a onetime reduction in fiscal year 2011.

(e) **Group Residential Housing Grants**	-0-	-0-

Reduction of Supplemental Service Rate. Effective July 1, 2011, to June 30, 2013, the commissioner shall decrease the group residential housing supplementary service rate under Minnesota Statutes, section 256I.05, subdivision 1a, by five percent for services rendered on or after that date, except that reimbursement rates for a group residential housing facility reimbursed as a nursing facility shall not be reduced. The reduction in this paragraph is in addition to the reduction under Laws 2009, chapter 79, article 8, section 79, paragraph (b), clause (11).

Base Adjustment. The general fund base is decreased by $700,000 in fiscal year 2012 and $700,000 in fiscal year 2013.

(f) **Children's Mental Health Grants**	(200,000)	(200,000)
(g) **Other Children's and Economic Assistance Grants**	-0-	-0-

Base Adjustment. The general fund base is increased by $130,000 in fiscal year 2012 and decreased by $360,000 in fiscal year 2013.

Subd. 5. **Children and Economic Assistance Management**

(a) **Children and Economic Assistance Administration**	-0-	-0-

Base Adjustment. The federal TANF fund base is decreased by $700,000 in fiscal year 2012 and $700,000 in fiscal year 2013.

(b) **Children and Economic Assistance Operations** -0- 196,000

Base Adjustment. The general fund base is decreased by $13,000 in fiscal year 2012 and $13,000 in fiscal year 2013.

Subd. 6. **Health Care Grants**

(a) **MinnesotaCare Grants** 998,000 15,312,000

This appropriation is from the health care access fund.

Health Care Access Fund Transfer to General Fund. The commissioner of management and budget shall transfer $998,000 in fiscal year 2010 and $217,265,000 in fiscal year 2011 from the health care access fund to the general fund. This paragraph is effective the day following final enactment.

The base for this transfer is $262,647,000 in fiscal year 2012 and $174,772,000 in fiscal year 2013.

MinnesotaCare Ratable Reduction. Effective for services rendered on or after July 1, 2010, to December 31, 2013, MinnesotaCare payments to managed care plans under Minnesota Statutes, section 256L.12, for single adults and households without children whose income is greater than 75 percent of federal poverty guidelines shall be reduced by ten percent. Managed care plans shall not pass these payment reductions on to providers. Notwithstanding any contrary provision of this article, this paragraph shall expire on December 31, 2013.

(b) **Medical Assistance Basic Health Care Grants - Families and Children**

Appropriations by Fund

General	-0-	(7,631,000)
Health Care Access	-0-	7,714,000

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

Nonadministrative Rate Reduction. For services rendered on or after July 1, 2010, to December 31, 2013, the commissioner shall reduce contract rates paid to managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, by three percent of the contract rate attributable to nonadministrative services in effect on June 30, 2010. Managed care plans shall not pass these rate reductions on to providers. Notwithstanding any contrary provision in this article, this rider expires on December 31, 2013.

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled**

	Appropriations by Fund	
General	-0-	(3,877,000)
Health Care Access	-0-	4,319,000

MnDHO Transition. Of the general fund appropriation for fiscal year 2011, $250,000 is to the commissioner to be made available to county agencies to assist in the transition of the approximately 1,290 current MnDHO members to the fee-for-service Medicaid program or another managed care option by January 1, 2011.

County agencies shall work with the commissioner, health plans, and MnDHO members and their legal representatives to develop and implement transition plans that include:

(1) identification of service needs of MnDHO members based on the current assessment or through the completion of a new assessment;

(2) identification of services currently provided to MnDHO members and which of those services will continue to be reimbursable through fee-for-service or another managed care option under the Medicaid state plan or a home and community-based waiver program;

(3) identification of service providers who do not have a contract with the county or who are currently reimbursed at a different rate than the county contracted rate; and

(4) development of an individual service plan that is within allowable waiver funding limits.

(d) **General Assistance Medical Care Grants**	-0-	(83,689,000)
(e) **Other Health Care Grants**	-0-	-0-

Cobra Carryforward. Unexpended funds appropriated in fiscal year 2010 for COBRA grants under Laws 2009, chapter 79, article 5, section 78, do not cancel and are available to the commissioner for fiscal year 2011 COBRA grant expenditures. Up to $111,000 of the fiscal year 2011 appropriation for COBRA grants provided in Laws 2009, chapter 79, article 13, section 3, subdivision 6, may be used by the commissioner for costs related to administration of the COBRA grants.

(f) **Medical Assistance Health Care Grants; Adults Without Children**	9,794,000	350,696,000

Medical Assistance Expansion. If the commissioner is not able to implement the medical assistance expansion for single adults under Minnesota Statutes, section 256B.055, subdivision 15, by June 1, 2010, the commissioner shall make medical assistance payments to providers retroactively to June 1, 2010.

Subd. 7. **Health Care Management**

(a) **Health Care Administration**	-0-	218,000

Minnesota Senior Health Options Reimbursement. Effective July 1, 2011, federal administrative reimbursement resulting from the Minnesota senior health options project is appropriated to the commissioner for this activity. Notwithstanding any contrary provision, this provision expires June 30, 2013.

Utilization Review. Effective July 1, 2011, federal administrative reimbursement resulting from prior authorization and inpatient admission certification by a professional review organization shall be dedicated to, and is appropriated to, the commissioner for these activities. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance. Notwithstanding any contrary provision of this article, this paragraph expires June 30, 2013.

Reporting Compliance. The entities named in Minnesota Statutes, section 256B.199, paragraph (b), clause (1), shall comply with the requirements of that statute by promptly reporting on a quarterly basis certified public expenditures that may qualify for federal matching funds.

Base Adjustment. The general fund base is decreased by $172,000 in fiscal year 2012 and $172,000 in fiscal year 2013.

(b) **Health Care Operations**

	Appropriations by Fund	
General	-0-	177,000
Health Care Access	-0-	150,000

The general fund appropriation is a onetime appropriation in fiscal year 2011.

Base Adjustment. The health care access

fund base for health care operations is decreased by $755,000 in fiscal year 2012 and $893,000 in fiscal year 2013.

Subd. 8. **Continuing Care Grants**

(a) **Aging and Adult Services Grants**	-0-	(937,000)

Base Adjustment. The general fund base for aging and adult services grants is increased by $1,124,000 in fiscal year 2012 and $1,126,000 in fiscal year 2013.

(b) **Medical Assistance Long-Term Care Facilities Grants**	-0-	10,173,000

Variable Rate Adjustments. Of this appropriation, $683,000 in fiscal year 2011 is to the commissioner for variable rate adjustments under Minnesota Statutes, section 256B.5013, subdivision 1, for services provided on or after July 1, 2010, to June 30, 2011. This is a onetime appropriation.

(c) **Medical Assistance Long-Term Care Waivers and Home Care Grants**	-0-	(4,515,000)

Manage Growth in Traumatic Brain Injury and Community Alternatives for Disabled Individuals Waivers. During the fiscal year beginning July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to six allocations per month and the CADI waiver to 60 allocations per month. The limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of

CS, MT, or HL. Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in the Developmental Disability (DD) Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the November 2010 forecast to six additional diversion allocations each month for the calendar year that begins on January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. This provision is effective through December 31, 2011.

(d) **Adult Mental Health Grants**	(3,500,000)	-0-

Compulsive Gambling Lottery Prize Fund. The lottery prize fund appropriation for compulsive gambling is reduced by $80,000 in fiscal year 2010 and $79,000 in fiscal year 2011. This is a onetime reduction.

Compulsive Gambling Special Revenue Account. $149,000 for fiscal year 2010 and $27,000 for fiscal year 2011 from the compulsive gambling special revenue account established under Minnesota Statutes, section 245.982, shall be transferred and deposited into the general fund by June 30 of each respective fiscal year.

(e) **Chemical Dependency Entitlement Grants**	-0-	(1,738,000)
(f) **Chemical Dependency Nonentitlement Grants**	(389,000)	-0-
(g) **Other Continuing Care Grants**	-0-	250,000

This is a onetime appropriation in fiscal year 2011.

Subd. 9. **Continuing Care Management**	-0-	303,000

Base Adjustment. The general fund base for continuing care management is increased by $107,000 in fiscal year 2012 and $99,000 in fiscal year 2013.

Subd. 10. **State-Operated Services**

Obsolete Laundry Depreciation Account. $669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010.

Operating Budget Reductions. No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

Prohibition on Commingling Funds. The commissioner shall not commingle state-operated services funds and mental health funds and grants. The appropriations to the commissioner for state-operated services and mental health services and grants must not be consolidated in any manner or transferred within the Department of Human Services, without specific legislative approval. Notwithstanding any contrary provision in this article, this paragraph shall not expire.

(a) **Adult Mental Health Services** -0- 6,888,000

Base Adjustment. The general fund base is decreased by $12,286,000 in fiscal year 2012 and $12,394,000 in fiscal year 2013.

Appropriation Requirements. (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The commissioner

shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to restaff, reopen, and operate the community behavioral health hospital with hospital level of care in Wadena until June 30, 2011. The collections associated with this hospital continue to be submitted to the general fund until June 30, 2011. The commissioner shall develop a conversion plan and may convert the community behavioral health hospital to psychiatric extensive recovery treatment services after June 30, 2011. This is a onetime appropriation and expires on June 30, 2011;

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative

approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of $6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through

strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees.

Base level funding is reduced by $6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

(b) **Minnesota Sex Offender Services** -0- (289,000)

Sex Offender Services. Base level funding for Minnesota sex offender services is reduced by $837,000 in fiscal year 2012 and $837,000 in fiscal year 2013 for the 50-bed sex offender treatment program within the Moose Lake correctional facility in which Department of Human Services staff from Minnesota sex offender services provide clinical treatment to incarcerated offenders. This reduction shall become part of the base for the Department of Human Services.

Interagency Agreements. The commissioner shall terminate by June 30, 2010, all interagency agreements with the Department of Corrections to provide chemical dependency treatment services. This paragraph is effective the day following final enactment.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ (2,367,000) $ (3,963,000)**

Appropriations by Fund

2010 2011

General	(2,367,000)	(4,011,000)		
State Government Special Revenue	-0-	9,000		
Health Care Access	-0-	39,000		

Subd. 2. **Community and Family Health** (221,000) (5,347,000)

Base Level Adjustment. The general fund base is increased by $4,912,000 in fiscal year 2012 and $4,912,000 in fiscal year 2013.

Subd. 3. **Policy, Quality, and Compliance**

	Appropriations by Fund	
	2010	2011
General	(1,797,000)	451,000
State Government Special Revenue	-0-	9,000
Health Care Access	-0-	39,000

The health care access fund appropriation is onetime in fiscal year 2011.

Public Health Grant Reductions. The reductions in public health grants shall only be applied to county public health entities and not to municipal or tribal entities.

Health Care Reform. Funds appropriated in Laws 2008, chapter 358, article 5, section 4, subdivision 3, for health reform activities to implement Laws 2008, chapter 358, article 4, are available until expended. Notwithstanding any contrary provision in this article, this provision shall not expire.

Rural Hospital Capital Improvement Grants. Of the general fund reductions in fiscal year 2010, $1,755,000 is from the rural hospital capital improvement grant program. This paragraph is effective the day following final enactment.

Base Level Adjustment. The general fund base is decreased by $207,000 in fiscal year 2012 and $207,000 in fiscal year 2013. The

state government special revenue fund base is decreased by $2,000 in fiscal year 2012 and $2,000 in fiscal year 2013.

Comprehensive Advanced Life Support Program. Of the general fund appropriation, $377,000 in fiscal year 2011 is to the commissioner for the comprehensive advanced life support educational program. For fiscal year 2012, base level funding for this program shall be $377,000.

Birth Centers. Of the appropriation in fiscal year 2011 from the state government special revenue fund, $9,000 is to the commissioner to license birth centers. Base level funding for this activity shall be $7,000 in fiscal year 2012 and $7,000 in fiscal year 2013.

Office of Unlicensed Health Care Practice. Of the general fund appropriation, $74,000 in fiscal year 2011 is for the Office of Unlicensed Complementary and Alternative Health Care Practice. This is a onetime appropriation.

Section 125 Plans. The remaining balance from the Laws 2008, chapter 358, article 5, section 4, subdivision 3, appropriation for Section 125 Plan Employer Incentives is canceled.

Advisory Group on Administrative Expenses. Of the health care access fund appropriation for fiscal year 2011, $39,000 is to the commissioner for the advisory group established under Minnesota Statutes, section 62D.31. This is a onetime appropriation.

Subd. 4. **Health Protection** (349,000) 985,000

Base Adjustment. The general fund base is increased by $194,000 in fiscal year 2012 and $738,000 in fiscal year 2013.

Birth Defects Information System. Of the general fund appropriation for fiscal year 2011, $1,165,000 is for the Minnesota Birth Defects Information System established under Minnesota Statutes, section 144.2215.

Subd. 5. **Administrative Support Services** -0- (100,000)

The general fund base is reduced by $22,000 in fiscal year 2012 and $22,000 in fiscal year 2013.

Sec. 5. **DEPARTMENT OF VETERANS AFFAIRS** **$ (50,000)** **$ -0-**

Cancellation of Prior Appropriation. By June 30, 2010, the commissioner of management and budget shall cancel the $50,000 appropriation for fiscal year 2008 to the board in Laws 2007, chapter 147, article 19, section 5, in the paragraph titled "Pay for Performance."

Sec. 6. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 113,000** **$ 615,000**

The appropriations in this section are from the state government special revenue fund.

The transfers in this section are onetime in the fiscal year 2010-2011 biennium.

The appropriations for each purpose are shown in the following subdivisions.

Transfers. In addition to transfers required under Laws 2009, chapter 79, article 13, section 5, subdivision 1, $301,000 in fiscal year 2010 and $442,000 in fiscal year 2011 shall be transferred from the state government special revenue fund to the general fund. The boards must allocate this reduction to boards carrying a positive balance as of July 1, 2009.

Subd. 2. **Board of Marriage and Family Therapy** 47,000 22,000

Operating Costs and Rulemaking. Of this appropriation, $22,000 in fiscal year 2010 and $22,000 in fiscal year 2011 are for operating costs. This is an ongoing appropriation. Of this appropriation, $25,000 in fiscal year 2010 is for rulemaking. This is a onetime appropriation.

Subd. 3. **Board of Nursing Home Administrators** 51,000 61,000

Subd. 4. **Board of Pharmacy** -0- 517,000

Prescription Electronic Reporting. Of the state government special revenue fund appropriation, $517,000 in fiscal year 2011 is to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126. Base level funding for this activity in fiscal year 2012 shall be $356,000.

Subd. 5. **Board of Podiatry** 15,000 15,000

Purpose. This appropriation is to pay health insurance coverage costs and to cover the cost of expert witnesses in disciplinary cases. This is a onetime appropriation.

Subd. 6. **Board of Dentistry**

Dental Therapy Program. Of the appropriation to the Board of Dentistry in Laws 2009, chapter 95, article 1, section 7, for fiscal year 2010, $12,500 shall be awarded as a grant to the University of Minnesota School of Dentistry for the implementation of the university's dental therapy program and $12,500 shall be awarded as a grant to Minnesota State Colleges and Universities for the implementation of Metropolitan State University's and Normandale Community College's advanced dental therapy program.

Sec. 7. **EMERGENCY MEDICAL SERVICES BOARD** **$ 215,000 $ (382,000)**

Appropriation Transfer Repeal. Any portion of the $250,000 appropriation in Laws 2009, chapter 79, article 13, section 6, as amended by Laws 2009, chapter 173, article 2, section 4, not yet expended or encumbered by the Department of Public Safety for a medical response unit reimbursement pilot program, estimated to be $235,000, must be retained by or returned to the Emergency Medical Services Board to be spent for board purposes. This section is effective the day following final enactment.

Sec. 8. **UNIVERSITY OF MINNESOTA** **$** **-0-** **$** **93,000**

This appropriation is from the special revenue fund for the couples on the brink program.

Sec. 9. **DEPARTMENT OF CORRECTIONS** **$** **-0-** **$** **-0-**

Sex Offender Services. From the general fund appropriations to the commissioner of corrections, the commissioner shall transfer $837,000 each year of the biennium beginning on July 1, 2011, to the commissioner of human services to provide clinical treatment to incarcerated offenders. This transfer shall become part of the base for the Department of Corrections.

Sec. 10. **DEPARTMENT OF COMMERCE** **$** **-0-** **$** **19,000**

Health Plan Filings. This appropriation is for the review and approval of new health plan filings due to Minnesota Statutes, section 62Q.545. This is a onetime appropriation in fiscal year 2011.

Sec. 11. Minnesota Statutes 2008, section 214.40, subdivision 7, is amended to read:

Subd. 7. **Medical professional liability insurance.** (a) Within the limit of funds appropriated for this program, the administrative services unit must purchase medical professional liability insurance, if available, for a health care provider who is registered in accordance with subdivision 4 and who is not otherwise covered by a medical professional liability insurance policy or self-insured plan either personally or through another facility or employer. The administrative services unit is authorized to prorate payments or otherwise limit the number of participants in the program if the costs of the insurance for eligible providers exceed the funds appropriated for the program.

(b) Coverage purchased under this subdivision must be limited to the provision of health care services performed by the provider for which the provider does not receive direct monetary compensation.

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

Sec. 12. Laws 2009, chapter 79, article 13, section 3, subdivision 1, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$** 5,225,451,000 **$** 6,002,864,000

Appropriations by Fund

2010 2011

General	4,375,689,000	5,209,765,000
State Government Special Revenue	565,000	565,000
Health Care Access	450,662,000	527,411,000
Federal TANF	286,770,000	263,458,000
Lottery Prize	1,665,000	1,665,000
Federal Fund	110,000,000	0

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the Minnesota Office of Enterprise Technology, funded by the legislature, and approved by the commissioner of finance, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary, except that any transfers to one project that exceed $1,000,000 or multiple transfers to one project that exceed $1,000,000 in total require the express approval of the legislature. The preceding requirement for legislative approval does not apply to transfers made to establish a project's initial operating budget each year; instead, the requirements of section 11, subdivision 2, of this article apply to those transfers. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations. Any computer project with a total cost exceeding $1,000,000, including, but not limited to, a replacement for the proposed HealthMatch system, shall not be commenced without the express approval of the legislature.

HealthMatch Systems Project. In fiscal year 2010, $3,054,000 shall be transferred from the HealthMatch account in the state systems account in the special revenue fund to the

general fund.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort.

(a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of noncitizen MFIP recipients who qualify for the medical assistance without federal financial participation program under Minnesota Statutes, section 256B.06, subdivision 4, paragraphs (d), (e), and (j); ~~and~~

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (6), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of finance for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3),

the commissioner may supplement the MOE claim with working family credit expenditures to the extent such expenditures or other qualified expenditures are otherwise available after considering the expenditures allowed in this section.

(e) Minnesota Statutes, section 256.011, subdivision 3, which requires that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(f) Notwithstanding any contrary provision in this article, this provision expires June 30, 2013.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures for fiscal year 2010 through fiscal year 2011.

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

(1) fiscal year 2010, ~~$50,973,000~~ $50,897,000;

(2) fiscal year 2011, ~~$53,793,000~~ $54,243,000;

(3) fiscal year 2012, ~~$23,516,000~~ $23,345,000; and

(4) fiscal year 2013, ~~$16,808,000~~ $16,585,000.

Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

Food Stamps Employment and Training. (a) The commissioner shall apply for and claim the maximum allowable federal matching funds under United States Code, title 7, section 2025, paragraph (h), for state expenditures made on behalf of family

stabilization services participants voluntarily engaged in food stamp employment and training activities, where appropriate.

(b) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal food stamps employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures for two-parent families must be deposited in the general fund. The amount of funds must be limited to $3,350,000 in fiscal year 2010 and $4,440,000 in fiscal years 2011 through 2013, contingent on approval by the federal Food and Nutrition Service.

(c) Consistent with the receipt of these federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2013.

ARRA Food Support Administration. The funds available for food support administration under the American Recovery and Reinvestment Act (ARRA) of 2009 are appropriated to the commissioner to pay actual costs of implementing the food support benefit increases, increased eligibility determinations, and outreach. Of these funds, 20 percent shall be allocated to the commissioner and 80 percent shall be allocated to counties. The commissioner shall allocate the county portion based on caseload. Reimbursement shall be based on actual costs reported by counties through existing processes. Tribal reimbursement must be made from the state portion based on a caseload factor equivalent to that of a county.

ARRA Food Support Benefit Increases. The funds provided for food support benefit increases under the Supplemental Nutrition

Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Emergency Fund for the TANF Program. TANF Emergency Contingency funds available under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) are appropriated to the commissioner. The commissioner must request TANF Emergency Contingency funds from the Secretary of the Department of Health and Human Services to the extent the commissioner meets or expects to meet the requirements of section 403(c) of the Social Security Act. The commissioner must seek to maximize such grants. The funds received must be used as appropriated. Each county must maintain the county's current level of emergency assistance funding under the MFIP consolidated fund and use the funds under this paragraph to supplement existing emergency assistance funding levels.

Sec. 13. Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is amended to read:

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

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

(a) MFIP/DWP Grants

	Appropriations by Fund	
General	63,205,000	89,033,000
Federal TANF	100,818,000	84,538,000

(b) Support Services Grants

	Appropriations by Fund	
General	8,715,000	12,498,000
Federal TANF	116,557,000	107,457,000

MFIP Consolidated Fund. The MFIP consolidated fund TANF appropriation is

reduced by $1,854,000 in fiscal year 2010 and fiscal year 2011.

Notwithstanding Minnesota Statutes, section 256J.626, subdivision 8, paragraph (b), the commissioner shall reduce proportionately the reimbursement to counties for administrative expenses.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers and providers to maximize these TANF emergency fund grants.

Supported Work. Of the TANF appropriation, $4,700,000 in fiscal year 2010 and $4,700,000 in fiscal year 2011 are to the commissioner for supported work for MFIP recipients and is available until expended. Supported work includes paid transitional work experience and a continuum of employment assistance, including outreach and recruitment, program orientation and intake, testing and assessment, job development and marketing, preworksite training, supported worksite experience, job coaching, and postplacement follow-up, in addition to extensive case management and referral services. This is a onetime appropriation.

Base Adjustment. The general fund base is reduced by $3,783,000 in each of fiscal years 2012 and 2013. The TANF fund base

is increased by $5,004,000 in each of fiscal years 2012 and 2013.

Integrated Services Program Funding. The TANF appropriation for integrated services program funding is $1,250,000 in fiscal year 2010 and $0 in fiscal year 2011 and the base for fiscal years 2012 and 2013 is $0.

TANF Emergency Fund; Nonrecurrent Short-Term Benefits. (a) TANF emergency contingency fund grants received due to increases in expenditures for nonrecurrent short-term benefits must be used to offset the increase in these expenditures for counties under the MFIP consolidated fund, under Minnesota Statutes, section 256J.626, and the diversionary work program. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters. Growth in expenditures for the diversionary work program over the amount expended in the calendar quarters in the TANF emergency fund base year shall be used to leverage these funds.

(b) To the extent that the commissioner can claim eligible tax credit growth as nonrecurrent short-term benefits, the commissioner shall use those funds to leverage the increased expenditures in paragraph (a).

(c) TANF emergency funds for nonrecurrent short-term benefits received in excess of the amounts necessary for paragraphs (a) and (b) shall be used to reimburse the general fund for the costs of eligible tax credits in fiscal year 2011. The amount of such funds shall not exceed $18,964,000 in fiscal year 2010.

(d) This rider is effective the day following final enactment.

(c) MFIP Child Care Assistance Grants	61,171,000	65,214,000

Acceleration of ARRA Child Care and Development Fund Expenditure. The

commissioner must liquidate all child care and development money available under the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5, by September 30, 2010. In order to expend those funds by September 30, 2010, the commissioner may redesignate and expend the ARRA child care and development funds appropriated in fiscal year 2011 for purposes under this section for related purposes that will allow liquidation by September 30, 2010. Child care and development funds otherwise available to the commissioner for those related purposes shall be used to fund the purposes from which the ARRA child care and development funds had been redesignated.

School Readiness Service Agreements. $400,000 in fiscal year 2010 and $400,000 in fiscal year 2011 are from the federal TANF fund to the commissioner of human services consistent with federal regulations for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(d) Basic Sliding Fee Child Care Assistance Grants 40,100,000 45,092,000

School Readiness Service Agreements. $257,000 in fiscal year 2010 and $257,000 in fiscal year 2011 are from the general fund for the purpose of school readiness service agreements under Minnesota Statutes, section 119B.231. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Child Care Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,244,000 in fiscal year 2010 from the federal child care development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The

commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

Basic Sliding Fee. $4,000,000 in fiscal year 2010 and $4,000,000 in fiscal year 2011 are from the federal child care development funds received from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of basic sliding fee child care assistance under Minnesota Statutes, section 119B.03. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Basic Sliding Fee Allocation for Calendar Year 2010. Notwithstanding Minnesota Statutes, section 119B.03, subdivision 6, in calendar year 2010, basic sliding fee funds shall be distributed according to this provision. Funds shall be allocated first in amounts equal to each county's guaranteed floor, according to Minnesota Statutes, section 119B.03, subdivision 8, with any remaining available funds allocated according to the following formula:

(a) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(b) Up to three-fourths of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in Minnesota Statutes, section 119B.03, subdivision 2, and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules,

part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (d).

(c) The amount necessary to serve all families in paragraphs (a) and (b) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

(d) Funds in excess of the amount necessary to serve all families in paragraphs (a) and (b) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation. To the extent that funds are available, and notwithstanding Minnesota Statutes, section 119B.03, subdivision 8, for the period January 1, 2011, to December 31, 2011, each county's guaranteed floor must be equal to its original calendar year 2010 allocation.

Base Adjustment. The general fund base is decreased by $257,000 in each of fiscal years 2012 and 2013.

(e) Child Care Development Grants	1,487,000	1,487,000

Family, friends, and neighbor grants. $375,000 in fiscal year 2010 and $375,000 in fiscal year 2011 are from the child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services for family, friends, and neighbor grants under Minnesota Statutes, section 119B.232. This appropriation may be used on programs receiving family, friends, and neighbor grant funds as of June 30, 2009, or on new programs or projects. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system training, coaching, consultation, and supports. $633,000 in fiscal year 2010 and $633,000 in fiscal year 2011 are from the federal child care development fund required targeted quality funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of providing grants to provide statewide child-care provider training, coaching, consultation, and supports to prepare for the voluntary Minnesota quality rating system rating tool. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

Voluntary quality rating system. $184,000 in fiscal year 2010 and $1,200,000 in fiscal year 2011 are from the federal child care development fund required targeted funds for quality expansion and infant/toddler from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to the commissioner of human services consistent with federal regulations for the purpose of implementing the voluntary Parent Aware quality star rating system pilot in coordination with the Minnesota Early Learning Foundation. The appropriation for the first year is to complete and promote the voluntary Parent Aware quality rating system pilot program through June 30, 2010, and the appropriation for the second year is to continue the voluntary Minnesota quality rating system pilot through June 30, 2011. This is a onetime appropriation. Any unexpended balance the first year is available in the second year.

(f) Child Support Enforcement Grants	3,705,000	3,705,000

(g) Children's Services Grants

	Appropriations by Fund	
General	48,333,000	50,498,000
Federal TANF	340,000	240,000

Base Adjustment. The general fund base is decreased by $5,371,000 in fiscal year 2012 and decreased $5,371,000 in fiscal year 2013.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2010 and fiscal year 2011 for the adoption incentive grants are appropriated to the commissioner for postadoption services including parent support groups.

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

(h) Children and Community Services Grants 67,663,000 67,542,000

Targeted Case Management Temporary Funding Adjustment. The commissioner shall recover from each county and tribe receiving a targeted case management temporary funding payment in fiscal year 2008 an amount equal to that payment. The commissioner shall recover one-half of the funds by February 1, 2010, and the remainder by February 1, 2011. At the commissioner's discretion and at the request of a county or tribe, the commissioner may revise the payment schedule, but full payment must not be delayed beyond May 1, 2011. The commissioner may use the recovery procedure under Minnesota Statutes, section 256.017, to recover the funds. Recovered funds must be deposited into the general fund.

(i) General Assistance Grants 48,215,000 48,608,000

General Assistance Standard. The commissioner shall set the monthly standard

of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $7,889,812 in fiscal year 2010 and $7,889,812 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(j) Minnesota Supplemental Aid Grants	33,930,000	35,191,000

Emergency Minnesota Supplemental Aid Funds. The amount appropriated for emergency Minnesota supplemental aid funds is limited to no more than $1,100,000 in fiscal year 2010 and $1,100,000 in fiscal year 2011. Funds to counties must be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.46.

(k) Group Residential Housing Grants	111,778,000	114,034,000

Group Residential Housing Costs Refinanced. (a) Effective July 1, 2011, the commissioner shall increase the home and community-based service rates and county allocations provided to programs for persons with disabilities established under section 1915(c) of the Social Security Act to the extent that these programs will be paying for the costs above the rate established in Minnesota Statutes, section 256I.05, subdivision 1.

(b) For persons receiving services under Minnesota Statutes, section 245A.02, who reside in licensed adult foster care beds for which a difficulty of care payment was being made under Minnesota Statutes,

section 256I.05, subdivision 1c, paragraph (b), counties may request an exception to the individual's service authorization not to exceed the difference between the client's monthly service expenditures plus the amount of the difficulty of care payment.

(l) Children's Mental Health Grants 16,885,000 16,882,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(m) Other Children and Economic Assistance Grants 16,047,000 15,339,000

Fraud Prevention Grants. Of this appropriation, $228,000 in fiscal year 2010 and ~~$228,000~~ $379,000 in fiscal year 2011 is to the commissioner for fraud prevention grants to counties.

Homeless and Runaway Youth. $218,000 in fiscal year 2010 is for the Runaway and Homeless Youth Act under Minnesota Statutes, section 256K.45. Funds shall be spent in each area of the continuum of care to ensure that programs are meeting the greatest need. Any unexpended balance in the first year is available in the second year. Beginning July 1, 2011, the base is increased by $119,000 each year.

ARRA Homeless Youth Funds. To the extent permitted under federal law, the commissioner shall designate $2,500,000 of the Homeless Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law 111-5, for agencies providing homelessness prevention and rapid rehousing services to youth.

Supportive Housing Services. $1,500,000 each year is for supportive services under Minnesota Statutes, section 256K.26. This is a onetime appropriation.

Community Action Grants. Community action grants are reduced one time by $1,794,000 each year. This reduction is due to the availability of federal funds under the American Recovery and Reinvestment Act.

Base Adjustment. The general fund base is increased by ~~$773,000~~ $903,000 in fiscal year 2012 and ~~$773,000~~ $413,000 in fiscal year 2013.

Federal ARRA Funds for Existing Programs. (a) Federal funds received by the commissioner for the emergency food and shelter program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, but not previously approved by the legislature are appropriated to the commissioner for the purposes of the grant program.

(b) Federal funds received by the commissioner for the emergency shelter grant program including the Homelessness Prevention and Rapid Re-Housing Program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant programs.

(c) Federal funds received by the commissioner for the emergency food assistance program from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

(d) Federal funds received by the commissioner for senior congregate meals and senior home-delivered meals from the American Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the Minnesota Board on Aging, for purposes of the grant programs.

(e) Federal funds received by the commissioner for the community services block grant program from the American

Recovery and Reinvestment Act of 2009, Public Law 111-5, are appropriated to the commissioner for the purposes of the grant program.

Long-Term Homeless Supportive Service Fund Appropriation. To the extent permitted under federal law, the commissioner shall designate $3,000,000 of the Homelessness Prevention and Rapid Re-Housing Program funds provided under the American Recovery and Reinvestment Act of 2009, Public Law, 111-5, to the long-term homeless service fund under Minnesota Statutes, section 256K.26. This appropriation shall become available by July 1, 2009. This paragraph is effective the day following final enactment.

Sec. 14. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is amended to read:

Subd. 8. **Continuing Care Grants**

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

(a) Aging and Adult Services Grants	13,499,000	15,805,000

Base Adjustment. The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013.

Information and Assistance Reimbursement. Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity.

Community Service Development Grant Reduction. Funding for community service development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

Community Service Development Grant Community Initiative. Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

Senior Nutrition Use of Federal Funds. For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

(b) Alternative Care Grants	50,234,000	48,576,000

Base Adjustment. The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(c) Medical Assistance Grants; Long-Term Care Facilities.	367,444,000	419,749,000
(d) Medical Assistance Long-Term Care Waivers and Home Care Grants	853,567,000	1,039,517,000

Manage Growth in TBI and CADI Waivers. During the fiscal years beginning on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for

nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Manage Growth in DD Waiver. The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

Adjustment to Lead Agency Waiver Allocations. Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

Alternatives to Personal Care Assistance Services. Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.

(e) Mental Health Grants

	Appropriations by Fund	
General	77,739,000	77,739,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(f) Deaf and Hard-of-Hearing Grants 1,930,000 1,917,000

(g) Chemical Dependency Entitlement Grants 111,303,000 122,822,000

Payments for Substance Abuse Treatment. For ~~services provided~~ placements beginning during fiscal years 2010 and 2011, county-negotiated rates and provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

(1) rates charged for these services on January 1, 2009; or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, ~~statewide average rates~~ the statewide aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the ~~average rates charged for these services on January 1, 2009~~ projected aggregate payment under the rates in effect for fiscal year 2011, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the

contrary in this article, this provision expires on June 30, 2013.

Chemical Dependency Special Revenue Account. For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

County CD Share of MA Costs for ARRA Compliance. Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

(h) Chemical Dependency Nonentitlement Grants	1,729,000	1,729,000
(i) Other Continuing Care Grants	19,201,000	17,528,000

Base Adjustment. The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

Technology Grants. $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

Other Continuing Care Grants; HIV Grants. Money appropriated for the HIV drug and insurance grant program in fiscal year 2010 may be used in either year of the biennium.

Quality Assurance Commission. Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 15. Laws 2009, chapter 79, article 13, section 5, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 3, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing Home Administrators**	1,211,000	1,023,000

Administrative Services Unit - Operating Costs. Of this appropriation, $524,000 in fiscal year 2010 and $526,000 in fiscal year 2011 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Retirement Costs. Of this appropriation in fiscal year 2010, $201,000 is for onetime retirement costs in the health-related boards. This funding may be transferred to the health boards incurring those costs for their payment. These funds are available either year of the biennium.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, ~~$79,000~~ $130,000 in fiscal year 2010 and ~~$89,000~~ $150,000 in fiscal year 2011 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2010 and $200,000 in fiscal year 2011 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section and for unforeseen expenditures of an urgent nature. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with

the approval of the commissioner of finance. This appropriation does not cancel. Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years. The boards receiving funds under this section shall include these amounts when setting fees to cover their costs.

Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2011, unless a different expiration date is explicit.

Sec. 17. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2010, unless a different effective date is explicit.

ARTICLE 8

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **SUMMARY OF APPROPRIATIONS.**

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

	2010	2011	Total
General	$ (109,876,000)	$ (28,344,000)	$ (138,220,000)
Health Care Access	$ 99,654,000	$ 276,500,000	$ 376,154,000
Federal TANF	$ (9,830,000)	$ 15,133,000	$ 5,303,000
Total	**$ (20,052,000)**	**$ 263,289,000**	**$ 243,237,000**

Sec. 2. **DEPARTMENT OF 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, article 13, as amended by Laws 2009, chapter 173, article 2, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, 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 is 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 unless a different effective date is explicit.

APPROPRIATIONS
Available for the Year
Ending June 30

	2010	2011
Sec. 3. **DEPARTMENT OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (20,052,000)**	**$ 263,289,000**

Appropriations by Fund

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

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

Subd. 2. **Revenue and Pass-through**

Appropriations by Fund

Federal TANF	390,000	(251,000)

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

Appropriations by Fund

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

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

(a) **MFIP Grants**

General	7,916,000	(14,481,000)
Federal TANF	(10,220,000)	15,384,000

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

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

	Appropriations by Fund	
General	(62,770,000)	29,192,000
Health Care Access	99,654,000	276,500,000

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

(a) **MinnesotaCare Grants**

Health Care Access	99,654,000	276,500,000

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

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

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

Sec. 4. **EFFECTIVE DATE.**

This article is effective the day following final enactment."

Delete the title and insert:

"A bill for an act relating to government finance; appropriating and transferring money and supplementing or reducing appropriations for the Departments of Health, Human Services, Veterans Affairs, Corrections, and Commerce, health-related boards, the Emergency Medical Services Board, and the University of Minnesota; establishing, regulating, or modifying health care services programs, continuing care services, children and family services, and Department of Health provisions; amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision; 62J.692, subdivision 4; 144.226, subdivision 3; 144D.03, subdivision 2, by adding a subdivision; 144D.04, subdivision 2; 144E.37; 144G.06; 152.126, as amended; 214.40, subdivision 7; 245C.27, subdivision 2; 245C.28, subdivision 3; 246.18, by adding a subdivision; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.9657, subdivisions 1, 2, 3, 3a; 256.969, subdivisions 21, 26, by adding a subdivision; 256B.04, subdivision 14a; 256B.055, by adding a subdivision; 256B.056, subdivisions 3, 4; 256B.0625, subdivision 22, by adding a subdivision; 256B.0631, subdivisions 1, 3; 256B.0644, as amended; 256B.0753, by adding a subdivision;

256B.0915, by adding a subdivision; 256B.441, subdivision 53; 256B.49, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 5a, 27, by adding a subdivision; 256B.692, subdivision 1; 256B.76, subdivisions 2, 4; 256D.0515; 256J.24, subdivision 6; 256L.12, subdivisions 5, 9, by adding a subdivision; 517.08, subdivision 1c, as amended; 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections 150A.06, subdivision 1d; 150A.106, subdivision 1; 157.16, subdivision 3; 245C.27, subdivision 1; 256.045, subdivision 3; 256.969, subdivisions 2b, 3a; 256.975, subdivision 7; 256B.0625, subdivision 13h; 256B.0659, subdivision 11; 256B.0911, subdivision 3c; 256B.441, subdivision 55; 256B.69, subdivision 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256J.425, subdivision 3; 256L.03, subdivision 5; 327.15, subdivision 3; 517.08, subdivision 1b; Laws 2009, chapter 79, article 3, section 18; article 5, sections 75, subdivision 1; 78, subdivision 5; article 13, sections 3, subdivisions 1, as amended, 4, as amended, 6, 8, as amended; 5, subdivision 8, as amended; Laws 2010, chapter 200, article 1, sections 12; 16; 21; article 2, section 2, subdivisions 1, 5, 8; proposing coding for new law in Minnesota Statutes, chapters 62D; 62Q; 137; 144D; 256B; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3, 3a, 5, 6, 7, 8; Laws 2010, chapter 200, article 1, sections 12; 18; 19."

And when so amended the bill do pass.

Joint Rule 2.03 suspended. Amendments adopted. Report adopted.

SECOND READING OF SENATE BILLS

S.F. Nos. 3043, 3318, 3028 and 2337 were read the second time.

SECOND READING OF HOUSE BILLS

H.F. No. 3056 was read the second time.

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.

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 Messages From the House and First Reading of House Bills.

MESSAGES FROM THE HOUSE

Mr. President:

I have the honor to announce the passage by the House of the following House File, herewith

transmitted: H.F. No. 2614.

Albin A. Mathiowetz, Chief Clerk, House of Representatives

Transmitted May 4, 2010

FIRST READING OF HOUSE BILLS

The following bill was read the first time.

H.F. No. 2614: A bill for an act relating to state government; licensing; state health care programs; continuing care; children and family services; health reform; Department of Health; public health; health plans; assessing administrative penalties; modifying foreign operating corporation taxes; requiring reports; making supplemental and contingent appropriations and reductions for the Departments of Health and Human Services and other health-related boards and councils; amending Minnesota Statutes 2008, sections 62D.08, by adding a subdivision; 62J.07, subdivision 2, by adding a subdivision; 62J.38; 62J.692, subdivision 4; 62Q.19, subdivision 1; 62Q.76, subdivision 1; 62U.05; 119B.025, subdivision 1; 119B.09, subdivision 4; 119B.11, subdivision 1; 144.05, by adding a subdivision; 144.226, subdivision 3; 144.291, subdivision 2; 144.293, subdivision 4, by adding a subdivision; 144.651, subdivision 2; 144.9504, by adding a subdivision; 144A.51, subdivision 5; 144E.37; 214.40, subdivision 7; 245C.27, subdivision 2; 245C.28, subdivision 3; 246B.04, subdivision 2; 254B.01, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivision 4, by adding a subdivision; 254B.05, subdivision 4; 254B.06, subdivision 2; 254B.09, subdivision 8; 256.01, by adding a subdivision; 256.9657, subdivision 3; 256B.04, subdivision 14; 256B.055, by adding a subdivision; 256B.056, subdivisions 3, 4; 256B.057, subdivision 9; 256B.0625, subdivisions 8, 8a, 8b, 18a, 22, 31, by adding subdivisions; 256B.0631, subdivisions 1, 3; 256B.0644, as amended; 256B.0754, by adding a subdivision; 256B.0915, subdivision 3b; 256B.19, subdivision 1c; 256B.441, by adding a subdivision; 256B.5012, by adding a subdivision; 256B.69, subdivisions 20, as amended, 27, by adding subdivisions; 256B.692, subdivision 1; 256B.75; 256B.76, subdivisions 2, 4, by adding a subdivision; 256D.03, subdivision 3b; 256D.0515; 256D.425, subdivision 2; 256I.05, by adding a subdivision; 256J.20, subdivision 3; 256J.24, subdivision 10; 256J.37, subdivision 3a; 256J.39, by adding subdivisions; 256L.02, subdivision 3; 256L.03, subdivision 3, by adding a subdivision; 256L.04, subdivision 7; 256L.05, by adding a subdivision; 256L.07, subdivision 1, by adding a subdivision; 256L.12, subdivisions 5, 6, 9; 256L.15, subdivision 1; 290.01, subdivision 5, by adding a subdivision; 290.17, subdivision 4; 326B.43, subdivision 2; 626.556, subdivision 10i; 626.557, subdivision 9d; Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 157.16, subdivision 3; 245A.11, subdivision 7b; 245C.27, subdivision 1; 246B.06, subdivision 6; 252.025, subdivision 7; 252.27, subdivision 2a; 256.045, subdivision 3; 256.969, subdivision 3a; 256B.056, subdivision 3c; 256B.0625, subdivisions 9, 13e; 256B.0653, subdivision 5; 256B.0911, subdivision 1a; 256B.0915, subdivision 3a; 256B.69, subdivisions 5a, 23; 256B.76, subdivision 1; 256B.766; 256D.03, subdivision 3, as amended; 256D.44, subdivision 5; 256J.425, subdivision 3; 256L.03, subdivision 5; 256L.11, subdivision 1; 289A.08, subdivision 3; 290.01, subdivisions 19c, 19d; 327.15, subdivision 3; Laws 2005, First Special Session chapter 4, article 8, section 66, as amended; Laws 2009, chapter 79, article 3, section 18; article 5, sections 17; 18; 22; 75, subdivision 1; 78, subdivision 5; article 8, sections 2; 51; 81; article 13, sections 3, subdivisions 1, as amended, 3, as amended, 4, as amended, 8, as amended; 5, subdivision 8, as amended; Laws 2009, chapter 173, article 1, section 17; Laws 2010, chapter 200, article 1, sections 12, subdivisions 5, 6, 7, 8;

13, subdivision 1b; 16; 21; article 2, section 2, subdivisions 1, 8; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 62E; 62J; 62Q; 144; 245; 254B; 256; 256B; proposing coding for new law as Minnesota Statutes, chapter 62V; repealing Minnesota Statutes 2008, sections 254B.02, subdivisions 2, 3, 4; 254B.09, subdivisions 4, 5, 7; 256D.03, subdivisions 3a, 3b, 5, 6, 7, 8; 290.01, subdivision 6b; 290.0921, subdivision 7; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3; Laws 2009, chapter 79, article 7, section 26, subdivision 3; Laws 2010, chapter 200, article 1, sections 12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 18; 19.

Senator Pogemiller moved that H.F. No. 2614 be laid on the table. The motion prevailed.

MEMBERS EXCUSED

Senators Gimse, Johnson and Scheid were excused from the Session of today at 5:00 p.m. Senator Clark was excused from the Session of today at 5:45 p.m.

ADJOURNMENT

Senator Pogemiller moved that the Senate do now adjourn until 1:00 p.m., Wednesday, May 5, 2010. The motion prevailed.

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