Sec. 5. Minnesota Statutes 2000, section 144A.04, subdivision 7, is amended to read:

Subd. 7. **MINIMUM NURSING STAFF REQUIREMENT.** Notwithstanding the provisions of Minnesota Rules, part 4655.5600, the minimum staffing standard for nursing personnel in certified nursing homes is as follows:

(a) The minimum number of hours of nursing personnel to be provided in a nursing home is the greater of two hours per resident per 24 hours or 0.95 hours per standardized resident day. Upon transition to the 34 group, RUG-III resident classification system, the 0.95 hours per standardized resident day shall no longer apply.

(b) For purposes of this subdivision, "hours of nursing personnel" means the paid, on-duty, productive nursing hours of all nurses and nursing assistants, calculated on the basis of any given 24-hour period. "Productive nursing hours" means all on-duty hours during which nurses and nursing assistants are engaged in nursing duties. Examples of nursing duties may be found in Minnesota Rules, parts 4655.5900, 4655.6100, and 4655.6400. Not included are vacations, holidays, sick leave, in-service classroom training, or lunches. Also not included are the nonproductive nursing hours of the in-service training director. In homes with more than 60 licensed beds, the hours of the director of nursing are excluded. "Standardized resident day" means the sum of the number of residents in each case mix class multiplied by the case mix weight for that resident class, as found in Minnesota Rules, part 9549.0059, subpart 2, calculated on the basis of a facility's census for any given day. For the purpose of determining a facility's census, the commissioner of health shall exclude the resident days claimed by the facility for resident therapeutic leave or bed hold days.

(c) Calculation of nursing hours per standardized resident day is performed by dividing total hours of nursing personnel for a given period by the total of standardized resident days for that same period.

(d) A nursing home that is issued a notice of noncompliance under section 144A.10, subdivision 5, for a violation of this subdivision, shall be assessed a civil fine of $300 for each day of noncompliance, subject to section 144A.10, subdivisions 7 and 8.

Presented to the governor March 22, 2002

Signed by the governor March 25, 2002, 2:14 p.m.

CHAPTER 277—S.F.No. 3126

An act relating to human services; making technical changes in health care programs; amending Minnesota Statutes 2000, sections 13.05, subdivision 4; 245.4932, subdivision 3; 253B.045, subdivision 2; 256.01, subdivision 11; 256.023; 256.9685, subdivision 1; 256.9866; 256B.041, subdivision 5; 256B.0575; 256B.0625, subdivision 27; 256B.0629, subdivision 2;

256B.0915, subdivision 1c; 256B.0945, subdivision 4; 256B.19, subdivisions 1, 1d, 2b; 256B.37, subdivision 5a; 256B.692, subdivision 3; 256F.10, subdivision 9; 256F.13, subdivision 1; 256L.05, subdivision 3; 256L.07, subdivision 3; Minnesota Statutes 2001 Supplement, sections 245.474, subdivision 4; 256B.0623, subdivision 14; 256B.0625, subdivisions 13, 20; 256B.0915, subdivision 3; 256B.0924, subdivision 6; 256B.19, subdivision 1c; 256L.06, subdivision 3; Laws 2001, First Special Session chapter 9, article 2, section 76; repealing Minnesota Statutes 2000, sections 256.025; 256B.0635, subdivision 3; 256B.19, subdivision 1a; 256B.77, subdivision 24.

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

Section 1. Minnesota Statutes 2000, section 13.05, subdivision 4, is amended to read:

Subd. 4. **LIMITATIONS ON COLLECTION AND USE OF DATA.** Private or confidential data on an individual shall not be collected, stored, used, or disseminated by political subdivisions, statewide systems, or state agencies for any purposes other than those stated to the individual at the time of collection in accordance with section 13.04, except as provided in this subdivision.

(a) Data collected prior to August 1, 1975, and which have not been treated as public data, may be used, stored, and disseminated for the purposes for which the data was originally collected or for purposes which are specifically approved by the commissioner as necessary to public health, safety, or welfare.

(b) Private or confidential data may be used and disseminated to individuals or agencies specifically authorized access to that data by state, local, or federal law enacted or promulgated after the collection of the data.

(c) Private or confidential data may be used and disseminated to individuals or agencies subsequent to the collection of the data when the responsible authority maintaining the data has requested approval for a new or different use or dissemination of the data and that request has been specifically approved by the commissioner as necessary to carry out a function assigned by law.

(d) Private data may be used by and disseminated to any person or agency if the individual subject or subjects of the data have given their informed consent. Whether a data subject has given informed consent shall be determined by rules of the commissioner. The format for informed consent is as follows, unless otherwise prescribed by the HIPAA, Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82, 461 (2000) (to be codified as Code of Federal Regulations, title 45, section 164): informed consent shall not be deemed to have been given by an individual subject of the data by the signing of any statement authorizing any person or agency to disclose information about the individual to an insurer or its authorized representative, unless the statement is:

(1) in plain language;

(2) dated;

(3) specific in designating the particular persons or agencies the data subject is authorizing to disclose information about the data subject;

(4) specific as to the nature of the information the subject is authorizing to be disclosed;

(5) specific as to the persons or agencies to whom the subject is authorizing information to be disclosed;

(6) specific as to the purpose or purposes for which the information may be used by any of the parties named in clause (5), both at the time of the disclosure and at any time in the future;

(7) specific as to its expiration date which should be within a reasonable period of time, not to exceed one year except in the case of authorizations given in connection with applications for life insurance or noncancelable or guaranteed renewable health insurance and identified as such, two years after the date of the policy.

The responsible authority may require a person requesting copies of data under this paragraph to pay the actual costs of making, certifying, and compiling the copies.

(e) Private or confidential data on an individual may be discussed at a meeting open to the public to the extent provided in section 13D.05.

Sec. 2. Minnesota Statutes 2001 Supplement, section 245.474, subdivision 4, is amended to read:

Subd. 4. **STAFF SAFETY TRAINING.** The commissioner shall ~~by rule~~ require all staff in mental health and support units at regional treatment centers who have contact with persons with mental illness or severe emotional disturbance to be appropriately trained in violence reduction and violence prevention and shall establish criteria for such training. Training programs shall be developed with input from consumer advocacy organizations and shall employ violence prevention techniques as preferable to physical interaction.

Sec. 3. Minnesota Statutes 2000, section 245.4932, subdivision 3, is amended to read:

Subd. 3. **PAYMENTS.** ~~Notwithstanding section 256.025, subdivision 2,~~ Payments under sections 245.493 to 245.496 to providers for services for which the collaborative elects to pay the nonfederal share of medical assistance shall only be made of federal earnings from services provided under sections 245.493 to 245.496.

Sec. 4. Minnesota Statutes 2000, section 253B.045, subdivision 2, is amended to read:

Subd. 2. **FACILITIES.** Each county or a group of counties shall maintain or provide by contract a facility for confinement of persons held temporarily for observation, evaluation, diagnosis, treatment, and care. When the temporary confinement is provided at a regional center, the commissioner shall charge the county of financial responsibility for the costs of confinement of persons hospitalized under section 253B.05, subdivisions 1 and 2, and section 253B.07, subdivision 2b, except that the commissioner shall bill the responsible ~~prepaid plan for medically necessary hospitalizations for individuals enrolled in a prepaid plan under contract to provide~~

~~medical assistance, general assistance medical care, or MinnesotaCare services. If the prepaid plan determines under the terms of the medical assistance, general assistance medical care, or MinnesotaCare contract that a hospitalization was not medically necessary~~ health plan first. If the person has health plan coverage, but the hospitalization does not meet the criteria in subdivision 6 or section 62M.07, 62Q.53, or 62Q.535, the county is responsible. "County of financial responsibility" means the county in which the person resides at the time of confinement or, if the person has no residence in this state, the county which initiated the confinement. The charge shall be based on the commissioner's determination of the cost of care pursuant to section 246.50, subdivision 5. When there is a dispute as to which county is the county of financial responsibility, the county charged for the costs of confinement shall pay for them pending final determination of the dispute over financial responsibility. Disputes about the county of financial responsibility shall be submitted to the commissioner to be settled in the manner prescribed in section 256G.09.

Sec. 5. Minnesota Statutes 2000, section 256.01, subdivision 11, is amended to read:

Subd. 11. **CENTRALIZED DISBURSEMENT SYSTEM.** The state agency may establish a system for the centralized disbursement of food coupons, assistance payments, and related documents. Benefits shall be issued by the state or county ~~and funded under this section according to section 256.025, subdivision 3, and~~ subject to section 256.017.

Sec. 6. Minnesota Statutes 2000, section 256.023, is amended to read:

256.023 **ONE HUNDRED PERCENT COUNTY ASSISTANCE.**

The commissioner of human services may maintain client records and issue public assistance benefits that are over state and federal standards or that are not required by state or federal law, providing the cost of benefits is paid by the counties to the department of human services. ~~Payment methods for this section shall be according to section 256.025, subdivision 3.~~

Sec. 7. Minnesota Statutes 2000, section 256.9685, subdivision 1, is amended to read:

Subdivision 1. **AUTHORITY.** (a) The commissioner shall establish procedures for determining medical assistance and general assistance medical care payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment.

(b) The commissioner may reduce the types of inpatient hospital admissions that are required to be certified as medically necessary after notice in the State Register and a 30-day comment period.

Sec. 8. Minnesota Statutes 2000, section 256.9866, is amended to read:

256.9866 **COMMUNITY SERVICE AS A COUNTY OBLIGATION.**

Community service shall be an acceptable sentencing option but shall not reduce the state or federal share of any amount to be repaid or any subsequent recovery. Any reduction or offset of any such amount ordered by a court shall be treated as follows:

(1) any reduction in an overpayment amount, to include the amount ordered as restitution, shall not reduce the underlying amount established as an overpayment by the state or county agency;

(2) total overpayments shall continue as a debt owed and may be recovered by any civil or administrative means otherwise available to the state or county agency; and

(3) any amount ordered to be offset against any overpayment shall be deducted from the county share only of any recovery and shall be based on the prevailing state minimum wage. ~~To the extent that any deduction is in fact made against any state or county share, it shall be reimbursed from the county share of payments to be made under section 256.025.~~

Sec. 9. Minnesota Statutes 2000, section 256B.041, subdivision 5, is amended to read:

Subd. 5. **PAYMENT BY COUNTY TO STATE TREASURER.** If required by federal law or rules promulgated thereunder, or by authorized rule of the state agency, each county shall pay to the state treasurer the portion of medical assistance paid by the state for which it is responsible. ~~The county's share of cost shall be ten percent of that portion not met by federal funds.~~

The county shall advance ~~ten percent of that portion of~~ medical assistance costs not met by federal funds, based upon estimates submitted by the state agency to the county agency, stating the estimated expenditures for the succeeding month. Upon the direction of the county agency, payment shall be made monthly by the county to the state for the estimated expenditures for each month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

~~Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of local agency expenditures under this subdivision from January 1, 1991, on.~~ Payment to counties under this subdivision is subject to the provisions of section 256.017.

Sec. 10. Minnesota Statutes 2000, section 256B.0575, is amended to read:

256B.0575 **AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.**

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized ~~spouse~~ person that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Sec. 11. Minnesota Statutes 2001 Supplement, section 256B.0623, subdivision 14, is amended to read:

Subd. 14. **BILLING WHEN SERVICES ARE PROVIDED BY QUALIFIED STATE STAFF.** When rehabilitative services are provided by qualified state staff who are assigned to pilot projects under section 245.4661, the county or other local entity to which the qualified state staff are assigned may consider these staff part of the local provider entity for which certification is sought under this section and may bill the medical assistance program for qualifying services provided by the qualified state staff. ~~Notwithstanding section 256.025, subdivision 2,~~ Payments for services provided by state staff who are assigned to adult mental health initiatives shall only be made from federal funds.

Sec. 12. Minnesota Statutes 2001 Supplement, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **DRUGS.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve three-year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure

Act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the drug formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14;

(iii) anorectics, except that medically necessary anorectics shall be covered for a recipient previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese;

(iv) drugs for which medical value has not been established; and

(v) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

(c) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed

dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the nine percent deduction. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. The commissioner shall set maximum allowable costs for multisource drugs that are not on the federal upper limit list as described in United States Code, title 42, chapter 7, section 1396r-8(e), the Social Security Act, and Code of Federal Regulations, title 42, part 447, section 447.332. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written - brand necessary" on the prescription as required by section 151.21, subdivision 2.

(d) For purposes of this subdivision, "multisource drugs" means covered outpatient drugs, excluding innovator multisource drugs for which there are two or more drug products, which:

(1) are related as therapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations";

(2) are pharmaceutically equivalent and bioequivalent as determined by the Food and Drug Administration; and

(3) are sold or marketed in Minnesota.

"Innovator multisource drug" means a multisource drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider; the average wholesale price minus five percent; or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraph (c).

Sec. 13. Minnesota Statutes 2001 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **MENTAL HEALTH CASE MANAGEMENT.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under sections 245.4886 and 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.

(i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4888, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

(j) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe.

(k) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(l) The commissioner shall set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(m) ~~Notwithstanding section 256.025, subdivision 2,~~ Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to county-contracted vendors shall include both the federal earnings and the county share.

(n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the state treasurer. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(o) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(p) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(q) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.

(s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.

(t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:

(1) a continuation of the minimum allocation in paragraph (h); or

(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.

(u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.

Sec. 14. Minnesota Statutes 2000, section 256B.0625, subdivision 27, is amended to read:

Subd. 27. **ORGAN AND TISSUE TRANSPLANTS.** Medical assistance coverage for organ and tissue transplant procedures is limited to those procedures covered by the Medicare program~~; heart-lung transplants for persons with primary pulmonary hypertension and~~ or approved by the Advisory Committee on Organ and Tissue Transplants. All organ transplants must be performed at ~~Minnesota~~ transplant centers meeting united network for organ sharing criteria ~~to perform heart-lung transplants; lung transplants using cadaveric donors and performed at Minnesota transplant centers meeting united network for organ sharing criteria to perform lung transplants; pancreas transplants for uremic diabetic recipients of kidney transplants and performed at Minnesota facilities meeting united network for organ sharing criteria to perform pancreas transplants; and allogenic bone marrow transplants for persons with stage III or IV Hodgkin's disease~~ or at Medicare-approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy or be approved by the Advisory Committee on Organ and Tissue Transplants. Transplant procedures must comply with all applicable laws, rules, and regulations governing (1) coverage by the Medicare program, (2) federal financial participation by the Medicaid program, and (3) coverage by the Minnesota medical assistance program. ~~Transplant centers must meet american society of hematology and clinical oncology criteria for bone marrow transplants and be located in Minnesota to receive reimbursement for bone marrow~~ Transplants performed out of Minnesota or the local trade area must be prior authorized.

Sec. 15. Minnesota Statutes 2000, section 256B.0629, subdivision 2, is amended to read:

Subd. 2. **FUNCTION AND OBJECTIVES.** ~~The advisory committee shall meet at least twice a year.~~ The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and experience of various forms of transplantation not approved by Medicare;

(2) collection of information from Minnesota transplant providers on available services, success rates, and the current status of transplant activity in the state;

(3) development of guidelines for determining when and under what conditions organ and tissue transplants not approved by Medicare should be eligible for reimbursement by medical assistance and general assistance medical care;

(4) providing recommendations~~, at least annually,~~ to the commissioner on: (i) organ and tissue transplant procedures, beyond those approved by Medicare, that should also be eligible for reimbursement under medical assistance and general assistance medical care; and (ii) which transplant centers should be eligible for reimbursement from medical assistance and general assistance medical care.

Sec. 16. Minnesota Statutes 2000, section 256B.0915, subdivision 1c, is amended to read:

Subd. 1c. **CASE MANAGEMENT ACTIVITIES UNDER THE STATE PLAN.** The commissioner shall seek an amendment to the home and community-based services waiver for the elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner is unable to secure the approval of the secretary of health and human services for the requested waiver amendment by December 31, 1993, the commissioner shall amend the medical assistance state plan to provide that case management provided under the home and community-based services waiver for the elderly is performed by counties as an administrative function for the proper and effective administration of the state medical assistance plan. ~~Notwithstanding section 256.025, subdivision 3,~~ The state shall reimburse counties for the nonfederal share of costs for case management performed as an administrative function under the home and community-based services waiver for the elderly.

Sec. 17. Minnesota Statutes 2001 Supplement, section 256B.0915, subdivision 3, is amended to read:

Subd. 3. **LIMITS OF CASES, RATES, PAYMENTS, AND FORECASTING.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by the greater of any legislatively adopted home and community-based services cost-of-living

percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

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

(d) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waivered services, a monthly conversion limit for the cost of elderly waivered services may be requested. The monthly conversion limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented, the monthly conversion limit for the cost of elderly waiver services shall be the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.437 for that resident in the nursing facility where the resident currently resides multiplied by 365 and divided by 12, less the recipient's maintenance needs allowance as described in subdivision 1d. The limit under this clause only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waivered services on or after July 1, 1997. The following costs must be included in determining the total monthly costs for the waiver client:

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

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

(e) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(f) A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care service rate shall be negotiated between the county agency and the foster care provider. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(h) Payment for assisted living service shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(1) The individualized monthly negotiated payment for assisted living services as described in section 256B.0913, subdivision 5, paragraph (g) or (h), and residential care services as described in section 256B.0913, subdivision 5, paragraph (f), shall not exceed the nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit is being calculated, of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.437 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly negotiated payment for the services described in this clause shall not exceed the limit described in this clause which was in effect on June 30 of the previous state fiscal year and which has been adjusted by the greater of any legislatively adopted home and community-based services cost-of-living percentage increase or any legislatively adopted statewide percent rate increase for nursing facilities.

(2) The individualized monthly negotiated payment for assisted living services described in section 144A.4605 and delivered by a provider licensed by the department of health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other elderly waiver services, including case management, must not exceed the limit specified in paragraph (b).

(i) The county shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the county's current approved rate. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

(k) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall

establish statewide maximum service rate limits and eliminate county-specific service rate limits.

(1) Effective July 1, 2001, for service rate limits, except those described or defined in paragraphs (g) and (h), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(2) Counties may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

~~(l) Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision on or after January 1, 1991, for individuals who are receiving medical assistance.~~

Sec. 18. Minnesota Statutes 2001 Supplement, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **PAYMENT FOR TARGETED CASE MANAGEMENT.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact with the adult or the adult's legal representative.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) ~~Notwithstanding section 256.025, subdivision 2,~~ Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the state treasurer. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 19. Minnesota Statutes 2000, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **PAYMENT RATES.** (a) Notwithstanding sections ~~256.025, subdivision 2;~~ 256B.19~~;~~ and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to subdivision 2, paragraph (a), shall be the federal share of the contract rate. Payment to counties for services provided according to subdivision 2, paragraph (b), shall be a proportion of the per day contract rate that relates to rehabilitative mental health

services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

Sec. 20. Minnesota Statutes 2000, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. **DIVISION OF COST.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

~~(1) ninety percent state funds and ten percent county funds, unless otherwise provided below;~~

~~(2)~~ beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Sec. 21. Minnesota Statutes 2001 Supplement, section 256B.19, subdivision 1c, is amended to read:

Subd. 1c. **ADDITIONAL PORTION OF NONFEDERAL SHARE.** (a) Hennepin county shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs~~, but shall not be subject to payback provisions of section 256.025~~.

(b) Beginning July 1, 2001, Hennepin county's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately $3,400,000, plus any available federal matching funds, to recognize higher than average medical education costs.

Sec. 22. Minnesota Statutes 2000, section 256B.19, subdivision 1d, is amended to read:

Subd. 1d. **PORTION OF NONFEDERAL SHARE TO BE PAID BY CERTAIN COUNTIES.** In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs~~, but shall not be subject to payback provisions of section 256.025~~.

Sec. 23. Minnesota Statutes 2000, section 256B.19, subdivision 2b, is amended to read:

Subd. 2b. **PILOT PROJECT REIMBURSEMENT.** In counties where a pilot or demonstration project is operated under the medical assistance program, the state may pay 100 percent of the administrative costs for the pilot or demonstration project after June 30, 1990. ~~Reimbursement for these costs is subject to section 256.025.~~

Sec. 24. Minnesota Statutes 2000, section 256B.37, subdivision 5a, is amended to read:

Subd. 5a. **SUPPLEMENTAL PAYMENT BY MEDICAL ASSISTANCE.** Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by medical assistance and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the medical assistance rate minus the third party payment amount.

A negative difference will not be implemented.

All providers must reduce their submitted charge to medical assistance programs to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract. The net submitted charge may not be greater than the patient liability for the service.

Sec. 25. Minnesota Statutes 2000, section 256B.692, subdivision 3, is amended to read:

Subd. 3. **REQUIREMENTS OF THE COUNTY BOARD.** A county board that intends to purchase or provide health care under this section, which may include purchasing all or part of these services from health plans or individual providers on a fee-for-service basis, or providing these services directly, must demonstrate the ability to follow and agree to the following requirements:

(1) purchase all covered services for a fixed payment from the state that does not exceed the estimated state and federal cost that would have occurred under the prepaid medical assistance and general assistance medical care programs;

(2) ensure that covered services are accessible to all enrollees and that enrollees have a reasonable choice of providers, health plans, or networks when possible. If the county is also a provider of service, the county board shall develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers, which meet the same quality and cost requirements are available;

(3) issue payments to participating vendors or networks in a timely manner;

(4) establish a process to ensure and improve the quality of care provided;

(5) provide appropriate quality and other required data in a format required by the state;

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

(7) ~~for counties within the seven-county metropolitan area,~~ ensure that the implementation and operation of the Minnesota senior health options demonstration project and the Minnesota disability health options demonstration project, authorized under section 256B.69, subdivision 23, will not be impeded;

(8) ensure that all recipients that are enrolled in the prepaid medical assistance or general assistance medical care program will be transferred to county-based purchasing without utilizing the department's fee-for-service claims payment system;

(9) ensure that all recipients who are required to participate in county-based purchasing are given sufficient information prior to enrollment in order to make informed decisions; and

(10) ensure that the state and the medical assistance and general assistance medical care recipients will be held harmless for the payment of obligations incurred by the county if the county, or a health plan providing services on behalf of the county, or a provider participating in county-based purchasing becomes insolvent, and the state has made the payments due to the county under this section.

Sec. 26. Minnesota Statutes 2000, section 256F.10, subdivision 9, is amended to read:

Subd. 9. **PAYMENTS.** ~~Notwithstanding section 256.025, subdivision 2,~~ Payments to certified providers for child welfare targeted case management expenditures under section 256B.094 and this section shall only be made of federal earnings from services provided under section 256B.094 and this section. Payments to contracted vendors shall include both the federal earnings and the nonfederal share.

Sec. 27. Minnesota Statutes 2000, section 256F.13, subdivision 1, is amended to read:

Subdivision 1. **FEDERAL REVENUE ENHANCEMENT.** (a) **DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.** The commissioner of human services may enter into an agreement with one or more family services collaboratives to enhance federal reimbursement under Title IV-E of the Social Security Act and federal administrative reimbursement under Title XIX of the Social Security Act. The commissioner may contract with the department of children, families, and learning for purposes of transferring the federal reimbursement to the commissioner of children, families, and learning to be distributed to the collaboratives according to clause (2). The commissioner shall have the following authority and responsibilities regarding family services collaboratives:

(1) the commissioner shall submit amendments to state plans and seek waivers as necessary to implement the provisions of this section;

(2) the commissioner shall pay the federal reimbursement earned under this subdivision to each collaborative based on their earnings. ~~Notwithstanding section 256.025, subdivision 2,~~ Payments to collaboratives for expenditures under this subdivision will only be made of federal earnings from services provided by the collaborative;

(3) the commissioner shall review expenditures of family services collaboratives using reports specified in the agreement with the collaborative to ensure that the base level of expenditures is continued and new federal reimbursement is used to expand education, social, health, or health-related services to young children and their families;

(4) the commissioner may reduce, suspend, or eliminate a family services collaborative's obligations to continue the base level of expenditures or expansion of services if the commissioner determines that one or more of the following conditions apply:

(i) imposition of levy limits that significantly reduce available funds for social, health, or health-related services to families and children;

(ii) reduction in the net tax capacity of the taxable property eligible to be taxed by the lead county or subcontractor that significantly reduces available funds for education, social, health, or health-related services to families and children;

(iii) reduction in the number of children under age 19 in the county, collaborative service delivery area, subcontractor's district, or catchment area when compared to the

number in the base year using the most recent data provided by the state demographer's office; or

(iv) termination of the federal revenue earned under the family services collaborative agreement;

(5) the commissioner shall not use the federal reimbursement earned under this subdivision in determining the allocation or distribution of other funds to counties or collaboratives;

(6) the commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of this subdivision;

(7) the commissioner shall recover from the family services collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the family services collaborative's actions in the integrated fund, or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample; and

(8) the commissioner shall establish criteria for the family services collaborative for the accounting and financial management system that will support claims for federal reimbursement.

(b) **FAMILY SERVICES COLLABORATIVE RESPONSIBILITIES.** The family services collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the family services collaborative shall be the party with which the commissioner contracts. A lead county shall be designated as the fiscal agency for reporting, claiming, and receiving payments;

(2) the family services collaboratives may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement, or to expand education, social, health, or health-related services to families and children;

(3) the family services collaborative must continue the base level of expenditures for education, social, health, or health-related services to families and children from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under this subdivision, would have been available for those services, except as provided in subdivision 1, paragraph (a), clause (4). The base year for purposes of this subdivision shall be the four-quarter calendar year ending at least two calendar quarters before the first calendar quarter in which the new federal reimbursement is earned;

(4) the family services collaborative must use all new federal reimbursement resulting from federal revenue enhancement to expand expenditures for education, social, health, or health-related services to families and children beyond the base level, except as provided in subdivision 1, paragraph (a), clause (4);

(5) the family services collaborative must ensure that expenditures submitted for federal reimbursement are not made from federal funds or funds used to match other federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family services collaborative expenditures under agreement with the department, the nonfederal share of costs shall be provided by the family services collaborative from sources other than federal funds or funds used to match other federal funds;

(6) the family services collaborative must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the agreement; and

(7) the family services collaborative shall submit an annual report to the commissioner as specified in the agreement.

Sec. 28. Minnesota Statutes 2000, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **EFFECTIVE DATE OF COVERAGE.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the date of entry into the family. The effective date of coverage for other new recipients added to the family receiving covered health services is the first day of the month following the month in which eligibility is approved or at renewal, whichever the family receiving covered health services prefers. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

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

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

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

Sec. 29. Minnesota Statutes 2001 Supplement, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **ADMINISTRATION AND COMMISSIONER'S DUTIES.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon changes in enrollee income; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or annual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

Sec. 30. Minnesota Statutes 2000, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **OTHER HEALTH COVERAGE.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, Medicare Part A or B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-4, is considered health coverage. An applicant or enrollee may not refuse Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

Sec. 31. Laws 2001, First Special Session chapter 9, article 2, section 76, is amended to read:

Sec. 76. **REPEALER.**

(a) Minnesota Statutes 2000, section ~~256B.0635, subdivision 3, and~~ 256B.19, subdivision 1b, ~~are~~ is repealed effective July 1, 2001.

(b) Minnesota Statutes 2000, section 256L.02, subdivision 4, is repealed effective January 1, 2003.

Sec. 32. **REVISOR INSTRUCTION.**

In the next edition of Minnesota Statutes and Minnesota Rules, the revisor shall replace the terms "Health Care Financing Administration" and "federal Department of Health, Education and Welfare" with "Centers for Medicare and Medicaid Services" wherever it refers to the federal agency that provides funding for the medical assistance program.

Sec. 33. **REPEALER WITHOUT EFFECT.**

The repeal of Minnesota Statutes 2000, section 256B.0635, subdivision 3, by Laws 2001, First Special Session chapter 9, article 2, section 76, with an effective date of July 1, 2001, is without effect and section 256B.0635, subdivision 3, remains in effect after June 30, 2001.

Sec. 34. **REPEALER.**

(a) Minnesota Statutes 2000, section 256B.0635, subdivision 3, is repealed effective July 1, 2002.

(b) Minnesota Statutes 2000, sections 256.025; 256B.19, subdivision 1a; and 256B.77, subdivision 24, are repealed.

Presented to the governor March 22, 2002

Signed by the governor March 25, 2002, 2:17 p.m.

CHAPTER 278—S.F.No. 3117

An act relating to the metropolitan council; providing for the transfer or disposal of interceptor facilities; proposing coding for new law in Minnesota Statutes, chapter 473.

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

Section 1. **[473.5111] TRANSFER OR DISPOSAL OF NONMETROPOLITAN INTERCEPTORS.**

Subdivision 1. **DEFINITIONS.** In this section, the definitions in this subdivision apply, except as otherwise expressly provided or indicated by the context.

(a) The term "in good operating condition" with reference to an interceptor means that the facility is currently operational and that the pipes or sewer mains portion only of the facility is expected to have structural integrity, as appropriate for the proposed use of the pipe, for a period of ten or more years after the date of a determination or certification of good operating condition under this section.

(b) The term "interceptor" has the meaning given it in section 473.121, subdivision 23, and includes a designated portion of an interceptor.

(c) The term "local government unit," with respect to an interceptor that is a storm sewer, means a local governmental unit as defined in section 473.121, subdivision 6. The term local government unit, with respect to an interceptor that is not a storm sewer, means a local government unit as defined in section 473.501, subdivision 3.

(d) The term "storm sewer" means a facility that currently carries exclusively water runoff, surface water, or other drainage, rather than sewage.

(e) The term "use as a local facility" includes use as either a sanitary sewer or a storm sewer.

Subd. 2. **NONMETROPOLITAN STATUS DETERMINATION.** The council may determine that an interceptor is no longer needed to implement the council's comprehensive plan for the collection, treatment, and disposal of sewage in the metropolitan area. If the council makes the determination, it may use the procedures in this section to sell, transfer, abandon, or otherwise dispose of the interceptor.