

STATE OF MINNESOTA

Journal of the House

EIGHTY-SIXTH SESSION — 2010

SIXTY-THIRD DAY

SAINT PAUL, MINNESOTA, FRIDAY, FEBRUARY 12, 2010

The House of Representatives convened at 10:30 a.m. and was called to order by Margaret Anderson Kelliher, Speaker of the House.

Prayer was offered by the Reverend Dennis J. Johnson, House Chaplain.

The members of the House gave the pledge of allegiance to the flag of the United States of America.

The roll was called and the following members were present:

Anderson, B.	Doepke	Hoppe	Liebling	Newton	Simon
Anderson, P.	Doty	Hornstein	Lieder	Nornes	Slawik
Anderson, S.	Downey	Hortman	Lillie	Norton	Slocum
Atkins	Drazkowski	Hosch	Loeffler	Obermueller	Smith
Beard	Eastlund	Howes	Loon	Olin	Solberg
Benson	Eken	Huntley	Mack	Otremba	Sterner
Bigham	Emmer	Jackson	Magnus	Pelowski	Swails
Bly	Falk	Johnson	Mahoney	Peppin	Thissen
Brod	Faust	Juhnke	Mariani	Peterson	Torkelson
Brown	Fritz	Kahn	Marquart	Poppe	Urdahl
Brynaert	Gardner	Kalin	Masin	Rosenthal	Wagenius
Bunn	Garofalo	Kath	McFarlane	Rukavina	Ward
Carlson	Greiling	Kelly	McNamara	Sailer	Welti
Champion	Hamilton	Kiffmeyer	Morgan	Sanders	Westrom
Clark	Hansen	Knuth	Morrow	Scalze	Winkler
Cornish	Hausman	Koenen	Mullery	Scott	Zellers
Davids	Hayden	Kohls	Murdock	Seifert	Spk. Kelliher
Dean	Hilstrom	Laine	Murphy, E.	Sertich	
Dettmer	Hilty	Lanning	Murphy, M.	Severson	
Dittrich	Holberg	Lenczewski	Nelson	Shimanski	

A quorum was present.

Abeler, Anzelc, Buesgens, Davnie, Demmer, Dill, Gottwalt, Gunther, Hackbarth, Haws, Lesch, Paymar, Persell, Reinert, Ruud, Thao and Tillberry were excused.

The Chief Clerk proceeded to read the Journal of the preceding day. McFarlane moved that further reading of the Journal be dispensed with and that the Journal be approved as corrected by the Chief Clerk. The motion prevailed.

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PETITIONS AND COMMUNICATIONS

The following communication was received:

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Margaret Anderson Kelliher
Speaker of the House of Representatives

The Honorable James P. Metzen
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 2010 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

<i>S. F. No.</i>	<i>H. F. No.</i>	<i>Session Laws Chapter No.</i>	<i>Time and Date Approved 2010</i>	<i>Date Filed 2010</i>
848		180	February 11, 1:24 p.m.	February 11
740		181	February 11, 1:25 p.m.	February 11

Sincerely,

MARK RITCHIE
Secretary of State

REPORTS OF STANDING COMMITTEES AND DIVISIONS

Eken from the Committee on Environment Policy and Oversight to which was referred:

H. F. No. 1217, A bill for an act relating to solid waste; requiring a product stewardship program operated by drug producers to collect and dispose of unwanted drugs; providing civil penalties; creating an account; proposing coding for new law in Minnesota Statutes, chapter 115A.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1

Section 1. **[115A.1410] TITLE.**

Sections 115A.1410 to 115A.1420 may be cited as the "Minnesota Safe Drug Disposal Act of 2010."

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

Sec. 2. **[115A.1411] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of sections 115A.1410 to 115A.1420, the terms in this section have the meanings given.

Subd. 2. **Covered product.** "Covered product" means all prescription drugs and all nonprescription drugs, including both brand name and generic drugs.

Subd. 3. **Controlled substance.** "Controlled substance" means a substance listed in section 152.02 or a substance designated by the Minnesota State Board of Pharmacy under section 152.02, subdivision 7, 8, or 12.

Subd. 4. **Drug wholesaler.** "Drug wholesaler" has the meaning given wholesale drug distributor in section 151.44, paragraph (b).

Subd. 5. **Drugs.** "Drugs" means:

(1) articles recognized in the official United States pharmacopoeia, the official national formulary, the official homeopathic pharmacopoeia of the United States, or any supplement of the formulary or those pharmacopoeias;

(2) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans;

(3) substances, other than food, intended to affect the structure or any function of the body of humans; or

(4) substances intended for use as a component of any substances specified in this subdivision, but not including medical devices or their component parts or accessories.

Subd. 6. **Entity.** "Entity" means a person other than an individual.

Subd. 7. **Generic drug.** "Generic drug" means a drug that is chemically identical or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use, though inactive ingredients may vary.

Subd. 8. **Mail-back program.** "Mail-back program" means a system whereby residential generators of unwanted products obtain prepaid and preaddressed mailing envelopes in which to place unwanted products for shipment to an entity that will dispose of them safely and legally.

Subd. 9. **Nonprescription drug.** "Nonprescription drug" means any drug that may be lawfully sold without a prescription.

Subd. 10. **Person.** "Person" means an individual, firm, sole proprietorship, corporation, limited liability company, general partnership, limited partnership, limited liability partnership, association, cooperative, or other legal entity, however organized.

Subd. 11. **Plan.** "Plan" means a plan required under section 115A.1413 that describes the manner in which a program will be provided.

Subd. 12. **Prescription drug.** "Prescription drug" has the meaning given in section 151.44, paragraph (d).

Subd. 13. **Producer.** (a) "Producer" means a person who has legal ownership of the brand, brand name, or co-brand of a covered product or manufactures a generic covered product sold in Minnesota.

(b) Producer does not include a retailer who:

(1) puts its store label on a covered product;

(2) imports a covered product branded or manufactured by a producer who meets the requirements of paragraph (a) and who has no physical presence in the United States; or

(3) sells at wholesale a covered product, does not have legal ownership of the brand, and elects to fulfill the responsibilities of the producer for that product.

Subd. 14. Product stewardship organization. "Product stewardship organization" means an organization designated by a group of producers to act as an agent on behalf of each producer to operate a program in this state.

Subd. 15. Program. "Program" means a program operated by a county, a producer, a group of producers, or a product stewardship organization to collect, transport, and provide for the final disposition of unwanted products.

Subd. 16. Residential generators. "Residential generators" means single- and multiple-family residences and locations where drugs are unused, unwanted, discarded, or abandoned, such as hospice services, nursing homes, boarding care homes, schools, foster care, day care, and other locations where people reside on a temporary or permanent basis. Residential generators do not include airport security, drug seizures by law enforcement, pharmacy waste, business waste, or any other source identified by the agency as a nonresidential source.

Subd. 17. Unwanted product. "Unwanted product" means a covered product no longer wanted by its owner or that has been abandoned, discarded, or is intended to be discarded by its owner.

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

Sec. 3. [115A.1412] REGISTRATION; FEE.

Subdivision 1. Requirement for sale. On or after January 1, 2011, a producer may not sell or offer for sale in this state a covered product unless the producer has filed a registration with the agency under subdivision 2 and paid a registration fee, unless the producer is exempt from the fee under subdivision 3, paragraph (c).

Subd. 2. Producer's registration. (a) A producer of covered products must, before January 1, 2011, submit a registration to the agency that includes:

(1) a list of the producer's brands of drugs offered for sale in this state;

(2) the name, address, and contact information of a person responsible for ensuring compliance with sections 115A.1410 to 115A.1420; and

(3) an estimate of the revenues from sales of covered products in this state during the previous calendar year.

(b) A producer who begins to sell or offer for sale covered products in this state after January 1, 2011, and has not filed a registration under this subdivision must submit a registration to the agency within ten days of beginning to sell or offer for sale covered products.

(c) A registration must be updated within 60 days after a change in the producer's brands of covered products sold or offered for sale in this state.

(d) A registration is effective upon receipt by the agency and is valid until January 1 of each year.

(e) The agency must review each registration and notify the producer of any information required by this section that is omitted from the registration. Within 30 days of receipt of a notification from the agency, the producer must submit a revised registration providing the information noted by the agency.

Subd. 3. **Producer's registration fee.** (a) Each producer that registers under this section must, by January 1, 2011, and each year thereafter, pay to the commissioner an annual registration fee of \$..... to cover estimated agency costs to administer the program and the program costs of counties that elect to offer a program during that calendar year, unless exempted under paragraph (c). The commissioner must deposit the fee in the account established in section 115A.1416.

(b) A producer who begins to sell or offer for sale covered products in this state after January 1, 2011, must pay the registration fee required by this subdivision when the producer submits a registration to the agency.

(c) A producer that operates its own program under section 115A.1413 individually or participates in a program in concert with other producers or through a product stewardship organization is not required to pay a registration fee.

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

Sec. 4. **[115A.1413] UNWANTED PRODUCTS COLLECTION PROGRAM.**

Subdivision 1. **Program requirements.** A program established under this section must:

- (1) accept all unwanted products presented to the program by a residential generator, regardless of the producer;
- (2) offer program services at no cost to a residential generator;
- (3) offer convenient collection options;
- (4) comply with applicable state and federal health, safety, controlled substance, and environmental laws, rules, and regulations regarding handling, transporting, and arranging for the final disposition of all unwanted products collected, including the required presence of law enforcement officials;
- (5) promote the program to residential generators, pharmacists, retailers of covered products, and health care practitioners as the proper and safe method for the final disposition of unwanted products;
- (6) prepare education and outreach materials that publicize the location and operation of collection locations throughout the county and disseminate them to health care facilities, pharmacies, and other interested parties. The program may also establish a Web site publicizing collection locations and program operations and a toll-free telephone number that residential generators can call to find nearby collection locations and understand how the program works; and
- (7) obtain written assurance from the federal Drug Enforcement Agency that the program complies with the federal Controlled Substances Act and regulations adopted thereunder.

Subd. 2. **Program plan.** (a) Each county, producer, group of producers, or product stewardship organization offering a program under this section must submit a program plan to the agency and receive the agency's approval of the plan before collecting unwanted products. A program plan must contain:

- (1) contact information for the individual directing the program;

(2) a description of the methods by which unwanted products from residential generators will be collected in all areas of the county, including the location of each collection site, and an explanation of how the collection system will be convenient and adequate to serve the needs of residents in both urban and rural areas;

(3) a description of how the unwanted products will be safely and securely tracked and handled from collection through final disposition and the policies and procedures to be followed to ensure security and compliance with state and federal health, safety, controlled substance, and environmental laws and regulations;

(4) a description of public education and outreach activities and how their effectiveness will be evaluated; and

(5) a starting date when collection of unwanted products will begin.

(b) Program plans must be submitted to the agency for approval. Within 90 days after receipt of a plan, the agency shall determine whether the plan complies with sections 115A.1410 to 115A.1420. If the agency approves a plan, it shall notify the applicant of its approval in writing. If the agency rejects a plan, it shall notify the applicant in writing of its reasons for rejecting the plan. An applicant whose plan has been rejected by the agency must submit a revised plan to the agency within 60 days after receiving notice of the rejection.

Subd. 3. **Election.** The Western Lake Superior Sanitary District may elect to offer a program under this section. If the district elects to offer a program, it has identical authority and responsibilities given to a county under sections 115A.1410 to 115A.1420 to operate a program within its legal boundaries.

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

Sec. 5. **[115A.1414] FINAL DISPOSITION OF UNWANTED PRODUCTS.**

Each county, producer, group of producers, or product stewardship organization operating a collection program under a plan that has been approved under section 115A.1413 must arrange for final disposition of all unwanted products from residential generators in accordance with all applicable state and federal laws.

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

Sec. 6. **[115A.1415] REPORTS.**

(a) On or before June 30, 2012, and in each subsequent year, each county, producer, group of producers, or product stewardship organization operating a program approved by the agency must prepare and submit to the agency an annual report describing the program's activities during the previous reporting period. The report must include the following:

(1) the amount, by weight, of unwanted products collected from residential generators at each drop-off site and the total amount by weight collected through a mail-back program, if applicable;

(2) a description of the collection system, including the location of each collection site and locations where envelopes for a mail-back program are provided, if applicable;

(3) the name and location of facilities at which unwanted products were disposed of and the weight of unwanted products collected from residential generators disposed of at each facility;

(4) the amount and proportion, by weight, of controlled substances collected at each drop-off site and through a mail-back program, if applicable;

(5) whether policies and procedures for collecting, transporting, and final disposition of unwanted products, as established in the plan, were followed and a description of any noncompliance;

(6) whether any safety or security problems occurred during the collection, transportation, or final disposition of unwanted products and, if so, what changes have or will be made to policies, procedures, or tracking mechanisms to alleviate the problem and to improve safety and security;

(7) a description of public education and outreach activities implemented, including the methodology used to evaluate the outreach and program activities; and

(8) any other information that the agency may reasonably require.

For the purposes of this section, "reporting period" means the period beginning January 1 and ending December 31 of the same calendar year.

(b) By January 1, 2013, the agency shall submit a report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over solid waste policy and solid waste finance that examines options and makes recommendations regarding methods to estimate the amount of unwanted products collected and disposed of under all active plans in a program year as a proportion of the total amount of unwanted products extant in this state during that year. The report shall suggest financial and other incentives that may be offered to producers or counties to increase the proportion of unwanted products collected.

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

Sec. 7. [115A.1416] ACCOUNT; APPROPRIATION.

(a) The pharmaceutical waste account is created in the environmental fund. The commissioner must deposit all revenue from the fee established in section 115A.1412, subdivision 3, in the account. Any interest earned on the account must be credited to the account. Money from other sources may be credited to the account.

(b) Until June 30, 2012, money in the account is annually appropriated to the commissioner to implement sections 115A.1410 to 115A.1420.

Sec. 8. [115A.1417] AGENCY DUTIES.

(a) The agency shall administer sections 115.1410 to 115A.1420.

(b) The agency shall review and approve, reject, or modify program plans submitted under section 115A.1413.

(c) The agency shall manage the account established in section 115A.1416 and shall reimburse counties for reasonable program costs incurred by the counties. If the revenues in the account exceed the amount that the agency determines is necessary for efficient and effective operation and administration of the program, including any amount for contingencies, the agency must recommend to the legislature that the producer fee be lowered in order to reduce revenues collected in the subsequent program year by the estimated amount of the excess.

(d) The agency shall provide on its Web site a list of all producers that have filed a complete registration and paid a registration fee to the agency and a list of all producers the agency has identified as noncompliant with section 115A.1412 or 115A.1415.

(e) The agency shall consult with counties and producers to estimate the costs of collection, transportation, and final disposition of drugs and may set maximum rates, on a per-pound or other basis, at which counties may be reimbursed for program activities.

(f) The agency shall provide technical assistance to counties seeking to develop a program plan or to improve an existing plan's operations, including producing a program plan template.

(g) The agency shall research alternative options for the final disposition of unwanted products.

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

Sec. 9. **[115A.1418] OTHER COLLECTION PROGRAMS.**

(a) Nothing in sections 115A.1410 to 115A.1420 prohibits or restricts the operation of any program collecting, transporting, and providing for final disposition of covered products in addition to those approved by the agency under section 115A.1413 or prohibits or restricts any persons from receiving, collecting, transporting, or providing for final disposition of covered products, provided that those persons are registered with the agency under section 115A.1412 and comply with the reporting requirements under section 115A.1415, paragraph (a), and all other applicable state and federal laws.

(b) A county or other public agency may not require households to use public facilities to collect, transport, and arrange for final disposition of covered products to the exclusion of other lawful programs available.

Sec. 10. **[115A.1419] ANTICOMPETITIVE CONDUCT.**

(a) A producer, group of producers, or product stewardship organization that organizes a system to collect, transport, and arrange for the final disposition of unwanted products under sections 115A.1410 to 115A.1420 may engage in anticompetitive conduct to the extent necessary to plan and implement its chosen organized collection system and is immune from liability under state laws relating to antitrust, restraint of trade, unfair trade practices, and other regulation of trade or commerce.

(b) An organization of producers, an individual producer, and its officers, members, employees, and agents who cooperate with a political subdivision that organizes a system to collect, transport, and arrange for the final disposition of unwanted products under sections 115A.1410 to 115A.1420 may engage in anticompetitive conduct to the extent necessary to plan and implement the organized collection system, provided that the political subdivision actively supervises the participation of each entity. An organization, entity, or person covered by this paragraph is immune from liability under state law relating to antitrust, restraint of trade, unfair trade practices, and other regulation of trade or commerce.

Sec. 11. **[115A.1420] ENFORCEMENT.**

Subdivision 1. **Generally.** Sections 115A.1410 to 115A.1420 shall be enforced in the manner provided by section 115.071, subdivisions 1 to 6.

Subd. 2. **Producer penalties.** (a) Upon first determining that a producer is offering a covered product for sale in this state but has not filed a complete registration with the agency, or has not paid a registration fee, the agency shall send the producer a written warning that the producer is in violation of section 115A.1412.

(b) A producer that has not filed a complete registration or paid a registration fee to the agency and whose covered product continues to be sold in this state 60 days after receiving a written warning from the agency must be assessed a penalty of \$10,000 for each calendar day that the violation continues.

(c) All penalties levied under this section must be deposited into the pharmaceutical waste account established under section 115A.1416.

Subd. 3. **Wholesaler penalties.** (a) It is the responsibility of a drug wholesaler offering covered products for sale in this state to view the agency's Web site to determine if a producer of products the wholesaler is offering for sale in this state is in compliance with sections 115A.1412 and 115A.1415. If a drug wholesaler is unsure of the status of a producer or believes a producer is not in compliance, the drug wholesaler shall contact the agency to determine the producer's status.

(b) The agency shall send a written notice to a drug wholesaler known to be selling a product in this state from a producer who is not in compliance with section 115A.1412 or 115A.1415.

(c) A drug wholesaler that continues to sell a covered product from a producer that is not in compliance with section 115A.1412 or 115A.1415 60 days after receiving a written notice from the agency must be assessed a penalty of \$1,000 for each day of noncompliance.

(d) All penalties levied under this section must be deposited into the pharmaceutical waste account established under section 115A.1416.

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

ARTICLE 2

Section 1. **[144.569] HANDLING OF PHARMACEUTICAL WASTE IN HEALTH CARE FACILITIES.**

Subdivision 1. **Pharmaceutical waste disposal.** Health care facilities licensed or regulated by the commissioner of health, including but not limited to nursing homes, home care and hospice entities, boarding care homes, and supervised living facilities, must not destroy or dispose of any drug by flushing the drug into the sewer or septic system. Health care facilities licensed or regulated under chapters 144, 144A, 144D, and 144G must comply with the requirements of sections 115A.1410 to 115A.1420 for the final disposition of unused or contaminated drugs.

Subd. 2. **Penalty.** For a violation of subdivision 1, the commissioner of health may impose a civil penalty not exceeding \$10,000 for each separate violation.

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

Sec. 2. Minnesota Statutes 2008, section 151.37, subdivision 6, is amended to read:

Subd. 6. **Exclusion for course of employment.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by an employee, agent, or sales representative of a registered drug manufacturer, or an employee or agent of a registered drug wholesaler, or registered pharmacy, while acting in the course of employment.

(b) Nothing in this chapter shall prohibit the following entities from possessing a legend drug for the purpose of disposing of the legend drug as pharmaceutical waste:

(1) a law enforcement officer;

(2) a hazardous waste transporter licensed by the Department of Transportation;

(3) a facility permitted by the Pollution Control Agency to treat, store, or dispose of hazardous waste, including household hazardous waste;

(4) a facility licensed by the Pollution Control Agency or a metropolitan county as a very small quantity generator collection program or a minimal generator; or

(5) a county or other entity that collects, stores, transports, or disposes of a legend drug pursuant to a program plan approved by the Pollution Control Agency under section 115A.1413 or a person authorized by one of these entities to conduct one or more of these activities.

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

Sec. 3. Minnesota Statutes 2008, section 151.37, subdivision 7, is amended to read:

Subd. 7. **Exclusion for prescriptions.** (a) Nothing in this chapter shall prohibit the possession of a legend drug by a person for that person's use when it has been dispensed to the person in accordance with a ~~written or oral~~ valid prescription issued by a practitioner.

(b) Nothing in this chapter shall prohibit a person, for whom a legend drug has been dispensed in accordance with a written or oral prescription by a practitioner, from designating a family member, caregiver, or other individual to handle the legend drug for the purpose of assisting the person in obtaining or administering the drug or sending the drug for destruction.

(c) Nothing in this chapter shall prohibit a person for whom a prescription drug has been dispensed in accordance with a valid prescription issued by a practitioner from transferring the legend drug to a county or other entity that collects, stores, transports, or disposes of a legend drug pursuant to a program plan approved under section 115A.1413 or to a person authorized by one of these entities to conduct one or more of these activities.

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

Sec. 4. Minnesota Statutes 2008, section 151.44, is amended to read:

151.44 DEFINITIONS.

As used in sections 151.43 to 151.51, the following terms have the meanings given in paragraphs (a) to ~~(h)~~ (h):

(a) "Wholesale drug distribution" means distribution of prescription or nonprescription drugs to persons other than a consumer or patient or reverse distribution of such drugs, but does not include:

(1) a sale between a division, subsidiary, parent, affiliated, or related company under the common ownership and control of a corporate entity;

(2) the purchase or other acquisition, by a hospital or other health care entity that is a member of a group purchasing organization, of a drug for its own use from the organization or from other hospitals or health care entities that are members of such organizations;

(3) the sale, purchase, or trade of a drug or an offer to sell, purchase, or trade a drug by a charitable organization described in section 501(c)(3) of the Internal Revenue Code of 1986, as amended through December 31, 1988, to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

(4) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug among hospitals or other health care entities that are under common control;

(5) the sale, purchase, or trade of a drug or offer to sell, purchase, or trade a drug for emergency medical reasons;

(6) the sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription;

(7) the transfer of prescription or nonprescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage;

(8) the distribution of prescription or nonprescription drug samples by manufacturers representatives; or

(9) the sale, purchase, or trade of blood and blood components.

(b) "Wholesale drug distributor" means anyone engaged in wholesale drug distribution including, but not limited to, manufacturers; repackers; own-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and pharmacies that conduct wholesale drug distribution. A wholesale drug distributor does not include a common carrier or individual hired primarily to transport prescription or nonprescription drugs.

(c) "Manufacturer" means anyone who is engaged in the manufacturing, preparing, propagating, compounding, processing, packaging, repackaging, or labeling of a prescription drug.

(d) "Prescription drug" means a drug required by federal or state law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to United States Code, title 21, sections 811 and 812.

(e) "Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

(f) "Blood components" means that part of blood separated by physical or mechanical means.

(g) "Reverse distribution" means the receipt of prescription or nonprescription drugs received from or shipped to Minnesota locations for the purpose of returning the drugs to their producers or distributors.

(h) "Reverse distributor" means a person engaged in the reverse distribution of drugs.

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

Delete the title and insert:

"A bill for an act relating to solid waste; requiring drug producers to register and pay a fee; providing for a drug collection program funded by drug producers; requiring reports; creating an account; providing penalties; expanding categories of persons allowed to possess legend and nonprescription drugs to include those disposing of them; modifying definitions; prohibiting flushing drugs into sewer system by health care facilities; appropriating money; amending Minnesota Statutes 2008, sections 151.37, subdivisions 6, 7; 151.44; proposing coding for new law in Minnesota Statutes, chapters 115A; 144."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Health Care and Human Services Policy and Oversight.

The report was adopted.

Hilstrom from the Committee on Public Safety Policy and Oversight to which was referred:

H. F. No. 1457, A bill for an act relating to public safety; eliminating various unfunded mandates affecting local governmental units; amending Minnesota Statutes 2008, sections 260B.171, subdivision 3; 609.115, subdivision 1.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Mariani from the Committee on K-12 Education Policy and Oversight to which was referred:

H. F. No. 2360, A bill for an act relating to Special School District No. 1, Minneapolis; providing for two members appointed by Special School District No. 1, Minneapolis, on the Minneapolis reapportionment commission; establishing standards.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"Section 1. **SPECIAL SCHOOL DISTRICT NO. 1, MINNEAPOLIS.**

Notwithstanding chapter 1, section 3, of the home rule charter of the city of Minneapolis, the Board of Education of Special School District No. 1, Minneapolis, may appoint two members to serve on the Minneapolis redistricting commission to replace the two members of the commission appointed by the majority and minority caucuses of the city council for the purpose of determining the redistricting of Special School District No. 1, Minneapolis Board of Education districts.

The two members appointed by the school board shall participate with the other appointed members of the redistricting commission, except city council appointees, to determine the redistricting of school board districts. School board appointees shall not sit in considering the redistricting of city council ward boundaries. The redistricting commission may adopt necessary procedures to ensure full participation by school board appointees in its process.

Sec. 2. **STANDARDS.**

Within the time specified in chapter 1, section 3, and chapter 16, section 1, of the home rule charter of the city of Minneapolis, the redistricting commission shall set the boundaries of the school board districts in accordance with the following standards:

(1) The ideal population for each district shall be determined by dividing the total population of the school district by six. In no case shall any district, when readjusted, have a population more than five percent over or under the ideal population.

(2) Each district shall consist of contiguous compact territory not more than twice as long as it is wide. The existence of a lake within a district shall not be contrary to this provision. Whenever possible, district boundary lines shall follow the center line of streets, avenues, alleys, and boulevards and as nearly as practicable, shall run due east and west or north and south.

(3) To the extent possible, each newly drawn district shall retain the same numerical designation as the previously existing district from which the newly drawn district received the largest portion of its population.

(4) The districts must not dilute the voting strength of racial or language minority populations. Where a concentration of a racial or language minority makes it possible, the districts must increase the probability that members of the minority will be elected.

(5) The districts should attempt to preserve communities of interest where that can be done in compliance with the preceding standards.

(6) Population shall be determined by use of the official population, as stated by census tracts and blocks in the official United States Census. Whenever it is necessary to modify census data in fixing a district boundary, the redistricting commission may compute the population of any part by use of other pertinent data or may have a special enumeration made of any block or blocks using the standards of the United States Census. If the population of any block or blocks is so determined, the redistricting commission may assume that the remainder of the census tract has the remaining population shown by the census. In every such case, the determination of the redistricting commission as to population shall be conclusive, unless clearly contrary to the census.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day after Special School District No. 1, Minneapolis, complies with Minnesota Statutes, section 645.021, subdivision 3."

Delete the title and insert:

"A bill for an act relating to Special School District No. 1, Minneapolis; providing for two members appointed by Special School District No. 1, Minneapolis, on the Minneapolis redistricting commission; establishing standards."

With the recommendation that when so amended the bill pass and be re-referred to the Committee on State and Local Government Operations Reform, Technology and Elections.

The report was adopted.

Hilstrom from the Committee on Public Safety Policy and Oversight to which was referred:

H. F. No. 2470, A bill for an act relating to crime; including use of scanning device and reencoder to acquire information from payment cards as identity theft; amending Minnesota Statutes 2008, section 609.527, subdivisions 1, 6, by adding a subdivision; Minnesota Statutes 2009 Supplement, section 388.23, subdivision 1.

Reported the same back with the following amendments:

Page 3, line 6, before the period, insert ", driver's license, or state-issued identification card"

Page 3, line 8, after "card" insert ", driver's license, or state-issued identification card"

Page 3, line 9, after "card" insert ", driver's license, state-issued identification card,"

Page 3, line 31, delete the new language and reinstate the stricken language

Page 3, line 31, after "5a" insert "or 5b"

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Finance.

The report was adopted.

Hilstrom from the Committee on Public Safety Policy and Oversight to which was referred:

H. F. No. 2616, A bill for an act relating to traffic regulations; allowing bicyclist to stop and proceed through red light under limited circumstances; amending Minnesota Statutes 2008, section 169.06, subdivision 9.

Reported the same back with the recommendation that the bill pass.

The report was adopted.

Carlson from the Committee on Finance to which was referred:

H. F. No. 2680, A bill for an act relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2, 3; 256.969, subdivisions 21, 26, 27; 256B.0625, subdivision 13f, by adding a subdivision; 256B.69, by adding a subdivision; 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a, 30; 256B.195, subdivision 3; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

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

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

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

(a) Mental health urgent care includes:

(1) initial mental health screening;

(2) mobile crisis assessment and intervention;

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

(4) nonhospital crisis stabilization residential beds; and

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

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

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

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

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

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

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

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

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

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

(4) the first priority for this service is to provide the consultations required under section 256B.0625, subdivision 13j; and

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

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

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

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

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

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

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

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

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

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

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

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

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

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

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

The amounts in this paragraph shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(d) The commissioner may adjust the intergovernmental transfers under paragraph (c) and the payments under paragraph (a) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limits imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding increased local share.

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

Sec. 5. Minnesota Statutes 2008, section 256.969, subdivision 27, is amended to read:

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

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

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

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

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

with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, paragraphs (a) to (d), except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on general assistance medical care payments for services rendered on or after March 1, 2010, to June 30, 2011, the amount of the three percent ratable reduction required under this paragraph shall be deposited in the account established in section 256D.032.

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

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

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

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

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

Sec. 6. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 5.

Sec. 8. Minnesota Statutes 2009 Supplement, section 256B.196, subdivision 2, is amended to read:

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

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

(c) Beginning January 1, 2010, Hennepin County and Ramsey County ~~shall~~ may make monthly voluntary intergovernmental transfers to the commissioner in ~~the following~~ amounts: ~~\$133,333 by~~ not to exceed \$12,000,000 per year from Hennepin County and \$100,000 by \$6,000,000 per year from Ramsey County. The commissioner shall increase the medical assistance capitation payments to ~~Metropolitan Health Plan and HealthPartners by any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Hennepin County Medical Center or Regions Hospital.~~ The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation-, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Hennepin County Medical Center and Regions Hospital by those plans. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

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

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

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

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

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) The commissioner may adjust the intergovernmental transfers under paragraph (e) and the payments under paragraph (g) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limitations imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding increased local share.

(k) This section shall be implemented upon federal approval of the rate increase and a federal determination that the increased transfers do not violate the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding the local share, retroactive to admissions occurring on or after July 15, 2010.

Sec. 10. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is amended to read:

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

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

(2) who is a resident of Minnesota; and

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

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

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

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

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

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

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

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

- (2) fail to meet the requirements of section 256L.09, subdivision 2;
- (3) are homeless as defined by United States Code, title 42, section 11301, et seq.;
- (4) are classified as end-stage renal disease beneficiaries in the Medicare program;
- (5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;
- (6) are eligible under paragraph (k);
- (7) receive treatment funded pursuant to section 254B.02; or
- (8) reside in the Minnesota sex offender program defined in chapter 246B.

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

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

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

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

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

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

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

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

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

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

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

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

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

Sec. 11. Minnesota Statutes 2008, section 256D.03, subdivision 3a, is amended to read:

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

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

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

Sec. 12. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

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

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

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

Sec. 13. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

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

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

(2) outpatient hospital services;

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

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the copayment.

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

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

Subd. 6. Coordinated care delivery option. (a) A county or group of counties may elect to provide health care and supportive services to individuals who are eligible for general assistance medical care under this section and who reside within the county or counties through a coordinated care delivery option. The health care services provided by the county must include the services described in subdivision 5 with the exception of outpatient prescription drug coverage but including drugs administered in an outpatient setting. Support services may include, but are not limited to, social services, outreach, health care navigation, housing, and transportation. Counties that elect to provide health care services through this option must ensure that the requirements of this subdivision are met. Upon electing to provide services through this option, the county accepts the financial risk of the delivery of the health care services described in this subdivision to general assistance medical care recipients residing in the county for the period beginning July 1, 2010, and ending July 1, 2011, for the fixed payments described in subdivision 10.

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

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

(2) the geographic area to be served.

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

(d) A county must demonstrate the ability to:

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

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

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

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

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

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

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

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

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

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

Subd. 9. Payments; fee-for-service rates for the period between July 1, 2010, and July 1, 2011. (a) Effective for services provided on or after July 1, 2010, and before July 1, 2011, to general assistance medical care recipients residing in counties that are not served through the coordinated care delivery option, payments shall be made by the commissioner to providers at rates described in this subdivision.

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

(1) 65.6 percent of the general assistance medical care rate in effect on February 28, 2010, if the inpatient hospital services were provided in a hospital where the fee-for-service inpatient and outpatient hospital general assistance medical care payments to the hospital for admissions provided in calendar year 2007 totaled \$1,000,000

or more or the hospital's fee-for-service inpatient and outpatient hospital general assistance medical care payments received for calendar year 2007 admissions was one percent or more of the hospital's net patient revenue received for services provided in calendar year 2007; or

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

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

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

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

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

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

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

Subd. 11. Veterans medical review team. (a) To ensure the timely processing of determinations of service-connected disabilities among veterans enrolled in the temporary general assistance medical care program, the commissioner shall review all medical evidence submitted by enrollees with a referral and seek additional information from providers, applicants, and enrollees to support the determination of a service-connected disability when necessary. Service-connected disability shall be determined according to the regulations and policies of the United States Department of Veterans Affairs.

(b) Prior to a denial or withdrawal of a requested determination of service-connected disability due to insufficient evidence, the commissioner shall:

(1) ensure that the missing evidence is necessary and appropriate to a determination of service-connected disability; and

(2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and veterans affairs finance and budget the following information on the activities of the veterans medical review team by August 1, 2010, and provide an update by January 1, 2011:

(1) the number of applications to the veterans medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals and appeal results;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for service-connected veterans benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

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

Sec. 14. **[256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

The general assistance medical care account is created in the special revenue fund. Money deposited into the account is subject to appropriation by the legislature, and shall be used only for expenditures related to the general assistance medical care program or as provided in this act.

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

Sec. 15. Minnesota Statutes 2008, section 256D.06, subdivision 7, is amended to read:

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

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

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

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

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

Sec. 16. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:

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

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

Sec. 17. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

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

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

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

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

Sec. 19. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

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

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

Sec. 20. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

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

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

Sec. 21. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

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

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

Sec. 22. **DRUG REBATE PROGRAM.**

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

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

Sec. 23. **PROVIDER PARTICIPATION.**

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

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

Sec. 24. TEMPORARY SUSPENSION.

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

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

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

Sec. 25. COORDINATED CARE DELIVERY ORGANIZATION DEMONSTRATION PROJECT.

The commissioner of human services shall develop, and present to the legislature by December 15, 2010, a plan to establish a demonstration project to deliver inpatient hospital, primary care, and specialist services to general assistance medical care enrollees through coordinated care delivery organizations, beginning January 1, 2012. Each coordinated care delivery organization must deliver coordinated care through at least one hospital and one physician group practice, and may include counties and other health care providers. The coordinated care delivery organization must provide inpatient hospital services to general assistance medical care enrollees eligible for the program under Minnesota Statutes, section 256D.03 or 256D.031. The coordinated care delivery organization must accept responsibility for the quality of care and must assume financial risk for the services provided. The plan must include:

(1) financial incentives for coordinated care delivery organizations to reduce the growth in the volume and cost of services provided, while maintaining or improving the quality of care;

(2) recommendations for the delivery of services not provided through a coordinated care delivery organization and coordination of outpatient and inpatient health care services;

(3) recommendations as to the size and scope of the demonstration project and whether participation would be mandatory or voluntary for general assistance medical care enrollees; and

(4) recommendations for managing financial risk within a coordinated care delivery organization.

Sec. 26. APPROPRIATION TRANSFERS.

(a) Of the general fund appropriation to the commissioner of human services for health care management in Laws 2009, chapter 79, article 13, section 3, subdivision 7, as amended by Laws 2009, chapter 173, article 2, section 1, \$3,300,000 for health care administration and \$4,100,000 for health care operations shall be transferred on March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032. These amounts are appropriated to the commissioner for the administration and operation of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation and accounting, the commissioner may transfer the amounts appropriated for program administration and operation to the general fund.

(b) Of the general fund appropriation to the commissioner of human services for general assistance medical care grants in fiscal year 2010 in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (d), as amended by Laws 2009, chapter 173, article 2, section 1, \$44,000,000 shall be transferred on March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032, and any unexpended amount not used for general assistance medical care expenditures incurred prior to March 1, 2010, does not cancel and shall be transferred to the fund established in Minnesota Statutes, section 256D.032, by January 1, 2011.

(c) The commissioner of finance shall transfer \$169,733,000 in fiscal year 2011 and \$12,979,000 in fiscal year 2012, from the general fund to the fund established in Minnesota Statutes, section 256D.032.

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

Sec. 27. **APPROPRIATION REDUCTION; TRANSFER.**

(a) The general fund appropriation to the commissioner of human services for children and community services grants in Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is reduced by \$11,560,000 in fiscal year 2011 and is reduced by \$1,062,000 in fiscal year 2012. The general fund base for children and community service grants is increased by \$11,560,000 per year for fiscal years 2012 and 2013. The general fund base for children and community service grants is further increased by \$1,062,000 for fiscal year 2013. This \$1,062,000 increase is onetime.

(b) The general fund appropriation to the commissioner of human services for adult mental health grants in Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is reduced by \$11,560,000 in fiscal year 2011 and is reduced by \$1,062,000 in fiscal year 2012. The general fund base for adult mental health grants is increased by \$11,560,000 per year in fiscal years 2012 and 2013. The general fund base for adult mental health grants is further increased by \$1,062,000 for fiscal year 2013. This \$1,062,000 increase is onetime.

(c) \$23,120,000 shall be transferred in fiscal year 2011 from the general fund to the general assistance medical care account established in Minnesota Statutes, section 256D.032.

(d) \$2,124,000 shall be transferred in fiscal year 2012 from the general fund to the general assistance medical care account established in Minnesota Statutes, section 256D.032. \$2,124,000 shall be transferred in fiscal year 2013 from the general assistance medical care account established in Minnesota Statutes, section 256D.032, to the general fund.

Sec. 28. **APPROPRIATIONS.**

\$..... for the period from March 1, 2010, to June 30, 2010, and \$..... for fiscal year 2011 is appropriated from the account established in Minnesota Statutes, section 256D.032, to the commissioner of human services for the general assistance medical care program established in Minnesota Statutes, section 256D.031.

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

Delete the title and insert:

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

With the recommendation that when so amended the bill pass and be re-referred to the Committee on Ways and Means.

The report was adopted.

Solberg from the Committee on Ways and Means to which was referred:

H. F. No. 2700, A bill for an act relating to capital improvements; authorizing spending to acquire and better public land and buildings and other improvements of a capital nature with certain conditions; establishing new programs and modifying existing programs; authorizing the sale and issuance of state bonds; cancelling and modifying previous appropriations; appropriating money; amending Minnesota Statutes 2008, sections 16A.105; 16A.66, subdivision 2; 103F.161, subdivision 3; 103F.515, by adding a subdivision; 116J.435, as amended; 174.50, subdivisions 6, 7; 256E.37, subdivisions 1, 2; 462A.36, subdivision 4, by adding a subdivision; Minnesota Statutes 2009 Supplement, sections 16A.647, subdivisions 1, 5; 16A.86, subdivision 3a; Laws 2005, chapter 20, article 1, sections 19, subdivision 4; 23, subdivision 12, as amended; Laws 2006, chapter 258, sections 5, subdivision 3; 8, subdivision 4; 17, subdivision 5; 21, subdivision 14, as amended; Laws 2008, chapter 152, article 2, section 3, subdivision 2; Laws 2008, chapter 179, sections 5, subdivision 4; 7, subdivisions 8, 27; 21, subdivision 9; Laws 2008, chapter 365, sections 4, subdivision 3; 5, subdivision 2; 24, subdivision 2; 25; Laws 2009, chapter 93, article 1, sections 11, subdivision 5; 20; proposing coding for new law in Minnesota Statutes, chapters 16A; 16B; repealing Laws 2009, chapter 93, article 1, section 45.

Reported the same back with the following amendments:

Page 63, after line 27, insert:

"Sec. 30. Minnesota Statutes 2008, section 16A.501, is amended to read:

16A.501 REPORT ON EXPENDITURE OF BOND PROCEEDS.

(a) The commissioner of management and budget must report annually to the legislature on the degree to which entities receiving appropriations for capital projects in previous omnibus capital improvement acts have encumbered or expended that money. The report must be submitted to the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee by January 1 of each year.

(b) The commissioner of management and budget must report annually to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over capital investment, finance, and ways and means, on the amount and percentage of each agency's capital appropriation that is used to pay for the capital costs of staff directly attributable to the capital project or projects funded with state general obligation bond proceeds. The report must also include information on agencies' compliance with the commissioner's policies governing the use of general obligation bond proceeds to pay staff costs and any changes to the commissioner's policies.

Page 71, delete sections 42 and 43

Renumber the sections in sequence and correct the internal references

Correct the title numbers accordingly

With the recommendation that when so amended the bill pass.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 1457, 2616 and 2700 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House Files were introduced:

Greiling and Otremba introduced:

H. F. No. 2918, A bill for an act relating to food safety; authorizing certain beverage production in basements; directing the commissioner of agriculture to amend Minnesota Rules.

The bill was read for the first time and referred to the Committee on Commerce and Labor.

Anderson, S.; Drazkowski; Murdock; Urdahl; Scott; Hamilton and Gunther introduced:

H. F. No. 2919, A bill for an act relating to state finance; requiring a balanced budget prior to passage of other legislation; proposing coding for new law in Minnesota Statutes, chapter 16A.

The bill was read for the first time and referred to the Committee on Finance.

Welti introduced:

H. F. No. 2920, A bill for an act relating to motor vehicles; clarifying definition of motor vehicle; amending Minnesota Statutes 2008, sections 65B.43, subdivision 2; 169.09, subdivision 5a.

The bill was read for the first time and referred to the Transportation and Transit Policy and Oversight Division.

Hornstein, Lieder, Hausman, Paymar and Masin introduced:

H. F. No. 2921, A bill for an act relating to highways; imposing moratorium on electronic advertising devices; amending Minnesota Statutes 2008, section 160.02, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 160.

The bill was read for the first time and referred to the Transportation and Transit Policy and Oversight Division.

Thissen introduced:

H. F. No. 2922, A bill for an act relating to retirement; Minneapolis Employees Retirement Fund; transfer of administrative functions to the Public Employees Retirement Association; creation of MERF consolidation account within the Public Employees Retirement Association; appropriating money; amending Minnesota Statutes 2008, sections 11A.23, subdivision 4; 13D.01, subdivision 1; 43A.17, subdivision 9; 43A.316, subdivision 8; 69.021, subdivision 10; 126C.41, subdivision 3; 256D.21; 353.01, subdivision 2b, by adding subdivisions; 353.03, subdivision 1; 353.05; 353.27, as amended; 353.34, subdivisions 1, 6; 353.37, subdivisions 1, 2, 3, 4, 5; 353.46, subdivisions 2, 6; 353.64, subdivision 7; 353.71, subdivision 4; 353.86, subdivisions 1, 2; 353.87, subdivisions 1, 2; 353.88; 354.71; 354A.011, subdivision 27; 354A.39; 356.214, subdivision 1; 356.215, subdivision 8; 356.30, subdivision 3; 356.302, subdivisions 1, 7; 356.303, subdivision 4; 356.407, subdivision 2; 356.431, subdivision 1; 356.465, subdivision 3; 356.64; 356.65, subdivision 2; 356.91; 422A.101, subdivision 3; 422A.26; 473.511,

subdivision 3; 473.606, subdivision 5; 475.52, subdivision 6; Minnesota Statutes 2009 Supplement, sections 6.67; 69.011, subdivision 1; 69.031, subdivision 5; 352.01, subdivision 2b; 353.01, subdivision 2a; 353.06; 356.20, subdivision 2; 356.215, subdivision 11; 356.32, subdivision 2; 356.401, subdivision 3; 356.415, subdivision 2; 356.96, subdivision 1; 480.181, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 353; repealing Minnesota Statutes 2008, sections 13.63, subdivision 1; 69.011, subdivision 2a; 356.43; 422A.01, subdivisions 1, 2, 3, 4, 4a, 5, 6, 7, 8, 9, 10, 11, 12, 13a, 17, 18; 422A.02; 422A.03; 422A.04; 422A.05, subdivisions 1, 2a, 2b, 2c, 2d, 2e, 2f, 5, 6, 8; 422A.06, subdivisions 1, 2, 3, 5, 6, 7; 422A.08, subdivision 1; 422A.09; 422A.10; 422A.101, subdivisions 1, 1a, 2, 2a; 422A.11; 422A.12; 422A.13; 422A.14, subdivision 1; 422A.15; 422A.151; 422A.155; 422A.156; 422A.16, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; 422A.17; 422A.18, subdivisions 1, 2, 3, 4, 5, 7; 422A.19; 422A.20; 422A.21; 422A.22, subdivisions 1, 3, 4, 6; 422A.23, subdivisions 1, 2, 5, 6, 7, 8, 9, 10, 11, 12; 422A.231; 422A.24; 422A.25; Minnesota Statutes 2009 Supplement, sections 422A.06, subdivision 8; 422A.08, subdivision 5.

The bill was read for the first time and referred to the Committee on State and Local Government Operations Reform, Technology and Elections.

Johnson introduced:

H. F. No. 2923, A bill for an act relating to human services; appropriating money for the Ramsey County mothers first program to fund early intervention efforts designed to discourage pregnant women from using alcohol and illegal drugs.

The bill was read for the first time and referred to the Committee on Finance.

Hayden and Johnson introduced:

H. F. No. 2924, A bill for an act relating to human services; restoring state matching funds for county financial workers; appropriating money.

The bill was read for the first time and referred to the Committee on Finance.

Kath; Murphy, M.; Solberg; Gunther and Davids introduced:

H. F. No. 2925, A bill for an act relating to Public Facilities Authority; amending certain programs; making technical changes; amending Minnesota Statutes 2008, sections 446A.03, subdivision 5; 446A.07, subdivision 8; 446A.072, subdivisions 1, 3, 5a, 9; 446A.081, subdivision 9; 446A.086, subdivisions 1, 2, 11; Minnesota Statutes 2009 Supplement, sections 446A.075, subdivisions 1a, 2, 4, 5; 446A.081, subdivision 8.

The bill was read for the first time and referred to the Committee on Finance.

Hosch introduced:

H. F. No. 2926, A bill for an act relating to human services; amending children's mental health policy provisions; making a technical change to community health workers; amending Minnesota Statutes 2008, section 260C.157, subdivision 3; Minnesota Statutes 2009 Supplement, sections 245.4885, subdivisions 1, 1a; 256B.0625, subdivision 49; 256B.0943, subdivision 9.

The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight.

Thisen introduced:

H. F. No. 2927, A bill for an act relating to health; providing administrative simplification by adding a health care clearinghouse for health care provider transactions; amending Minnesota Statutes 2008, sections 62J.51, by adding subdivisions; 62J.536, subdivisions 1, 2b, by adding a subdivision.

The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight.

Champion, Pelowski, Hornstein, Davnie and Hayden introduced:

H. F. No. 2928, A bill for an act relating to state government; modifying provisions governing observance of Juneteenth; amending Minnesota Statutes 2008, section 10.55.

The bill was read for the first time and referred to the Committee on State and Local Government Operations Reform, Technology and Elections.

Kelly introduced:

H. F. No. 2929, A bill for an act relating to capital investment; appropriating money for the Red Wing River Way Trail; authorizing the sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Finance.

Hamilton introduced:

H. F. No. 2930, A bill for an act relating to motor vehicles; creating a special license plate for veterans who are Korean Defense Service Medal recipients; proposing coding for new law in Minnesota Statutes, chapter 168.

The bill was read for the first time and referred to the Committee on Finance.

Eastlund introduced:

H. F. No. 2931, A bill for an act relating to capital improvements; appropriating money to replace a municipal bridge in the city of Cambridge; authorizing the sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Finance.

Jackson, Howes, McNamara, Solberg and Scalze introduced:

H. F. No. 2932, A bill for an act relating to capital investment; appropriating money for aquatic and wildlife management areas and critical habitat; authorizing the sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Finance.

Hansen introduced:

H. F. No. 2933, A bill for an act relating to elections; requiring application for a waiver allowing certain overseas absentee ballots to be counted.

The bill was read for the first time and referred to the Committee on State and Local Government Operations Reform, Technology and Elections.

Slocum and Hausman introduced:

H. F. No. 2934, A bill for an act relating to capital improvements; appropriating money for emergency building stabilization at Fort Snelling Upper Bluff; authorizing sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Finance.

Demmer introduced:

H. F. No. 2935, A bill for an act relating to state lands; authorizing conveyance of certain surplus state land.

The bill was read for the first time and referred to the Committee on Environment Policy and Oversight.

Morrow, Garofalo, Kohls, Brown, Poppe, Urdahl, Slocum, Emmer, Scalze, Brynaert and Olin introduced:

H. F. No. 2936, A bill for an act relating to crimes; providing penalty for careless driving resulting in death; providing for revocation of violator's driver's license; amending Minnesota Statutes 2008, sections 169.13, by adding a subdivision; 171.17, subdivision 1; 171.30, subdivision 2a.

The bill was read for the first time and referred to the Committee on Public Safety Policy and Oversight.

Hortman and Welti introduced:

H. F. No. 2937, A bill for an act relating to transportation; requiring annual report to legislature on passenger rail projects; amending Minnesota Statutes 2009 Supplement, section 174.636.

The bill was read for the first time and referred to the Committee on Finance.

Thissen, Loeffler, Fritz and Murphy, E., introduced:

H. F. No. 2938, A bill for an act relating to human services; modifying programs and licensure provisions for services to persons with disabilities; amending Minnesota Statutes 2008, section 326B.43, subdivision 2; Minnesota Statutes 2009 Supplement, sections 245A.03, subdivision 7; 245A.11, subdivisions 7a, 7b; 256D.44, subdivision 5; Laws 2009, chapter 79, article 8, sections 81; 84.

The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight.

Hosch introduced:

H. F. No. 2939, A bill for an act relating to traffic regulations; authorizing protective agents to use flashing lights in certain traffic situations; amending Minnesota Statutes 2008, sections 169.64, subdivision 3, by adding a subdivision; 326.338, subdivision 4.

The bill was read for the first time and referred to the Committee on Public Safety Policy and Oversight.

Loeffler, Abeler, Bunn and Gardner introduced:

H. F. No. 2940, A bill for an act relating to human services; repealing prohibition on using a broker to coordinate medical assistance covered transportation services; appropriating money; repealing Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 18b.

The bill was read for the first time and referred to the Committee on Finance.

Anzelc, Solberg, Johnson, Abeler and Anderson, S., introduced:

H. F. No. 2941, A bill for an act relating to insurance; regulating dental insurance provider agreements; amending Minnesota Statutes 2008, section 62Q.76, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 62Q.

The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight.

Atkins and Hoppe introduced:

H. F. No. 2942, A bill for an act relating to commerce; regulating various licensees and other entities; modifying informational requirements, continuing education requirements, and notice requirements; making various housekeeping, technical, and clarifying changes; reorganizing various provisions relating to real estate brokers, salespersons, and closing agents; modifying the membership requirements of, and appointment authority to, the real estate appraiser advisory board; amending Minnesota Statutes 2008, sections 45.0112; 60A.084; 60A.204; 60K.31, subdivision 10; 61A.092, subdivision 3; 62A.17, subdivision 5; 62A.65, subdivision 2; 62E.02, subdivision 15; 62E.14, subdivision 4c; 62L.05, subdivision 4; 62S.24, subdivision 8; 62S.266, subdivision 4; 62S.29, subdivision 1; 72A.20, subdivisions 36, 37; 72A.492, subdivision 2; 80A.41; 82.17, subdivision 15, by adding a subdivision; 82.19; 82.21, subdivision 2; 82.24, subdivision 3; 82.29, subdivisions 4, 5, 8; 82.31, subdivisions 1, 2; 82.33, subdivisions 1, 2, by adding a subdivision; 82.34, subdivisions 1, 2, 4, 5, 13; 82.39; 82.41, subdivisions 1, 2, by adding a subdivision; 82.45, subdivision 3, by adding subdivisions; 82.48, subdivisions 2, 3; 82B.05, as amended; Minnesota Statutes 2009 Supplement, sections 45.027, subdivision 1; 45.30, subdivision 4; 60A.9572, subdivision 6; 65A.29, subdivision 13; 82.31, subdivision 4; 82.32; proposing coding for new law in Minnesota Statutes, chapter 82; repealing Minnesota Statutes 2008, sections 82.19, subdivision 3; 82.22, subdivisions 1, 6, 7, 8, 9; 82.31, subdivision 6; 82.34, subdivision 16; 82.41, subdivisions 3, 7; 332.335; Minnesota Statutes 2009 Supplement, section 65B.133, subdivision 3.

The bill was read for the first time and referred to the Committee on Commerce and Labor.

Sterner, Jackson, Juhnke, Koenen and Rosenthal introduced:

H. F. No. 2943, A bill for an act relating to the military; appropriating money for payments to certain current and former Army National Guard members to satisfy federal obligations to those members.

The bill was read for the first time and referred to the Committee on Finance.

Greiling; Ward; Murphy, M.; Mariani; Davnie; Tillberry; Anzelc; Slocum; Newton; Paymar; Lillie; Hornstein and Kelliher introduced:

H. F. No. 2944, A bill for an act relating to education finance; modifying the school finance system; creating a new education funding framework; making changes to income tax schedules; amending Minnesota Statutes 2008, sections 123B.53, subdivision 5; 124D.4531, as amended; 124D.59, subdivision 2; 124D.65, subdivision 5; 125A.76, subdivision 5; 125A.79, subdivision 7; 126C.01, by adding subdivisions; 126C.05, subdivisions 1, 3, 5, 6, 8, 16, 17; 126C.10, subdivisions 1, 2, 2a, 3, 4, 6, 13, 14, 18, by adding subdivisions; 126C.13, subdivisions 4, 5; 126C.17, subdivisions 1, 5, 6; 126C.20; 126C.40, subdivision 1; 127A.51; 290.06, subdivision 2d; Minnesota Statutes 2009 Supplement, section 290.06, subdivision 2c; proposing coding for new law in Minnesota Statutes, chapters 123B; 126C; repealing Minnesota Statutes 2008, sections 123B.54; 123B.57, subdivisions 3, 4, 5; 123B.591; 125A.76, subdivision 4; 125A.79, subdivision 6; 126C.10, subdivisions 2b, 13a, 13b, 24, 25, 26, 27, 28, 29, 30, 31, 31a, 31b, 32, 33, 34, 35, 36; 126C.12; 126C.126; 127A.50.

The bill was read for the first time and referred to the Committee on Finance.

Mahoney, Nelson and Lanning introduced:

H. F. No. 2945, A bill for an act relating to the State Building Code; modifying municipal enforcement provisions; amending Minnesota Statutes 2008, section 326B.121, subdivision 2.

The bill was read for the first time and referred to the Committee on State and Local Government Operations Reform, Technology and Elections.

MESSAGES FROM THE SENATE

The following message was received from the Senate:

Madam Speaker:

I have the honor to announce the passage by the Senate of the following Senate File, herewith transmitted:

S. F. No. 2168.

PETER S. WATTSON, Secretary of the Senate (Legislative)

FIRST READING OF SENATE BILLS

S. F. No. 2168, A bill for an act relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.969, subdivision 27, by adding a subdivision; 256B.0625, subdivision 13f, by adding a

subdivision; 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a; 256B.196, subdivision 2; 256B.199; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D.

The bill was read for the first time and referred to the Committee on Ways and Means.

MOTIONS AND RESOLUTIONS

Simon moved that the name of Scalze be added as an author on H. F. No. 224. The motion prevailed.

Brod moved that the name of Zellers be added as an author on H. F. No. 1057. The motion prevailed.

Fritz moved that the name of Zellers be added as an author on H. F. No. 1058. The motion prevailed.

Gottwalt moved that the name of Zellers be added as an author on H. F. No. 1196. The motion prevailed.

Smith moved that the name of Zellers be added as an author on H. F. No. 1197. The motion prevailed.

Nelson moved that the name of Ward be added as an author on H. F. No. 1793. The motion prevailed.

Davnie moved that the name of Paymar be added as an author on H. F. No. 2329. The motion prevailed.

Hansen moved that the names of Simon and Obermueller be added as authors on H. F. No. 2412. The motion prevailed.

Pelowski moved that the name of Welti be added as an author on H. F. No. 2476. The motion prevailed.

Ward moved that the names of Newton and Doty be added as authors on H. F. No. 2538. The motion prevailed.

Shimanski moved that his name be stricken as an author on H. F. No. 2583. The motion prevailed.

Ward moved that the name of Welti be added as an author on H. F. No. 2601. The motion prevailed.

Hansen moved that the name of Garofalo be added as an author on H. F. No. 2658. The motion prevailed.

Juhnke moved that the names of Faust and Urdahl be added as authors on H. F. No. 2678. The motion prevailed.

Marquart moved that the name of Lanning be added as an author on H. F. No. 2688. The motion prevailed.

Sertich moved that the name of Welti be added as an author on H. F. No. 2690. The motion prevailed.

Davnie moved that the name of Lanning be added as an author on H. F. No. 2750. The motion prevailed.

Lenczewski moved that the name of Rosenthal be added as an author on H. F. No. 2763. The motion prevailed.

Benson moved that the name of Clark be added as an author on H. F. No. 2799. The motion prevailed.

Obermueller moved that the name of McFarlane be added as an author on H. F. No. 2801. The motion prevailed.

Juhnke moved that the name of Brown be added as an author on H. F. No. 2806. The motion prevailed.

Bunn moved that the names of Mullery, Kalin, Morrow and Lanning be added as authors on H. F. No. 2839. The motion prevailed.

Downey moved that the name of Severson be added as an author on H. F. No. 2843. The motion prevailed.

Smith moved that the name of Lanning be added as an author on H. F. No. 2844. The motion prevailed.

Downey moved that the name of Scott be added as an author on H. F. No. 2845. The motion prevailed.

Nornes moved that his name be stricken as an author on H. F. No. 2846. The motion prevailed.

Downey moved that the name of Severson be added as an author on H. F. No. 2846. The motion prevailed.

Norton moved that the name of Kalin be added as an author on H. F. No. 2849. The motion prevailed.

Downey moved that the name of Severson be added as an author on H. F. No. 2853. The motion prevailed.

Newton moved that the name of Kalin be added as an author on H. F. No. 2861. The motion prevailed.

Greiling moved that her name be stricken as an author on H. F. No. 2867. The motion prevailed.

Doty moved that the name of Ward be added as an author on H. F. No. 2869. The motion prevailed.

Juhnke moved that the name of Morrow be added as an author on H. F. No. 2889. The motion prevailed.

Johnson moved that the name of Morrow be added as an author on H. F. No. 2907. The motion prevailed.

Kohls moved that the names of McNamara, Murdock and Draskowski be added as authors on H. F. No. 2911. The motion prevailed.

Brod moved that the names of Dettmer, Kalin, Ward and Morrow be added as authors on H. F. No. 2917. The motion prevailed.

FISCAL CALENDAR ANNOUNCEMENT

Pursuant to rule 1.22, Solberg announced his intention to place H. F. No. 2700 on the Fiscal Calendar for Monday, February 15, 2010.

ADJOURNMENT

Sertich moved that when the House adjourns today it adjourn until 1:00 p.m., Monday, February 15, 2010. The motion prevailed.

Sertich moved that the House adjourn. The motion prevailed, and the Speaker declared the House stands adjourned until 1:00 p.m., Monday, February 15, 2010.

ALBIN A. MATHIOWETZ, Chief Clerk, House of Representatives

