# House Research Act Summary

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# Article 1: Health Care

## Overview

This article contains provisions related to state health care programs administered by the Department of Human Services.

**1** **Hospital surcharge.** Amends § 256.9657, subd. 2. Effective July 1, 2010, increases the hospital surcharge from 1.4 to 2.63 percent of net patient revenues. Effective October 1, 2011, the surcharge is reduced to 2.30 percent.

**2** **Surcharge on HMOs and community integrated service networks.** Amends § 256.9657, subd. 3. Effective October 1, 2010, increases the health maintenance organization surcharge from 0.6 percent of total premium revenues to 1.45 percent. Also requires each county-based purchasing plan to pay a surcharge of 1.45 percent of total premium revenues. Requires money collected to be deposited in the health care access fund.

**3** **Operating payment rates.** Amends § 256.969, subd. 2b. Eliminates partial rebasing of MA inpatient hospital rates scheduled to begin January 1, 2011, and delays full rebasing, now scheduled to occur on April 1, 2012, until January 1, 2013. Also provides that a Minnesota long-term hospital shall be rebased effective January 1, 2011, and specifies the methodology for this.

**4** **Payments.** Amends § 256.969, subd. 3a. Increases MA inpatient fee-for-service hospital rates by 5 percent from July 1, 2010, to June 30, 2011, after which time the rate increase is reduced to 1.96 percent.

**5** **Mental health or chemical dependency admissions; rates.** Amends § 256.969, subd. 21. Effective July 1, 2010, increases MA inpatient hospital rates for certain listed mental health diagnoses at private, nonprofit hospitals with high rates of mental health admissions. The total cost of the rate increases, including state and federal shares, may not exceed $10 million in each fiscal year.

**6** **Greater Minnesota payment adjustment after June 30, 2001.** Amends § 256.969, subd. 26. Effective July 1, 2010, increases MA inpatient hospital fee-for-service rates at hospitals located outside of the seven-county metropolitan area for 16 listed diagnostic-related groups (DRGs) to 100 percent of the metropolitan area average. Currently, these DRGs are reimbursed at 90 percent.

**7** **Hospital payment adjustment after June 30, 2010.** Amends § 256.969, by adding subd. 31. Establishes two per-admission increases in MA inpatient hospital rates. The first increase is provided to private, nonprofit hospitals and varies based on the percentage of hospital admissions reimbursed by government payers. The rate is effective July 1, 2010, to March 31, 2011.

The second increase goes to all Minnesota hospitals and is set at $850 per admission from July 1, 2010, to March 31, 2011, after which time the payment is reduced to $320.

**8** **Adults without children.** Amends § 256B.055, by adding subd. 15. Allows MA to be paid for a person over age 21 and under age 65, who is not pregnant, not entitled to Medicare, not an adult in a MinnesotaCare family with children, and who is not otherwise eligible for

MA. States that the section is effective July 1, 2011.

**9** **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Provides that no asset limit shall apply to persons eligible under § 256B.055, subd. 15.

**10** **Income.** Amends § 256B.056, subd. 4. Sets the income standard for adults without children on MA eligible under § 256B.055, subd. 15, at 75 percent of the federal poverty guidelines. States that the section is effective July 1, 2011.

**11** **Physical therapy.** Amends § 256B.0625, subd. 8. Requires authorization by the commissioner to provide medically necessary physical therapy services to a recipient beyond the following one-time service thresholds, except when the commissioner has established a lower threshold: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or re-evaluations. Eliminates coverage for specialized maintenance therapy. Provides an effective date of July 1, 2010, for fee-for-service and January 1, 2011, for managed care.

**12** **Occupational therapy.** Amends § 256B.0625, subd. 8a. Requires authorization by the commissioner to provide medically necessary occupational therapy services beyond the following one-time service thresholds, except when the commissioner has established a lower threshold: (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or re-evaluations. Eliminates coverage for specialized maintenance therapy. Provides an effective date of July 1, 2010, for fee-for-service and January 1, 2011, for managed care.

**13** **Speech language pathology and audiology services.** Amends § 256B.0625, subd. 8b. Requires authorization by the commissioner to provide medically necessary speech language pathology and audiology services beyond the following one-time service thresholds, except when the commissioner has established a lower threshold: (1) 50 treatment sessions with any combination of approved CPT codes; and (2) one evaluation. Eliminates coverage for specialized maintenance therapy. Provides an effective date of July 1, 2010 for fee-for-service and January 1, 2011 for managed care.

**14** **Chiropractic services.** Amends § 256B.0625, by adding subd. 8d. Limits payment for chiropractic services to one annual evaluation and 12 visits per year unless prior authorization is obtained.

**15** **Medication therapy management services.** Amends § 256B.0625, subd. 13h. Provides that if there are no pharmacists who meet the requirements to provide medication therapy management services within a reasonable geographic distance of the patient, a pharmacist who does meet the requirements may provide the services by two-way interactive video.

**16** **Access to medical services.** Amends § 256B.0625, subd. 18a. Provides that MA will cover face-to-face oral language interpreter services only if the interpreter used by the provider is listed in the registry or roster established by the commissioner of health under § 144.058. Provides a January 1, 2011 effective date.

**17** **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Allows the commissioner to set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

**18** **Services provided in birth centers.** Amends § 256B.0625, by adding subd. 54. (a) Provides that MA covers services provided in a licensed birth center by a licensed health professional, if the service would otherwise be covered if provided in a hospital.

(b) Sets payment rates for facility services provided by a birth center at the lower of billed charges or 70 percent of the statewide average for facility payments to hospitals for uncomplicated vaginal births. If the recipient is transported from a birth center to a hospital prior to delivery, sets payments for facility services provided by the birth center at the lower of billed charges or 15 percent of the statewide average for facility payments to hospitals for uncomplicated vaginal births.

(c) Sets payment rates for nursery services at the lower of the billed charge or 70 percent of the statewide average payment rate to a hospital.

(d) Sets payments for professional services provided by licensed traditional midwives at the lower of billed charges or 100 percent of the rate paid to a physician. Prohibits billing for delivery services if a recipient is transported from a birth center to a hospital prior to delivery. States that services by an unlicensed traditional midwife are not covered.

(e) Directs the commissioner to apply for any necessary federal waivers to allow birth centers and birth center providers to be reimbursed.

Provides an effective date of July 1, 2011.

**19** **Co-payments.** Amends § 256B.0631, subd. 1. Effective July 1, 2010, reduces the MA co-payment for nonemergency visits to a hospital-based emergency room from $6 to $3.50.

**20** **Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to the reduction in the co-payment for nonemergency visits to an emergency room.

**21** **Reimbursement under other state health care programs.** Amends § 256B.0644. Strikes references to the coordinated care delivery system and GAMC. States that this section is effective July 1, 2010.

**22** **Home care therapies.** Amends § 256B.0653, subd. 5. Makes a conforming change related to elimination of coverage for specialized maintenance therapy.

**23** **Health care delivery systems demonstration project.** Adds § 256B.0755.

**Subd. 1. Implementation.** Requires the commissioner to develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services based on total cost of care or a risk-gain sharing payment arrangement. Requires the commissioner to develop a request for proposals and specifies requirements for the request for proposals. Also specifies requirements to participate in the demonstration project.

**Subd. 2. Enrollment.** Allows individuals eligible for MA or MinnesotaCare to enroll in the health care delivery system and specifies requirements related to choice of a system and assignment.

**Subd. 3. Accountability.** Requires health care delivery systems to accept responsibility for the quality of care and the cost of care and service utilization. Specifies provider contract requirements.

**Subd. 4. Payment system.** Requires the commissioner to establish a total cost of care benchmark or a risk/gain sharing payment model, and specifies related requirements.

**Subd. 5. Outpatient prescription drug coverage.** States that outpatient prescription drug coverage may be provided through an accountable care organization

only if the delivery method qualifies for federal prescription drug rebates.

**Subd. 6. Federal approval.** Requires the commissioner to apply for any necessary federal waivers or approvals, and to apply for applicable grants or demonstration projects under federal health care reform.

**Subd. 7. Expansion.** Requires the commissioner to explore the expansion of the project to include additional MA and MinnesotaCare enrollees, and to seek Medicare participation and participation by the privately insured.

**24** **Hennepin and Ramsey counties pilot program.** Adds § 256B.0756. Directs the commissioner of human services, upon federal approval of a new waiver request or amendment of an existing demonstration, to establish a pilot program in Hennepin or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks. States that eligible persons are MA adults without children who reside in Hennepin or Ramsey counties. Caps pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County. Specifies other criteria for the pilot program.

**25** **Managed care contracts.** Amends § 256B.69, subd. 5a. Effective for services provided on or after January 1, 2011, establishes a managed care plan performance target related to reducing the use of emergency rooms by state health care program enrollees. Sets a reduction target of 5 percent per year, and states that the withhold continues until the emergency room utilization rate is reduced by 25 percent.

**26** **Rate modifications.** Amends § 256B.69, by adding subdivision 5k. For services provided on or after October 1, 2010, increases managed care and county-based purchasing plan payments under MA by 1.28 percent.

**27** **Ombudsperson.** Amends § 256B.69, subd. 20. Strikes language related to the GAMC program.

**28** **Information for persons with limited English-language proficiency.** Amends § 256B.69, subd. 27. Eliminates a cross-reference to a GAMC provision that was repealed. Provides a retroactive effective date of April 1, 2010.

**29** **In general.** Amends § 256B.692, subd. 1. Removes references to the prepaid general assistance medical care program. Provides a retroactive effective date of April 1, 2010.

**30** **Physician reimbursement.** Amends § 256B.76, subd. 1a.

A new paragraph (d) reduces payments for physician and professional services by an additional 7 percent, for services provided on or after July 1, 2010. Certain primary care providers and services are exempt from this reduction. Also exempts physical therapy, occupational therapy, speech pathology, and mental health services. Requires payments to managed care and county-based purchasing plans to reflect this reduction, effective October 1, 2010.

A new paragraph (e) increases payment rates, effective October 1, 2010, for physician and professional services billed by physicians employed by and clinics owned by a nonprofit HMO, by 25 percent. Also requires payments to managed care and county-based purchasing plans to reflect this payment increase, beginning October 1, 2010.

**31** **Dental reimbursement.** Amends § 256B.76, subd. 2. A new paragraph (f) provides that state-operated dental clinics are to be paid effective October 1, 2010, using a cost-based

payment system, based on Medicare cost-finding methods and allowable costs. States that the paragraph is effective January 1, 2011, for managed care enrollees receiving services at state-operated dental clinics.

A new paragraph (g) provides that, beginning FY 2011, if payments to state-operated dental clinics are less than $1.85 million per fiscal year, a supplemental state payment equal to the difference between payments and this specified amount is to be paid from the general fund to state-operated services for the operation of the dental clinics.

A new paragraph (h) provides that if the cost-based payment system does not receive federal approval, the state-operated dental clinics shall be designated as critical access providers.

**32** **Critical access dental providers.** Amends § 256B.76, subd. 4. Modifies the criteria the commissioner must use to determine which dentists and dental clinics are critical access dental providers. Requires the commissioner to designate as critical access providers: (1) certain nonprofit community clinics; (2) federally qualified health centers, rural health clinics; (3) county owned and operated hospital-based dental clinics; (4) a dental clinic or dental group owned and operated by a nonprofit operation with more than 10,000 patient encounters per year with patients who are uninsured or covered by MA, GAMC, or MinnesotaCare; and (5) a dental clinic is associated with an oral health or dental education program operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system.

States that the section is effective July 1, 2010.

**33** **Reimbursement for basic care services.** Amends § 256B.766. States that the basic care reduction applies to physical therapy, occupational therapy, and speech language pathology and related services, effective July 1, 2010. Requires the commissioner to classify these services as basic care services, effective July 1, 2010. Requires payments made to managed care and county-based purchasing plans to reflect this change effective October 1, 2010.

**34** **Medicare payment limit.** Adds § 256B.767. Effective July 1, 2010, provides that fee-for-service payments for physician and professional services and basic care services shall not exceed the applicable Medicare payment rate. Requires this section to be implemented after any rate adjustment effective July 1, 2010. Requires rates to be reduced by first reducing or eliminating provider rate add-ons.

**35** **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. The amendment to paragraph (b) provides that GAMC coverage of pharmacy services includes medication therapy management.

A new paragraph (d) specifies that for the period April 1, 2010, to May 31, 2010, GAMC covered services are those specified in subdivision 4 (services covered under the old GAMC program) rather than those services covered under the modified GAMC program. Provides a retroactive effective date of April 1, 2010.

**36** **Cooperation.** Amends § 256D.03, subd. 3b. Eliminates provisions related to GAMC coverage of persons with cost-effective insurance, effective July 1, 2010.

**37** **Payment rates and contract modification; April 1, 2010, to June 30, 2010.** Amends § 256D.031, subd. 5. Extends the GAMC fee-for-service period through June 30, 2010 (under

current law, this period would have ended May 31, 2010). Provides that for the month of June, the GAMC fee-for-service payment rate is 27 percent of the payment rate in effect on March 31, 2010. Provides an immediate effective date.

**38** **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. The amendment to paragraph (a) reduces the MinnesotaCare co-payment for nonemergency visits to a hospital-based emergency room from $6 to $3.50, effective January 1, 2011.

A new paragraph (g) states that provider and managed care plan payments shall not be increased due to the reduction in the co-payment.

**39** **Enrollees 18 or older.** Amends § 256L.11, subd. 6. For admissions on or after July 1, 2011, for MinnesotaCare enrollees who are single adults and households without children, requires the commissioner to pay hospitals directly, up to the MA payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any copayment.

**40** **Firefighters; volunteer ambulance attendants.** Amends § 256L.07, by adding subd. 9. (a) Defines a "qualified individual" as: (1) a volunteer firefighter with a department, who has passed the probationary period; and (2) a volunteer ambulance attendant.

(b) States that a qualified individual, who documents to the satisfaction of the commissioner status as a qualified individual, by completing and submitting a one-page form developed by the commissioner, is eligible for MinnesotaCare without meeting other eligibility requirements, but must pay premiums equal to the average expected capitation rate for adults with no children. Specifies that the benefit set is that provided to adults with no children. Provides an effective date of April 1, 2011.

**41** **Eligibility for other state programs.** Amends § 256L.12, subd. 5. Removes references to prepaid GAMC. Provides a retroactive effective date of April 1, 2010.

**42** **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. For services provided on or after January 1, 2011, requires the commissioner to withhold an additional 3 percent of MinnesotaCare managed care payments. Requires the withheld funds to be returned between July 1 and July 31, 2012. Provides that return of this withhold is not subject to meeting performance targets. Allows a plan to include as admitted assets any amount withheld under the section (current law applies this provision to one paragraph within the section).

A new paragraph (d) establishes a withhold related to a performance target tied to reducing emergency room utilization, effective for services provided on or after January 1, 2011.

**43** **Rate setting; increase effective October 1, 2010.** Amends § 256L.12, by adding subd. 9c. Effective October 1, 2010, increase MinnesotaCare payments to managed care and county-based purchasing plans by 1.28 percent.

**44** **Medical assistance coverage.** Amends Laws 2009, chapter 79, article 5, section 75, subd. 1. Expands coverage under the asthma coverage demonstration project to include home environmental assessments for triggers of asthma and in-home asthma education on the medical management of asthma by a certified asthma educator or public health nurse with asthma management training. Limits visits to two per child. Sets the home visit payment rate. Requires durable medical equipment to be covered if the item is "medically useful"

rather than "medically necessary" to reduce asthma symptoms.

**45** **Expiration.** Amends Laws 2009, ch. 79, art. 5, § 78, subd. 5. Extends the expiration date for the state premium subsidy program for COBRA continuation coverage from December 31, 2010, to August 31, 2011, and extends the exemption from the four-month uninsured requirement to February 28, 2012, to reflect the extension of the federal premium subsidy program for continuation coverage.

**46** **Effective date.** Amends the effective date section of Laws 2010, ch. 200, art. 1, § 12, to provide that subdivision 4 of that section (covered benefits under the modified GAMC program) is effective June 1, 2010, rather than April 1, 2010. Provides an immediate effective date.

**47** Amends Laws 2010, ch. 200, art. 1, § 16 (retroactive MinnesotaCare coverage for GAMC recipients at renewal), by providing an effective date for that section of June 1, 2010.

**48** **Repealer.** Amends Laws 2010, ch. 200, art. 1, § 21. Changes the effective date for the repeal of § 256D.03, subdivision 4 (covered benefits under the old GAMC program) from April 1 to June 1, 2010. Provides a retroactive effective date of April 1, 2010.

**49** **Special revenue fund transfers.** Amends Laws 2010, ch. 200, art. 2, § 2, subd. 1. Requires transfers for FY 2010 and FY 2011 from the special revenue fund to the general fund. Provides an immediate effective date.

**50** **Base adjustment.** Amends Laws 2010, chapter 200, art. 2, § 2, subd. 5. Corrects a base adjustment rider.

**51** **Compulsive gambling appropriation.** Amends Laws 2010, ch. 200, art. 2, § 2, subd. 8. Clarifies that the lottery prize fund appropriation for compulsive gambling administration is reduced by specified amounts, and that these are onetime reductions. Provides an immediate effective date.

**52** **Prepaid health plan rates.** Requires the commissioner of human services to take into account anticipated savings from expanding MA coverage to services provided in a licensed birth center when negotiating managed care contract rates.

**53** **State plan amendment; federal approval.** Requires the commissioner of human services to seek a state plan amendment or federal waiver, to receive federal funds for MA coverage of single adults without children.

**54** **Upper payment limit report.** Requires an annual report from DHS on: (1) the estimated room under the hospital upper payment limit (UPL) for the upcoming federal fiscal year; (2) the amount of an MA inpatient hospital rate increase that would raise MA spending to the UPL; and (3) the amount of a surcharge increase that would be needed to generate the state share for the possible increase.

**55** **Revisor's instruction.** Directs the Revisor to remove references to GAMC in statutes and rules.

**56** **Repealer.** (a) Repeals section 256D.03, subdivisions 3 (GAMC eligibility), 3a (claims), 3b (cooperation), 5 (county share), 6 (division of costs), 7 (duties of commissioner), and 8 (private insurance) effective July 1, 2011.

(b) Repeals Laws 2010, chapter 200, article 1, sections 12 (the modified GAMC program),

18 (drug rebate program), and section 19 (phase-out of transitional MinnesotaCare), effective July 1, 2011.

## Article 2: Continuing Care

**1** **Registration information. Amends §** 144D.03, subd. 2. Expands the list of information a housing with services establishment must provide to the Minnesota Department of Health (MDH) in order to be registered to include whether services are included in the base rate to be paid by the resident.

**2** **Certificate of transitional consultation. Amends § 144D.03, subd. 3**. Prohibits a housing with services establishment from contracting with a prospective resident or allowing a prospective resident to move in until the establishment receives certification that the person has received a transition to housing with services consultation. Requires the Senior LinkAge Line to issue certification within 24 hours of contact by a prospective resident.

**3** **Contents of contract. Amends § 144D.04, subdivision 2.** Requires a housing with services contract to include a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate.

**4** **Uniform consumer information guide. Creates § 144D.08. R**equires housing with services establishments to make available to prospective and current residents information consistent with the uniform format and required components of a uniform consumer information guide adopted by MDH.

**5** **Termination of lease. Creates § 144D.09. R**equires a housing with services establishment to include with a lease termination notice information about how to contact the ombudsman for long-term care and how to request problem-solving assistance.

**6** **Uniform consumer information guide. Amends § 144G.06. R**equires the Uniform Consumer Information Guide to include information on which services may be covered by Medicare.

**7** **Contribution amount.** Amends § 252.27, subd. 2a. Modifies the parental fees for children receiving MA through the TEFRA option for the period from July 1, 2010, to June 30, 2013.

**8** **Report regarding programs and services for people with disabilities.** Creates § 256.4825. Allows the Minnesota Council on Disability and other organizations to submit an annual report by January 15 of each year, beginning in 2012, to the legislature. Lists the information that must be included in the report. Requires certain commissioners to provide information to assist in the preparation of the report.

**9** ICF/MR license surcharge. Amends § 256.9657, subd. 3a. Increases the license surcharge on intermediate care facilities for persons with mental retardation (ICFs/MR) by $2,997, to a total of $4,037 per bed per year.

**10** Consumer information and assistance and long-term care options counseling; Senior LinkAge Line. Amends § 256.975, subd. 7. Requires the Senior LinkAge Line service to incorporate information about registered housing with services establishments. It requires the establishments and their home care providers to provide information to facilitate price comparisons. It requires DHS and MDH to align data elements required by the Uniform Consumer Information Guide and by the Senior LinkAge Line language to provide

consumers standardized information and ease of comparison for long-term care options.

**11** **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Clarifies that persons participating in MA-EPD may have excess earnings or assets. Removes an obsolete date. Requires the commissioner to notify enrollees annually beginning at least 24 months before a person's 65th birthday of the MA rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65. Makes this section effective January 1, 2011.

**12** **Personal care assistant; requirements. Amends § 256B.0659, subd. 11**. Reduces the maximum number of hours per month that a personal care assistant may provide and be paid for services to 275 hours, down from the current 310-hour limit, effective July 1, 2011.

**13** **Transition to housing with services. Amends § 256B.0911, subd. 3c.** Requires all housing with services establishments to inform prospective residents of the requirement to contact the Senior LinkAge Line for long-term care options counseling and transitional consultation. It restates the prohibition on admitting persons to establishments until provision of counseling and consultation under this subdivision to the prospective resident has been certified. Requires prospective residents refusing to contact the Senior LinkAge Line to sign a waiver form supplied by the provider. This section also excludes from this provision a person moving from the community, a hospital, or an institutional setting to a housing with services establishment during nonworking hours under certain conditions.

**14** **Rate reduction for customized living and 24-hour customized living services. Amends § 256B.0915, subd. 3i.** Reduces service component rates and service rate limits for customized living services and 24-hour customized living services by 5 percent, effective July 1, 2010. To implement these rate reductions, managed care organization rates are reduced by 10 percent from January 1, 2011, to June 30, 2011, and by 5 percent after that.

**15** **Phase–in of rebased operating payment rates.** Amends § 256B.441, subd. 55. Suspends nursing facility rebasing rate adjustments during the period from October 1, 2009, to September 30, 2013.

**16** **Rate increase effective June 1, 2010.** Amends § 256B.5012, subd. 9. Increases rates paid to ICFs/MR by $8.74 per bed per day.

**17** **Alternative services; elderly and disabled persons.** Amends § 256B.69, subd. 23. Removes obsolete language. Removes language requiring grant amounts received for this purpose to be deposited in the special revenue fund and appropriated to the commissioner to be used for actuarial and administrative costs. Closes MnDHO enrollment effective December 31, 2010. Allows the commissioner to reopen enrollment if all applicable conditions of this section are met.

**18** **Effective date.** Amends Laws 2009, chapter 79, article 8, section 51. Delays the effective date of the essential community support grants until July 1, 2011.

**19** **Housing options.** Amends Laws 2009, ch. 79, art. 8, § 84. Modifies the information that must be included in a report on the availability and affordability of housing options for persons with disabilities.

**20** **Case management reform.** Requires the commissioner of human services to provide specific recommendations and language for proposed legislation to reform case management for persons with disabilities by February 1, 2011. Requires the commissioner to consider the recommendations in the 2007 Redesigning Case Management Services for

Persons with Disabilities report and to consult with certain stakeholder groups in developing the recommendations. Makes this section effective the day following final enactment.

**21** **Commissioner to seek federal match.** Requires the commissioner to seek federal financial participation for eligible activity related to fiscal year 2010 and 2011 grants to Advocating Change Together to establish a statewide self-advocacy network for persons with developmental disabilities and for eligible activities under any future grants to the organization. Requires the commissioner to report to designated legislative committees by December 15, 2010, with the results of the application for federal matching funds

**22** **ICF/MR rate increase.** Increases the daily rate at a specific ICF/MR facility in Clearwater County for the rate period from July 1, 2010, to June 30 2011.

## Article 3: Children and Family Services

**1** **Asset limitations for food stamp households.** Amends § 256D.0515. Modifies the Food Stamp program by eliminating the asset limit and increasing the income limit to 165 percent of federal poverty guidelines. The current income limit is 130 percent of federal poverty guidelines. This section is effective November 1, 2010.

**2** **Supplemental rate; Mahnomen County.** Amends § 256I.05 by adding subd. 1n. Increases the GRH supplemental rate for a specific facility in Mahnomen County for the rate period from July 1, 2010, to June 30, 2011.

**3** **Family cap.** Amends § 256J.24, subd. 6. Amends the MFIP family cap, clarifying that the law does not apply to the mother's first child subsequent to a pregnancy that did not result in a live birth. This section is effective September 1, 2010.

**4** **Hard-to-employ participants.** Amends § 256J.425, subd. 3. Modifies the definition of "severely limits the person's ability to obtain or maintain suitable employment."

**5** **Repealer.** Repeals Minnesota Statutes, section 256J.621 (MFIP work participation cash benefit) effective December 1, 2010.

## Article 4: Miscellaneous

**1** **Coverage of private duty nursing services.** Adds § 62Q.545. Requires a health plan to cover private duty nursing services for persons who are concurrently covered by a health plan & enrolled in medical assistance. Allows a period of private duty nursing services to be subject to the same cost-sharing as an inpatient hospital stay. Provides that the section is effective July 1, 2010, and applies to health plans offered, sold, issued, or renewed on or after that date.

**2** **Minnesota couples on the brink project.** Adds § 137.32. Requires the Department of Human Services (DHS) to implement, within the limits of available appropriations, a Minnesota Couples on the Brink project to develop, evaluate, and disseminate best practices for promoting successful reconciliation between married couples who are considering or have commenced marriage dissolution and who choose to try reconciliation. The project

must be implemented through the University of Minnesota and funded with federal grants, state appropriations, and in-kind services.

**3** **~~Schedule II and III~~ Controlled substances prescription electronic reporting system.** Amends § 152.126, as amended by Laws 2009, ch. 79, art. 11, §§ 9, 10, and 11. Makes a number of minor changes to the controlled substances prescription electronic reporting system, and establishes funding sources for the system.

**4** **Chemical and mental health services transformation advisory task force.** Creates § 246.125.

**Subd. 1. Establishment.** Establishes an advisory task force which is to make recommendations to the commissioner of human services regarding the continuum of services needed to provide services to individuals who are mentally ill, chemically dependent, developmentally disabled, or have a traumatic brain injury.

**Subd. 2. Duties.** Lists the duties of the advisory task force.

**Subd. 3. Membership.** Lists the representatives who are to be appointed to the advisory group.

**Subd. 4. Administration.** Requires the commissioner to convene and provide administrative support for the advisory group.

**Subd. 5. Recommendations.** Requires the advisory group to issue recommendations to the commissioner and the legislature by December 15, 2010.

**Subd. 6. Member requirement.** Instructs the commissioner to pay per diem and travel to consumers or family members and whose participation is not as a paid representative of an agency.

**5** **Notification to legislature required.** Creates § 246.128. Requires the commissioner to notify the legislature of any plans to redesign, close, or relocate state-operated services programs.

**6** **Legislative approval required.** Creates § 246.129. Provides that if the commissioner plans to close a facility and agreement cannot be reached with the employees' bargaining units to transfer the employees to other jobs, then the commissioner must have legislative approval to close the facility. States that this provision does not apply to state-operated enterprise services.

**7** **State-operated services account.** Amends § 246.18, by adding subd. 8. Establishes the state-operated services account, and requires revenue from specified programs to be deposited into this account.

**8** **American Indian.** Amends § 254B.01, subd. 2. Makes a technical change to conform with amendments to the chemical dependency treatment fund.

**9** **Chemical dependency treatment allocation.** Amends § 254B.02, subd. 1. Strikes the formula for the chemical dependency treatment fund allocation.

**10** **Administrative adjustment.** Amends § 254B.02, subd. 5. Adjusts the administrative payment to local agencies.

**11** **Division of costs.** Amends § 254B.03, subd. 4. Increases the county match for chemical dependency treatment services from 15 percent to 16.14 percent. This increase is projected

to offset the loss of funds that will occur as a result of the elimination of the maintenance of effort.

12 **Regional treatment centers.** Amends § 254B.05, subd. 4. Makes a technical change striking the reference to county allocations.

13 **Allocation of collections.** Amends § 254B.06, subd. 2. Strikes references to county maintenance of effort requirements.

14 **Payments to improve services to American Indians.** Amends § 254B.09, subd. 8. Clarifies that the commissioner may set rates according to the American Indian Health Improvement Act for chemical dependency services to American Indians.

15 **Pilot projects; chemical health care.** Creates § 254B.13.

**Subd. 1. Authorization for pilot projects**. Allows the commissioner to approve and implement pilot projects that were developed pursuant to the state-county chemical health care home pilot project.

**Subd. 2. Program design and implementation.** Paragraph (a) requires the commissioner and participating counties to work together to refine and implement the pilot projects.

Paragraph (b) requires planning to be completed by June 30, 2010, and agreements entered if plans are approved by the commissioner. Implementation is not to occur until after July 1, 2010.

**Subd. 3. Program evaluation.** Requires the commissioner to evaluate the pilot programs and make a report to the legislature by June 30, 2013.

**Subd. 4. Notice of project discontinuation.** Permits discontinuation for any reason by the county or the commissioner after 30 days' written notice to the other party. Unspent funds are to be transferred to the general fund.

**Subd. 5. Duties of the commissioner.** Paragraph (a) grants the commissioner authority to authorize pilot projects.

Paragraph (b) allows the commissioner to restructure payment schedules between the state and participating counties. Limits state expenditures to no more than what would have been spent from the chemical dependency treatment fund.

Paragraph (c) permits the commissioner to deposit unexpended funds in the special revenue fund for those pilot project regions that spend less than state fiscal year expenditures for the use of those regions in the following year. For those regions that exceed the amount expected, those regions are responsible for the excess portion of nontreatment expenses.

Paragraph (d) permits the commissioner to waive the administrative rules.

Paragraph (e) prohibits entering into any agreement that would put current or future federal funding at risk.

**Subd. 6. Duties of county board.** Requires the county board, or other entity administering the pilot project, to ensure that the project complies with the program design and objectives, provides chemical dependency treatment services to eligible individuals, and provide the commissioner with information as negotiated in the pilot

project agreement.

16 **Term of license; fee; premarital education.** Amends § 517.08, subd. 1b. Increase the marriage license application fee by $5.00.

17 **Disposition of license fee.** Amends § 517.08, subd. 1c, as amended by Laws 2010, ch. 200, art. 1, § 17. Requires the local registrar to pass along the $5.00 increase to the commissioner of management and budget to be deposited in a special revenue account for the couples on the brink project.

18 **Requiring the development of community-based mental health services for patients committed to the Anoka-Metro Regional Treatment Center.** Amends Laws 2009, ch. 79, art. 3, § 18. Provides that the Chemical and Mental Health Transformation Task Force, rather than the commissioner of human services, is to recommend community-based services for patients at AMRTC. Requires these services to be established in partnership with specified providers and organizations and to be staffed by state employees. Requires savings to be used to fund supportive housing staffed by state employees.

19 **Report on human services fiscal notes.** Requires the commissioner of human services to issue a report to the legislature no later than November 15, 2010, making recommendations for the establishment of a legislative budget office which would prepare and complete fiscal notes for DHS. This office would be created in the legislative auditor's office. Lists areas that must be addressed in the report.

20 **Prescription drug waste reduction.** Requires the board of pharmacy in cooperation with listed commissioners to study prescription drug waste reduction techniques and technologies. Requires a report to the legislature by December 15, 2011.

21 **Veterinary practice and controlled substance abuse study.** Requires the board of pharmacy to study the issue of controlled substances being diverted from veterinary practice. Requires a report to the legislature by December 15, 2011, including recommendations on whether to include veterinarians in the prescription electronic reporting system.

22 **Repealer.** Repeals sections 254B.02, subdivision 2, 3, and 4; and 254B.09, subdivisions 4, 5, and 7. These repealed subdivisions all relate to calculation of the county maintenance of effort.

23 **Effective date.** Makes the sections related to county maintenance of effort, sections 8 to 14 and 22, effective for claims paid on or after July 1, 2010.

## Article 5: Department of Health

1 **Consistent administrative expenses and investment income reporting.** Amends § 62D.08, by adding subd. 7. Requires health maintenance organizations to allocate administrative expenses to specific lines of business or products when the information is available. Remaining expenses must be allocated based on recommendations of the advisory group established in the next section. The information must be reported on a template provided by MDH. This section also requires investment income to be allocated based on cumulative net income over time by business line or product. This section is effective January 1, 2013.

**2** **Advisory group on administrative expenses.** Adds § 62D.31.

**Subd. 1. Establishment.** Establishes the Advisory Group on Administrative Expenses to make recommendations on consistent guidelines and reporting requirements for administrative expenses by individual publicly funded programs.

**Subd. 2. Membership.** States that membership of the group is to be comprised of: the commissioners of health, human services, and commerce, or their designees; and representatives of HMOs and county-based purchasers appointed by the commissioner of health.

**Subd. 3. Administration.** Requires the commissioner of health to convene the first meeting of the advisory group and provide administrative support and staff. Allows the commissioner to contract with a consultant.

**Subd. 4. Recommendations.** Requires the advisory group to report recommendations to the commissioner of health and the legislature by February 15, 2012.

**Subd. 5. Expiration.** States that this section expires after submission of the report or June 30, 2012, whichever is sooner.

**3** **Designation.** Amends § 62Q.19, subdivision 1. Adds licensed birth centers to the list of essential community provider designations.

**4** **Firearms data.** Amends § 144.05 by adding subd. 5. Modifies the general duties of the commissioner of health by prohibiting the department's collection of data on individuals related to lawful firearm ownership.

**5** **Birth record surcharge.** Amends § 144.226, subd. 3. Establishes an additional surcharge of $10 for each certified birth record. This fee must be deposited in the general fund. Provides a July 1, 2010, effective date.

**6** **Duration of consent.** Amends § 144.293, subd. 4. Modifies current law related to the duration consent for the release of health records is valid, by stating that consent can be valid for any period of time stated in the consent.

**7** **Birth Centers.** Adds § 144.615. Establishes state licensure for birth centers.

**Subd. 1. Definition.** Defines "birth center;" "CABC;" and "low-risk pregnancy" for purposes of this section.

**Subd. 2. License required.** Requires birth centers to be licensed beginning January 1, 2011, in order to operate in the state.

**Subd. 3. Temporary license.** Provides a process for issuing a temporary license that would be valid for a six-month period while a birth center awaits accreditation.

**Subd. 4. Application.** Requires that the license application and fee be submitted to the commissioner of health on a form provided by the commissioner and specifies information that it must contain.

**Subd. 5. Suspension, revocation, and refusal to renew.** Permits the

commissioner to refuse to grant or renew, or to suspend or revoke a license to operate a birth center on the same grounds as such action may be taken against a hospital under § 144.55, subd. 6.

**Subd. 6. Standards for licensure.** Requires that a birth center be accredited by the Commission for the Accreditation of Birthing Centers (CABC) and have procedures in place for specifying patient risk status in order to obtain a state license. Requires birth centers to provide the commissioner, upon request, with any documentation submitted to the CABC during the accreditation process.

**Subd. 7. Limitations of services.** Limits procedures that may be performed at a birth center: surgical procedures must be limited to those done during an uncomplicated birth; abortions must not be administered; and general and regional anesthesia must not be administered.

**Subd. 8. Fees.** Imposes a biennial licensing fee of $365 and a $365 fee for a temporary license. Requires that fees be collected and deposited according to the same provisions has fees are collected for hospitals.

**Subd. 9. Renewal.** Requires renewal of a birth center license every two years, except that a temporary license expires after six months and may be renewed for one additional six-month period.

**Subd. 10. Records.** Subjects records maintained at birth centers to the Minnesota Health Records Act.

**Subd. 11. Report.** Requires the commissioner of health, with the commissioner of human services and representatives of the licensed birth centers, to evaluate the quality of care and outcomes of services provided in birth centers. Requires a report to the legislature by January 15, 2014.

**8** **Definitions.** Amends § 144.651, subd. 2. Modifies the definition of "patient" for purposes of the Health Care Bill of Rights by including a person who receives care at a licensed birth center.

**9** **Blood lead level guidelines.** Amends § 144.9504 by adding subd. 12. (a) Requires the commissioner to revise clinical and case management guidelines by January 1, 2011. Specifies that these guidelines must include recommendations for protective action and follow-up services for child blood lead levels that exceed 5 µg/dL. Requires the new guidelines to be implemented to the extent possible with available resources.

(b) Requires the commissioner of health to consult with certain entities and organizations when revising the guidelines for blood lead levels greater than 5 µg/dL.

**10** **Health facility.** Amends § 144A.51, subd. 5. Modifies the definition of "health facility" for purposes of oversight of the Office of Health Facility Complaints by including birth centers.

**11** **Comprehensive advanced life support.** Amends § 144E.37. Makes conforming change to section 15. Establishes a July 1, 2010, effective date.

**12** **Health plan and county administrative cost reduction; reporting requirements.** Permits health plans and county-based purchasers to complete an inventory of data collection and reporting requirements and submit the list to the commissioners of health and human

services. Permits that the report to the commissioners may include information on administrative time and expense attributed to fulfilling reporting requirements. Requires the commissioners, upon receipt of such a report, to submit to the legislature recommendations as to whether action should be taken to streamline reporting requirements.

**13** **Vendor accreditation simplification.** Requires the Minnesota Hospital Association to coordinate with the Minnesota Credentialing Collaborative to make recommendations to the legislature on uniform credentialing standards for vendors and providers in hospitals and clinics.

**14** **Application process for health information exchange.** Requires the commissioner of health, when applying for additional federal funds to support a state health information exchange, to ensure applications are made through an open process that gives service providers equal opportunity to receive funds.

**15** **Transfer.** Transfers the powers and duties of the Emergency Medical Services Regulatory Board (EMSRB) with respect to the comprehensive advanced life-support educational program, under current Minnesota Statutes § 144E.37, to the commissioner of health, effective July 1, 2010.

**16** **Revisor's instruction.** Provides an instruction to the Revisor to move the comprehensive advanced life-support educational program's statutory reference to a Department of Health chapter, Minnesota Statutes, chapter 144.

## Article 6: Public Health

**1** **Distribution of funds.** Amends § 62J.692, subd. 4. Modifies the uses of distributed medical education funds by specifying that $150,000 must be used to support internationally trained, legal resident, physicians who commit to serving the underserved.

**2** **Establishing fees; definitions.** Amends § 157.16, subd. 3. Provides that youth camps that pay additional food and beverage establishment fees need not pay additional youth camp fees too.

**3** **Fees manufactured home parks and recreational camping areas.** Amends § 327.15, subd. 3. Provides that operators of a manufactured home park shall pay only one base fee.

**4** **Food support for children with severe allergies.** Directs the commissioner of human services to seek a federal waiver for the supplemental nutrition assistance program in order to increase the income eligibility to 375 percent of federal poverty guidelines for infants and children in order to treat or manage life-threatening food allergies.

# Article 7: Health Care Reform

## Overview

This article contains provisions related to the implementation of federal health care reform.

**1 Relationship to temporary federal risk pool.**

**Subd. 1. Definitions.** Defines "the association" as the Minnesota Comprehensive Health Association ("MCHA"), which is Minnesota's high-risk health insurance pool for people who cannot get coverage in the regular private market due to preexisting health conditions. Defines "the federal law" as the section of the 2010 federal health reform law that requires the federal government to create and sponsor a new federal temporary high risk pool, which will begin about July 1, 2010, and end in 2014, in each state that desires one. Defines "federal qualified high risk pool" as the type of high-risk pool provided for under "the federal law" defined above.

**Subd. 2. Timing of this section.** Makes this section apply beginning as of the date a federal qualified high risk pool begins providing coverage in MN.

**Subd. 3. Maintenance of effort.** Requires that the dollar-amount of assessments made by the association (MCHA) comply with the federal law's maintenance of (state) effort requirement for state risk pool funding, to the extent that the federal requirement applies to the assessments.

**Subd. 4. Coordination with state health care programs.** Requires the commissioner of human service and MCHA to ensure that applicants for coverage under the federal high-risk pool or the association (MCHA) are referred to medical assistance or MinnesotaCare if they may be qualified for those state programs. Requires the commissioner of human services to ensure that applicants for coverage under MA or MinnesotaCare, if determined to be not eligible for those programs, are provided with information about coverage under the federal high-risk pool and the association.

**Subd. 5. Federal funding.** Requires the state to coordinate its efforts with the U.S. Department of Health and Human Services to obtain the federal funds to implement the federal qualified high-risk pool in Minnesota.

**2 Coordinated care through a health home.** Adds § 256B.0756.

**Subd. 1. Provision of coverage.** (a) Requires the commissioner to provide MA coverage of health home services for eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home.

(b) Requires the commissioner to implement this section in compliance with the requirements of the Patient Protection and Affordable Care Act (the federal health care reform act). States that terms used in this section have the meaning provided in the federal act.

**Subd. 2. Eligible individual.** Defines eligible individuals as persons who are eligible for MA and have: (1) two chronic conditions; (2) one chronic condition and are at risk of having a second chronic condition; or (3) one serious and persistent mental health condition.

**Subd. 3. Health home services.** (a) Defines health home services as comprehensive and timely high-quality services that are provided by a health home. States that these services include: (1) comprehensive care management; (2) care coordination and health promotion; (3) comprehensive transitional care; (4) patient and family support; (5) referral to community and social support services; and (6) use of health information technology to link services.

(b) Requires the commissioner to maximize the number and type of services included in this subdivision, to the extent permissible under federal law, including physician, outpatient, mental health treatment, and rehabilitation services necessary for comprehensive transitional care following hospitalization.

**Subd. 4. Health teams.** Requires the commissioner to establish health teams to support the patient-centered health home and to provide health home services. Requires the commissioner to apply for grants or contracts available under federal health care reform legislation to establish health teams and provide capitated payments to primary care providers. Defines health teams.

**Subd. 5. Payments.** Directs the commissioner to make payments to each health home and health team for the provision of health home services to eligible individuals.

**Subd. 6. Coordination.** Requires the commissioner, to the extent feasible, to ensure that the requirements and payment methods for health homes and health teams are consistent with state requirements for health care homes. Allows the commissioner to modify requirements and payment methods for health care homes to be consistent with federal health home requirements and payment methods.

**Subd. 7. State plan amendment.** Requires the commissioner to submit a state plan amendment by January 1, 2011, to implement this section.

Provides that the section is effective January 1, 2011, or upon federal approval, whichever is later.

**3** **Federal health care reform demonstration projects and grants.** (a) Requires the commissioner of human services to seek to participate in the following demonstration projects or apply for the following grants, as described in federal health care reform legislation:

(1) demonstration project to evaluate integrated care around a hospitalization;

(2) Medicaid global payment demonstration project;

(3) pediatric accountable care organization demonstration project;

(4) Medicaid emergency psychiatric demonstration project; and

(5) grants to provide incentives for prevention of chronic diseases in Medicaid.

(b) Requires the commissioner of human services to report to specified legislative chairs and ranking minority members on the status of the demonstration project and grant applications, and if accepted as a participant or awarded a grant, to notify the chairs and ranking minority members of any legislative changes needed to implement the projects or grants.

(c) Requires the commissioner of health to apply for federal grants available under the federal health care reform bill to fund wellness and prevention and health improvement programs. Requires the commissioner, to the extent permitted under federal law, to use the state health improvement program to implement these grant programs.

**4 Health Care Reform Task Force.**

**Subd. 1. Task force.** Requires the governor to convene a Health Care Reform Task Force to advise and assist the governor and the legislature in implementing federal health care reform legislation. Specifies membership of the task force and requires the Departments of Health, Human Services, and Commerce to provide staff support. Also allows the task force to accept outside resources.

**Subd. 2. Duties.** Requires the task force, by December 15, 2010, to develop and present to the legislature and governor a preliminary report and recommendations on state implementation of federal health care reform legislation. Requires the report to contain recommendations on state law and program changes necessary to comply with federal reform legislation, and recommendations for implementing federal reform provisions that are optional for states. In developing recommendations, requires the task force to consider the extent to which an approach maximizes federal funding to the state. Also requires the task force, in consultation with the governor and the legislature, to establish timelines and criteria for future reports.

**5 American Health Benefit Exchange; planning provisions.**

**Subd. 1. Federal planning grants.** Requires the commissioners of commerce, health, and human services to apply for federal grants made available in the federal health reform legislation. The grants will pay for state planning for state health insurance exchanges required under that legislation.

**Subd. 2. Consideration of early creation and operation of exchange.** Requires the commissioners referenced in subdivision 1 to analyze the advantages and disadvantages to the state of planning to implement a health insurance exchange before the January 1, 2014, federal deadline for states to do so. Requires the commissioners to provide a written report to the legislature on that subject by December 15, 2010.

## Article 8: Human Services Forecast Adjustments

See spreadsheet for details.

# Article 9: Human Services Contingent Appropriations

**1** **Summary of human services appropriations.** Summarizes direct appropriations, by fund, made in this article.

**2** **Health and human services contingent appropriations.** Specifies that these appropriations are in addition to appropriations made in 2009 and specifies the fiscal years in which the appropriations are made. Makes appropriations in section 3 for fiscal year 2011 upon enactment of the extension of the enhanced federal medical assistance percentage.

**3** **Commissioner of human services.** Appropriates money in fiscal year 2011 to the commissioner of human services for MinnesotaCare grants, MA basic health care grants, long-term care facilities grants, long-term care waivers and home care grants, and chemical dependency entitlement grants.

**4** **Hospice care.** Amends § 256B.0625, subd. 22. Specifies that recipients age 21 or under who elect to receive hospice services do not waive coverage for services that are related to treatment of the condition for which a diagnosis of terminal illness has been made. Makes this section effective retroactive from March 23, 2010.

**5** **Definitions.** Amends § 256B.0911, subd. 1a. Corrects a cross-reference.

**6** **Additional portion of nonfederal share.** Amends § 256B.19, subd. 1c. Reduces Hennepin County IGT monthly payments for the period October 1, 2008, to December 30, 2010, from $566,000 to $434,688, to comply with federal requirements prohibiting increases in the percentage of MA costs paid for by local units of government. Extends this lower payment amount through June 30, 2011, if the federal government extends the enhanced federal medical assistance percentage (FMAP) through that date. Also makes changes in a provision dealing with payment to Metropolitan Health Plan, to reflect changing federal matching rates.

**7** **Premium determination.** Amends § 256L.15, subd. 1. Under current law, paragraph (c) of this subdivision is set to expire on June 30, 2010. This section specifies that if the expiration of this provision is in violation of federal law, this provision will expire on the date when it is no longer in violation of the American Recovery and Reinvestment Act of 2009. Requires the commissioner of human services to notify the revisor of statutes of that date.

**8** **Effective date.** Amends Laws 2009, chapter 173, article 3, section 24. Modifies the effective date of coverage for new household members for MinnesotaCare to comply with federal MOE requirements contained in the American Recovery and Reinvestment Act of 2009.

**9** **Effective date.** Amends Laws 2009, chapter 79, article 5, section 17. Modifies an effective date related to MA and MinnesotaCare self-employment to comply with federal MOE requirements contained in the American Recovery and Reinvestment Act of 2009.

**10** **Effective date.** Amends Laws 2009, chapter 79, article 5, section 18. Modifies an effective date related to modification of asset reduction for MA applicants to comply with federal MOE requirements contained in the American Recovery and Reinvestment Act of 2009.

**11** **Effective date.** Amends Laws 2009, chapter 79, article 5, section 22. Modifies an effective date related to long-term care services period of ineligibility to comply with federal MOE

requirements contained in the American Recovery and Reinvestment Act of 2009.

**12** **Effective date.** Amends Laws 2009, chapter 79, article 8, section 4. Changes the nursing facility level of care effective date from January 1, 2011, to July 1, 2011, to comply with federal MOE requirements.

**13** **Effective date.** Amends Laws 2009, chapter 173, article 1, section 17. Modifies an effective date related to pooled trust exclusions to comply with federal MOE requirements contained in the American Recovery and Reinvestment Act of 2009.

## Article 10: Health and Human Services Appropriations

See spreadsheet for details.