..... moves to amend H.F. No. 1233 as follows:

Page 3, delete section 2 and insert:

"Sec. 2. **[256.0131] FEDERAL APPROVAL OF HEALTH CARE COVERAGE WAIVER.**

Subdivision 1. **Federal approval.** (a) The commissioner of human services shall seek federal authority from the United States Department of Health and Human Services necessary to operate a health insurance program for Minnesotans with incomes up to 275 percent of the federal poverty guidelines (FPG). The proposal shall seek to secure all funding available from at least the following services:

(1) all premium tax credits and cost-sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals with incomes above 133 percent and at or below 275 percent of FPG who would otherwise be enrolled in the Health Insurance Exchange;

(2) Medicaid funding; and

(3) other funding sources identified by the commissioner that support coverage or care redesign in Minnesota.

(b) Funding received must be used to design and implement a health insurance program that creates a single streamlined program and meets the needs of Minnesotans with incomes up to 275 percent of FPG and shall incorporate:

(1) payment reform characteristics included in the Health Care Delivery System and Accountable Care Organization payment models;

(2) flexibility in benefit set design such that benefits can be targeted to meet enrollee needs in different income and health status situations and to create a more seamless transition from public to private health care coverage;

(3) flexibility in co-payment or premium structures to incent patients to seek high quality, low-cost care settings; and

(4) flexibility in premium structures to ease the transition from public to private health care coverage.

(c) The commissioner shall develop and submit a proposal consistent with the above criteria and shall seek all federal authority necessary to implement the coverage program. In developing the request, the commissioner shall consult with appropriate stakeholder groups and consumers.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals under paragraph (b) prior to 2017.

(e) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by December 1, 2014.

(f) The commissioner is authorized to accept and expend federal funds that support the purposes of this section."

Page 12, line 34, delete "(b)" and insert "(c)"

Page 21, after line 11 insert:

"Sec. 28. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 29. Minnesota Statutes 2012, section 256L.01, subdivision 3a, is amended to read:

Subd. 3a. **Family ~~with children~~.** (a) ~~"Family with children" means:~~

~~(1) parents and their children residing in the same household; or~~

~~(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; and their wards who are children residing in the same household.~~ "Family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2012, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** ~~(a)~~ "Income" has the meaning given for ~~earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income~~ modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1.

~~(b) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 31. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all eligible providers. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of ~~inpatient hospital services,~~ special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services~~, inpatient mental health services, and chemical dependency services~~.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

Subd. 1a. **~~Pregnant women and~~ Children; MinnesotaCare health care reform waiver.** ~~Beginning January 1, 1999,~~ Children ~~and pregnant women~~ are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. ~~Pregnant women and~~ Children are exempt from the provisions of subdivision 5, regarding co-payments. ~~Pregnant women and~~ Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient

hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000.~~

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 35. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in ~~paragraphs (b) and (c)~~ this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

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

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

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

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

~~(f)~~ (e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, ~~any charges submitted towards the $10,000 annual inpatient benefit limit, and~~ any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

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

~~(h)~~ (g) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (6). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** ~~(a)~~ Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than ~~275~~ 200 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18~~, including the insurance-related barriers to enrollment under section 256L.07,~~ shall apply unless otherwise specified.

~~(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.~~

~~(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.~~

~~(d) Parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.~~

~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision 8, are exempt from the eligibility requirements of this subdivision.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** ~~(a)~~ The definition of eligible persons includes all individuals and ~~households~~ families with no children who have ~~gross family~~ incomes that are above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

~~(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 250 percent of the federal poverty guidelines.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other

conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance. ~~Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), may choose to enroll in either MinnesotaCare or medical assistance.~~

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States~~, qualified noncitizens, and other persons residing~~ and lawfully ~~in the United States~~ present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens ~~and nonimmigrants~~ are ineligible for MinnesotaCare. 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(a)(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. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or

nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Eligible persons include individuals who are lawfully present and ineligible for medical assistance by reason of immigration status, who have family income equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 40. Minnesota Statutes 2012, section 256L.04, subdivision 12, is amended to read:

Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant or enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare. ~~An enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision 3a.~~ Applicants or enrollees residing in a correctional or detention facility pending disposition of charges are eligible for MinnesotaCare.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 41. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

(b) The commissioner shall coordinate eligibility and coverage such that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2012, 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 modified adjusted 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)~~ (c) 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)~~ (d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

~~(f)~~ (e) The effective date of coverage for children eligible under section 256L.07, subdivision 8, is the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may

demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

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

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

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 44. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** ~~(a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 200 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance.~~

~~Parents~~ Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~275~~ 200 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. ~~Beginning January~~

~~1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner.~~ For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

~~(b) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).~~

~~(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 45. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage ~~through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible~~ that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) This subdivision does not apply to a family or individual ~~who was enrolled in MinnesotaCare within six months or less of reapplication and~~ who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. ~~This subdivision does not apply to children with family gross incomes that are equal to or less than 200 percent of federal poverty guidelines.~~

~~(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal~~

~~Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) ~~Families and individuals enrolled in the MinnesotaCare program must have no~~ To be eligible, a family or individual must not have minimum essential health coverage ~~while enrolled~~, as defined by section 5000A of the Internal Revenue Code. ~~Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:~~

~~(1) lacks two or more of the following:~~

~~(i) basic hospital insurance;~~

~~(ii) medical-surgical insurance;~~

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

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

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

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

~~(b) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.~~

~~(c)~~ (b) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social

Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

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

~~(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, ~~pregnant women,~~ individuals, and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 48. Minnesota Statutes 2012, section 256L.11, subdivision 6, is amended to read:

Subd. 6. ~~**Enrollees 18 or older**~~ **Reimbursement of inpatient hospital services.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, ~~subdivisions~~ subdivision 1 ~~and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).~~, shall be at the medical assistance rate minus any co-payment required

under section 256L.03, subdivision 5. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

~~(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.~~

~~(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:~~

~~(1) the amount remaining in the enrollee's benefit limit; or~~

~~(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.~~

~~The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.~~

~~(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

~~(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the~~

~~first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.~~

~~(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.~~

~~(d)~~ (b) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 50. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly ~~gross individual or~~ family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of

chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

~~(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.~~

~~(c)~~ (b) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph ~~(d)~~ (c) with the exception that children in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums. For purposes of paragraph ~~(d)~~ (c), "minimum" means a monthly premium of $4.

~~(d)~~ (c) The following premium scale is established for individuals and families with ~~gross family~~ incomes of ~~275~~ 200 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
~~165-191~~	
165-200%	4.6%
~~192-219%~~	~~5.6%~~
~~220-248%~~	~~6.5%~~
~~249-275%~~	~~7.2%~~

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Page 21, delete subdivision 2 and insert:

"Subd. 2. **Repeal; certain MinnesotaCare provisions.** Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, and 10a;

256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, and 9; 256L.11, subdivision 5; and 256L.17 are repealed effective January 1, 2014."

Page 23, line 14, delete "and" and insert a comma and after "disabilities" insert ", and people with mental illnesses"

Page 23, line 16, after the period, insert "The report shall be submitted to the legislature no later than August 15, 2015."

Page 32, line 25, delete "who are"

Page 32, line 26, delete "admitted to a nursing facility from a hospital"

Page 36, after line 22, insert

"**EFFECTIVE DATE.** This section is effective October 1, 2013."

Page 37, after line 31, insert:

"**EFFECTIVE DATE.** This section is effective October 1, 2013."

Page 38, after line 26, insert:

"**EFFECTIVE DATE.** This section is effective October 1, 2013."

Page 39, after line 2, insert:

"**EFFECTIVE DATE.** This section is effective October 1, 2013."

Page 45, line 32, after "a" insert "Medicaid-certified"

Page 45, line 33, strike "from a hospital"

Page 47, after line 7, insert:

"**EFFECTIVE DATE.** This section is effective October 1, 2013."

Page 53, line 27, after "uniformity" insert "for payment rates" and delete "ICLS shall not be"

Page 53, delete line 28 and insert "Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and Human Services to avoid conflict with provider regulatory standards pursuant to section 144A.43 and chapter 245D."

Page 55, line 16, after "program" insert "governed by a board, the majority of whose members reside within the program's service area,"

Page 63, line 29, delete "acting as the employer of record" and insert "by directly employing support workers"

Page 64, line 14, delete "including employing workers specifically selected by the participant"

Page 65, line 4, delete "regulatory requirements when acting as an employer of record for"

Page 65, line 5, delete "support workers or employer agent, that are" and insert " employer-related requirements"

Page 65, line 9, delete "for the" and insert "to facilitate participant"

Page 67, line 3, after "to" insert "assistance regarding"

Page 67, line 10, delete "a regular or temporary employee of the agency-provider,"

Page 67, line 11, delete "the financial management services contractor, or the participant" and insert "an employee of the agency provider or of the participant"

Page 67, line 17, delete "and"

Page 67, line 18, after "accounts" insert ", or other forms of employee compensation and benefits"

Page 67, line 19, before "CFSS" insert "(a)"

Page 67, line 29, delete "is determined eligible" and insert "require assistance and be determined dependent in one activity of daily living or Level I behavior"

Page 70, line 4, delete "(a)"

Page 70, line 14, delete "and"

Page 70, line 17, after the semicolon insert "and"

Page 70, before line 18, insert:

"(iii) fit within the annual limit of the participant's approved service allocation or budget;"

Page 70, line 19, before the period, insert "or intervention needed due to a participant's symptoms"

Page 71, delete lines 9 and 10

Page 71, line 26, delete "CFSS" and insert "PCA"

Page 76, line 10, delete "accept" and insert "can exercise"

Page 76, delete lines 12 and 13 and insert:

"(1) participants directly employ support workers;

(2) participants may use a budget allocation to obtain supports and goods as defined in subdivision 7; and"

Page 76, line 14, delete "(2)" and insert "(3)"

Page 76, line 15, delete "for" and insert "services relating to"

Page 76, line 17, after "the" insert "participant's"

Page 76, line 18, delete the second "and" and insert "for"

Page 76, line 30, delete "employer and employer agent functions" and insert " assisting participants in fulfilling employer-related requirements in accordance with"

Page 77, line 6, delete the comma

Page 77, line 7, delete everything before the semicolon and insert "or service delivery models as authorized by the commissioner"

Page 78, line 7, delete "record for"

Page 78, line 24, before "FMS" insert "assistance of the"

Page 79, line 34, after "practices," insert "orientation to responding to a mental health crisis,"

Page 85, line 10, delete "triage system for investigations" and insert "system for referring reports to the lead investigative agencies"

Page 85, line 31, delete "This"

Page 85, delete line 32

Page 85, line 33, delete everything before "This"

Page 86, delete section 48 and insert:

"Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.

(b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are repealed effective October 1, 2013."

Page 87, line 25, delete "$18,814,000" and insert "$16,992,000"

Page 115, line 31, before "tribe" insert "county or"

Page 160, delete lines 23 to 30 and insert:

"(1) improving permanency for a child or children;

(2) maintaining permanency for a child or children;

(3) administrative simplification;

(4) accessing additional federal funds;

(5) converting pre-Northstar Care for Children relative custody assistance under section 257.85 to the guardianship assistance component of Northstar Care for Children;

(6) complying with federal regulations; and

(7) financial and budgetary constraints."

Page 167, delete lines 30 and 31

Page 167, line 32, delete "(d)" and insert "(c)"

Page 168, line 1, delete "(e)" and insert "(d)"

Page 168, after line 3, insert:

"Section 1. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families,

advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, Minnesota specialty treatment facility is defined as an intensive rehabilitative mental health service under section 256B.0622, subdivision 2, paragraph (b).

Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) residential services funds administered under Minnesota Rules, parts 9535.2000 to 9535.3000, in an amount to be determined by mutual agreement between the project's managing entity and the commissioner of human services after an examination of the county's historical utilization of facilities located both within and outside of the county and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

(2) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(3) other mental health special project funds;

(4) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; ~~and~~

(5) regional treatment center resources consistent with section 246.0136, subdivision 1.~~;~~ and

(6) funds transferred from section 246.18, subdivision 8, for grants to providers to participate in mental health specialty treatment services, awarded to providers through a request for proposal process.

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project."

Page 169, line 17, delete "and"

Page 169, line 19, delete the period and insert "; and"

Page 169, after line 19, insert:

"(3) to fund the operation of the Intensive Residential Treatment Service program in Willmar."

Page 170, after line 21, insert:

"Sec. 6. Minnesota Statutes 2012, section 256B.0946, is amended to read:

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

Subdivision 1. **Required covered service components.** (a) Effective ~~July 1, 2006,~~ upon enactment and subject to federal approval, medical assistance covers medically necessary intensive treatment services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental illness residing in ~~treatment~~ foster ~~care~~ family settings ~~must meet the relevant standards for mental health services under sections 245.487 to 245.4889. In addition,~~ that comprise specific required service components provided in clauses (1) to (5), are reimbursed by medical assistance ~~must~~ when they meet the following standards:

~~(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;~~

(1) psychotherapy provided by a mental health professional as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) ~~psychotherapy,~~ crisis assistance~~, and skills training components must meet the~~ provided according to standards for children's therapeutic services and supports in section 256B.0943; ~~and~~

(3) individual family, and group psychoeducation services ~~under supervision of~~, defined in subdivision 1a, paragraph (q), provided by a mental health professional~~.~~ or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

(d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;

(e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

(f) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(g) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

(h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11.

(i) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

(j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(k) "Foster family setting" means the foster home in which the license holder resides.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15.

(m) "Mental health practitioner" has the meaning given in Minnesota Rules, part 9505.0370, subpart 17.

(n) "Mental health professional" has the meaning given in Minnesota Rules, part 9505.0370, subpart 18.

(o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart 20.

(p) "Parent" has the meaning given in section 260C.007, subdivision 25.

(q) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and to achieve optimal mental health and long-term resilience.

(r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370, subpart 27.

(s) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including

adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

Subd. 2. **Determination of client eligibility.** ~~A client's eligibility to receive treatment foster care under this section shall be determined by~~ An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment~~,~~ and an evaluation of level of care needed, ~~and development of an individual treatment plan,~~ as defined in paragraphs (a) ~~to (c)~~ and (b).

(a) The diagnostic assessment must:

(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a ~~psychiatrist, licensed psychologist, or licensed independent clinical social worker that is~~ mental health professional or a clinical trainee;

(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;

(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;

(4) be performed within 180 days ~~prior to~~ before the start of service; and

~~(2) include current diagnoses on all five axes of the client's current mental health status;~~

~~(3) determine whether or not a child meets the criteria for severe emotional disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness in section 245.462, subdivision 20; and~~

~~(4) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental status and service needs.~~

(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.

(b) The evaluation of level of care must be conducted by the placing county ~~with an instrument~~, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour

medical monitoring. The commissioner shall update the list of approved level of care ~~instruments~~ tools annually and publish on the department's Web site.

~~(c) The individual treatment plan must be:~~

~~(1) based on the information in the client's diagnostic assessment;~~

~~(2) developed through a child-centered, family driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific measurable treatment goals and objectives for the client and treatment strategies for the client's family and foster family;~~

~~(3) reviewed at least once every 90 days and revised; and~~

~~(4) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client.~~

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section.

(b) For purposes of this section, a provider agency must ~~have an individual placement agreement for each recipient and must be a licensed child placing agency, under Minnesota Rules, parts 9543.0010 to 9543.0150, and either~~ be:

(1) a ~~county~~ county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity ~~under contract with a county board~~.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

Subd. 4. ~~**Eligible provider responsibilities**~~ **Service delivery payment requirements.** (a) To be ~~an~~ eligible ~~provider~~ for payment under this section, a provider must develop and practice written policies and procedures for ~~treatment foster care services~~ intensive treatment in foster care, consistent with subdivision 1, paragraph (b), ~~clauses (1), (2), and (3)~~ and comply with the following requirements in paragraphs (b) to (n).

~~(b) In delivering services under this section, a treatment foster care provider must ensure that staff caseload size reasonably enables the provider to play an active role in service planning, monitoring, delivering, and reviewing for discharge planning to meet~~

~~the needs of the client, the client's foster family, and the birth family, as specified in each client's individual treatment plan.~~

(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.

(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.

(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received and this information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

(e) Each client receiving treatment must be assessed for a trauma history and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(f) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s).

(g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

(h) Each client must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment, and the crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(i) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

(j) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(k) Treatment must be developmentally and culturally appropriate for the client.

(l) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications,

including those prescribed on an off-label basis, and members of the service team must be aware of the medication regimen and potential side effects.

(m) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(n) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

~~(1) treatment foster care services provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;~~

~~(2) service components of children's therapeutic services and supports simultaneously provided by more than one treatment foster care provider;~~

~~(3) home and community-based waiver services; and~~

~~(4) treatment foster care services provided to a child without a level of care determination according to section 245.4885, subdivision 1.~~

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

~~(1) mental health case management services under section 256B.0625, subdivision 20; and~~

~~(2)~~ (1) psychotherapy and ~~skill~~ skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b~~.~~;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (m);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for intensive treatment in foster care services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b)."

Page 174, line 24, before "financial" insert "the provider's"

Page 176, line 12, after "provider" insert ", license holder, controlling individual,"

Page 176, line 18, after "provider" insert ", license holder, or controlling individual"

Page 176, line 19, after the comma, insert "license holder, or controlling individual"

Page 178, line 33, before "appealed" insert "timely"

Page 178, lines 35 and 36, delete "an" and insert "a timely"

Page 179, line 24, before "action" and insert "the"

Page 179, line 25, delete "and" and insert "or" and before "program" insert "child care assistance"

Page 179, line 26, delete "an overpayment" and insert "a financial misconduct sanction"

Page 179, line 27, delete "recovery action"

Page 184, delete section 7 and insert:

"Sec. 7. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; ~~and~~ (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. The determination of services not medically necessary may be made by the commissioner

in consultation with a peer advisory task force appointed by the commissioner on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date

the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. Fines may be assessed when the commissioner has no evidence that services were not provided and services are partially documented in the health service or financial record, but specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 10. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for initial enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage in the amount of ~~$50,000~~ $100,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is ~~less~~ more. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal

care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

Page 201, line 33, delete everything after the period and insert "The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Discount Program by 33 percent."

Page 201, delete lines 34 and 35

Page 201, line 36, delete "commissioner."

Page 202, after line 22, insert:

"Sec. 3. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication."

Page 203, after line 14, insert:

"Sec. 5. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to read:

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an $8.50 fee per dose~~ for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program."

Page 203, after line 20, insert:

"Sec. 7. Minnesota Statutes 2012, section 256B.76, is amended by adding a subdivision to read:

Subd. 7. **Payment for certain primary care services and immunization administration.** Payment for certain primary care services and immunization administration services rendered on or after January 1, 2013, through December 31, 2014, shall be made in accordance with section 1902(a)(13) of the Social Security Act.

Sec. 8. Minnesota Statutes 2012, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

EFFECTIVE DATE. This section is effective July 1, 2013."

Page 205, line 22, after "(2)" insert "the license holder's beds occupied by residents whose primary diagnosis is mental illness and"

Page 206, line 19, before "The" insert "(a)"

Page 206, after line 22, insert:

"(b) For the purposes of this section, the commissioner has the authority to transfer funds between the medical assistance account and the home and community-based services transitions grants account."

Page 207, lines 29 and 33, delete "June" and insert "September"

Page 208, line 36, delete "July" and insert "October"

Page 219, line 34, delete "June" and insert "September"

Page 220, delete sections 14 and 15 and insert:

"Sec. 14. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46b. **Calculation of operating rate increase and quality add-on for the October 1, 2013, rate year.** (a) Effective October 1, 2013, the commissioner shall implement operating payment rate increases for each facility. The increase shall be equal to 1.09 percent multiplied by the difference between the operating rates in effect on September 30, 2013, less any amount received under section 256B.434, subdivision 4.

(b) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The quality add-on amounts shall be based on rates in effect on September 30, 2013, less any amount received under section 256B.434, subdivision 4. For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero. The quality add-ons shall be the operating payment rates multiplied by the quality factor multiplied by 2.60 percent. The commissioner shall implement the quality add-ons effective October 1, 2013.

(c) Facilities receiving rate adjustments under subdivision 55a must have rate increases under paragraphs (a) and (b) computed based on their rates in effect before the increases given under subdivision 55a became effective. The amount of rate increases computed under this subdivision shall be added to the rates that the nursing facility would otherwise be paid without application of subdivision 55a.

Sec. 15. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46c. **Calculation of operating rate increase and quality add-on for the October 1, 2014, rate year.** (a) Effective October 1, 2014, the commissioner shall implement operating payment rate increases for each facility. The increase shall be equal to 1.09 percent multiplied by the difference between the operating rates in effect on September 30, 2014, less any amount received under section 256B.434, subdivision 4.

(b) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The quality add-on amounts shall be based on rates in effect on September 30, 2014, less any amount received under section 256B.434, subdivision 4. For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero. The quality add-ons shall be the operating payment rates multiplied by the quality factor multiplied by 2.60 percent. The commissioner shall implement the quality add-ons effective October 1, 2014.

(c) Facilities receiving rate adjustments under subdivision 55a must have rate increases under paragraphs (a) and (b) computed based on their rates before subdivision 55a became effective. The amount of rate increases computed under this subdivision shall be added to the rates that the nursing facility would otherwise be paid without application of subdivision 55a, but after the increases computed in subdivision 46b."

Page 221, delete sections 16 and 17 and insert:

"Sec. 16. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46d. **Calculation of quality add-on for the October 1, 2015, rate year.** (a) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The quality add-on amounts shall be based on rates in effect on September 30, 2015, less any amount received under section 256B.434, subdivision 4. For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero. The quality add-ons shall be the operating payment rates multiplied by the quality factor multiplied by 5.40 percent. The commissioner shall implement the quality add-ons effective October 1, 2015.

(b) Facilities receiving rate adjustments under subdivision 55a must have rate increases under paragraph (a) computed based on their rates before subdivision 55a became effective. The amount of rate increases computed under this subdivision shall be added to the rates that the nursing facility would otherwise be paid without application of subdivision 55a, but after the sum of the increases computed in subdivisions 46b and 46c.

Sec. 17. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 46e. **Calculation of quality add-on for the October 1, 2016, rate year.** (a) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The quality add-on amounts shall be based on rates in effect on September 30, 2016, less any amount received under section 256B.434, subdivision 4. For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero. The quality add-ons shall be the operating payment rates multiplied by the quality factor multiplied by 5.40 percent. The commissioner shall implement the quality add-ons effective October 1, 2016.

(b) Facilities receiving rate adjustments under subdivision 55a must have rate increases under paragraph (a) computed based on their rates before subdivision 55a became effective. The amount of rate increases computed under this subdivision shall be added to the rates that the nursing facility would otherwise be paid without application of subdivision 55a, but after the sum of the increases computed in subdivisions 46b to 46d."

Page 222, line 12, delete "June" and insert "September"

Page 226, line 5, delete "developmental disabilities waiver" and insert "brain injury, community alternatives for disabled individuals, or community alternative care waivers"

Page 227, after line 23, insert:

"Sec. 27. **REPEALER.**

Minnesota Statutes 2012, section 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed."

Page 229, line 4, delete everything after the period

Page 229, delete line 5

Page 229, line 7, delete "aversive and"

Page 229, line 8, delete "for" and insert "with persons receiving services from providers regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, and incidents involving persons receiving services from"

Page 229, line 9, delete everything after the period and insert "Providers shall report the data in a format and at a frequency provided by the commissioner of human services."

Page 229, delete lines 10 to 13 and insert:

"(b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures in a format and at a frequency provided by the commissioner."

Page 232, after line 29, insert:

"Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall prohibit a program that is excluded from licensure under subdivision 2, paragraph (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any application received from such an excluded provider is processed in the same manner as all other applications for child care center licensure."

Page 251, after line 26, insert:

"Subd. 2a. **Authorized representative.** "Authorized representative" means a parent, family member, advocate, or other adult authorized by the person or the person's legal representative, to serve as a representative in connection with the provision of services licensed under this chapter. This authorization must be in writing or by another method that clearly indicates the person's free choice. The authorized representative must have no financial interest in the provision of any services included in the person's service delivery plan and must be capable of providing the support necessary to assist the person in the use of home and community-based services licensed under this chapter."

Page 253, line 8, delete "person's conduct" and insert "person"

Page 253, line 9, delete everything after "and" and insert "is the least restrictive intervention that would achieve safety."

Page 253, line 13, after "health" insert "or mental health"

Page 255, line 8, delete everything after the period and insert "Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney"

Page 255, delete lines 9 to 11

Page 258, lines 22 and 27, after "plan" insert "or coordinated service and support plan addendum"

Page 259, line 2, after the period, insert "For the purpose of chapter 245D, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced."

Page 259, line 7, after "health" insert "or mental health"

Page 260, line 16, after "training" insert "treatment,"

Page 263, after line 20, insert:

"Subd. 4. **Program certification.** An applicant or a license holder may apply for program certification as identified in section 245D.33."

Page 263, delete section 18

Page 271, line 13, delete "community" and insert "coordinated"

Page 272, delete lines 27 to 30 and insert:

"(d) If a person is prescribed a psychotropic medication, monitoring the use of the psychotropic medication must be assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum. The assigned license holder must monitor the psychotropic medication as required by this section."

Page 273, delete lines 10 and 11

Page 273, after line 34, insert:

"(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death has already been reported."

Page 274, line 1, strike "(f)" and insert "(g)"

Page 274, line 13, delete "(g)" and insert "(h)" and after "must" insert "verbally"

Page 274, line 14, delete "and to the Department of Human Services Licensing"

Page 274, line 15, delete "Division" and delete "conduct an" and insert "ensure the written report and"

Page 274, line 16, after "restraints" insert "are completed"

Page 275, line 6, after "plan" insert "or coordinated service and support plan addendum"

Page 275, strike line 19

Page 275, line 20, delete the new language and strike the old language

Page 275, strike lines 21 to 23

Page 278, line 3, after "(2)" insert "the type of" and after "restraint" insert "used" and delete "possible"

Page 278, line 4, delete everything after "safety" and insert ". The manual restraint must end when the threat of harm ends."

Page 278, delete line 5

Page 278, line 19, after "plan" insert "addendum"

Page 279, line 27, delete "The license" and insert "Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency

use must report in writing to the designated coordinator the following information about the emergency use:"

Page 279, delete lines 28 to 30

Page 282, line 11, delete "and"

Page 282, after line 13, insert:

"(vii) the communicative intent of behaviors; and

(viii) relationship building;"

Page 283, line 28, after "planning" insert "requirements for basic support services"

Page 283, line 31, delete "service plan" and insert "coordinated service and support plan addendum"

Page 283, line 32, delete "develop and"

Page 283, delete line 33 and insert "review and revise as needed the preliminary coordinated service and support plan addendum to document the services that"

Page 284, line 13, after "245D.07" insert ", subdivisions 1 and 3,"

Page 284, line 18, delete "service plan" and insert "coordinated service and support plan addendum"

Page 285, line 20, delete "developed under" and insert "to be implemented to support the accomplishment of outcomes related to acquiring, retaining, or improving skills"

Page 285, line 21, delete "paragraph (a)"

Page 286, line 11, after "plan" insert "or coordinated service and support plan addendum"

Page 287, delete lines 35 and 36 and insert:

"(4) a minimum of 50 hours of education and training related to human services and disabilities, and"

Page 288, line 2, after "older" insert "under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3)"

Page 289, lines 13 and 25, after "plan" insert "or coordinated service and support plan addendum"

Page 289, line 18, after "plan" insert "or coordinated service and support plan addendum"

Page 291, line 5, after "plan" insert "or coordinated service and support plan addendum"

Page 296, line 29, after "plan" insert "or coordinated service and support plan addendum"

Page 297, line 18, after "plan" insert "or coordinated service and support plan addendum"

Page 298, line 8, after "plan" insert "or coordinated service and support plan addendum"

Page 301, line 6, strike "revised policies and procedures" and insert "procedural revisions to policies" and after "person's" insert "service-related or protection-related"

Page 301, line 7, after "254D.04" insert "and maltreatment reporting policies and procedures"

Page 301, line 8, strike "reason" and insert "reasonable cause"

Page 301, after line 12, insert:

"(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures."

Page 303, line 2, delete everything before the comma and insert "coordinated service and support plan addendum"

Page 304, line 2, after the semicolon, insert "and"

Page 304, delete lines 3 to 7

Page 304, line 11, after the period, insert "The license holder must not refuse to admit a person based solely on the type of residential services the person is receiving, or solely on the person's severity of disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of communication skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress."

Page 306, line 10, delete "must be" and after "aid" insert "must be available on site"

Page 306, line 11, after "plan" insert "or coordinated service and support plan addendum" and delete everything after "resuscitation," and insert "whenever persons are present and staff are required to be at the site to provide direct service. The training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a first aid instructor."

Page 306, delete line 12

Page 309, line 15, after the period, insert "A person may choose to use a mattress other than an innerspring mattress and may choose to not have the mattress on a mattress frame or support."

Page 309, line 17, after the period, insert "If a person chooses to use a mattress other than an innerspring mattress or chooses to not have a mattress frame or support, the license holder must document this choice and allow the alternative desired by the person."

Page 311, line 28, delete "and each staff person or employee"

Page 318, after line 17, insert:

"Sec. 45. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8, a foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

(b) Residential support services must meet the following criteria:

~~(1) providers of residential support services must own or control the residential site;~~

~~(2) the residential site must not be the primary residence of the license holder;~~

~~(3)~~ (1) the residential site must have a designated ~~program supervisor~~ person responsible for program management, oversight, development, and implementation of policies and procedures;

~~(4)~~ (2) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

~~(5)~~ (3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~ must be licensed according to chapter 245D. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (g), are considered registered under this section."

Page 319, after line 13, insert:

"Sec. 48. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1, 2013, facilities and services to be licensed under chapter 245D shall submit data regarding the use of emergency use of manual restraint as identified in section 245D.061 in a format and at a frequency identified by the commissioner."

Page 319, line 16, delete "8" and insert "9"

Page 319, line 29, delete "9" and insert "10"

Page 322, delete lines 24 and 25

Page 322, line 26, delete "(c)" and insert "(b)"

Page 349, line 21, before "The" insert "For providers regulated pursuant to sections 144A.043 to 144A.482,"

Page 350, lines 3, 16, and 23, before "The" insert "For providers regulated pursuant to sections 144A.043 to 144A.482,"

Page 373, line 30, delete "determination of" and insert "failure to report"

Page 373, line 31, delete everything after "626.557" and insert a semicolon

Page 373, delete lines 32 and 33

Page 373, before line 34 insert:

"(2) failure to establish and implement procedures for reporting suspected maltreatment under section 144A.479, subdivision 6, paragraph (a);

(3) failure to complete and implement an abuse prevention plan under section 144.479, subdivision 6, paragraph (b);"

Renumber the clauses in sequence

Page 410, delete section 4 and insert:

"Sec. 4. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing ~~and the~~, recording ~~and~~ of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health. ~~The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966.~~

(c) The fee ~~is $101 per specimen. Effective July 1, 2010, the fee shall be increased to $106~~ to support the newborn screening program, including tests administered under this section and section 144.966, shall be $135 per specimen. ~~The increased fee amount~~

~~shall be deposited in the general fund. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.~~ This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $5 per specimen. This fee shall be deposited in the state treasury and credited to the general fund."

Page 412, after line 8, insert:

"Sec. 17. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing Minnesotans;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low-incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) This subdivision expires June 30, ~~2013~~ 2019."

Page 426, line 4, delete "for licensing" and insert "to license and operate"

Page 428, line 9, delete "data" and insert "date"

Page 441, line 22, delete "training which" and insert "procedures"

Page 441, line 23, delete everything before "for"

Page 441, line 24, after "personnel" insert a comma

Page 442, line 4, delete "place" and insert "placed"

Page 442, line 33, delete "4" and insert "12"

Page 444, line 35, delete "by certified alkaline hydrolysis facility staff"

Page 444, line 36, after "remains" insert ", only by staff licensed or registered by the commissioner of health"

Page 447, line 5, delete "20" and insert "29"

Page 447, after line 33, insert:

"**ARTICLE 13**

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, as amended by Laws 2012, chapter 247, article 6, and Laws 2012, chapter 292, article 3, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal years indicated for each purpose. The figure "2013" used in this article means that the appropriations listed under them are available for the fiscal year ending June 30, 2013.

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (161,031,000)**

Appropriations by Fund	2013
General Fund	(158,668,000)
Health Care Access	(7,179,000)
TANF	4,816,000

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP Grants**

Appropriations by Fund	
General Fund	(8,211,000)
TANF	4,399,000

(b) **MFIP Child Care Assistance Grants** 10,113,000

(c) **General Assistance Grants** 3,230,000

(d) **Minnesota Supplemental Aid Grants** (1,008,000)

(e) **Group Residential Housing Grants** (5,423,000)

(f) **MinnesotaCare Grants** (7,179,000)

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants** (159,733,000)

(h) **Alternative Care Grants** -0-

(i) **CD Entitlement Grants** 2,364,000

Subd. 3. **Technical Activities** 417,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment."

Page 448, delete section 1 and insert:

"Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2014	**2015**	**Total**
General	$ 5,648,596,000	$ 5,914,450,000	$ 11,563,046,000
State Government Special Revenue	70,996,000	73,066,000	144,062,000
Health Care Access	597,449,000	424,738,000	1,022,187,000
Federal TANF	269,628,000	266,526,000	536,154,000
Lottery Prize Fund	1,665,000	1,665,000	3,330,000
Total	**$ 6,588,334,000**	**$ 6,680,445,000**	**$ 13,268,779,000**"

Page 448, line 28, delete "6,418,000,000" and insert "6,460,239,000" and delete " 6,382,943,000" and insert "6,493,273,000"

Page 448, line 31, delete "5,564,459,000" and insert "5,565,387,000" and delete " 5,899,531,000" and insert "5,836,434,000"

Page 448, line 34, delete "589,992,000" and insert "631,207,000" and delete " 218,768,000" and insert "394,096,000"

Page 448, line 35, delete "257,819,000" and insert "257,915,000" and delete " 256,714,000" and insert "254,813,000"

Page 454, line 8, delete "96,928,000" and insert "98,727,000" and delete "91,123,000" and insert "94,277,000"

Page 454, line 11, delete "12,453,000" and insert "13,177,000" and delete "12,453,000" and insert "13,004,000"

Page 455, line 11, delete "$1,883,000" and insert "$1,825,000"

Page 455, line 12, delete "$2,347,000" and insert "$2,502,000"

Page 455, line 16, delete "$3,219,000" and insert "$3,222,000"

Page 455, line 17, delete "$3,062,000" and insert "$3,037,000"

Page 455, line 19, delete "$6,085,000" and insert "$6,662,000" and delete "is" and insert "and $1,148,000 in fiscal year 2015 are"

Page 455, line 25, delete "$6,085,000" and insert "$6,662,000"

Page 455, line 26, after "appropriation" insert "in fiscal year 2014 and the $1,148,000 appropriation in fiscal year 2015"

Page 456, line 10, delete "$18,814,000" and insert "$16,992,000"

Page 456, line 12, delete "$6,813,000" and insert "$6,099,000"

Page 456, line 13, delete "$2,672,000" and insert "$1,185,000" and after the period, insert "The health access fund base is decreased by $551,000 in fiscal years 2016 and 2017."

Page 456, line 16, delete "7,967,000" and insert "8,082,000" and delete "7,910,000" and insert "8,018,000"

Page 456, line 34, delete "$94,000" and insert "$300,000"

Page 457, line 5, delete "13,817,000" and insert "13,843,000" and delete "13,530,000" and insert "13,639,000"

Page 457, line 6, delete "24,602,000" and insert "26,404,000" and delete "22,634,000" and insert "29,914,000"

Page 457, line 8, delete "$1,842,000" and insert "$8,177,000"

Page 457, line 9, before the period, insert "and by $6,712,000 in fiscal year 2017"

Page 457, line 12, delete "19,414,000" and insert "19,503,000" and delete "20,769,000" and insert "21,044,000"

Page 457, line 20, delete "$9,207,000" and insert "$3,324,000"

Page 457, line 21, delete "$9,182,000" and insert "$3,324,000"

Page 457, line 24, delete "4,482,000" and insert "4,494,000" and delete "4,282,000" and insert "4,294,000"

Page 457, line 31, delete "77,783,000" and insert "73,742,000" and delete "75,831,000" and insert "75,261,000"

Page 457, line 32, delete "77,846,000" and insert "80,342,000" and delete "78,452,000" and insert "76,851,000"

Page 457, line 33, delete "58,771,000" and insert "64,316,000" and delete "63,383,000" and insert "68,536,000"

Page 458, line 1, delete "54,259,000" and insert "54,787,000" and delete "55,566,000" and insert "56,068,000"

Page 458, line 19, delete "38,642,000" and insert "38,646,000" and delete "39,814,000" and insert "39,821,000"

Page 458, line 20, delete "138,614,000" and insert "141,138,000" and delete "148,515,000" and insert "150,988,000"

Page 458, line 26, delete "233,186,000" and insert "296,581,000" and delete "38,928,000" and insert "227,598,000"

Page 458, delete lines 27 to 31

Page 459, line 2, delete "4,362,916,000" and insert "4,348,570,000" and delete "4,676,238,000" and insert "4,602,815,000"

Page 459, line 3, delete "318,811,000" and insert "292,067,000" and delete "143,813,000" and insert "121,417,000"

Page 459, line 8, delete "46,452,000" and insert "46,653,000" and delete "44,650,000" and insert "44,500,000"

Page 459, line 18, delete "79,807,000" and insert "81,440,000" and delete "81,169,000" and insert "74,875,000"

Page 459, line 28, delete "9,833,000" and insert "13,333,000" and delete "11,633,000" and insert "13,333,000"

Page 459, line 29, delete "98,111,000" and insert "94,611,000" and delete "96,311,000" and insert "94,611,000"

Page 459, line 30, delete "$668,000" and insert "$2,168,000"

Page 459, line 31, delete ", and $1,500,000"

Page 459, delete line 32

Page 460, line 19, delete "in fiscal year 2014 is from the" and insert "each year"

Page 460, delete line 20

Page 460, line 21, delete "fiscal year 2015"

Page 460, line 30, delete "in fiscal year 2014" and insert "each year"

Page 460, line 31, delete ", and $200,000 in"

Page 460, delete line 32

Page 460, line 33, delete "fund,"

Page 461, delete lines 1 to 3 and insert "The TANF fund base is increased by $200,000 in fiscal years 2016 and 2017."

Page 461, line 17, delete "$2,918,000" and insert "$4,618,000"

Page 461, line 18, after the period, insert "The TANF fund base is increased by $1,700,000 in fiscal years 2016 and 2017."

Page 461, line 20, delete "39,900,000" and insert "40,351,000" and delete "42,894,000" and insert "43,658,000"

Page 461, line 22, delete "$1,442,000" and insert "$1,278,000"

Page 461, line 23, delete "$1,552,000" and insert "$1,349,000"

Page 462, delete lines 29 to 31

Page 462, line 32, delete "16,222,000" and insert "18,897,000" and delete "16,223,000" and insert "18,903,000"

Page 463, after line 3, insert:

"**Family Assets for Independence.** $250,000 each year is for the Family Assets for Independence Minnesota program. This appropriation is available in either year of the biennium and may be transferred between fiscal years. This appropriation is added to the base."

Page 463, line 7, delete "190,000" and insert "2,228,000" and delete "190,000" and insert "1,413,000"

Page 463, after line 7, insert:

"**Base Adjustment.** The health care access fund is decreased by $1,223,000 in fiscal years 2016 and 2017."

Page 463, delete lines 22 to 24

Page 463, line 26, delete "17,895,000" and insert "18,048,000"

Page 463, line 32, delete "$1,016,000" and insert "$502,000"

Page 463, line 33, delete "$1,190,000" and insert "$676,000"

Page 464, line 3, delete "68,310,000" and insert "68,803,000"

Page 464, line 12, delete "$5,802,000" and insert "$4,461,000"

Page 465, line 9, delete "$2,000,000" and insert "$1,000,000"

Page 465, line 11, delete "and"

Page 465, line 14, before the period, insert ", and up to $2,713,000 each year is available for the purposes of paragraph (b), clause (3), of that subdivision"

Page 465, after line 28 insert:

"Subd. 10. **Transfer.**

The commissioner of management and budget must transfer $65,000,000 in fiscal year 2014 from the general fund to the health care access fund. This is a onetime transfer."

Page 466, line 2, delete "49,515,000" and insert "50,203,000" and delete "50,076,000" and insert "50,123,000"

Page 468, line 11, delete "15,849,000" and insert "16,537,000" and delete "16,407,000" and insert "16,454,000"

Page 468, line 15, delete "$20,000" and insert "$2,000" and delete "years 2016" and insert "year 2017."

Page 468, line 16, delete "and 2017."

Renumber the articles and sections in sequence and correct the internal references

Amend the title as follows:

Page 1, line 11, delete "repealing"

Page 1, line 12, delete "MinnesotaCare;"

Correct the title numbers accordingly