..... moves to amend H.F. No. 2627 as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

**HEALTH CARE**

Section 1. Minnesota Statutes 2010, section 62J.497, subdivision 2, is amended to read:

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish, maintain, and use an electronic prescription drug program. This program must comply with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Notwithstanding paragraph (a), any clinic with two or fewer practicing physicians is exempt from this subdivision if the clinic is making a good-faith effort to

meet the electronic health records system requirement under section 62J.495 that includes an electronic prescribing component. This paragraph expires January 1, 2015.

**EFFECTIVE DATE.** This section is effective retroactively from January 1, 2011.

Sec. 2. Minnesota Statutes 2010, section 62J.536, subdivision 1, is amended to read:

Subdivision 1. **Electronic claims and eligibility transactions required.** (a) Beginning January 15, 2009, all group purchasers must accept from health care providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all group purchasers must accept from health care providers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(b) Beginning January 15, 2009, all group purchasers must transmit to providers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all group purchasers must transmit to providers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(c) Beginning January 15, 2009, all health care providers must submit to group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning July 15, 2009, all health care providers must submit to group purchasers the health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K.

(d) Beginning January 15, 2009, all health care providers must accept from group purchasers the eligibility for a health plan transaction described under Code of Federal Regulations, title 45, part 162, subpart L. Beginning December 15, 2009, all health care providers must accept from group purchasers the health care payment and remittance advice transaction described under Code of Federal Regulations, title 45, part 162, subpart P.

(e) Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction. An appropriate, standard, electronic National Council for Prescription Drug Programs response must be used for prescription drug claims or equivalent encounter information. The acknowledgment provided for claims or equivalent encounter information, other than for prescription drugs,

must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions:

(1) TA1;

(2) ~~997;~~

~~(3)~~ 999; or

~~(4)~~ (3) 277CA.

Health care providers, health care clearinghouses, and group purchasers may send and receive more than one type of standard acknowledgment as mutually agreed upon. The mutually agreed upon acknowledgments must be exchanged electronically. Electronic exchanges of acknowledgments do not include e-mail or facsimile.

(f) Each of the transactions described in paragraphs (a) to (e) shall require the use of a single, uniform companion guide to the implementation guides described under Code of Federal Regulations, title 45, part 162. The companion guides will be developed pursuant to subdivision 2.

(g) Notwithstanding any other provisions in sections 62J.50 to 62J.61, all group purchasers and health care providers must exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines required under this subdivision. Group purchasers may not impose any fee on providers or providers' clearinghouses for the use of the transactions prescribed in this subdivision. Health care providers may not impose a fee on group purchasers or group purchasers' clearinghouses for the use of the transactions prescribed in this subdivision. A clearinghouse may not charge a fee solely to receive a standard transaction from a health care provider, a health care provider's clearinghouse, a group purchaser, or a group purchaser's clearinghouse when it is not an agent of the sending entity. A clearinghouse may not charge a fee solely to send a standard transaction to a health care provider, a health care provider's clearinghouse, a group purchaser, or a group purchaser's clearinghouse when it is not an agent of the receiving entity.

(h) Nothing in this subdivision shall prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology for complying with the requirements of this subdivision. Any direct data entry method for conducting the transactions specified in this subdivision must be consistent with the data content component of the single, uniform companion guides required in paragraph (f) and the implementation guides described under Code of Federal Regulations, title 45, part 162.

**EFFECTIVE DATE.** This section is effective July 1, 2012.

Sec. 3. Minnesota Statutes 2010, section 256.962, is amended by adding a subdivision to read:

Subd. 8. **Coverage dates.** The commissioner, upon the request of a managed care or county-based purchasing plan, shall include the end of coverage dates on the monthly rosters of medical assistance and MinnesotaCare enrollees provided to the plans. The commissioner may assess plans a fee for the cost of producing the monthly roster of enrollees with end of coverage dates.

## ARTICLE 2

## HUMAN SERVICES

Section 1. Minnesota Statutes 2010, section 256.0112, is amended by adding a subdivision to read:

Subd. 9. **Contracting for performance.** In addition to the agreements in subdivision 8, a local agency may negotiate a supplemental agreement to a contract executed between a lead agency and an approved vendor under subdivision 6 for the purposes of contracting for specific performance. The supplemental agreement may augment the lead contract requirements and rates for services authorized by that local agency only. The additional provisions must be negotiated with the vendor and designed to encourage successful, timely, and cost-effective outcomes for clients, and may establish incentive payments, penalties, performance-related reporting requirements, and similar conditions. The per diem rate allowed under this subdivision must not be less than the rate established in the lead county contract. Nothing in the supplemental agreement between a local agency and an approved vendor binds the lead agency or other local agencies to the terms and conditions of the supplemental agreement.

Sec. 2. Minnesota Statutes 2010, section 256J.575, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** ~~(a) The~~ Family stabilization services serve families who are not making significant progress within the regular employment and training services track of the Minnesota family investment program (MFIP) due to a variety of barriers to employment.

~~(b) The goal of the services is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, or providing care for a disabled household member. These services promote and support families to achieve the greatest possible degree of self-sufficiency.~~

Sec. 3. Minnesota Statutes 2010, section 256J.575, subdivision 2, is amended to read:

Subd. 2. **Definitions.** The terms used in this section have the meanings given them in paragraphs (a) ~~to (d)~~ and (b).

(a) ~~"Case manager" means the county-designated staff person or employment services counselor.~~

~~(b) "Case management"~~ "Family stabilization services" means ~~the~~ programs, activities, and services provided by or through the county agency or through the employment services agency to participating families~~, including~~. Services include, but are not limited to, assessment as defined in 256J.521, subdivision 1, ~~information,~~ referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

~~(c)~~ (b) "Family stabilization plan" means a plan developed ~~by a case manager and~~ with the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the family's circumstances.

~~(d) "Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:~~

~~(1) obtaining and retaining unsubsidized employment;~~

~~(2) family stability;~~

~~(3) economic stability; and~~

~~(4) barrier reduction.~~

~~The goal of the services is to achieve the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.~~

Sec. 4. Minnesota Statutes 2010, section 256J.575, subdivision 5, is amended to read:

Subd. 5. **~~Case management;~~ Family stabilization plans; ~~coordinated~~ services.** (a) The county agency or employment services provider shall provide ~~family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family is determined to be eligible for family stabilization services. The case manager, with the full involvement of the participant, shall recommend, and the county agency shall establish and modify as necessary,~~ a family stabilization plan for each participating family. Once a participant has been determined eligible for family stabilization services, the county agency or employment services provider must attempt to meet with the participant to develop a plan within 30 days.

(b) If a participant is already assigned to a county case manager or a county-designated case manager in social services, disability services, or housing services that case manager already assigned may be the case manager for purposes of these services.

~~(b) The family stabilization plan must include:~~

~~(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;~~

~~(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and~~

~~(3) an identification of the services, supports, education, training, and accommodations needed to reduce or overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.~~

~~(c) The case manager and the participant shall meet within 30 days of the family's referral to the case manager. The initial family stabilization plan must be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and, if necessary, modify the plan under the following circumstances:~~

~~(1) there is a lack of satisfactory progress in achieving the goals of the plan;~~

~~(2) the participant has lost unsubsidized or subsidized employment;~~

~~(3) a family member has failed or is unable to comply with a family stabilization plan requirement;~~

~~(4) services, supports, or other activities required by the plan are unavailable;~~

~~(5) changes to the plan are needed to promote the well-being of the children; or~~

~~(6) the participant and case manager determine that the plan is no longer appropriate for any other reason.~~

(c) Participants determined eligible for family stabilization services must have access to employment and training services under sections 256J.515 to 256J.575, to the extent these services are available to other MFIP participants.

Sec. 5. Minnesota Statutes 2010, section 256J.575, subdivision 6, is amended to read:

Subd. 6. **Cooperation with services requirements.** ~~(a)~~ A participant who is eligible for family stabilization services ~~under this section shall comply with paragraphs (b) to (d).~~

~~(b) Participants~~ shall engage in family stabilization ~~plan~~ services for the appropriate number of hours per week ~~that the activities are scheduled and available,~~ based on the needs of the participant and the participant's family, unless good cause exists for not

doing so, as defined in section 256J.57, subdivision 1. ~~The appropriate number of hours must be based on the participant's plan.~~

~~(c) The case manager shall review the participant's progress toward the goals in the family stabilization plan every six months to determine whether conditions have changed, including whether revisions to the plan are needed.~~

~~(d) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision is excused when the case management services, training and educational services, or family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.~~

Sec. 6. Minnesota Statutes 2010, section 256J.575, subdivision 8, is amended to read:

Subd. 8. **Funding.** (a) The commissioner of human services shall treat MFIP expenditures made to or on behalf of any minor child under this section, who is part of a household that meets criteria in subdivision 3, as expenditures under a separately funded state program. These expenditures shall not count toward the state's maintenance of effort requirements under the federal TANF program.

(b) A family is no longer part of a separately funded program under this section if the caregiver no longer meets the criteria for family stabilization services in subdivision 3~~, or if it is determined at recertification that a caregiver with a child under the age of six is working at least 87 hours per month in paid or unpaid employment, or a caregiver without a child under the age of six is working at least 130 hours per month in paid or unpaid employment, whichever occurs sooner~~.

Sec. 7. **RECIPROCAL AGREEMENT; CHILD SUPPORT ENFORCEMENT.**

The commissioner of human services shall initiate procedures no later than October 1, 2012, to enter into a reciprocal agreement with Bermuda for the establishment and enforcement of child support obligations under United States Code, title 42, section 659a(d).

**EFFECTIVE DATE.** This section is effective upon Bermuda's written acceptance and agreement to enforce Minnesota child support orders. If Bermuda does not accept and declines to enforce Minnesota orders, this section expires December 31, 2013.

# ARTICLE 3

# DISABILITY SERVICES

Section 1. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 15 calendar days after the date on which an assessment was requested or recommended. After January 1, 2011, these requirements also apply to personal care assistance services, private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives

available were offered to the individual, and alternatives to residential settings, including, but not limited to, foster care settings that are not the primary residence of the license holder. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.

(f) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to the services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The team must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

(4) the person's freedom to accept or reject the recommendations of the team;

(5) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(6) the long-term care consultant's decision regarding the person's need for institutional level of care as determined under criteria established in section 144.0724, subdivision 11, or 256B.092; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date

for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 2. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year

updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 3. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at

least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency."

Amend the title accordingly