Bill Summary Comparison of Health and Human Services

Senate Language UEH1233-1

Article 2, Contingent Reform 2020; Redesigning Home and Community-Based Services

House File 1233-3

Article 2: Reform 2020; Redesigning Home and Community-Based Services

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Section	**Article 2: Contingent Reform 2020: Redesigning Home and Community-Based Services**		**Article 2: Reform 2020; Redesigning Home and Community-Based Services**
1	**Section 1 (144.0724, subdivision 4)** allows assessments for determining nursing facility level of care to include: the nursing facility preadmission screening process; preadmission screenings completed by the Senior LinkAge Line, Disability Linkage Line, or other organization under contract with the Minnesota Board on Aging; and the level of care determination process.	Identical	**Section 1. Resident assessment schedule.** Amends § 144.0724, subd. 4. Modifies the list of assessments used to determine nursing facility level of care.
2	**Section 2 (144.351)** requires the Department of Human Services (DHS) to conduct a onetime critical access study due by August 15, 2015, on the local capacity and availability of home and community-based services (HCBS) for older adults and people with disabilities.	Identical	**Section 2. Balancing long-term care services and supports: report and study required.** Amends § 144A.351. **Subd. 1. Report requirements.** No changes. **Subd. 2. Critical access study.** Requires the commissioner to conduct a onetime study to assess local capacity and availability of home and community-based services for older adults and people with disabilities and people with mental illnesses. Requires the study to assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. Requires the report to be submitted to the legislature no later than August 15, 2015.
3	**Section 3 (148E.065, subdivision 4a)** specifies that cities, counties, and state agencies are not required to have licensed social workers assisting older adults and people with disabilities with long-term care counseling.	Identical	**Section 3. City, county, and state social workers.** Amends § 148E.065, subd. 4a. Exempts city, county, and state agencies employing staff designated to perform duties under the Senior LinkAge Line and Disability LinkAge Line from employing licensed social workers.

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4	**Section 4 (256.01, subdivision 2)** adds to the list of the specific powers of the Commissioner of Human Services the designation of the Senior LinkAge Line and Disability Linkage Line as the state's Aging and Disability Resource Centers under federal law.	Technical differences. Staff recommends the Senate.	**Section 4. Specific powers.** Amends § 256.01, subd. 2. Requires the commissioner to designate agencies that operate the Senior LinkAge Line and the Disability LinkAge Line as the state of Minnesota Aging and the Disability Resource Centers under federal law and to incorporate cost reimbursement claims from the designated centers into the federal cost reimbursement claiming processes. Requires reimbursements to be appropriated to the commissioner to be granted to the Aging and Disability Resource Center designated agencies.
5	**Section 5 (256.01, subdivision 24)** designates the Disability Linkage Line as a state Aging and Disability Resource Center under federal law, requires that it be available during business hours through a toll-free number and the Internet, and adds nursing facility preadmission screening to its list of duties.	Technical differences. Staff recommends the Senate.	**Section 5. Disability LinkAge Line.** Amends § 256.01, subd. 24. Modifies the Disability LinkAge Line.
6	**Section 6 (256.975, subdivision 7)** designates the Senior LinkAge Line as a state Aging and Disability Resource Center under federal law; requires the Senior LinkAge Line to receive referrals from nursing facility staff and residents, and to identify and contact residents deemed appropriate for discharge after developing criteria in consultation with DHS.	House requires Board on Aging to consult with entities serving elderly and disabled individuals, requires Senior LinkAge Line to maintain a database searchable down to the neighborhood level, and requires an outreach plan to seniors.	**Section 6. Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** Amends § 256.975, subd. 7. Modifies the Senior LinkAge Line.
7	**Section 7 (256.975, subdivision 7a)** adds a subdivision to conform Medicaid certified nursing facility preadmission screening activities to federal law by requiring everyone seeking admission to be screened regardless of income, assets, or funding sources with certain exceptions; establishes the criteria and process for preadmission screening; states that the purpose of the screening is to determine if the potential	Identical	**Section 7. Preadmission screening activities related to nursing facility admissions.** Amends § 256.975, by adding subd. 7a. Requires all individuals seeking admission to Medicaid certified nursing facilities to be screened prior to admission. States the purpose of the screening is to determine the need for nursing facility level of care and to complete federally required activities related to mental illness and

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	resident meets the nursing facility level of care criteria. This section is effective October 1, 2013.		developmental disabilities. Lists the criteria that apply to the preadmission screening. Allows the local county mental health authority or the state developmental disability authority to prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services. Lists the screener's duties in assessing a person's needs. Makes this section effective October 1, 2013.
8	**Section 8 (256.975, subdivision 7b)** adds a new subdivision listing exemptions to federal nursing facility preadmission screening requirements, and allowing emergency nursing facility admission without screening under conditions listed in the subdivision; requires nursing facilities to provide all admitted people written information on their right to request and receive long-term care consultation services. This section is effective October 1, 2013.	Identical	**Section 8. Exemptions and emergency admissions.** Amends § 256.975, subd. 7b. Lists exemptions from the federal screening requirements. Lists persons who are exempt from preadmission screening for purposes of level of care determination. Specifies when a screening must occur for persons admitted to a Medicaid certified nursing facility from the community on an emergency basis or from an acute care facility on a nonworking day. Allows emergency admissions to a nursing facility prior to a screening under certain conditions. Requires nursing facilities to provide written information to all persons admitted regarding a person's right to request and receive long-term care consultation services. Makes this section effective October 1, 2013.
9	**Section 9 (256.975, subdivision 7c)** adds a new subdivision allowing nursing facility admission screening to be conducted by telephone or face-to-face interviews and requires the Senior LinkAge Line to identify each individual's need for a telephone or face-to-face interview. This section is effective October 1, 2013.	Identical	**Section 9. Screening requirements.** Amends § 256.975, by adding subd. 7c. Lists preadmission screening requirements. Makes this section is effective October 1, 2013.

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10	**Section 10 (256.975, subdivision 7d)** adds a new subdivision requiring DHS to provide preadmission screening funding to the Minnesota Board on Aging. This section is effective October 1, 2013.	Identical	**Section 10. Payment for preadmission screening.** Amends § 256.975, by adding subd. 7d. Specifies funding sources for preadmission screening. Requires the Minnesota Board on Aging to employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding for the service. Makes this section is effective October 1, 2013.
11	**Section 11 (256.9754, subdivision 3a)** adds a new subdivision requiring the Minnesota Department of Health (MDH) to give priority to grantees of community services development grants for older adults if technology is used as part of a proposal; the Department of Transportation must also give priority to community services development grantees when distributing transportation-related funds to create options for older adults.	Similar; House has language regarding technology grant preferences if they conflict with Department of Transportation grant awards.	**Section 11. Priority for other grants.** Amends § 256.9754, by adding subd. 3a. Requires the commissioner of health to give priority to community services development grantees using technology as a part of a proposal when awarding technology-related grants. Requires the commissioner of transportation to give priority to grantees creating transportation options for older adults when distributing transportation-related funds.
12	**Section 12 (256.9754, subdivision 3b)** adds a new subdivision allowing MDH to waive state laws and rules on a time-limited basis if it is determined that community services development grantees require a waiver in order to achieve the demonstration project goals.	Identical	**Section 12. State waivers.** Amends § 256.9745, by adding subd. 3b. Allows the commissioner of health to waive applicable state laws and rules on a time-limited basis if the commissioner determines that a participating grantee requires a waiver in order to achieve demonstration project goals.
13	**Section 13 (256.9754, subdivision 5)** requires DHS to give preference when awarding community services development grants to areas identified with service needs in the Balancing Long-Term Care Services and Supports report due to the Legislature by August 15, 2013.	Identical	**Section 13. Grant preference.** Amends § 256.9754, subd. 5. Requires the commissioner to give preference when awarding community services development grants to areas with identified home and community-based services needs.

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14	**Section 14 (256B.021, subdivision 4a)** adds a subdivision requiring DHS to evaluate projects intended to: offer more flexible and updated community support services; improve information and assistance to inform long-term care decisions; and implement nursing facility level of care criteria.	Identical	**Section 14. Evaluation.** Amends §256B.021, by adding subd. 4a. Requires the commissioner to evaluate certain Medicaid Reform Waiver projects and lists the information that must be included in the evaluation.
15	**Section 15 (256B.021, subdivision 6)** adds a subdivision creating a demonstration project, upon federal approval, to provide navigation, employment supports, and benefits planning services to a targeted group of Medical Assistance (MA) recipients beginning July 1, 2014.	Identical	**Section 15. Work, empower, and encourage independence.** Amends § 256B.021, by adding subd. 6. Upon federal approval, requires the commissioner to establish a demonstration project to provide navigation, employment supports, and benefits planning services to a targeted group of Medicaid recipients beginning July 1, 2014. Requires the project to promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants.
16	**Section 16 (256B.021, subdivision 7)** adds a subdivision creating a demonstration project, upon federal approval, to provide service coordination, outreach, in-state, tenancy support, and community living assistance to a targeted group of MA recipients beginning July 1, 2014.	Identical	**Section 16. Housing stabilization.** Amends § 256B.021, by adding subd. 7. Upon federal approval, requires the commissioner to establish a demonstration project to provide service coordination, outreach, in-reach, tenancy support, and community living assistance to a targeted group of Medicaid recipients beginning January 1, 2014. Requires this project to promote housing stability, reduce costly medical interventions, and increase opportunities for independent community living.
17	**Section 17 (256B.0911, subdivision 1)** updates cross-references.	Identical	**Section 17. Purpose and goal.** Amends § 256B.0911, subd. 1. Updates cross-references.

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18	**Section 18 (256B.0911, subdivision 1a)** removes a reference to federally mandated preadmission screening activities, as the subdivisions cited are repealed (but language replaced); updates a cross-reference.	Identical	**Section 18. Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definitions of "long-term care consultation services" and "long-term care options counseling" by updating cross-references and making conforming changes.
19	**Section 19 (256B.0911, subdivision 3a)** updates a cross-reference; requires lead agencies to provide DHS-provided materials to individuals receiving assessment or support planning on the need and purpose of preadmission screening; requires lead agencies to forward to the long-term care options counselor information to complete the level of care determinations if the individual selects nursing facility placement.	Technical differences. Staff recommends the Senate.	**Section 19. Assessment and support planning.** Amends § 256B.0911, subd. 3a. Updates cross-references and modifies the information that must be provided to the person receiving assessment or support planning, or the person's legal representative.
20	**Section 20 (256B.0911, subdivision 4d)** modifies the preadmission screening requirement for individuals from 65 years of age to 60 years of age for nursing facility admission directly from a hospital, effective October 1, 2013.	Similar; Senate has language stating the current assessment payment process for individuals under age 65 continue until September 30, 2013.	**Section 20. Preadmission screening of individuals under 60 years of age.** Amends § 256B.0911, subd. 4d. Modifies the age at which preadmission screening is required, updates cross-references, makes conforming changes, specifies the funding source for preadmission screenings provided by the Disability LinkAge Line, and requires the Disability LinkAge Line to employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding. Makes this section is effective October 1, 2013.
21	**Section 21 (256B.0911, subdivision 4e)** adds a subdivision requiring level of care determinations for nursing facilities, hospitals, and intermediate care facilities in accordance with criteria developed by DHS, until the level of care changes made in 2008 are implemented in 2014 for individuals 21 years of age and older, and in 2019 for individuals under 21.	Identical	**Section 21. Determination of institutional level of care.** Amends § 256B.0911, by adding subd. 4e. Requires the determination of the need for nursing facility, hospital, and ICF/DD levels of care to be made according to criteria developed by the commissioner. Specifies the criteria to be used in determining the need for nursing facility level of care.

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22	**Section 22 (256B.0911, subdivision 6)** eliminates the requirement that nursing facilities pay the county fee for long-term care consultation services as of October 1, 2013.	Identical, though Senate has this provision in Contingency Article; House has it in Continuing Care Article.	**House article 7, section 6. Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Specifies payment for long-term care consultation face-to-face assessments shall be made until September 30, 2013. Specifies the alternative payment methodology for long-term care consultation services is effective October 1, 2013. Requires the alternative payment methodology to include the use of appropriate time studies and the state financing of nonfederal share as part of the state's MA program.
23	**Section 23 (256B.0911, subdivision 7)** updates cross-references to incorporate changes in this article.	Identical	**Section 22. Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Updates cross-references.
24	**Section 24 (256B.0913, subdivision 4)** updates a cross-reference.	Identical	**Section 23. Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Updates a cross-reference.
25	**Section 25 (256B.0913, subdivision 17)** adds a new subdivision establishing Essential Community Supports Grants for individuals 65 years of age or older who do not meet the nursing facility level of care criteria but would otherwise qualify for the Alternative Care program.	Identical	**Section 24. Essential community supports grants.** Amends § 256B.0913, by adding subd. 17. Specifies the purpose of the essential community supports grant program. Lists grant eligibility criteria. Requires a person receiving any of the essential community supports to also receive service coordination as part of their community support plan. Requires essential community supports grant recipients to be reassessed annually. Authorizes the commissioner to use federal matching funds for essential community supports. Makes essential community supports available, upon federal approval, to individuals who meet specified criteria related to loss of eligibility for MA payment of nursing facility services. Lists services available through essential community supports.

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26	**Section 26 (256B.0915, subdivision 5)** updates a cross-reference.	Identical	**Section 27. Assessments and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Updates a cross-reference.
27	**Section 27 (256B.0917, subdivision 1a)** adds a new subdivision stating the purpose of SAIL projects is to make strategic changes in the long-term services and supports for older adults and lists the goals of these projects.	Identical	**Section 28. Home and community-based services for older adults.** Amends § 256B.0917, by adding subd. 1a. Specifies the purpose of projects selected by the commissioner is to make strategic changes in the long-term services and supports system for older adults. States the projects are intended to create incentives for new and expanded home and community-based services in order to meet listed goals. Makes the services provided by these projects available to older adults who are eligible for MA and the elderly waiver, the alternative care program, or essential community supports grants, and to persons who have their own funds to pay for services.
28	**Section 28 (256B.0917, subdivision 1b)** adds a new subdivision listing definitions applicable to Minnesota Statutes, section 256B.0917.	Technical differences. Staff recommends the Senate.	**Section 29. Definitions.** Amends § 256B.0917, by adding subd. 1b. Defines "community," "core home and community-based services provider," "eldercare development partnership," "long-term services and supports," and "older adult."
29	**Section 29 (256B.0917, subdivision 1c)** adds a new subdivision directing DHS to contract, through a request for proposal (RFP) process, with eldercare development partnerships capable of providing statewide service development and assistance.	Technical differences. Staff recommends the Senate.	**Section 30. Eldercare development partnerships.** Amends § 256B.0917, by adding subd. 1c. Requires the commissioner to select and contract with eldercare development partnerships. Lists the duties of the eldercare development partnerships.
30	**Section 30 (256B.0917, subdivision 6)** requires DHS to create projects to increase caregiver support and respite care services	Technical differences	**Section 31. Caregiver support and respite care projects.** Amends § 256B.0917, subd. 6. Modifies caregiver support

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	administered by nonprofit agencies and chosen through an RFP process.		and respite care projects under SAIL.
31	**Section 31 (256B.0917, subdivision 7a)** adds a new subdivision requiring DHS to create projects to provide services and supports to older adults and their informal caregivers, administered by HCBS providers and chosen through an RFP process.	Identical	**Section 32. Core home and community-based services.** Amends § 256B.0917, by adding subd. 7a. Requires the commissioner to select and contract with core home and community-based services providers for projects to provide services and supports to older adults. Lists criteria projects must meet.
32	**Section 32 (256B.0917, subdivision 13)** modifies the preference for awarding community service grants to not only areas where nursing facilities have closed but to areas identified in the Balancing Long-Term Care Services and Supports report.	Identical	**Section 33. Community service grants.** Amends § 256B.0917, subd. 13. Broadens the preference for awarding community service grants to include areas with service needs identified in a needs determination process. Removes a list of services for which the commissioner must consider grants.
33	**Section 33 (256B.439, subdivision 1)** requires DHS and MDH to develop and implement long-term care quality profiles for all nursing facilities no later than July 1, 2014.	Identical	**Section 35. Development and implementation of quality profiles.** Amends § 256B.439, subd. 1. Requires the commissioner to develop quality profiles for providers of long-term care services by July 1, 2014. Requires the quality profiles to be developed using existing data sets and to be incorporated with information on quality maintained by specified organizations and the long-term care database.
34	**Section 34 (256B.439, subdivision 2)** makes a technical change.	Identical	**Section 36. Quality measurement tools.** Amends § 256B.439, subd. 2. Removes unnecessary language.
35	**Section 35 (256B.439, subdivision 3)** specifies that consumer surveys of long-term care services are for nursing facility services.	Identical	**Section 37. Consumer surveys of nursing facilities residents.** Amends § 256B.439, subd. 3. Specifies consumer surveys are surveys of nursing facility residents.

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36	**Section 36 (256B.439, subdivision 3a)** adds a subdivision requiring DHS and MDH to work with existing DHS advisory groups to develop recommendations for creating an HCBS report card, with a report due to the Legislature by August 1, 2014, and report cards available July 1, 2015.	Senate requires DHS and MDH to work with existing DHS advisory groups to develop the HCBS report cards, and report to the Legislature on July 1, 2015. House requires the development with HCBS without advisory group input and without a report to the Legislature.	**Section 38. Home and community-based services report card in cooperation with the commissioner of health.** Amends § 256B.439, by adding subd. 3a. Requires the profiles developed for home and community-based services providers to be incorporated into a report card and maintained by the Minnesota Board on Aging. Specifies the categories that must be used to organize the consumer information in the profiles. Requires the commissioner to develop and disseminate the quality profiles for a limited number of provider types initially, and to develop quality profiles for additional provider types as measurement tools are developed and data becomes available. Specifies this includes providers of services to older adults and people with disabilities, regardless of payor source.
37	**Section 37 (256B.439, subdivision 4)** requires DHS and MDH to publicly disseminate the long-term care quality profiles through the Senior LinkAge Line and Disability Linkage Line.	Identical	**Section 39. Dissemination of quality profiles.** Amends § 256B.439, subd. 4. Modifies requirements related to the dissemination of quality profiles.
38	**Section 38 (256B.441, subdivision 13)** removes long-term care consultation fees from the definition of "external fixed costs" for nursing facilities only until September 30, 2013.	Identical	**House article 7, section 22. External fixed costs.** Amends § 256B.441, subd. 13. Modifies the definition of "external fixed costs."
39	**Section 39 (256B.441, subdivision 53)** removes long-term care consultation fees from the definition of "external fixed costs" for nursing facilities only until September 30, 2013.	Identical	**House article 7, section 23. Calculation of payment rate for external fixed costs.** Amends § 256B.441, subd. 53. Modifies the calculation of payment rates for external fixed costs by removing costs for long-term care consultations beginning October 1, 2013.
40	**Section 40 (256B.49, subdivision 12)** updates a cross-reference.	Identical	**Section 40. Informed choice.** Amends § 256B.49, subd. 12. Modifies a cross-reference.

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41	**Section 41 (256B.49, subdivision 14)** updates a cross-reference.	Identical	**Section 41. Assessment and reassessment.** Amends § 256B.49, subd. 14. Modifies a cross-reference.
42	**Section 42 (256B.85)** creates a new section, COMMUNITY FIRST SERVICES AND SUPPORTS. The entire section is effective upon receiving federal approval.	Some differences	**Section 43. Community first services and supports.** Creates § 256B.85.
	Subdivision 1 establishes the Community First Services and Supports (CFSS) program's basis and scope, and replaces the personal care assistance (PCA) program, contingent upon federal approval.	Technical differences. Staff recommends the Senate.	**Subd. 1. Basis and scope.** Requires the commissioner to establish a MA state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)," upon federal approval. Specifies program features. Makes CFSS replace the PCA program upon federal approval.
	Subdivision 2 lists the definitions applicable to the CFSS section.	Senate and House have different definitions of "behavior," "complex health-related needs," and "dependency," and the Senate defines "extended CFSS." Senate creates the "budget model," whereas House creates a similar "flexible spending model."	**Subd. 2. Definitions.** Defines "activities of daily living," "agency-provider model," "behavior," "complex health-related needs," "community first services and supports," "community first services and supports service delivery plan," "critical activities of daily living," "dependency," "financial management services contractor or vendor," "flexible spending model," "health-related procedures and tasks," "instrumental activities of daily living," "legal representative," "medication assistance," "participant's representative," "person-centered planning process," "shared services," "support specialist," "support worker," and "wages and benefits."
	Subdivision 3 provides who is eligible (and not eligible) for CFSS, including people receiving certain MA	House subdivision has additional provisions related to eligibility, participation, and disenrollment in the flexible	**Subd. 3. Eligibility.** Lists eligibility requirements in order to receive CFSS services. Specifies under

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	services, Alternative Care recipients, certain HCBS waiver recipients, among others.	spending model.	what circumstances the commissioner must disenroll or exclude participants from the flexible spending model and transfer them to the agency-provider model. Specifies appeal rights.
	Subdivision 4 states that CFSS participation does not restrict access to other services provided under the state plan MA benefit or other services provided under the Alternative Care program.	Identical	**Subd. 4. Eligibility for other services.** Prohibits selection of CFSS by a participant from restricting access to other medically necessary care and services furnished under the state plan MA benefit or other services available through alternative care.
	Subdivision 5 establishes the CFSS assessment process.	Technical differences; and the Senate allows lead agencies to authorize temporary CFSS services.	**Subd. 5. Assessment requirements.** Specifies requirements related to the assessment of functional needs. Allows a participant who is residing in a facility to be assessed and choose CFSS for the purpose of using CFSS to return to the community. Requires assessment results and recommendations and authorizations for CFSS to be determined and communicated in writing by the lead agency's certified assessor to the participant and the participant's chosen provider within 40 calendar days.
	Subdivision 6 outlines the CFSS delivery plan requirements, including: that it be a "person-centered planning process" as defined in subdivision 2, and outlined in paragraph (c); and that DHS establishes the format and criteria.	Technical differences. Senate language references the "budget model" and House language references the "flexible spending model."	**Subd. 6. Community first services and support service delivery plan.** Requires the CFSS service delivery plan to be developed, implemented, and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a support specialist. Requires the service delivery plan to reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the

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			support plan. Requires the commissioner to establish the format and criteria for the CFSS service delivery plan. Lists requirements for the CFSS service delivery plan. Allows the amount of funds used each month to vary, but additional funds must not be provided above the annual service authorization amount unless a change in condition is assessed, authorized, and documented.
	Subdivision 7 lists the services covered under CFSS, including: · assistance with activities of daily living (ADL), instrumental activities of daily (IADL), and health-related procedures and tasks as defined in subdivision 2; · assistance in allowing participants to complete ADLs, IADLs and health-related procedures and tasks on their own; · expenditures on services, supports, environmental modifications, and goods—including assistive technology—to allow participants greater independence; · behavioral observations, redirections, and assessments; · back-up systems and technological devices such as pagers or other electronic devices to ensure service and support continuity;	House has a provision stating covered services must fit within annual budget limits, and requires an assessment of behaviors for behavioral observation and redirection services to be covered under CFSS.	**Subd. 7. Community first services and supports; covered services.** Lists the services and supports covered under CFSS.

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	· costs of transitioning to less-restrictive living settings; and · support specialist services, as defined in subdivision 2.		
	Subdivision 8 requires DHS to create a home care rating methodology for determining the amount of CFSS for each participant.	House requires DHS to develop a home care rating system to determine the amount of CFSS; Senate language has the home care rating system.	**Subd. 8. Determination of CFSS service methodology.** Requires all CFSS services to be authorized by the commissioner before services begin except for certain assessments. Requires authorizations to be completed within 30 days after receiving a complete request. Requires the amount of CFSS authorized to be based on the recipient's home care rating. Specifies how the home care rating is determined. Specifies the methodology for determining the number of minutes of CFSS to authorize.
	Subdivision 9 lists services and goods not covered under CFSS, including: · those not authorized by a certified assessor or included in the CFSS service delivery plan; · those provided prior to authorization or approval of the CFSS service delivery plan; · those that duplicate those of other paid services in the CFSS service delivery plan; · those that supplant unpaid supports on a voluntary basis, chosen by the participant;	Similar; Senate has a provision allowing services for caregivers – such as training – to be considered a covered service if they directly benefit the CFSS participant.	**Subd. 9. Noncovered services.** Lists services and supports that are not eligible for payment under CFSS.

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	· those that do not meet the participant's needs; · those available through other funding streams; · those not directly benefiting the participant; · fees incurred by the participant, such as co-pays and legal fees; · insurance, except for those related to employee coverage; · room and board costs, not including transition costs in subdivision 7; · any goods, service, or support not related to an assessed need; · special education and related services under certain federal laws; · technological devices, not including those listed in subdivision 7; · medical supplies and equipment; · environmental modifications, not including those listed in subdivision 7; · expenses related to training the participant or others exceeding $500 a year; · experimental treatments;		

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	· goods and services covered by MA state plan services, including medications, premiums, and co-pays, among others; · membership dues, unless necessary and appropriate to treat, improve, or maintain the participant's physical condition; · vacation expenses; · vehicle maintenance or enhancement not related to the disability, health condition, or need; and · recreational event-related costs.		
	Subdivision 10 requires DHS to develop policies and procedures to ensure provider integrity and financial accountability, and establishes provider qualifications and requirements, including: · enrolling as an MA health care programs provider; · complying with MA enrollment requirements; · demonstrating compliance with CFSS policies; · complying with background study requirements; · verifying and maintaining participants' service and expense records; · refraining from agency-initiated contact or marketing activity to potential participants, guardians,	Senate requires DHS Commissioner to develop policies and procedures to ensure program integrity and fiscal accountability. House requires consultation of the Development and Implementation Council to develop similar policies and procedures, with a report due to the Legislature by November 15, 2013.	**Subd. 10. Provider qualifications and general requirements.** Lists requirements for agency-providers delivering services under the agency-provider model and financial management service contractors. Requires the commissioner to develop recommendations, policies, and procedures designed to ensure self-direction, program integrity, and fiscal accountability for goods and services provided under CFSS.

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	family members. or participants' representatives; · paying support workers and specialists based on actual service hours provided; · complying with all federal and state payroll tax laws; · paying unemployment and liability insurance, taxes, and workers' compensation; · entering into written agreements with participants and their representatives assigning roles and responsibilities before goods, services, and supports are provided; · reporting suspected neglect and abuse appropriately; and · providing participants with a copy of their service-related rights.		

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	Subdivision 11 specifies the agency-provider model (defined in subdivision 2) characteristics, including allowing participants a role in selecting and dismissing support workers, and sharing CFSS services; and requiring agency-providers to use 72.5 percent of MA-generated revenue towards supporting worker wages and benefits.	Technical differences. Staff recommends the Senate.	**Subd. 11. Agency-provider model.** Limits the agency-provider model to the services provided by support workers and support specialists who are employed by an agency-provider. Requires the agency-provider to allow the participant to retain the ability to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the service delivery plan. Allows participants to use authorized units of CFSS services as needed within a service authorization that is not greater than 12 months. Allows participants to share services. Requires agency-providers to use a minimum of 72.5 percent of the revenue generated by MA payment for CFSS for support worker wages and benefits. Requires the agency-provider model to be used by individuals who have been restricted by the Minnesota restricted recipient program.
	Subdivision 12 specifies initial enrollment requirements for CFSS provider agencies, including providing: · current contact information; · proof of surety bond coverage; · proof of fidelity bond coverage; · proof of workers' compensation insurance coverage; · proof of liability insurance coverage;	House requires DHS and Development and Implementation Council to develop provider standards and requirements, with a report due to the Legislature by November 15, 2013. Senate language outlines the specific CFSS provider standards and requirements.	**Subd. 12. Requirements for initial enrollment of CFSS provider agencies.** Requires the commissioner to develop CFSS provider enrollment standards and to provide recommendations to the legislature by November 15, 2013.

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	· a description of the agency's organizational structure, including the names of owners, managing employees, staff, board of directors, and their affiliations to other service providers; · copies of the agency's written policies and procedures; · copies of forms used by the agency in the daily course of business; · training requirements of the agency's staff; · documentation of training completed by staff; · documentation of the agency's marketing practices; · disclosure of ownership, leasing, or management of all residential properties currently or potentially used for home care services; · documentation of adherence to the MA-generated revenue requirement in subdivision 11; and · documentation that demonstrates the agency does not prevent former employees from working for a CFSS participant , via a signed agreement, in order to allow CFSS participants the right to choose their service provider.		
	Subdivision 13 specifies the budget model (defined in subdivision 2) characteristics, including:	Similar; House creates the "flexible spending model" and the Senate creates the "budget model."	**Subd. 13. Flexible spending model.** Allows participants to exercise more responsibility and control

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	· allowing CFSS participants to directly employ workers and purchase other goods and services; · describing the role of the financial management services (FMS) contractor in assisting participants in managing their budgets and payment responsibilities; · allowing participants' representatives the authority to manage the participants budget, if agreed to by the participant; · preventing FMS contractors from providing CFSS services; · outlining FMS contractor duties and responsibilities; and · outlining DHS's duties and responsibilities.	Senate outlines the process for participants to disenroll in the budget model. House states only that participants disenrolled in the flexible spending model must be enrolled in the agency-provider model.	over services and supports under the flexible spending model. Lists functions of the flexible spending model. Lists service functions that must be provided by the financial management services contractor. Lists duties of the commissioner related to financial management services contractors. Specifies participants who are disenrolled from this model are transferred to the agency-provider model.
	Subdivision 14 lists the participants' responsibilities under the budget model.	Similar; language differences.	**Subd. 14. Participant's responsibilities under flexible spending model.** Lists participant responsibilities under the flexible spending model.
	Subdivision 15 establishes documentation requirements for all support services provided to CFSS participants in both agency-provider and budget models.	House requires DHS and the Development and Implementation Council to develop documentation standards, with a report due to the Legislature by November 15, 2013. Senate language outlines the specific documentation requirements.	**Subd. 15. Documentation of support services provided.** Requires the commissioner to develop CFSS documentation standards and to provide recommendations to the legislature by November 15, 2013.

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	Subdivision 16 lists support worker requirements, including background studies, training, and ability to provide the services and supports according to the CFSS participants' service delivery plan, among others; and lists circumstances where DHS may deny or terminate support worker employment with the provider agency or CFSS participant.	Similar. House requires DHS and the Development and Implementation Council to establish reasons for denying or terminating a support worker's provider enrollment; Senate allows commissioner to deny or terminate provider enrollment.	**Subd. 16. Support workers requirements.** Lists requirements for support workers. Requires the commissioner to establish reasons to deny or terminate a support worker's provider enrollment. Allows support workers to appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment.
	Subdivision 17 requires DHS to develop qualifications, requirements, and payment rates for support specialists.	Identical	**Subd. 17. Support specialist requirements and payments.** Requires the commissioner to develop qualifications, scope of functions, and payment rates and service limits for a support specialist that may provide additional or specialized assistance necessary to plan, implement, arrange, augment, or evaluate services and supports.
	Subdivision 18 establishes budget allocation parameters for both the agency-provider and budget models.	Similar; language differences.	**Subd. 18. Service unit and budget allocation requirements.** Specifies how services are authorized for the agency-provider model and the flexible spending model. Specifies how maximum CFSS budget allocations are determined.
	Subdivision 19 requires DHS to provide the support necessary to ensure CFSS participants are able to manage their care and budgets, if applicable.	Identical	**Subd. 19. Support system.** Requires the commissioner to provide information, consultation, training, and assistance to ensure the participant is able to manage the services and supports and budgets, if applicable. Requires the commissioner to provide assistance with the development of risk management agreements.

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	Subdivision 20 requires that CFSS participants must be provided the support and information necessary to choose and manage their services, and lists participants' service-related rights including: · person-centered planning; · the range and scope of individual choices; · the process of changing plans, services, and budgets; · the grievance process; · individual rights; · identifying and assessing appropriate services; · risks and responsibilities; and · risk management.	Similar. House and Senate have similar intent but different wording and structure.	**Subd. 20. Service-related rights.** Requires participants to be provided with adequate information, counseling, training, and assistance to ensure that the participant is able to choose and manage services, models, and budgets. Lists information that must be provided. Requires the commissioner to ensure that the participant has a copy of the most recent service delivery plan.
	Subdivision 21 requires DHS create a Development and Implementation Council, with a majority of members being individuals with disabilities, elderly individuals, and their representatives, to assist in the development and implementation of CFSS.	Similar; language differences.	**Subd. 21. Development and implementation council.** Requires the commissioner to establish a Development and Implementation Council. Requires the commissioner to consult and collaborate with this council when developing and implementing CFSS.
	Subdivision 22 requires DHS to establish quality assurance and risk management measures for use in developing and implementing CFSS.	Similar; Senate has a provision requiring the Development and Implementation Council to be consulted in developing data reporting requirements.	**Subd. 22. Quality assurance and risk management system.** Requires the commissioner to establish quality assurance and risk management measures for use in developing and implementing CFSS. Requires the commissioner to provide ongoing

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			technical assistance and resource and educational materials for CFSS participants. Requires performance assessment measures and ongoing monitoring of health and well-being to be identified in consultation with the Development and Implementation Council.
	Subdivision 23 allows DHS immediate access to the agency provider or FMS contractor's documents and office space (during regular business hours) without prior notice when investigating possible MA overpayment.	Identical	**Subd. 23. Commissioner's access.** Requires the commissioner to be given immediate access without prior notice to documentation and records related to services provided and submission of claims for services provided when the commissioner is investigating a possible overpayment of MA funds. States that denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment or the financial management services contract.
	Subdivision 24 requires CFSS agency-providers to initiate background studies on its owners, managing employees, support specialists, and support workers, and bars agency-providers from CFSS enrollment if certain conditions related to the background studies are not met.	Identical	**Subd. 24. CFSS agency-providers; background studies.** Specifies background study requirements for CFSS agency providers.
	The effective date of this section is January 1, 2014, or upon federal approval, whichever is later.	Similar; Senate specifies the services will start 90 days after federal approval or January 1, 2014, whichever is later.	Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when this occurs.

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43	**Section 43 (256I.05, subdivision 1o)** adds a subdivision modifying the group residential housing statute, by prohibiting a county from negotiating a supplementary rate for an individual who is eligible for the federal Housing Stability Services and who resides in a certain setting.	Identical	**Section 44. Supplementary service rate; exemptions.** Amends § 256I.05, by adding subd. 1o. Prohibits counties from negotiating GRH supplementary service rates for certain individuals determined to be eligible for Housing Stability Services.
44	**Section 44 (626.557, subdivision 4)** allows the common entry point (CEP) to accept electronic reports of abuse, neglect, or exploitation submitted through a Web-based reporting system, established by the commissioner.	Identical	**Section 45. Reporting.** Amends § 626.557, subd. 4. Modifies maltreatment of vulnerable adults reporting requirements by allowing the common entry point to accept electronic reports submitted through a Web-based reporting system established by the commissioner. Makes this section effective July 1, 2014.
45	**Section 45 (626.557, subdivision 9)** requires the commissioner to establish a CEP effective July 1, 2014. Current law allows each county to designate a common entry point. New language in paragraph (g) requires that the CEP have access to the centralized database to immediately identify prior reports. New paragraph (h) requires CEP staff to refer calls that do not allege abuse or neglect to other organizations, in an effort to resolve the reporter's concerns. New paragraph (i) provides that the CEP must be operated so the commissioner can perform the duties under this section. New paragraph (j) requires the Commissioner of Health and Human Services to collaborate on the creation of a triage system for investigations.	Identical	**Section 46. Common entry point designation.** Amends § 626.557, subd. 9. Removes language requiring each county board to designate a common entry point for reports of suspected maltreatment of vulnerable adults. Requires the commissioner to establish a common entry point effective July 1, 2014. Requires the common entry point to have access to the centralized database and to log reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation. Specifies requirements for the operation of the common entry point. Requires the commissioners of human services and health to collaborate on the creation of a system for referring reports to the lead investigative agencies.
46	**Section 46 (626.557, subdivision 9e)** requires the commissioner to conduct an outreach campaign to promote the CEP for reporting vulnerable adult maltreatment.	Identical	**Section 47. Education requirements.** Amends § 626.557, subd. 9e. Requires the commissioner of human services to conduct an outreach campaign to promote the common entry point for reporting vulnerable adult maltreatment.

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47	**Section 47** makes this article contingent upon federal approval.	Senate section simply states the entire article is effective contingent upon federal approval. House section outlines implementation procedures if federally approved, partially or fully, or in various stages.	**Section 49. Effective date; contingent systems modernization appropriation.**
			Subd. 1. Definitions. Defines "commissioner," "contingent systems modernization appropriation," "department," "plan," and "reform 2020."
			Subd. 2. Intent; effective dates generally. Specifies the purpose of this section is to outline how this article and the contingent systems modernization appropriation are implemented if Reform 2020 is fully, partially, or incrementally approved or denied. Specifies the changes contained in this article generate savings that are contingent upon federal approval of Reform 2020. Requires the commissioner to follow the provisions of subdivisions 3 and 4 in order for sections 1 to 48 to be effective.
			Subd. 3. Federal approval. Specifies the implementation of this article is contingent upon federal approval. Requires the commissioner to develop a plan for implementing the provisions in this article that receive federal approval as well as any that do not require federal approval. Lists the information that must be included in the plan. Allows the department to implement the plan upon approval of the commissioner of management and budget. Requires the commissioner to notify the legislature of the plan and to make the plan available online.
			Subd. 4. Disbursement; implementation.

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			Requires the commissioner of management and budget to disburse certain appropriations to the commissioner of human services to allow for implementation of the approved plan and make necessary adjustments in the accounting system to reflect any modified funding levels. Requires the commissioner of management and budget to reflect the modified funding levels in the first fund balance following the approval of the plan.
48	**Section 48** repeals a provision related to federal grants to establish a common entry point (section 245A.655), repeals several subdivisions relating to long-term care consultation (section 256B.0911, subdivisions 4a, 4b, 4c) and repeals several subdivisions in section 256B.0917 related to the Seniors' Agenda for Independent Living (SAIL).	Identical	**Section 48. Repealer.** (a) Repeals Minnesota Statutes, sections 245A.655 (federal grants to establish and maintain a single common entry point for reporting maltreatment of a vulnerable adult); and 256B.0917, subds. 1 (SAIL purpose, mission, goals and objectives), 2 (design of SAIL projects), 3 (local long-term care strategy), 4 (information, screening, and assessment function), 5 (service development and delivery), 7 (contract), 8 (living-at-home/block nurse program grant), 9 (state technical assistance center), 10 (implementation plan), 11 (SAIL evaluation and expansion), 12 (public awareness campaign), and 14 (essential community supports grants). (b) Repeals Minnesota Statutes, section 256B.0911, subds. 4a, 4b, and 4c (preadmission screening activities related to nursing facility admissions; exemptions and emergency admissions; screening requirements) effective October 1, 2013.