HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. 927 **DATE:** March 21, 2011

Version: delete-everything amendment (A11-0177)

DRAFT

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Subject: Health and Human Services Omnibus Bill

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Article 1: Children and Family Services

Overview

Article 1 makes changes to children and family services programs including child care assistance, general assistance, group residential housing, MFIP, EBT cards, and background studies conducted by the commissioner.

1 **Family.** Amends § 119B.011, subd. 13. Modifies the definition of "family" within the child care assistance statutes. Makes this section effective April 16, 2012.

2 **Establishment.** Amends § 119B.035, subd. 1. Requires the commissioner to set aside 2 percent of the basic sliding fee child care appropriation for the at-home infant child care program.

3 **Assistance.** Amends § 119B.035, subd. 4. Reduces the maximum rate of assistance that can be paid for the at-home infant child care program from 90 percent to 64 percent of the rate that is paid for licensed family child care assistance.

4 **Child care centers; assistance.** Amends § 119B.09, by adding subd. 9a. Paragraph (a) defines "qualifying child."

Paragraph (b) prohibits child care assistance funds from being used for child care services provided for a child by a provider who employs either the parent of the child or a person who resides with the child, unless at least 50 percent of the children being cared for by the provider meet the definition of qualifying child under paragraph (a).

Paragraph (c) specifies requirements providers must meet if at least 50 percent of the children in their care are not qualifying children in order to continue to receive payment under the child care assistance program.

Makes this section effective January 1, 2013.

5 **Payment of funds.** Amends § 119B.09, subd. 10. Prohibits child care assistance funds from being used for child care services provided by a provider who resides in the same household or occupies the same residence as the child for whom care is provided. Makes this section effective March 5, 2012.

6 **Child care in the child's home.** Amends § 119B.09, by adding subd. 13. Specifies conditions that must be met in order for child care in the child's home to be authorized under the child care assistance program. Makes this section effective March 5, 2012.

7 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Specifies that the maximum payment to a provider must not exceed the maximum daily or weekly rate. Prohibits child care providers from being paid activity fees or an additional rate above the maximum rates for care provided during nonstandard hours under the child care assistance program. Makes this section effective September 3, 2012, except the amendments to paragraph (e) are effective April 16, 2012.

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8 **Legal nonlicensed family child care provider rates.** Amends § 119B.13, subd. 1a. Reduces legal nonlicensed family child care provider rates from 80 percent to 64 percent of the rate paid for licensed family child care. Clarifies maximum daily and weekly rate calculations. Makes this section effective April 16, 2012, except the rate reduction is effective July 1, 2011.

9 **Absent days.** Amends § 119B.13, subd. 7. Modifies the absent day payment policy under the child care assistance programs. Limits absent day payments to ten full-day absent days per child, excluding holidays, in a fiscal year. Removes language related to documented medical conditions. Prohibits legal nonlicensed family child care providers from being paid for absent days. Removes exemptions from the absent day limits for families that meet certain criteria. Removes language allowing counties to pay for additional absent days if that is the current market practice in the county. Makes this section effective January 1, 2013.

10 **Background studies conducted by Department of Human Services.** Amends § 245C.08, subd. 1. Adds that the commissioner must consider information related to child abuse and neglect, and information from national crime information databases when conducting a background study on the relatives of a child who receive permanent and legal custody under section 260C.201, subdivision 11, paragraph (d), clause (1).

11 **Background studies conducted by the commissioner.** Amends § 245C.33, subd. 1. Adds paragraph (b) which requires the commissioner to conduct a background study on all individuals over the age of 13 who live in the home before approving the placement of a child for the purposes of transferring permanent and legal custody to a relative. Provides that if the relative holds a valid foster care license and a background study was previously conducted on members of the household, a new background study is not required.

12 **Electronic Benefit Transfer (EBT) debit card.** Creates § 256.987.

Subd. 1. EBT card. Paragraph (a) prohibits EBT cardholders in the GA, MSA, and MFIP programs from withdrawing cash from an ATM or receiving cash from vendors with the EBT debit card. Limits the use of EBT cards to use as a debit card.

Paragraph (b) requires cash benefits for programs listed under paragraph (a) to be issued on a separate EBT card with the head of household's name printed on the card. Requires the card to state that it is unlawful to purchase tobacco products or alcoholic beverages with the card. Requires the card to be issued within 30 days of an eligibility determination. Allows recipients to have benefits issued on a card without a name printed on the card during the initial 30 days of eligibility. Specifies that the temporary card does not need to meet the requirements of this section.

Paragraph (c) allows EBT cardholders to opt to have up to $20 per month accessible via ATM or to receive up to $20 cash back from a vendor.

Subd. 2. Photo identification. Allows retailers at a point-of-sale to request a photo identification card when an EBT card is presented for payment. Makes it

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unlawful for an EBT cardholder to allow another person to use the card.

Subd. 3. Prohibited purchases. Prohibits EBT cardholders in programs listed under subdivision 1 from using their EBT card to purchase tobacco products and alcoholic beverages. Makes it unlawful for an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic beverages with an EBT card.

Subd. 4. EBT use restricted to Minnesota vendors. Prohibits EBT debit cardholders from using the EBT debit card at vendors located outside of Minnesota. Specifies that this subdivision does not apply to the food portion.

Subd. 5. Fraud reports. Allows retailers who report to the commissioner substantiated incidents of EBT card fraud to receive 5 percent of any recovered funds.

13 **Resident.** Amends § 256D.02, subd. 12a. Modifies the definition of "resident" under the GA program to increase the residency requirement from 30 days to 90 days.

14 **Eligibility.** Amends § 256D.05, subd. 1. Modifies eligibility for the general assistance program by removing several categories of eligibility. Requires recipients to complete at least 20 hours per month of volunteer or paid work. Requires the county of residence to determine what may be considered volunteer work. Requires recipients to provide monthly proof of volunteer work on forms established by the county. Provides an exemption from the volunteer/work requirement for persons who are unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity.

15 **Eligibility; amount of assistance.** Amends § 256D.06, subd. 1. Increases the general assistance earned income disregard from $50 to $150 per month.

16 **Earned income savings account.** Amends § 256D.06, subd. 1b. Increases the maximum earned income disregard for certain persons receiving GA from $150 per month to $500 per month for persons meeting certain criteria. Increases the earned income savings account limit from $1,000 to $2,000.

17 **Special needs.** Amends § 256D.44, subd. 5. For individuals who are shelter needy, defines "gross income" as the recipient's prior month's income. Provides that if a service provider owns, operates, or controls housing occupied by service recipients, recipients can occupy a maximum of 50 percent of the units in a multifamily building of more than four units. Current law places the limit at a maximum of 50 percent of the units in a multifamily building of four or more units.

18 **Emergency aid.** Creates § 256D.461. Allows applicants for or recipients of MSA or SSI who have emergent need to apply for emergency GA.

19 **Supplementary rate for certain facilities receiving a supplementary service rate in excess of the state legislated maximum.** Amends § 256I.05, by adding subd. 10a. Prohibits county agencies from negotiating a supplementary rate for a GRH provider that does not include a residency requirement of at least 20 hours per month of volunteer or paid

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work. Provides an exemption from the volunteer/work requirement for persons who are unable to obtain or retain 20 hours per month of volunteer or paid work due to a professionally certified illness, injury, disability, or incapacity.

20 **90-day residency requirement.** Amends § 256J.12, subd. 1a. Modifies the MFIP residency requirement by increasing the requirement from 30 days to 90 days.

21 **Exceptions.** Amends § 256J.12, subd. 2. Contains a conforming change to the MFIP residency requirement modification.

22 **Other property limitations.** Amends § 256J.20, subd. 3. Reduces the MFIP vehicle asset limit from $15,000 to $10,000.

23 **Approval of postsecondary education or training.** Amends § 256J.53, subd. 2. Requires participants to be working in unsubsidized employment at least 20 hours per week in order for postsecondary education or training to be an approved activity in an MFIP employment plan. Specifies this requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

24 **Expedited issuance of food stamps.** Amends § 393.07, subd. 10a. Modifies the time in which counties have to issue food support for applicants who meet the federal criteria for expedited issuance of food support.

25 **Grant program to promote healthy community initiatives.** Requires the commissioner to contract with a specified organization to help local communities foster positive community development and effectively engage people in their community. Specifies the duties of the contracted organization. Specifies what communities must demonstrate in order to be eligible for a grant under this section. Requires the commissioner to evaluate the effectiveness of this program and make recommendations to the legislature by February 15, 2013, regarding whether or not this program should be made available statewide. Requires the contracted organization to annually report to the commissioner on services provided and grant money expended. Makes this section effective the day following final enactment.

26 **Circles of support grants.** Requires the commissioner to provide grants to community action agencies to foster social assets to assist people out of poverty through circles of support. Specifies the requirements of the circles of support initiatives. Makes this section effective July 1, 2011.

27 **Pilot project for homeless adults to be in-home caretakers of foreclosed homes.** Paragraph (a) allows Stepping Stone Emergency Housing to form a partnership with local banks who own foreclosed homes to allow homeless adults to be in-home caretakers of those homes if Stepping Stone Emergency Housing meets certain requirements. Makes this section expire June 30, 2013.

28 **Requirement for liquor stores, tobacco stores, gambling establishments, and tattoo parlors.** Requires liquor stores, tobacco stores, gambling establishments, and tattoo parlors to negotiate with their third party processors to block EBT cash transactions at their places of business and withdrawals of cash at ATMs located in their places of business.

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29 **Minnesota EBT Business Task Force.**

Subd. 1. Members. Establishes the membership of the Minnesota EBT Business Task Force.

Subd. 2. Duties. Establishes the duties of the task force.

Subd. 3. Report. Requires the task force to report to the legislative committees with jurisdiction over health and human services policy and finance by April 1, 2012, with recommendations related to the duties in subdivision 2.

Subd. 4. Expiration. Makes the task force expire on June 30, 2012.

30 **Direction to commissioner.** Requires the commissioner to issue a request for proposals for a third-party credit card processor who will prohibit the ability of EBT cards to be used to purchase tobacco products or alcoholic beverages. Requires the commissioner to enter into a contract for the services specified in this section by October 1, 2011, based on the responses to the request for proposals.

31 **Repealer.** Paragraph (a) repeals §§ 256.979, subds. 5, 6, 7, 10 (county child support incentive grants); 256.9791 (county medical support bonus incentive grants); and 256.9862, subd. 2 (EBT transaction fees).

Paragraph (b) repeals Minnesota Rules, part 3400.0130, subp. 8 (child care assistance payment of activity fees).

Article 2: Department of Health

1 **Exemption.** Amends § 62J.495 by adding subd. 7. Exempts certain small clinical practices from the current 2015 deadline for interoperable electronic health records. Provides that this exemption expires December 31, 2020.

2 **Additional standards for electronic prescribing.** Amends § 62J.497 by adding subd. 6. Modifies the current standards for electronic prescribing by requiring the commissioner of health to develop, by January 1, 2012, a method of inclusion of transmission of formulary exception and prior authorization requests.

3 **Medical education.** Amends § 62J.692.

Subd. 1. Definitions. Modifies the definition of "eligible trainee FTE's" to permit nursing facility training sites to be eligible for MERC funding. Prior to the 2007 changes to MERC, nursing facilities were eligible sites.

Subd. 3. Application process. Adds "advanced dental therapists" to the list of types of professionals teaching institutions can train and be eligible for MERC funding. States that there is an added emphasis for primary care in rural areas and for populations experiencing health disparities.

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Subd. 4. Distribution of funds. Modifies the existing MERC formula by removing the supplemental public program factor. Provides a $1000 minimum grant based on the formula. Changes existing direct payments by ending the payments to University of Minnesota Medical Center – Fairview and the School of Dentistry and redirecting funds to named entities to establish clinics, scholarship programs, and other grant programs.

Subd. 5. Report. Removes an existing oversight process related to submission of grant verification reports.

Subd. 6. Other available funds. No changes.

Subd. 7. Transfers from the commissioner. Redirects $100,000 from the dental innovation grants to a new health careers opportunities grant program. Makes a technical change.

Subd. 7a. Clinical medical education innovation grants. Makes conforming and technical changes.

Subd. 8. Federal financial participation. Makes a technical change.

Subd. 9. Review of eligible providers. Removes a reference to the Health Care Access Commission.

Subd. 11. Distribution of funds. Proposes a new MERC distribution formula, subject to federal approval, which would include (1) a public program volume factor for hospital training sites and (2) a weighted formula that would give preference for training primary care professionals and training sites in isolated and small rural areas, as defined by Rural Urban Commuting Area system.

4 **Fee schedules.** Amends § 62Q.735, subd. 5. Modifies the date health plan companies need to provide certain fee-related information from "upon request" to no later than 165 days before the next contract year.

Provides a section effective date of August 1, 2011, for contracts entered, renewed or amended on or after that date.

5 **Claims filing.** Amends § 62Q.75, subd. 3. Modifies permitted time periods for health care providers to submit certain charge data to health plan companies.

Provides a section effective date of August 1, 2011, for contracts entered, renewed, or amended on or after that date.

6 **Alzheimer's disease; prevalence and screening measures.** Adds § 620.15.

Subd. 1. Data from providers. (a) Requires the commissioner of health, beginning July 1, 2012, to review quality measure and make recommendations for future measurements for improving assessment and care related to Alzheimer's and other

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dementia diagnoses, including cognitive screening, diagnoses and treatment plans.

(b) Permits the commissioner to contact with a private entity to collect the data under this section and permits the commissioner to use an existing contract to do so.

Subd. 2. Learning collaborative. Requires the commissioner to develop, by July 1, 2012, a health care home learning collaborative curriculum for identification and management of Alzheimer's disease and other dementia patients.

Subd. 3. Comparison data. Requires the commissioners of health and human services, the Minnesota Board of Aging, and other appropriate state offices to conduct a literature review in order to estimate current outcomes and costs compared with improved practices related to Alzheimer's disease and other dementias.

Subd. 4. Reporting. Requires the commissioner to provide a progress report to the legislature by January 15, 2013.

7 **Education and training for health disparity populations.** Adds § 137.395. Requires the University of Minnesota Board of Regents, if it accepts the direct payments from the MERC funding under § 62J.692, to implement a scholarship program from students from populations experiencing health disparities. Requires that one-third of the funding provided for this program goes to students at the University of Minnesota, Medical School – Duluth.

8 **Health careers opportunities grant program.** Amends § 144.1499. Replaces the existing health care and long-term care careers program with a grant program directed at health care employers, education institutions, and other organizations working to increase the number of people from populations with health disparities who enter health care careers in the state.

9 **Definitions.** Amends § 144.1501, subd. 1. Modifies the definition of "designated rural area" for purposes of the health professionals loan forgiveness program, to include small rural and isolated rural areas as described by the Rural Urban Commuting Area system.

10 **Loan forgiveness.** Amends § 144.1501, subd. 4. Modifies the loan forgiveness program by directing the commissioner to give preference to applicants from populations experiencing health disparities who agree to serve in settings in the state that provide services to at least 50 percent American Indian or other population of color.

11 **Health professions opportunities scholarship program.** Adds § 144.1503. Establishes a scholarship program to increase the number of students from racial, ethnic, or cultural populations experiencing health disparities who enter health care professions. Provides that the scholarships are for eligible students entering the following professions: primary care physician, certified nurse practitioner, certified nurse midwife, certified clinical nurse specialist, chiropractor, physician assistant, registered nurse, dentist, and dental therapist.

12 **Patient safety survey.** Adds § 144.586. Requires hospitals licensed in the state to submit information to the Leapfrog Group as a method for publicly reporting patient safety measures.

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13 **Standards.** Amends § 144.98, subd. 2a. Makes a conforming change related to environmental lab accreditation.

14 **Initial accreditation and annual accreditation renewal.** Amends § 144.98, subd. 7. Makes a conforming change related to environmental lab accreditation.

15 **Exemption from national standards for quality control and personnel requirements.** Amends § 144.98 by adding subd. 8. Permits certain environmental labs to request an exemption from personnel requirements and specified quality control provisions, as of January 1, 2012. Permits the commissioner of health to grant exemptions provided the lab complies with methodology and quality control requirements.

16 **Exemption from national standards for proficiency testing frequency.** Amends § 144.98, by adding subd. 9. Requires labs requesting accreditations under the exemption in section 144.98, subdivision 8, to obtain acceptable proficiency test results and sets out requirements related to subsequent analysis of proficiency testing samples.

17 **Exemptions.** Amends § 144A.04, by adding subd. 13. Exempts CMS-certified boarding care homes and CMS-certified nursing homes from state licensures requirements adopted by the commissioner of health.

18 **License renewal.** Amends § 144A.05. Requires the commissioner of health to renew the state license of a boarding care home or nursing home provided that it maintains CMS certification.

19 **Electronic transmission.** Amends § 144A.61 by adding subd. 9. Requires the commissioner of health to accept electronic transmission of applications for the nursing assistant registry.

20 **Prehospital care data.** Amends § 144E.123. Modifies an existing data reporting requirement for EMS licensees by making it permissive until July 1, 2014, and removing the penalty for failing to report. Requires the EMS regulatory board to convene a working group, by October 1, 2011, to redesign policies related to data collection. Requires the working group to report its findings by January 1, 2014.

Provides an immediate effective date.

21 **White Earth Band urban clinic.** Adds § 145.9271. Requires the White Earth Band of Ojibwe Indians, if it accepts the direct payments from MERC funding under section 62J.692, to establish and operate one or more health clinics in Minneapolis to serve member of the White Earth tribe.

22 **Community mental health center grants.** Adds § 145.9272. Requires the commissioner of health to distribute grants to community mental health centers for providing services to low-income consumers and patients with mental illness. Provides a formula for determining the amount of the grant based on public program revenues.

23 **State-community partnerships; plan.** Amends § 145.928, subd. 2. Adds a list of

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culturally-based community organizations that help to develop and implement the state's plan to eliminate health disparities.

24 **Professionals from populations with health disparities.** Adds § 145.929. Requires the commissioner of health to survey the diversity of the health care work force and compare proportions of populations working in health care to the population as a whole. Requires the commissioner to determine, based on the survey, the ratio of training and residency positions needed versus those available in the state.

25 **Consultation and engagement of consumers and communities with poorer health outcomes.** Amends § 145.986 by adding subd. 7. Adds a requirement for grantees who receive statewide health improvement (SHIP) funding by requiring that they demonstrate engagement with local consumers, community organizations and leaders related to addressing health disparities.

26 **Coordination with payment reform demonstration projects.** Amends § 145.986 by adding subd. 8. Requires certain SHIP grantees that are also a payment reform demonstration project to coordinate activities to improve the health of the communities and patients under both programs.

27 **Community health centers development grants for underserved communities.** Amends § 145.987. Requires the commissioner of health to award grants to expand community health centers by establishing new centers in small or isolated rural areas, as described by the Rural Urban Commuting Area system. Specifies uses for these community health center development grants.

28 **Requirements for programs; process.** Amends § 145A.17, subd. 3. Requires local public health family home visiting programs to obtain permission from the family to share data with other family service providers to select a lead agency and coordinate available resources.

29 **Limited food establishment.** Amends § 157.15 by adding subd. 21. Creates a "limited food establishment" as a type of food, beverage, and lodging establishment and exempts them from the NSF International food service equipment standards and room finish requirements provided in the state Food Code (Minnesota Rules, ch. 4626).

30 **Waivers during inspection.** Amends § 157.20 by adding subd. 5. Permits an inspector operating pursuant to the state Food Code, to waive any plumbing or other facility requirement if the inspector deems such a waiver appropriate and reasonable.

31 **Tax and use tax on cigarettes.** Amends § 297F.10, subd. 1, Makes a conforming change related to the proposed formula changes to MERC distribution.

32 **Transfer of health quality data collection.** Transfers the duties of the commissioner of health under Minnesota Statutes, chapter 62U to the commissioner of human services.

33 **Patient and community engagement in payment reform and health care program reforms.** Requires the commissioners of health and human services to implement the recommendations of the report submitted pursuant to Laws 2010, First Special Session,

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chapter 1, article 19, section 23, related to health disparities data. Requires the commissioner of health to consult with an advisory committee representing racial and ethnic groups regarding implementation of this section and other major agency activities.

34 **Transfer of health-facility licensed duties.** Transfers the duties of the commissioner of health related to licensing and regulation of health facilities to the commissioner of human services.

35 **Transfer of HMO regulation.** Transfers the duties of the commissioner of health related to regulation of health maintenance organizations to the commissioner of commerce.

36 **Transfer of the health economics program.** Transfers the duties of the health economics program conducted under Minnesota Statutes, chapter 62J, to the commissioner of commerce.

37 **Study of for-profit health maintenance organizations.** Requires the commissioner of health to contract with an entity to study efficiency, cost, service quality and enrollee satisfaction data for for-profit health maintenance organizations (HMO) relative to the non-profit HMO's. Requires a report on the findings by January 15, 2012.

38 **Minnesota task force on prematurity.** Establishes a Minnesota Task Force of Prematurity to evaluate and make recommendations on methods to reduce prematurity and improve premature infant health care. Specifies membership of the task force and requires the commissioner of health to convene the first meeting by July 31, 2011. Requires a report on the current state of prematurity by November 30, 2011, and a final report by January 15, 2013.

39 **Repealer.** (a) Repeals §§ 144.1464 (summer health care interns) and 150A.22 (donated dental services).

(b) Repeals § 145A.14, subd. 1 (migrant health grants) and subd. 2. (Indian health grants), effective January 1, 2012 to allow completion of contacts with current grantees.

Article 3: Health Boards

1 **Conviction of a felony-level criminal sexual conduct offense.** Amends § 148.10, subd. 7. Provides that the Board of Chiropractic Examiners shall not grant or renew a license to practice to any person convicted on or after August 1, 2011, of one of the enumerated felony-level sexual offenses.

2 **Powers.** Amends § 148.191, subd. 2. Strikes obsolete language. Adds that the Board of Nursing may accept and expend grants or gifts of money or in-kind services for purposes consistent with the board's role and statutory authority. Adds that the board may accept registration fees for conferences and meetings.

3 **Requirements for criminal history check.** Creates § 148.192.

Subd. 1. Applicants. Requires the board to complete a criminal background check

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on all new applicants for a nursing license. Requires applicants to submit fingerprints and provide consent to perform the background check.

Subd. 2. Additional background check required. Provides that if an applicant has not been granted a license within one year from initial application and background check, the background check must be completed again.

Subd. 3. Fees. Requires applicants to pay all fees associated with the background check.

Subd. 4. Refusal to consent. Provides that if the applicant refuses to consent or fails to submit fingerprints within 90 days of submitting the application, then the board can deny a license to the applicant.

Subd. 5. Submission of fingerprints to Minnesota Bureau of Criminal Apprehension (BCA). Requires the board to submit applicant fingerprints to the BCA for the state background check. Requires the BCA to submit the fingerprints to the FBI for national criminal justice information. Requires the BCA to report the results to the board.

Subd. 6. Alternatives to finger-print based background check. Allows the board to require an alternative method of criminal history check for an applicant whose fingerprints are unreadable.

Subd. 7. Temporary permits. Allows the board to issue a temporary, nonrenewable permit to practice pending background study results to applicants who have complied with background check requirements.

Subd. 8. Denial of licensure. Requires the board to deny a license to an applicant convicted of any of the enumerated offenses in this subdivision.

Subd. 9. Conviction. States that for purposes of this section conviction means, convicted or found guilty, found guilty by a jury but adjudication of guilt was withheld, convicted by execution of the sentence was stayed, or pleaded guilty or entered an Alford plea or no contest plea.

Subd. 10. Consideration of other crimes. Allows the board to consider conviction of crimes not enumerated in subdivision 8 when determining an applicant's suitability for licensure.

Subd. 11. Order of denial. Allows the board to issue a public order of denial of licensure if an applicant is found to have been convicted of one of the enumerated crimes. States the board is not required to provide a hearing to the applicant prior to denial of a license.

Subd. 12. Reconsideration of denial. Provides the circumstances under which an applicant can request reconsideration, the procedure for requesting reconsideration, and the evidence that will be considered by the board. Allows the board to impose

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limitation on the applicant's license if a license is granted after reconsideration.

Subd. 13. Data practices. Provides that all state and federal criminal history data obtained by the board is confidential data on individuals and restricted to the exclusive use of the board.

Subd. 14. Current licensees. Permits the board to request a licensee who is the subject of an investigation to submit to a criminal background check if the board has reason to believe the licensee has been convicted of a crime.

Provides that this section is effective July 1, 2012, or as soon as interagency infrastructure is operational, whichever is later.

4 **Licensure by examination.** Amends § 148.211, subd. 1. Requires an applicant for licensure to submit evidence of completion of a nursing program which was conducted in English. Requires applicants who graduated from a nursing program in Quebec to meet the additional requirements imposed on graduates from a foreign nursing program.

5 **Issuance.** Amends §148.212, subd. 1. Strikes language allowing the board to issue a temporary permit to practice to an applicant for licensure who graduated from a foreign nursing program. Provides that applicants for licensure by endorsement may be granted a temporary permit for up to 60 days.

6 **Registration; failure to register; reregistration; verification.** Amends § 148.231. Strikes obsolete language and references to administrative rules.

7 **General requirements.** Amends § 148B.5301, subd. 1. Strikes obsolete language.

8 **Conversion from licensed professional counselor to licensed professional clinical counselor.** Amends § 148B.5301, subd. 3. Extends the conversion date from August 1, 2011, to August 1, 2013.

9 **Conversion to licensed professional clinical counselor after August 1, 2013.** Amends §148B.5301, subd. 4. Makes a conforming change to reflect the change in the conversion date made in section 8.

10 **Continuing education.** Amends § 148B.54, subd. 2. Adds that each licensee in the first four years of licensure must complete 40 hours of continuing education. Permits graduate course hours, successfully completed, in the first four years of licensure to apply both to the graduate credit requirement and the continuing education requirement.

11 **Relicensure following termination.** Amends § 148.54, subd. 3. Allows an individual whose license was terminated and who can demonstrate completion of graduate credit requirements to be exempt from continuing education requirements in order to get the license reinstated. Provides this section does not apply to individuals whose licenses have been canceled.

12 **Students and other persons not currently licensed in another jurisdiction.** Amends § 148E.060, subd. 1. Makes a technical change. Adds that a temporary license to practice

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social work expires after six months.

Provides this section is effective August 1, 2011.

13 **Emergency situations and persons currently licensed in another jurisdiction.** Amends § 148E.060, subd. 2. Makes a technical change. Adds that a temporary license to practice social work expires after six months.

Provides this section is effective August 1, 2011.

14 **Programs in candidacy status.** Amends § 148E.060, by adding subd. 2b. Paragraph (a) permits the board to issue a temporary license to practice social work to an applicant from a social work program in candidacy status if the application has complied with all licensure requirements.

Paragraph (b) provides that the temporary permit expires after 12 months, but may be extended at the board's discretion.

Provides this section is effective August 1, 2011.

15 **Teachers.** Amends § 148E.060, subd. 3. Provides that a temporary social work license issued to teachers expires after 12 months.

Provides an August 1, 2011, effective date.

16 **Temporary license term.** Amends § 148E.060, subd. 5. Makes conforming changes.

Provides an August 1, 2011, effective date.

17 **Requirements of supervisors.** Amends § 148E.120. Modifies the requirements for alternate supervisors. Paragraph (a) allows the board to approve a qualified licensed mental health professional to provide up to 25 percent of the required hours of supervision to become licensed as social worker.

Paragraph (b) provides the conditions under which the board can approve an alternate supervisor to provide up to 100 percent of the required supervision hours.

Paragraph (c) lays out the requirements the supervisee must meet in order to receive approval for an alternate supervisor.

Provides an effective date of August 1, 2011.

18 **Generally.** Amends § 150A.02, subd. 1. Requires one board member who is a licensed dentist to be involved with the education, employment or utilization of a dental therapist or advanced dental therapist.

19 **Specialty dentists.** Amends § 150A.06, subd. 1c. Makes a technical change.

20 **Dental therapist.** Amends § 150A.06, subd. 1d. Requires clinical examinations for dental therapy and advanced dental therapy to be comparable to those administered to dental

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students for the same competencies.

21 **Waiver of examination.** Amends § 150A.06, subd. 3. Makes technical changes.

22 **Licensure by credentials.** Amends § 150A.06, subd. 4. Adds a requirement that a dentist or dental therapist who is applying for licensure based on performance rather than examination to have passed all components of the National Board of Dental Examinations.

23 **Display of name and certificate.** Amends § 150A.06, subd. 6. Allows the board to permit a licensee to display a wallet-sized license and renewal certificate only at nonprimary practice locations.

24 **Criminal history record checks.** Amends § 150A.06, by adding subd. 10. Paragraph (a) requires that an applicant must submit to a criminal history record check.

Paragraph (b) requires an applicant to submit fingerprints, consent for a criminal history check, and pay the required fees.

Paragraph (c) instructs the board to maintain criminal history records in compliance with state and federal law.

Paragraph (d) prohibits the board from accepting criminal history records from an agency other than the BCA.

Paragraph (e) lists the areas the board is to consider in reviewing the criminal history data to determine whether an applicant should be granted an initial or reinstated license.

Paragraph (f) prohibits the board from granting an initial or reinstated license if the applicant does not comply with this subdivision.

Paragraph (g) sets out the board's authority to take action if an applicant has engaged in criminal behavior.

25 **Current address, change of address.** Amends § 150A.09, subd. 3. Requires licensees to provide their email address to the board.

26 **Use of dental assistants.** Amends § 150A.105, subd. 7. Makes technical changes.

27 **General.** Amends § 150A.106, subd. 1. Adds that an advanced dental therapist must pass a certification examination comparable to those administered to dental students.

28 **Immunity.** Amends § 150A.14. Adds a cross reference to the new language on criminal history record checks. Adds that members of the board and consultants retained by the board are considered state employees for purposes of tort claim indemnification.

29 **Health-related boards.** Amends § 214.09, by adding subd. 5. Prohibits current members of a board from seeking a paid employment position with that board.

30 **Health-related licensing boards; complaint, investigation, and hearing.** Amends § 214.103.

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Subd. 1. Application. No changes made in this subdivision.

Subd. 1a. Notifications and resolution. Paragraph (a) provides that within 14 days of receipt of a complaint, the board must notify the complainant of receipt of the complaint and a written description of the review process. Requires the board to contact the complainant at least every 120 days of the status of the complaint.

Paragraph (b) requires the board, within 60 days of receipt of the complaint, to notify the licensee of the substance of the complaint, the laws that have allegedly been violated, the sections of professional rules that have allegedly been violated, and whether an investigation is being conducted.

Paragraph (c) requires the board to notify the licensee at least every 120 days of the status of the complaint.

Paragraph (d) provides that the board is not required to make notifications to the licensee if the notice would compromise the investigation or the notice cannot reasonably be accomplished within the time frames.

Paragraph (e) requires the board to resolve or dismiss a complaint within one year unless this cannot reasonably be accomplished and is not in the public interest.

Paragraph (f) provides that the board's failure to comply with the above paragraphs does not deprive the board of jurisdiction to complete the investigation or take action against a licensee.

Subd. 2. Receipt of complaint. Requires complainants to state the complaint in writing or authorize transcription of an oral complaint.

Subd. 3. Referral to other agencies. Permits government agencies to coordinate and conduct joint investigations when a complaint involves more than one agency.

Subd. 4. Role of the attorney general. No changes.

Subd. 5. Investigation by the attorney general. Adds that when the designee of the attorney general completes an investigation, the designee shall forward the report to the executive director of the board with recommendations for further consideration or dismissal.

Subd. 6. Attempts at resolution. Adds that neither the executive director nor any member of the board's staff shall be a voting member on a disciplinary review panel. Strikes the provision that a contested case hearing can be initiated by the executive director if attempts at resolution are not satisfactory to the executive director.

Subd. 7. Contested case hearing. Requires the concurrence of a second board member in order for the executive director to initiate a contested case hearing when there is a determination that resolution of a complaint is not in the public interest.

Subd. 8. Dismissal and reopening of a complaint. Adds that the board cannot

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reopen a dismissed complaint unless it receives newly discovered information that was not available during the initial investigation or the board receives a new complaint that indicates a pattern of behavior or conduct.

Subd. 9. Information to complainant. No change.

Subd. 10. Prohibited participation by board member. No change.

31 Conviction of felony-level criminal sexual conduct offense. Creates section 214.107.

Subd. 1. Applicability. Provides that this section applies to all health-related licensing boards, except medical practice and chiropractic examiners; the Board of Barber Examiners; the Board of Cosmetologist Examiners; and speech-language pathologists and audiologists, hearing instrument dispensers, and occupational therapists and occupational therapy assistants (professions credentialed by the Minnesota Department of Health). The Board of Medical Practice and Board of Chiropractic Examiners already have statutes in place which prohibit granting a license to an individual who has been convicted of specified felony-level criminal sexual conduct crimes.

Subd. 2. Issuing and renewing a credential to practice. Paragraph (a) provides that a credentialing authority shall not issue or renew a credential to practice to any person convicted on, or after August 1, 2011, of any of the provisions of sections 609.342, subdivision 1 (criminal sexual conduct in the first degree), 609.343, subdivision 1 (criminal sexual conduct in the second degree), 609.344, subdivision 1, paragraphs (c) to (o) (criminal sexual conduct in the third degree), or 609.345, subdivision 1, paragraphs (b) to (o) (criminal sexual conduct in the fourth degree).

Paragraph (b) prohibits a credentialing authority from granting a credential to an individual who has been convicted in any other state or country on, or after August 1, 2011, of an offense where the elements are substantially similar to the offenses listed in paragraph (a).

Paragraph (c) provides for automatic revocation of a credential if a person is convicted of a crime listed in paragraph (a).

Paragraph (d) provides that denial or revocation of a license under this section is exempt from the provisions of chapter 364 (Criminal offenders; rehabilitation).

Paragraph (e) defines conviction.

Paragraph (f) establishes the conditions under which a credentialing authority can establish criteria to grant or renew a credential of an individual who has been convicted of an offense listed in paragraph (a). Prohibits a credentialing authority from granting or renewing a license if the victim of the offense was a patient or client at the time of the offense.

Provides an effective date of August 1, 2011.

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32 **Health-related licensing boards; licensee guidance.** Creates § 214.108. Allows a board to offer guidance to licensees about the application of laws and rules the board enforces. Provides that this guidance is not binding on any court or other adjudicatory body.

33 **Recordkeeping.** Creates § 214.109. Allows a board to take administrative action against a regulated person whose records do not meet professional standards. Records that are fraudulent or could result in patient harm may be handled through disciplinary action.

Allows the board to issue a warning for the first offense and require the regulated person to attend a remedial class. For a second offense, the board may require additional training and may assess a $50 penalty. For a third offense, the board may require additional training and may assess a $100 penalty.

States that action under this section is not disciplinary action.

34 **Exceptions.** Amends § 364.09. Adds that this section does not apply to individuals whose credential has been denied or revoked in accordance with section 214.107.

Adds that this section does not apply to individuals whose license to practice nursing has been denied or revoked pursuant to section 148.192.

Provides that this section is effective for credentials issued or renewed on, or after August 1, 2011.

35 **Effective date.** Amends Laws 2010, chapter 349, section 1, by making a change to the effective date language so that the section applies to licenses issued or renewed on, or after August 1, 2010.

36 **Effective date.** Amends Laws 2010, chapter 349, section 2, by making a change to the effective date language so that the section applies to licenses issued or renewed on, or after August 1, 2010.

37 **Report.** Requires the executive directors of the health related licensing boards to issue a report to the legislature with recommendations for the use of nondisciplinary cease and desist letters. Requires the report to be issued by December 15, 2011.

38 **Revisor's instruction.** Instructs the Revisor to include in each practice act regulated by a credentialing authority listed in section 31 a statement of notification that all applicants for a credential and individuals renewing a credential are subject to the provisions of section 214.107.

39 **Repealer.** Repeals Minnesota Rules, part 6310.3100, subp. 2 (nursing fees); 6310.3600 (nursing registration fees); and 6310.3700, subp. 1 (fees for dishonored checks).

Article 4: Miscellaneous

1 **Health note.** Amends § 3.98, by adding subdivision 5. Requires the commissioner of health, in consultation with other state agencies, to make recommendations to the legislature

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on a process by which a committee chair can request a health impact review of proposed legislation. The purpose of the review would be to evaluate the impact of the legislation on health care costs and on health status of the state or community. Permits the commissioner to consult with public and private organizations. Requires the report and recommendations to be provided by January 15, 2012.

2 **Special family day care homes.** Amends § 245A.14, subd. 4. Permits a family day care or group family day care provider to locate the program in a commercial space, rather than a residence, if the license holder is the primary provider of care and complies with specific requirements: local zoning regulations, specified fire code, and age and capacity limitations and square footage determinations as required by the fire code. Requires the license holder to display the license issued by the commissioner which will contain the statement, "This special family child care provider is not licensed as a child care center."

3 **Combined application form; referral of veterans.** Amends § 256.01, by adding subdivision 33. Requires the commissioner to modify the combined application form with a question asking whether an applicant is a U.S. military veteran. Requires the commissioner to ensure that all applicants who are veterans are referred to their county's veterans service office for assistance applying for benefits from the Department of Veterans Affairs.

4 **Spousal contribution.** Amends § 256B.14, by adding subdivision 3a.

Paragraph (a) provides definitions of commissioner, community spouse, cost of care, department, disabled child, income, and long-term care spouse.

Paragraph (b) requires the spouse of the long-term care spouse who receives medical assistance for long-term care services or alternative care services to contribute to the cost of care unless the community spouse is caring for a minor or disabled child in the home.

Paragraphs (c) to (f) provide the formula for computing the contribution amount.

Paragraph (g) requires the commissioner at the time of application for services to provide the spouse and community spouse a written explanation of the spousal contribution requirement, how to request a variance for undue hardship, review and redetermination of the contribution, and consequences for noncompliance.

Paragraph (h) provides that the contribution is to be assessed for each month the long term care spouse has a community spouse and is eligible for medical assistance or alternative care.

Paragraph (i) requires a review of the spousal contribution a minimum of once every 12 months and when there is a loss or gain of income in excess of 10 percent. Sets out the requirements for requesting a review and the commissioner's responsibilities in scheduling a redetermination.

Paragraph (j) provides that the contribution cannot exceed the amount of medical assistance expended or the cost of alternative care services provided. Sets out the method of reimbursement if the community spouse has contributed an amount in excess of costs.

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Paragraph (k) allows a community spouse who has personal medical needs to request a variance for undue hardship if the spouse needs to retain the contribution amount to pay for these medical needs. Sets out the method for requesting the variance.

Paragraph (l) sets out the appeal rights.

Paragraph (m) sets out the method to enforce payments.

5 **Elevators; entrances sealed.** Amends § 326B.175. Modifies the requirement that elevators not meeting building code requirements be taken out of service until modifications to bring the device into compliance with code requirements are completed. New compliance timeline is established in section 326B.188.

6 **Compliance timeline.** Creates § 326B.188. Provides an alternative compliance timeline for elevators that have a current law compliance deadline of January 29, 2012, or later. Owners of elevators that were notified of compliance issues before the effective date of this section, must submit a compliance plan for their devices by December 30, 2011. Owners not notified before the effective date of this section must submit a compliance plan by December 30, 2011, or within 60 days of notification, whichever is later. Any plan submitted under this section has to result in code compliance by the later of January 29, 2012, or within three years after submission of the compliance plan.

7 **Developmental disability waivered services.**

Subd. 1. Purpose. States that all individuals who are eligible for developmental disability waivered services are entitled to receive adequate services within the limits of available funding to ensure their basic needs are met.

Subd. 2. Instructions to the commissioner. Paragraph (a) instructs the commissioner of human services to convene a work group to define essential services. Establishes a hierarchy of need tier system.

Paragraph (b) provides that the commissioner and a county representative co-chair the work group. Provides instructions to the work group.

8 **Instructions to the commissioner.** Requires the commissioner to assess each county its proportionate share of cost based on county population to offset the cost of implementing the spousal contribution recovery program created in § 256B.14, subdivision 3a. Instructs the commissioner to divide ten percent of the recovery between the counties based on county population.

9 **Legislative approval for federal funds.** Requires the commissioners of health and human services to receive approval from three of the four chairs and ranking minority members of the legislative committees with jurisdiction over health and human services before spending any funds from federal grants or subsequent grant renewal.

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Article 5: Health Licensing Fees

1 **Renewal fees.** Amends § 148.07 subd. 1. Makes technical change to require the Board of Chiropractic Examiners to set fees in statute rather than by rule.

2 **Animal chiropractic.** Amends § 148.108 by adding subd. 4. Sets registration fees for animal chiropractors.

3 **Powers.** Amends § 148.191, subd. 2. Removes language related to adopting rules. Permits the Board of Nursing to accept and expend grants and gifts for purposes consistent with the board's authority. Permits the board to accept registration fees for certain meetings and conferences.

4 **Issuance.** Amends § 148.212 subd. 1. Modifies the requirements for a temporary permit to practice by the Board of Nursing.

5 **Registration; failure to register; reregistration; verification.** Amends § 148.231. Makes technical changes.

6 **Fees.** Adds § 148.242. Requires fees set in statute to be deposited in the state government special revenue fund.

7 **Fee amounts.** Adds § 148.243. Sets out the fee schedule in statute for the Board of Nursing.

8 **Fees.** Amends § 148B.17. Makes technical changes and sets out the fee schedule in statute for the Board of Marriage and Family.

9 **Fee.** Amends § 148B.33, subd. 2. Make a conforming change.

10 **Duties of the board.** Amends § 148B.52. Makes a technical change to require fees to be established in statute.

11 **Application fees.** Amends § 150A.091, subd. 2. Adds a fee for advanced dental therapist certification and for full faculty dentist.

12 **Initial license or permit fees.** Amends § 150A.091, subd. 3. Makes a conforming change.

13 **Annual license fees.** Amends § 150A.91, subd. 4. Clarifies annual license fee.

14 **Biennial license or permit fees.** Amends § 150A.91, subd. 5. Makes a conforming change.

15 **Duplicate license or certification fee.** Amends § 150A.091, subd. 8. Makes a conforming change.

16 **Failure of professional development portfolio audit.** Amends § 150A.091 by adding subd. 16. Provides a fee to be collected by the Board of Dentistry for a licensee who fails two consecutive professional development audits.

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17 **Fee amounts.** Adds § 151.065. Sets out a fee schedule in statute for the Board of Pharmacy.

18 **Meetings; examination fee.** Amends § 151.07. Makes a conforming change.

19 **Internship.** Amends § 151.101. Makes a conforming change and modifies a reference from licensure of interns to registration of interns.

20 **Registration fee.** Amends § 151.102 by adding subd. 3. Requires a fee for pharmacy technicians to be registered by the Board of Pharmacy.

21 **Reciprocity; licensure.** Amends § 151.12. Makes a conforming change.

22 **Renewal fee.** Amends § 151.13, subd. 1. Makes conforming changes and modifies references to fee changes by cross-referencing Minnesota Statutes, section 151.065.

23 **Registration; fees.** Amends § 151.19. Makes conforming changes and modifies references to fee changes by cross-referencing Minnesota Statutes, section 151.065.

24 **Registration of manufacturers; fee; prohibitions.** Amends § 151.25. Makes a conforming change.

25 **Requirements.** Amends § 151.47, subd. 1. Makes a conforming change.

26 **Out-of-state wholesale drug distributor licensing.** Amends § 151.48. Makes a conforming change.

27 **Research project use of controlled substances.** Amends § 152.12, subd. 3. Adds a cross-reference to fees set out in Minnesota Statutes, section 151.065.

Article 6: Health Care

1 **Establishment.** Amends § 62E.08, subd. 1. Provides that the MCHA premium for the high-deductible, basic plan offered under § 62E.121 shall range from 101 to 125 percent of the weighted average of rates for comparable plans offered outside of MCHA.

2 **High-deductible, basic plan.** Adds § 62E.121.

Subd. 1. Required offering. Requires MCHA to offer a high deductible, basic plan that meets the requirements in this section. Specifies that the plan is a one-person plan and that dependents must be covered separately.

Subd. 2. Annual deductible; out-of-pocket maximum. (a) Requires the plan to provide in-network annual deductible options of $3,000, $6,000, $9,000, and $12,000, with an in-network out-of-pocket maximum that is $1,000 greater than the amount of the annual deductible.

(b) Provides an annual increase in the deductible, based on the change in the CPI.

Subd. 3. Office visits for nonpreventive care. Specifies different levels of

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copayments for the first three nonpreventive office visits, depending upon the deductible option chosen. Provides 80 percent coverage for subsequent visits, after the deductible is met.

Subd. 4. Preventive care. Provides 100 percent coverage for preventive care, with no cost-sharing.

Subd. 5. Prescription drugs. Requires a $10 copayment for preferred generic drugs, and requires enrollees to pay 100 percent of the plan's rate for preferred brand name drugs.

Subd. 6. Convenience care center visits. Requires a $20 copayment for the first three convenience center visits, with 80 percent coverage for subsequent visits after the deductible is met.

Subd. 7. Urgent care center visits. Requires a $100 copayment for the first urgent care visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 8. Emergency room visits. Requires a $200 copayment for the first emergency room visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 9. Lab and x-ray; hospital services; ambulance; surgery. Provides that these services are covered at 80 percent after the deductible is met.

Subd. 10. Eyewear. Pays $50 per calendar year for eyewear.

Subd. 11. Maternity. Specifies that maternity, labor and delivery, and postpartum care are not covered. Provides 100 percent coverage for prenatal care with no deductible.

Subd. 12. Other eligible health care services. Provides 80 percent coverage for other eligible health care services after the deductible is met.

Subd. 13. Option to remove mental health and substance abuse coverage. Allows enrollees to remove mental health and substance abuse coverage and receive a reduced premium.

Subd. 14. Option to upgrade prescription drug coverage. Allows enrollees to upgrade prescription drug coverage in return for an increased premium.

Subd. 15. Out-of-network services. Provides that: the out-of-network deductible is twice the in-network annual deductible; there is no out-of-pocket maximum for out-of-network services; out-of-network benefits are covered at 60 percent after the deductible is met; and the lifetime maximum for out-of-network services is $1 million.

Subd. 16. Services not covered. Lists services not covered by the plan.

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3 **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** Amends § 62E.14, by adding subd. 4f. Allows individuals to enroll in an MCHA plan with a waiver of the preexisting condition limit, if they are eligible for the healthy Minnesota contribution program and have been denied private sector coverage.

4 **Growth limits; federal programs.** Amends § 62J.04, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

5 **Review of eligible providers.** Amends § 62J.692, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

6 **Billing for procedures to correct medical errors is prohibited.** Adds § 62J.824. Prohibits a health care provider from billing and being reimbursed for any service provided to reverse, correct, or otherwise minimize the effects of an adverse health event for which the health care provider is responsible.

7 **Local ombudsperson.** Amends § 62Q.32. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

8 **Provider peer grouping.** Amends § 62U.04, subd. 3. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

9 **Legislative oversight.** Amends § 62U.06, subd. 2. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

10 **Contingency contract fees.** Amends § 256.01, by adding subd. 33. When the commissioner enters into a contingency-based contract for the purpose of recovering MA or MinnesotaCare funds, allows the commissioner to retain that portion of recovered funds equal to the amount of the contingency fee.

11 **Operating payment rates.** Amends § 256.969, subd. 2b. Delays hospital rebasing for the first six months of the rebased period beginning January 1, 2013.

12 **Initiatives to reduce incidence of low birth-weight.** Amends § 256.969, by adding subd. 31. Requires level III pediatric hospitals located in the seven-county metropolitan area to implement strategies to reduce the incidence of low-birth weight in geographic areas with a higher than average incidence of low-birth weight. Specifies criteria for initiatives and requires implementation by July 1, 2012. Requires the commissioner to evaluate the strategies.

13 **General limit.** Amends § 256B.03, subd. 1. Prohibits MA payments to vendors located outside of Minnesota from exceeding the payment applicable to in-state vendors.

14 **Applications for medical assistance.** Amends § 256B.04, subd. 18. Requires the commissioner to modify the Minnesota health care programs application form to add a question asking applicants if they are U.S. military veterans.

15 **Technical assistance.** Amends § 256B.05, by adding subd. 4. Requires the commissioner,

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using existing resources, to provide technical assistance to county agencies in processing complex MA applications.

16 **Adults without children.** Amends § 256B.055, subd. 15. Requires the commissioner to eliminate MA coverage for adults without children, and suspend new enrollment, if the federal government eliminates or reduces the federal Medicaid match for this group.

17 **Citizenship requirements.** Amends § 256B.06, subd. 4. Clarifies services covered under emergency MA, by specifying that various services, including those related to chronic conditions, are not covered.

18 **Care coordination services provided through pediatric hospitals.** Amends § 256B.0625, by adding subd. 1b. Provides MA coverage for care coordination services provided by advanced practice nurses employed by, or under contract with, level III pediatric hospitals, to children with high-cost medical conditions or at-risk of recurrent hospitalization for acute or chronic illnesses.

19 **Elective induction of labor.** Amends § 256B.0625, by adding subd. 3g. Prohibits MA coverage of elective inductions of labor prior to 39 weeks gestation.

20 **Repeat testing.** Amends § 256B.0625, by adding subd. 4b. Prohibits MA coverage for certain repeat medical tests, unless prior authorization is obtained or a protocol developed by the commissioner to minimize unnecessary repeat testing is used. Requires capitation rates to managed care and county-based purchasing plans to be reduced to reflect cost-savings from implementation.

21 **Physical therapy.** Amends § 256B.0625, subd. 8. Requires services provided by a physical therapy assistant to be reimbursed at 65 percent of the physical therapist rate under all circumstances. (Under current law, payment is at 100 percent when the assistant is under the direction of a physical therapist who is on premises.)

22 **Occupational therapy.** Amends § 256B.0625, subd. 8a. Requires services provided by an occupational therapy assistant to be reimbursed at 65 percent of the occupational therapist rate under all circumstances. (Under current law, payment is at 100 percent when the assistant is under the direction of an occupational therapist who is on premises.)

23 **Chiropractic services.** Amends § 256B.0625, subd. 8e. Increases from 12 to 24 the number of chiropractic visits allowed before prior authorization is required.

24 **Acupuncture services.** Amends § 256B.0625, by adding subd. 8f. Provides that MA covers acupuncture, only when provided by a licensed acupuncturist, or by a practitioner for whom acupuncture is within scope of practice and who has specific acupuncture training or credentialing.

25 **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) converts MA payment for drug ingredient costs from a formula based on average wholesale price (AWP) to one based on wholesale acquisition cost (WAC). Sets payments at WAC plus four percent for independently owned pharmacies located in a designated rural area

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within Minnesota, and at WAC plus two percent for all other pharmacies.

The amendment to paragraph (d) sets payment rates for drugs administered in an outpatient setting at the lower of the usual and customary cost or 106 percent of the average sales price. Payment under current law is at the lower of the usual and customary cost or the amount established by Medicare.

The amendment to paragraph (e) includes antihemophilic factor products in the list of specialty pharmacy products for which the commissioner may negotiate lower reimbursement rates and require enrollees to obtain from providers that have agreed to the lower rates.

Provides an effective date of July 1, 2011, or upon federal approval.

26 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. Makes the following changes related to coverage of medication therapy management services:

- allows persons taking three or more prescriptions with one or more chronic conditions to be eligible (current law requires four or more prescriptions with two or more chronic conditions)
- allows coverage of persons with a drug therapy problem that is identified by a pharmacist and approved by the commissioner
- allows provision of the service in home settings, without an order from the provider-directed care coordination team, and also expands the definition of home settings to include long-term care settings, group homes, and assisted living facilities

27 **Transportation costs.** Amends § 256B.0625, subd. 17. Effective July 1, 2011, reduces nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.

28 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective July 1, 2011, reduces ambulance service rates by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.

29 **Bus or taxicab transportation.** Amends § 256B.0625, subd. 18. Removes language providing that MA covers the "costs" of the most appropriate and cost-effective form of transportation.

30 **Authorization with third-party liability.** Amends § 256B.0625, by adding subd. 25b. (a) Prohibits the commissioner from considering a request for authorization of a service when the recipient has third-party coverage, unless the provider has made a good faith effort to obtain payment or authorization from the third-party.

(b) States that a provider is not required to bill Medicare before requesting authorization from the commissioner, if the provider has reason to believe the service is not eligible for

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Medicare payment.

(c) Provides that authorization is not required if a third-party has made payment equal to or greater than 60 percent of the maximum payment allowed under MA.

31 **Augmentative and alternative communication systems.** Amends § 256B.0625, subd. 31a. Requires augmentative and alternative communication systems to be paid at the lower of: (1) the submitted charge; or (2) the manufacturer's suggested retail price minus 20 percent for providers that are manufacturers, or the manufacturer's invoice charge plus 20 percent for providers that are not manufacturers. (Under current law, payment is at the manufacturer's suggested retail price.)

32 **Payments for mental health services.** Amends § 256B.0625, subd. 38. Reduces payments for services provided by mental health professionals employed by community mental health centers from 100 to 80 percent of the rate paid to doctoral-prepared professionals.

33 **Payment for multiple services provided on the same day.** Amends § 256B.0625, by adding subd. 55. Requires the commissioner to allow payments for mental health or dental services, even if provided on the same day as other covered services furnished by the same provider.

34 **Medical care coordination.** Amends § 256B.0625, by adding subd. 55. (a) Provides MA coverage for in-reach community-based care coordination that is performed in a medical care facility as an eligible procedure under a state health care program or private insurance. States that this service includes navigating services to address mental health, chemical health, social, economic, and housing needs, and any other activity targeted at reducing emergency room and other nonmedically necessary health care utilization.

(b) Requires reimbursement to be made in 15-minute increments under Medicaid social work reimbursement methodology. Requires in-reach care coordinators to hold a minimum of a bachelor's degree in a specified field. Requires the commissioner to submit to the Centers for Medicare and Medicaid Services any waiver requests necessary to implement this subdivision.

(c) Defines "in-reach community-based care coordination" as the practice of a community-based worker meeting specified criteria working with an organization's staff to transition an individual back into the individual's living environment. Provides that this coordination includes working with an individual during discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

35 **Payment for Part B Medicare crossover claims.** Amends § 256B.0625, by adding subd. 57. Effective January 1, 2012, limits MA payment for an enrollee's Medicare Part B cost-sharing to an amount, when combined with Medicare payments, that does not exceed the MA rate.

36 **Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, by adding subd. 58. Limits MA payment amounts for EPSDT screening to the payment rate established in rule (75th percentile of charges) and in effect on October 1, 2010 (this has the

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effect of eliminating annual adjustments to the rate).

37 **Services provided by advanced dental therapists and dental therapists.** Amends § 256B.0625, by adding subd. 59. Provides MA coverage for services provided by advanced dental therapists and dental therapists, when provided within their scope of practice.

38 **Cost-sharing.** Amends § 256B.0631, subd. 1. Makes the following changes related to MA cost-sharing:

- reinstates certain co-payments (these had been reduced or eliminated by the legislature)
- requires a family deductible
- establishes tiered copayments for nonpreventive visits

39 **Exceptions.** Amends § 256B.0631, subd. 2. Makes a conforming change related to cost-sharing changes.

40 **Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to cost-sharing changes.

41 **Definitions.** Amends § 256B.0751, subd. 1. Allows mental health professionals, or chiropractors working in cooperation with a physician, physician assistant, or advanced practice nurse, to be personal clinicians in a health care home.

42 **Development and implementation of standards.** Amends § 256B.0751, subd. 2. Modifies criteria for health care homes. Changes include adding references to mental health professionals and chiropractors, requiring coordination between social, public health and other services, and adjusting various measures for socioeconomic factors.

43 **Requirements for clinicians certified as health care homes.** Amends § 256B.0751, subd. 3. Allows community mental health centers to be certified as health care homes. Makes conforming changes.

44 **Alternative models and waivers of requirements.** Amends § 256B.0751, subd. 4. A new paragraph (b) requires the commissioner of health to certify FQHCs and FQHC look-alikes as health care homes, without requiring all health care home standards to be met.

A new paragraph (c) allows the commissioner of health to waive health care home certification requirements if the applicant demonstrates that compliance will create a major financial hardship or is not feasible, and establishes an alternative method of meeting the objectives of the certification requirement.

45 **Coordination with local services.** Amends § 256B.0751, by adding subd. 8. Requires health care homes and counties to coordinate care and services for health care home enrollees with complex medical or socio-economic needs or a disability, who need or are eligible for waivered services, mental health services, or other local services.

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46 **Patient choice of health care home.** Amends § 256B.0751, by adding subd. 9. Allows the commissioner, subject to federal approval, to require state health care program enrollees to select a health care home from which to receive primary care and care coordination services, as a condition of program enrollment. Requires the enrollee to be allowed to choose from among all qualified providers, if the provider is certified as a health care home and agrees to accept the requirements for participation of the managed care plan, county-based purchasing plan, fee for service program, or demonstration project. Provides that reimbursement to FQHCs and FQHC look-alikes must be in compliance with federal law.

47 **Engagement of patients and communities in health care home.** Amends § 256B.0751, by adding subd. 10. Requires health care homes to demonstrate that their patients, and the racial and ethnic communities of patients, participate in evaluating the health care home and recommending improvements and changes to the home's methods and procedures, in order to improve health, quality, and patient satisfaction. Requires the commissioner to consult with racial and ethnic communities to identify whether health care home requirements limit the effectiveness of health care home services.

48 **Waiver recipients.** Amends § 256B.0753, by adding subd. 4. Requires health care homes to receive the highest level of care coordination payment for providing services to enrollees receiving home and community-based waiver services.

49 **Primary care provider tiering.** Amends § 256B.0754, by adding subd. 3. Requires the commissioner to establish a tiering system for Minnesota health care program providers, that differentiates providers based on the quality and cost-effectiveness of care and incorporates provider peer grouping measures. Requires payment rates to be adjusted on an annual basis. Classifies health care homes, rural health clinics, and FQHCs as high-performing providers under this subdivision. Provides an effective date of one year from the public release of peer grouping measures, or upon federal approval, whichever is later.

50 **Payment system.** Amends § 256B.0755, subd. 4. Requires the total cost of care benchmark for health care delivery system demonstration projects to be no greater than the capitation rate that would otherwise apply. Requires rate adjustments related to socioeconomic barriers and complexity.

51 **Coordination with local services.** Amends § 256B.0755, by adding subd. 8. Requires health care homes and counties to coordinate care and services for patients enrolled in a health care delivery system demonstration project with complex medical or socio-economic needs or a disability, who need or are eligible for waivered services, mental health services, or other local services.

52 **Rural demonstration projects.** Amends § 256B.0755, by adding subd. 8. Establishes requirements for health care delivery system projects serving rural areas. Requires consultation with local stakeholders, allows county public health or social services agencies or a county-based purchasing plan to establish a project, and requires the commissioner to approve only one project in rural areas where multiple projects are not possible.

53 **Patient choice of qualified provider.** Amends § 256B.0755, by adding subd. 9. Requires

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the commissioner to implement and approve health care delivery system demonstration projects in a manner that allows a patient to choose a primary care provider and health care home from among all qualified options. Requires the inclusion of essential community providers, if the ECP agrees to accept the requirements for participation in the demonstration project. Provides that reimbursement to FQHCs and FQHC look-alikes must be in compliance with federal law.

54 **Patient and community engagement.** Amends § 256B.0755, by adding subd. 10. Requires demonstration projects to demonstrate that consumers and communities to be served were consulted in project development. Also requires ongoing consultation.

55 **Care coordination system.** Amends § 256B.0755, by adding subd. 11. Requires the commissioner of human services, in consultation with the commissioner of health, to convene an advisory committee to advise the commissioner on establishing a system that will allow demonstration providers to effectively coordinate and deliver care. Requires the commissioner to contract with a vendor to establish and maintain the technology for the care coordination system. Requires planning, development, and establishment of the system to be funded through appropriations made for the purpose, and requires ongoing costs to be covered by payments from providers.

56 **Approval and implementation.** Amends § 256B.0755, by adding subd. 12. Requires the commissioner to approve delivery reform demonstration projects for MA and MinnesotaCare, to commence January 1, 2012. Allows approval of projects for fee-for-service and allows the commissioner to require managed care and county-based purchasing plans to contract with a demonstration project provider in the same manner as under fee-for-service.

57 **Hennepin and Ramsey counties pilot program.** Amends § 256B.0756. Requires this demonstration project to meet requirements that apply to delivery reform demonstration projects under section 256B.0755, subd. 8 to 11.

58 **Pregnancy care homes.** Adds § 256B.0758.

Subd. 1. Definitions. Defines terms.

Subd. 2. Development and implementation of standards. Requires the commissioners of human services and health to develop and implement certification standards for pregnancy care homes for state health care programs.

Subd. 3. Criteria for development of standards. Requires a pregnancy care home to meet certain health care home standards, and also the standards specified in this subdivision.

Subd. 4. Certification process. Allows certified providers to provide pregnancy care services through pregnancy care homes beginning July 1, 2012. Beginning July 1, 2014, requires all nonemergency pregnancy care services covered under state health care programs to be provided through pregnancy care homes.

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Subd. 5. Payments to pregnancy care homes. Requires the commissioner of human services, in coordination with the commissioner of health, to develop a payment system that provides a single per-person payment to cover all pregnancy services. Specifies other criteria for payments. Requires payments to be made beginning July 1, 2012, for services provided to pregnant women who are not high-risk, and requires payment beginning July 1, 2014, for both low-risk and high-risk pregnancies.

59 **Care coordination for enrollees.** Adds § 256B.0758.

Subd. 1. Qualified enrollee. Defines qualified enrollees as MA and MinnesotaCare enrollees.

Subd. 2. Selection of primary care provider. Directs the commissioner to require qualified enrollees without a designated medical condition to select a primary care provider and agree to receive primary care services from that provider as a condition of program participation.

Subd. 3. Selection of health care home; care coordination. Directs the commissioner to require qualified enrollees who have a medical condition designated by the commissioner to select a health care home, and agree to receive primary care and care coordination services through that provider as a condition of program participation. In order to receive payment from MA or MinnesotaCare for a non-emergency inpatient admission, requires hospitals to receive prior authorization from the enrollee's health care home.

Provides an effective date of January 1, 2012, for MinnesotaCare enrollees not eligible for a federal match, and January 1, 2012, or upon federal approval, whichever is later, for MA enrollees and MinnesotaCare enrollees eligible for a federal match.

60 **Elective surgery.** Adds § 256B.0759. Requires the commissioner to prohibit payment, beginning January 1, 2012, for elective or nonemergency surgical procedures for which less invasive and less costly alternative treatment methods are available, if these alternative methods have not been evaluated and provided to the enrollee if appropriate. Requires managed care plans to implement these prohibitions and reduces capitation rates to reflect cost-savings.

61 **Private benefits to be used first.** Amends § 256B.37, subd. 5. Provides that coverage provided through the U.S. Department of Veterans Affairs is primary to MA coverage.

62 **County authority.** Amends § 256B.69, subd. 3a. Requires the commissioner to involve county boards when issuing an RFP for health care delivery demonstration projects. Allows the county board to decide a maximum number of participating plans under PMAP or a health care delivery demonstration project. Requires the county board or the commissioner to select one or more qualified plans. If agreement cannot be reached on the selection of plans or demonstration projects, requires the commissioner to resolve disputes by approving the recommendations of a mediation panel. Provides that this section also applies to

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MinnesotaCare.

63 **Limitation of choice.** Amends § 256B.69, subd. 4. Requires the commissioner to assign individuals who do not choose a managed care plan to the county-based purchasing plan, if any, in the county of residence of the individual.

64 **Managed care contracts.** Amends § 256B.69, subd. 5a. Effective January 1, 2012, requires the commissioner to include as a performance target a reduction in a plan's rate subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.

65 **Medical education and research fund.** Amends § 256B.69, subd. 5c. Beginning in FY 2012, requires the commissioner to reduce the amount transferred from PMAP payments to the medical education research fund by $6,404,000.

66 **Risk corridor.** Amends § 256B.69, by adding subd. 51. Requires the commissioner to consider implementing, beginning January 1, 2012, a risk corridor payment system. Specifies criteria for the system.

67 **Service delivery.** Amends § 256B.69, subd. 6. Requires a managed care or county-based purchasing plan to accept into its MA and MinnesotaCare networks any health care or social service provider that agrees to the terms applicable to similarly situated providers.

68 **Provider payment rates.** Amends § 256B.69, by adding subd. 30. Requires managed care and county-based purchasing plans to implement progressive payment withhold methodologies, based upon a provider's risk adjusted total annual cost of care, relative to other providers of the same type. Requires each plan to establish a benchmark percentile for the return of the withhold that allows it to adjust provider payments to reflect the reduction in capitation rates. Requires the commissioner to reduce capitation rates by 10 percent, for the contract year beginning January 1, 2012, and allows additional reductions in future years.

69 **Initiatives to reduce incidence of low birth weight.** Amends § 256B.69, by adding subd. 30. Requires managed care and county-based purchasing plans to implement strategies to reduce the incidence of low-birth weight in geographic areas with a higher than average incidence of low-birth weight. Specifies criteria for initiatives and requires implementation by July 1, 2012. Requires the commissioner to evaluate the strategies.

70 **Health education.** Amends § 256B.69, by adding subd. 31. Directs the commissioner to require managed care and county-based purchasing plans to provide health education, wellness training, and information about the availability and benefits of preventive services to all MA and MinnesotaCare enrollees, beginning January 1, 2012.

71 **Duties of commissioner of health.** Amends § 256B.692, subd. 2. Allows a county-based purchasing plan to satisfy its fiscal solvency requirements by obtaining written financial guarantees from participating counties.

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72 **County proposals.** Amends § 256B.692, subd. 5. Eliminates the requirement that county boards submit preliminary proposals 15 months prior to the termination of health plan contracts to implement county-based purchasing.

73 **Dispute resolution.** Amends § 256B.692, subd. 7. In cases where the commissioner rejects a proposal for county-based purchasing, allows the county board to request a decision by a three-person mediation panel, and requires the commissioner to follow the decision of the panel.

74 **Patient choice of qualified provider.** Amends § 256B.692, by adding subd. 11. Effective January 1, 2012, requires county boards operating a county-based purchasing plan to ensure that each enrollee has the option of choosing a primary care provider or health care home from all qualified providers, who agrees to the terms, conditions, and payment rates offered by the plan to similarly situated providers. Requires FQHCs and FHQC look-alikes to be reimbursed as required under federal law.

75 **Sole-source or single-plan managed care contract.** Amends § 256B.694. Requires the commissioner, at the request of a county or group of counties, to approve contracting on a single-plan basis to serve Minnesota health care program enrollees. (Under current law, the commissioner is required to consider requests to serve persons with a disability.)

76 **Critical access dental providers.** Amends § 256B.76, subd. 4. Eliminates critical access dental provider eligibility for a dental clinic "associated with an oral health or dental education program" operated by the University of Minnesota or MNSCU, and requires a dental clinic to be owned and operated by these entities in order to qualify as a critical access dental provider.

77 **Patient-centered decision-making.** Adds § 256B.7671. (a) Effective January 1, 2012, requires the commissioner to require active participation in a patient-centered decision-making process before authorization is approved or payment made for specific procedures.

(b) Requires the list of procedures to be published in the State Register and reviewed at least every two years.

(c) Requires health care providers to certify that a patient has participated in a patient-centered decision-making process, and requires the format and process to be developed by the Health Services Policy Committee.

(d) Defines "patient-centered decision-making process."

(e) States that this section does not apply in emergency situations.

78 **Complementary and alternative medicine demonstration project.** Adds § 256B.771. Requires the commissioner of human services, in consultation with the commissioner of health, to contract with a Minnesota-based academic and research institution specializing in complementary and alternative medicine to implement a demonstration project to improve the care provided to MA enrollees with neck and back problems. The project must be conducted with FQHCs and FQHC look-alikes. Requires the project to be implemented

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beginning July 1, 2011, or upon federal approval, whichever is later.

79 Waiver application and process. Adds § 256B.841.

Subd. 1. Intent. Provides an intent statement.

Subd. 2. Waiver application. Requires the commissioner to apply for a waiver and any necessary state plan amendments that provides program flexibility and under which Minnesota will operate its MA program. Requires the commissioner to provide the relevant legislative committees with the waiver application and related materials. If the waiver application is approved, requires the commissioner to notify legislative chairs, allow review by legislative committees, and not implement the waiver until ten legislative days have passed following notification.

Subd. 3. Rulemaking; legislative proposals. Upon acceptance of the waiver, requires the commissioner to adopt rules and to propose any legislative changes needed to implement the waiver.

Subd. 4. Joint commission on waiver implementation. Requires the governor to establish a joint commission on waiver implementation. Specifies membership and duties.

80 Principles and goals for medical assistance reform. Adds § 256B.842.

Subd. 1. Goals for reform. Requires the commissioner to ensure that the reformed MA program is a person-centered, financially sustainable, and cost-effective program.

Subd. 2. Reformed medical assistance criteria. Establishes criteria for the reformed program.

Subd. 3. Annual report. Requires the commissioner to report annually to the governor and the legislature on the status of the administration and implementation of the waiver.

81 Waiver application requirements. Adds § 256B.843.

Subd. 1. Requirements for waiver request. Requires the commissioner to seek federal approval to enter into a five-year agreement with the federal government under section 1115a to waive specific provisions of Medicaid law, including but not limited to statewideness, comparability of services, and freedom of choice of providers. Also requires the commissioner to seek a waiver of Medicaid law provisions, in order to expand cost-sharing, establish health savings or power accounts, provide enrollees with a choice of appropriate private sector coverage, consolidate waivered services, and implement other specified initiatives.

Subd. 2. Agency coordination. Requires the commissioner to establish an intraagency assessment and coordination unit.

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82 **Gross individual or gross family income.** Amends § 256L.01, subd. 4a. Makes conforming changes to the reduction in the MinnesotaCare eligibility period from 12 to six months.

83 **Financial management.** Amends § 256L.02, subd. 3. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

84 **Financial management.** Amends § 256L.02, subd. 3. Makes a conforming change related to elimination of the Legislative Commission on Health Care Access.

85 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

86 **Cost-sharing.** Amends § 256L.03, subd. 5. Requires MinnesotaCare enrollees to pay a family deductible. Effective January 1, 2012, establishes tiered copayments for nonpreventive visits.

Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

87 **Healthy Minnesota contribution program.** Adds § 256L.031.

Subd. 1. Defined contribution to enrollees. (a) Requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are adults without children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan. Requires the commissioner, beginning January 1, 2012, or upon federal approval, whichever is later, to provide MinnesotaCare enrollees who are families and children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan.

(b) Exempts these enrollees from MinnesotaCare premiums, and required enrollment in a managed care or county-based purchasing plan.

(c) Provides that the provisions related to MinnesotaCare covered services and cost-sharing (§ 256L.03), the effective date of coverage (§ 256L.05, subd. 3), and provider payment rates (§ 256L.11) do not apply to these enrollees. Covered services, cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage are as provided by the terms of the health plan purchased by the enrollee.

(d) States that all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply, unless otherwise provided in this section.

Subd. 2. Use of defined contribution. Allows enrollees to use up to the monthly

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defined contribution only to pay premiums for coverage under a health plan.

Subd. 3. Determination of defined contribution amount. (a) Requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per-person defined contribution is a function of age and income. Specifies the monthly per-person base contribution for age groups, ranging from $122.79 for persons under age 21 to $357.19 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 150 to 80 percent, to obtain the monthly per-person defined contribution amount.

(b) Requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through the Minnesota Comprehensive Health Association (MCHA).

(c) Limits the monthly defined contribution to 90 percent of the maximum monthly premium for the health plan purchased by the enrollee. Reduces the monthly defined contribution amount by five percent if the enrollee purchases coverage that does not include mental health services and chemical dependency treatment services.

Subd. 4. Administration by commissioner. Requires the commissioner to administer the defined contributions, by calculating and processing defined contributions for enrollees and paying the defined contribution to health plan companies or MCHA, as applicable.

Subd. 5. Assistance to enrollees. Requires the commissioner of human services, in consultation with the commissioner of commerce, to develop an efficient and cost-effective method to refer applicants to professional insurance agent associations.

Subd. 6. MCHA. Beginning July 1, 2012, makes MinnesotaCare enrollees who are denied coverage under an individual health plan eligible for coverage under MCHA. Requires incremental costs to MCHA resulting from implementation of this act to be paid from the health care access fund.

Subd. 7. Federal approval. Requires the commissioner to seek all federal approvals and waivers necessary to implement coverage for enrollees eligible as families and children, with gross family incomes equal to or greater than 133 percent of FPG, while continuing to receive federal funds.

88 **Families with children.** Amends § 256L.04, subd. 1. Reduces the MinnesotaCare income limit for adults in families with children from 275 percent to 200 percent of the federal poverty guidelines. This reduction in the income limit is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. Also eliminates an exemption from the program income limit for certain children who transition from MA to MinnesotaCare (other provisions related to this transition group are repealed in this article; federal approval for this transition has not yet been obtained).

The elimination of the exemption from the income limit is effective retroactively to October

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1, 2008.

89 **Single adults and households with no children.** Reduces the MinnesotaCare income limit for adults without children from 250 percent to 200 percent of the federal poverty guidelines. This provision is effective January 1, 2012, and expires June 30, 2013.

90 **Commissioner's duties.** Amends § 256L.05, subd. 2. Reinstates language repealed in a previous session that requires the commissioner to verify both earned and unearned income for MinnesotaCare enrollees, and verify eligibility for employer-subsidized insurance.

91 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed every six months. (Under current law, eligibility must be renewed every 12 months.)

92 **Availability of private insurance.** Amends § 256L.05, subd. 5. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

93 **Referral of veterans.** Amends § 256L.05, by adding subd. 6. Requires the commissioner to ensure that all MinnesotaCare applicants with incomes less than 133 percent of FPG, who identify themselves as veterans, are referred to a county veterans service officer for assistance in applying to the U.S. Department of Veterans Affairs for any VA benefits for which they are eligible.

94 **General requirements.** Amends § 256L.07, subd. 1. Reinstates in law the $50,000 income limit for parents under MinnesotaCare (the increase to $57,500 has not yet been approved by the federal government). Also makes conforming changes related to the establishment of a six-month renewal period, and the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

95 **General requirements.** Amends § 256L.07, subd. 1. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.

96 **Eligibility as Minnesota resident.** Amends § 256L.09, subd. 4. Reinstates language repealed in a previous session that requires MinnesotaCare enrollees to maintain a residence at a verified address "other than a place of public accommodation."

97 **Critical access dental providers.** Amends § 256L.11, subd. 7. Reduces MinnesotaCare payments to critical access dental providers from 50 percent to 30 percent above the regular payment rate, effective July 1, 2011.

98 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. Effective January 1, 2012, requires the commissioner to include as a performance target under MinnesotaCare a reduction in a plan's rate of subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue until the plan's subsequent

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hospitalization rate is reduced by 25 percent.

99 **Payment options.** Amends § 256L.15, subd. 1a. Requires the commissioner to include information about MinnesotaCare premium payment options on each premium notice.

100 **Administrative costs.** Amends Laws 2008, chapter 63, article 18, section 3, subd. 5. Reduces the aggregate administrative cost limit for managed care and county-based purchasing plans from 6.6 to 6.1 percent of total contract payments.

101 **Plan to coordinate care for children with high-cost mental health conditions.** Requires the commissioner of human services to submit to the legislature, by December 15, 2011, a plan to provide care coordination to MA and MinnesotaCare enrollees who are children with high-cost mental health conditions.

102 **Data on claims and utilization.** Requires the commissioner of human services to develop and provide to the legislature, by December 15, 2011, a methodology and draft legislation necessary to allow the release, upon request, of summary data on claims and utilization for state health care programs to research institutions, to conduct analyses of health care outcomes and treatment effectiveness.

103 **Reduction of state mandated reports.** (a) Requires the commissioner of management and budget to convene a report reduction working group. Requires the commissioner and the working group to develop a plan for report reduction.

(b) Requires the commissioners of health, human services, and commerce to reduce, eliminate, or consolidate state-mandated reports according to the plan. Specifies other duties for the commissioners related to report reduction.

(c) Requires the commissioner of management and budget, by January 15, 2012, to report to legislative chairs and ranking minority members on the activities and results of the report reduction project.

104 **Competitive bidding pilot.** Requires the commissioner of human services, for managed care contracts effective January 1, 2012, to establish a competitive price bidding pilot for nonelderly, nondisabled adults and children in MA and MinnesotaCare in the seven-county metropolitan area. Requires a minimum of two managed care organizations to serve the metropolitan area. Provides that the pilot expires after two full calendar years, on December 31, 2013. Requires the commissioner to evaluate the pilot to determine cost-effectiveness and impacts on access to providers.

105 **Request for proposal; provider billing patterns.** Requires the commissioner of human services to issue a request for proposal to identify abnormal provider billing patterns. Requires the commissioner to enter into a contract by October 1, 2011.

106 **Health services policy committee studies.** (a) Requires the commissioner of human services, through the health services policy committee, to develop a process to limit payment to health professionals for services for which they are not trained to deliver in a high-quality manner. Requires the commissioner to report to the legislature by January 15, 2012.

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(b) Requires the commissioner of human services, through the health services policy committee, to study the effectiveness of new strategies for wound care treatment, and report to the legislature by December 15, 2011.

107 **Specialized maintenance therapy.** Requires the commissioner of human services to evaluate whether providing MA coverage for specialized maintenance therapy will reduce rates of hospitalization for enrollees with serious and persistent mental illness. Requires a report to the legislature by December 15, 2011.

108 **Coverage for lower-income MinnesotaCare enrollees.** Requires the commissioner of human services to develop and present to the legislature, by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees who are adults without children or families and children, with incomes less than 133 percent of FPG. Specifies plan criteria and requires the commissioner to consider innovative methods of service delivery, including but not limited to increasing the use and choice of private health plan coverage and encouraging the use of community clinics as health care homes.

109 **Direction to commissioner; federal waivers.** (a) Requires the commissioner of human services to apply to the Centers for Medicare and Medicaid Services, by July 1, 2011, for federal waivers to cover: (1) MinnesotaCare families and children; and (2) MinnesotaCare parents, guardians and caretakers, under the Healthy Minnesota Contribution Program. Requires the commissioner to report to the relevant legislative committees whether or not the waiver application is accepted, within ten working days of the decision. Provides an immediate effective date.

(b) Requires the commissioner of human services to apply to CMS for a demonstration waiver and any other necessary waivers and amendments that would provide the state with medical assistance program flexibility in exchange for federal budget certainty. Requires the commissioner to seek federal approval to enter into an agreement with CMS under which Minnesota would accept an aggregate annual allotment for MA, trended forward and with protections to cover medical inflation and projected caseload growth, and receive federal waivers of specified medical assistance program requirements.

Provides an immediate effective date.

110 **Enrolled provider networks.** Adds § 256B.0758.

Subd. 1. Review by commissioner. Requires the commissioner of human services to review the feasibility of implementing the reformed health care system described in subdivisions 2 to 9. Requires the commissioner to present recommendations to the legislature by December 15, 2011, on whether the system should be implemented, and allows recommendations to include modifications to the criteria and requirements of subdivisions 2 to 9.

Subd. 2. Definitions. Defines the following terms: demonstration provider, enrolled provider network, health plan company, metropolitan statistical area, and qualified enrollee. An "enrolled provider network" (EPN) means a health care

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provider, group of providers, or a partnership between a health care provider and a demonstration provider, accountable through a contract with the commissioner for the quality, coordination, and management of the cost of care provided to qualified enrollees. "Qualified individuals" are defined as MA enrollees who are families and children or adults without children, and MinnesotaCare enrollees.

Subd. 3. Establishment of reformed health care delivery system. (a) Requires the commissioner to implement, upon federal approval, a reformed health care delivery system under which qualified enrollees receive basic health care services through EPNs in MSAs, supplemented with coverage for non-basic care services. Provides that health care providers outside of an MSA may serve as an EPN.

(b) Requires the commissioner, upon federal approval, to discontinue MA and MinnesotaCare managed care contracts for qualified enrollees within an MSA.

Subd. 4. Provision of basic care services through enrolled provider networks. (a) Requires the commissioner to contract with EPNs in MSAs, and allows the commissioner to enter contracts with EPNs outside of an MSA, to provide basic care services in return for a per-enrollee, concurrently risk-adjusted, total cost of care payment.

(b) Specifies the basic are services that must be provided by an EPN.

(c) Allows an EPN to provide services beyond those listed in paragraph (b).

(d) States that there is not cost-sharing for basic care services.

(e) Requires an EPN to coordinate basic care services with non-basic care services.

(f) Allows an EPN to contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services.

(g) If an EPN does not enter into a contract to administer basic care services, requires the commissioner, by competitive bid, to contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services by EPNs and non-basic care services.

(h) Specifies requirements for the administrator.

(i) Requires the commissioner to report annually to the legislature on delivery of services through EPNs.

Subd. 5. Enrollee selection of enrolled provider network. (a) Requires a qualified enrollee in an MSA to select an EPN in order to receive covered services. Allows the commissioner to assign enrollees who do not make a choice to an EPN. Requires an enrollee to agree to receive all nonemergency covered services through the EPN, except for non-basic care services.

(b) Allows enrollees to appeal to the commissioner, using the state agency hearing

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process.

Subd. 6. Non-MSA providers. Requires the commissioner to consider payment mechanisms to achieve cost-savings.

Subd. 7. Non-basic care coverage. (a) Specifies non-basic care services.

(b) Allows an EPN to contract for the coverage and coordination of non-basic care services.

(c) States that no cost-sharing applies to coverage under the major medical policy.

(d) Allows the commissioner to require an EPN to enter into a risk/gain sharing agreement, under which the EPN is financially responsible for a portion of the risk-adjusted non-basic care costs incurred by qualified enrollees.

Subd. 8. Premiums. (a) Requires MinnesotaCare enrollees to pay the standard Minnesota Care sliding scale premium.

(b) Requires MA enrollees to pay premiums based on the MinnesotaCare sliding scale.

Subd. 9. Federal approval. Requires the commissioner to seek any necessary federal waivers and approvals necessary to implement this section.

Subd. 10. Approval required for implementation. Provides that subdivisions 2 to 9 shall be implemented only upon legislative approval.

111 Repealer.

(a) Repeals § 256.01, subd. 2b (pay-for-performance system for medical groups and clinics), effective July 1, 2011.

(b) Repeals § 62J.07, subds. 1, 2, and 3 (Legislative Commission on Health Care Access).

(c) Repeals an exemption for low-income children from the MinnesotaCare employer-subsidized insurance insurance barrier (see § 256L.07 subd. 2; this provision has not yet been approved by the federal government).

(d) Repeals an exemption for low-income children from the Minnesota four-month uninsured requirement (see § 256L.07, subd. 3; this provision has not yet been approved by the federal government).

(e) Repeals an exemption for low-income children from MinnesotaCare premiums (see § 256L.15, subd. 2; this provision has not yet been approved by the federal government).

(f) Repeals § 256L.07, subd. 7 (exemption of certain children transitioned from MA from MinnesotaCare insurance barriers) retroactively from October 1, 2008 (this provision has not yet been approved by the federal government).

(g) Repeals an exemption for certain children transitioned from MA from MinnesotaCare

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income limits (see § 256L.04, subd. 1) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government).

(h) Repeals a provision allowing children with incomes over 275 percent of FPG to remain on the program (see § 256L.04, subd. 1b) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government).

(i) Repeals a provision requiring a streamlined application and enrollment process for MA and MinnesotaCare enrollees (see § 256L.05, subd. 1c) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).

(j) Repeals a provision providing automatic MinnesotaCare eligibility for certain children from foster care and juvenile correctional facilities (see § 256L.07, subd. 8) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).

(k) Repeals a conforming change related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.04, subd. 7a).

(l) Repeals language establishing the effective date of coverage for children from foster care and juvenile correctional facilities (see § 256L.05, subd. 3).

(m) Repeals a provision that provides continued eligibility under MinnesotaCare for children who fail to submit renewal information in a timely manner (see § 256L.05, subd 3a) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).

(n) Repeals language related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.07, subd. 1; this provision has not yet been approved by the federal government).

(o) Repeals an exemption for low-income children from the MinnesotaCare employer-subsidized insurance insurance barrier (see § 256L.07, subd. 2; this provision has not yet been approved by the federal government).

(p) Repeals an exemption for low-income children from the MinnesotaCare four-month uninsured requirement (see § 256L.07, subd. 3; this provision has not yet been approved by the federal government).

(q) Repeals an exemption for low-income children from MinnesotaCare premiums (see § 256L.15, subd. 2; this provision has not yet been approved by the federal government).

(r) Repeals a provision exempting low-income children from MinnesotaCare premiums (see § 256L.15; this provision has not yet been approved by the federal government).

(s) Repeals a provision requiring the commissioner of human services to request approval from the federal government to eliminate the add-back of depreciation when determining income eligibility under MinnesotaCare for self-employed farmers (uncodified section; this

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request has not yet been approved by the federal government).

(t) Repeals § 256B.057, subdivision 2c (extended MA coverage for certain children; this provision has not yet been approved by the federal government).

(u) Repeals provisions providing MinnesotaCare enrollees with a renewal rolling month and a premium grace month (these provisions have not yet been approved by the federal government).

Article 7: Continuing Care

Overview

Article 7 makes changes to continuing care programs including case management, self-directed supports option for elderly and disabled individuals, MA home- and community-based waivers, nursing facility reimbursement, ICF/MR reimbursement, and PCA services; requires the commissioner to submit certain state plan amendments and home- and community-based waiver amendments; and requires a report on the redesign of case management services.

1 **Exclusion from licensure.** Amends § 245A.03, subd. 2. Excludes from human services licensing residential facilities that are federally certified as ICFs/MR.

2 **Contribution amount.** Amends § 252.27, subd. 2a. Makes TEFRA parental fee temporary increases made in 2010 permanent.

3 **Exceptions.** Amends § 252.291, subd. 2. Modifies the ICF/MR moratorium by allowing for larger facilities.

4 **Disability linkage line.** Amends § 256.01, subd. 24. Modifies the requirements of the disability linkage line. Makes this section effective July 1, 2011.

5 **State medical review team.** Amends § 256.01, subd. 29. Removes a cross-reference. Makes this section effective July 1, 2011.

6 **Case management temporary stay of demission.** Amends § 256.045, subd. 4a. Modifies administrative appeals language related to case management services. Makes this section effective January 1, 2012.

7 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Removes obsolete language, corrects an internal reference, and makes this section effective January 1, 2014.

8 **Spenddown adjustments.** Amends § 256B.056, by adding subd. 5d. Specifies when income adjustments must be made for persons on MA who are institutionalized.

9 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Makes technical changes reorganizing the language in this subdivision. Removes obsolete language.

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Excludes spousal assets for purposes of determining eligibility for MA-EPD. Increases the MA-EPD premium and increases the amount of unearned income that must be paid in addition to the premium. Requires the commissioner to reimburse enrollees with incomes below 200 percent of the federal poverty guidelines for Medicare Part B premiums. Makes this section effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

10 **Self-directed supports option.** Amends § 256B.0657.

Subd. 1. Definitions. Adds definitions for "lead agency," "legal representative," and "managing partner."

Subd. 2. Eligibility. Allows persons on the MA waivers for elderly and disabled persons and persons on the alternative care program to use the self-directed supports option.

Subd. 3. Eligibility for other services. Modifies who is not eligible for funding under the self-directed supports option.

Subd. 4. Assessment requirements. Modifies the requirements of the self-directed supports option assessment. Specifies that the person's annual self-directed supports option budget amount must be provided within 40 days after the personal care assessment or reassessment, or within 10 days after a request not related to an assessment. Requires the lead agency responsible for administration of the home- and community-based waivers and alternative care to provide annual and monthly self-directed services budget amounts for all eligible persons within 40 days after an initial assessment or annual review and within 10 days if requested at a time unrelated to the assessment or annual review.

Subd. 5. Self-directed supports option plan requirements. Modifies the requirements the plan for the self-directed supports option must meet. Modifies the commissioner's duties related to the self-directed supports option.

Subd. 6. Services covered. Adds services under the home- and community-based waivers, except those provided in licensed or registered settings, to the list of covered services under the self-directed supports option.

Subd. 7. Noncovered services. Modifies noncovered services under the self-directed supports option.

Subd. 8. Self-directed budget requirements. Specifies the manner in which self-directed supports budgets must be established for persons eligible for PCA services and for home- and community-based waivers and alternative care.

Subd. 9. Quality assurance and risk management. Requires the commissioner to provide certain assistance and materials to families and recipients selecting the self-directed option, including information on the quality assurance efforts and activities of region 10.

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Subd. 10. Fiscal support entity. Adds references to legal representatives and managing partners of recipients.

Subd. 11. Stakeholder consultation. Makes technical changes, requires the commissioner to seek recommendations from a stakeholder group in monitoring, evaluating, and modifying various elements of the self-directed supports option.

Subd. 12. Enrollment and evaluation. Modifies maximum enrollment for the self-directed supports option, makes the option available statewide, and makes this section effective July 1, 2012.

11 **Personal care assistance services; covered services.** Amends § 256B.0659, subd. 2. Adds rehabilitation services to the list of covered services under the PCA program.

12 **Personal care assistant; requirements.** Amends § 256B.0659, subd. 11. Limits payment to PCAs who are providing services to a relative.

13 **Home and community-based attendant services and supports.** Creates § 256B.0661.

Subd. 1. Definitions. Defines "activities of daily living," "extended home and community-based attendant services and supports," "health-related tasks," "home and community-based attendant services and supports," "individual's representative," "instrumental activities of daily living," "legal representative," and "qualified professional."

Subd. 2. Eligibility. Establishes eligibility requirements for the home- and community-based attendant services and supports option.

Subd. 3. Eligibility for other services. Specifies that selection of this option by a recipient does not restrict access to other medically necessary care and services provided under the state plan MA benefit or through other funding, with certain exceptions.

Subd. 4. Assessment requirements. Specifies the requirements the home- and community-based attendant services and supports assessment must meet. Requires the lead agency responsible for the implementation of this option to provide the annual and monthly self-directed service budget amounts for all eligible persons within 40 days after an initial assessment or annual review and within 10 days if requested at a time unrelated to the assessment or annual review.

Subd. 5. Service plan requirements. Specifies the requirements for the plan for home- and community-based attendant services and supports option.

Subd. 6. Covered services. Lists the covered services under the home and community-based attendant services and supports option. Specifies that services and supports purchased must be linked to an assessed need or goal established in the individual's person-centered service plan. Specifies the requirements shared services must meet.

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Subd. 7. Noncovered services. Lists the noncovered services under the home- and community-based attendant services and supports option.

Subd. 8. Service budget requirements. Requires the budget allocation under this option to be based on the budget amount allowed under the assessment for PCA services.

Subd. 9. Staff and qualified professional requirements. Requires home- and community-based attendants to meet the same requirements as a PCA. Requires a qualified professional to meet the same requirements as qualified professionals under the PCA program.

Subd. 10. Requirements for initial enrollment; annual reenrollment; enrollment after termination. Requires all home- and community-based attendant services and supports option provider agencies to meet the same requirements for initial enrollment, annual reenrollment, and enrollment after termination as provider agencies for PCA services.

Subd. 11. General duties of provider agencies. Requires home- and community-based attendant services and supports option provider agencies to meet the same general duties, background study requirements, prevention of communicable diseases, training requirements, and documentation requirements as PCA provider agencies.

Subd. 12. Stakeholder development and implementation council. Requires the commissioner to establish and consult with a stakeholder development and implementation council. Specifies the membership and duties of the council.

Subd. 13. Quality assurance and risk management. Paragraph (a) requires the commissioner to establish quality assurance and risk management measures for this option.

Paragraph (b) requires the commissioner to provide ongoing technical assistance and resource education and materials for recipients and their legal representatives and other involved parties.

Paragraph (c) requires performance assessment measures and other outcome data to be identified in consultation with the stakeholder council.

Subd. 14. Self-directed home and community-based services and supports. Specifies that this option includes the option for self-directed services.

Makes this section effective July 1, 2011.

14 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services." Makes this section effective January 1, 2012.

15 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Modifies the timeline for the long-term care consultation team to visit a person requesting services. For persons

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determined eligible for specified services, requires the community support plan to include the estimated annual and monthly budget amount for those services. Allows updated assessments to be completed by face-to-face visit, written communication, or telephone. Makes this section effective January 1, 2012.

16 **Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, subd. 4a. Modifies determination of nursing facility level of need to conform to federal maintenance of effort requirements.

17 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Modifies payment for long-term care consultation services. Allows counties to set a fee schedule for initial assessments and support plan development for individuals who are not financially eligible for MA or MinnesotaCare. Limits the maximum fee to no greater than the actual cost of the initial assessment and support plan development.

18 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.13, subd. 4. Modifies eligibility criteria for alternative care to conform to federal maintenance of effort requirements. Makes eligibility changes for individuals assigned a case mix classification A and reduces the monthly budget cap for these individuals.

19 **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Removes an automatic annual adjustment to EW monthly case mix caps related to nursing facility payment rates. Makes eligibility changes for individuals assigned a case mix classification A and reduces the monthly budget cap for these individuals.

20 **Cost limits for elderly waiver applicants who reside in a nursing facility.** Amends § 256B.0915, subd. 3b. Removes an automatic annual adjustment to EW monthly case mix caps related to nursing facility payment rates. Modifies the monthly conversion budget limit calculation.

21 **Customized living service rate.** Amends § 256B.0915, subd. 3e. Reduces the individualized monthly payment for customized living for low-needs individuals. Requires the new rate limit to be applied to all new applicants enrolled in the program on or after July 1, 2011, and to all other participants at reassessment. Requires licensed home care providers that do not participate in or accept Medicare assignment to refer and document the referral of dual-eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment. Prohibits providers from billing or otherwise charging an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits, nor for additional units of any allowable component services beyond those approved in the service plan by the lead agency.

22 **Service rate limits; 24-hour customized living services.** Amends § 256B.0915, subd. 3h. Increases the criteria for 24-hour customized living. Prohibits providers from billing or otherwise charging an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits, nor for additional units of any allowable component services beyond those approved in the service

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plan by the lead agency.

23 **Assessments and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Modifies determination of nursing facility level of need to conform to federal maintenance of effort requirements.

24 **Waiver payment rates; managed care organizations.** Amends § 256B.0915, subd. 10. Removes obsolete language. Prohibits MA rates paid to customized living providers by managed care organizations from exceeding the maximum component rates.

25 **Statewide availability of self-directed support services.** Amends § 256B.0916, subd. 6a. Paragraph (a) makes technical changes.

Paragraph (b) makes technical changes and specifies that this paragraph is in effect until a waiver amendment is effective.

Paragraph (c) makes technical changes.

Makes this section effective July 1, 2011.

26 **Case management services.** Amends § 256B.092, subd. 1a. Paragraph (a) removes language related to the administrative functions of case management. Specifies who will provide case management services. Specifies that case management services cannot be provided to a recipient by a private agency that has any financial interest in the provisions of any other services included in the recipient's coordinated service and support plan.

Paragraph (b) specifies who is eligible to receive case management services and what activities are included in case management services.

Paragraph (c) modifies who may provide case management services to a person with developmental disabilities.

Paragraph (d) removes language making case managers responsible for the administrative and service provisions listed in paragraphs (a) and (b).

Paragraph (f) prohibits case management for persons eligible for home- and community-based waivers from being billed as targeted case management.

Paragraph (g) allows persons to choose a case management service provider from among the public or private vendors enrolled.

Makes this section effective January 1, 2012.

27 **Coordinated service and support plan.** Amends § 256B.092, subd. 1b. Requires each recipient of case management services and any legal representative to be provided a written copy of the coordinated service and support plan and specifies requirements of the plans. Makes this section effective January 1, 2012.

28 **Case management service monitoring, coordination, and evaluation duties.** Amends § 256B.092, subd. 1e. Requires the case management service provider to assure that individual

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provider plans are developed by the providers when a need for the plans is identified in the coordinated service and support plan. Specifies the requirements the provider plans must meet. Makes technical changes. Makes this section effective January 1, 2012.

29 **Conditions not requiring development of a coordinated service and support plan.** Amends § 256B.092, subd. 1g. Makes conforming changes related to the re-naming of the plan. Makes this section effective January 1, 2012.

30 **Authorization and termination of services.** Amends § 256B.092, subd. 3. Makes technical and conforming changes. Makes this section effective January 1, 2012.

31 **Additional certified assessor duties.** Amends § 256B.092, subd. 8. Makes technical and conforming changes related to changes in terminology. Requires the certified assessor to provide written notice of the annual and monthly amount authorized to be spent for services for the recipient. Makes this section effective January 1, 2012.

32 **County notification.** Amends § 256B.092, subd. 8a. Modifies the procedure by which a county of financial responsibility places a person in another county for services. Makes this section effective July 1, 2011.

33 **Obligation of local agency to process medical assistance applications within established timelines.** Amends § 256B.19, by adding subd. 2d. Establishes timelines for counties to determine an applicant's eligibility for MA and mail a notice of its decision to the applicant. Makes the county responsible for the entire cost of MA services provided to an applicant by a nursing facility and not paid for by federal funds if a county fails to comply with the timelines in this subdivision and a person is ultimately found to be eligible for MA.

34 **Payment restrictions on leave days.** Amends § 256B.431, subd. 2r. Limits payments for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident and allows this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent.

35 **Property rate increase for a facility in Bloomington effective November 1, 2010.** Amends § 256B.431, by adding subd. 44. Requires money available for nursing facility moratorium projects to be used, effective November 1, 2010, to fund an approved moratorium exception project for a specific nursing facility in Bloomington up to a total property rate adjustment of $19.33.

36 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Suspends automatic property rate adjustments for the rate years beginning on October 1, 2011, and October 1, 2012.

37 **Planned closure rate adjustment.** Amends § 256B.437, subd. 6. Prohibits the commissioner from approving planned closure rate adjustments as of July 16, 2011.

38 **Rate increase for low-rate facilities.** Amends § 256B.441, by adding subd. 60. Paragraph (a) requires the commissioner to adjust operating payment rates, effective October 1, 2011, for nursing facilities whose operating payment rate on September 30, 2011, is greater than

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the 95th percentile of all nursing facility operating payment rates. Specifies how the commissioner shall determine the facilities with rates greater than the 95th percentile and how to reduce their rates.

Paragraph (b) specifies how the commissioner will compute the amount to be saved by the reductions.

Paragraph (c) distributes the amount reduced under paragraph (b) to facilities with the lowest DDF operating payment rates. Specifies how the commissioner will distribute the funds.

39 **Rate reduction for low-need residents.** Amends § 256B.441, by adding subd. 61. Beginning July 1, 2011, reduces operating payment rates for low-need residents and specifies how these rates must be reduced. Prohibits any operating payment rate increases from resulting under this provision.

40 **Prohibited practices.** Amends § 256B.48, subd. 1. Makes the nursing facility rate equalization provision expire on July 1, 2011.

41 **Definitions.** Amends § 256B.49, by adding subd. 10a. Defines the terms "comprehensive transitional service plan," "functional milestone," "fundamental service outcome," "natural community supports," "short-term service outcome," and "transitional service planning team."

42 **Informed choice.** Amends § 256B.49, subd. 12. Removes a cross-reference. This is related to nursing facility level of need determinations and federal maintenance of effort requirements.

43 **Case management.** Amends § 256B.49, subd. 13. Modifies how case management services are provided to recipients of the CAC, CADI, and TBI home- and community-based waivers. Aligns case management services for these recipients with case management services for recipients of the DD waiver. Makes this section effective January 1, 2012.

44 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Adds a cross-reference to assessments under long-term care consultation services. Requires the commissioner to develop criteria to identify individuals whose level of functioning is reasonably expected to improve and reassess these individuals every six months. Requires individuals who meet the commissioner's criteria to have a comprehensive transitional service plan developed. Makes counties, case managers, and service providers responsible for conducting these reassessments and for completing them within existing funds. Makes this section effective January 1, 2012.

45 **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Aligns the coordinated service and support plan requirements for recipients of waivers under this section with the requirements for recipients of the DD waiver. Specifies timelines and requirements in developing and implementing comprehensive transitional service plans and maintenance service plans. Makes this section effective January 1, 2012.

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46 **ICF/MR rate increase.** Amends § 256B.5012, by adding subd. 9. Requires the commissioner to increase the daily rate to $138.23 at a specified ICF/MR in Clearwater County. Makes this section effective July 1, 2011.

47 **ICF/MR rate adjustment.** Amends § 256B.5012, by adding subd. 10. Requires the commissioner to decrease operating payment rates for all facilities, with one exception, equal to an unspecified percent of the operating payment rates in effect on June 30, 2011. Specifies how the rate reduction must be applied to each facility by the commissioner.

48 **Excluded time.** Amends § 256G.02, subd. 6. Removes a reference to the PCA program from the definition of "excluded time" under the unitary residence and financial responsibility chapter. Makes this section effective July 1, 2011.

49 **Effective date.** Amends Laws 2009, ch. 79, art. 8, § 4, the effective date, as amended by Laws 2010, First Special Session, ch. 1, art. 24, § 12. Modifies an effective date to conform to federal maintenance of effort requirements.

50 **Effective date.** Amends Laws 2009, ch. 79, art. 8, § 51, the effective date, as amended by Laws 2010, First Special Session, ch. 1, art. 17, § 14. Modifies an effective date to conform to federal maintenance of effort requirements.

51 **Continuing care grants.** Amends Laws 2009, ch. 79, art. 13, § 3, subd. 8, as amended by Laws 2009, ch. 173, art. 2, § 1, subd. 8, and Laws 2010, First Special Session, ch. 1, art. 15, § 5, and art. 25, § 16. Removes a provision related to alternatives to PCA services.

52 **Directions to commissioner.**

Subd. 1. Community first choice option. Paragraph (a) requires the commissioner to provide information on all state-funded grants and MA-funded services and programs which could be included in the community first choice option. Requires the commissioner to provide specific information on those programs and any changes to statutes or rules necessary to implement the community first choice option to the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2012.

Paragraph (b) requires the commissioner to assure an assessment is completed by November 30, 2011, for certain individuals for home and community-based attendant services and supports.

Subd. 2. Co-payments for home and community-based services. Upon federal approval, requires the commissioner to develop and implement a co-payment schedule for individuals receiving MA home and community based services.

Subd. 3. Federal waiver amendment. Requires the commissioner to seek an amendment to the home and community-based waiver programs for persons with disabilities to allow properly licensed residential programs to provide residential services to up to eight individuals with physical or developmental disabilities, chronic

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illnesses, or traumatic brain injuries.

Subd. 4. Recommendations for personal care assistance service changes. Requires the commissioner to consult with stakeholder groups and make recommendations to the legislature by February 1, 2012, on changes that could be made to the program to improve oversight, program efficiency, and cost-effectiveness.

Subd. 5. Nursing facility pay-for-performance reimbursement system. Requires the commissioner to report to the legislative committees with jurisdiction over nursing facility policy and finance with recommendations for developing and implementing a pay-for-performance reimbursement system with a quality add-on by January 15, 2012.

Subd. 6. ICF/MR transition plan. Requires the commissioner to work with stakeholders to develop and implement a plan by June 30, 2013, to transition individuals currently residing in ICFs/MR into the least restrictive community settings possible. Specifies certain requirements of the plan. Requires the commissioner to provide certain information to facilities and counties in order to facilitate this process. Allows individuals residing in ICFs/MR who choose to remain there or whose health or safety would be put at risk in a less restrictive setting to continue to reside in ICFs/MR.

53 **State plan amendment to implement self-directed personal supports.** Requires the commissioner to submit a state plan amendment by July 15, 2011, to implement the self-directed supports option as soon as possible upon federal approval.

54 **Amendment for self-directed community supports.** Requires the commissioner to submit an amendment by September 1, 2011, to the home- and community-based waiver programs consistent with implementing the self-directed option through statewide enrolled providers contracted to provide certain services to all eligible recipients choosing this option and with shared care in some types of services. Requires the waiver amendment to be consistent with changes in case management services.

55 **Establishment of rates for shared home- and community-based waiver services.** Requires the commissioner to establish rates to be paid for in-home services and personal supports under all of the home- and community-based waiver programs by January 1, 2012, consistent with certain standards.

56 **Establishment of rate for case management services.** Requires the commissioner to establish the rate to be paid for case management services under the home- and community-based waiver programs for persons with disabilities by January 1, 2012, consistent with certain standards.

57 **Recommendations for further case management redesign.** Requires the commissioner to develop a legislative report with specific recommendations and language for proposed legislation to be effective July 1, 2012, for further case management redesign.

58 **My Life, My Choices Task Force.**

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Subd. 1. Establishment. Establishes the My Life, My Choices Task Force to create a system of supports and services for people with disabilities governed by certain specified principles.

Subd. 2. Membership. Establishes the membership of the task force including members appointed by the governor and by the legislature.

Subd. 3. Duties. Establishes the duties of the task force including making recommendations and reporting to the legislature by November 15, 2011, on creating a system of supports and services for people with disabilities as governed by the principles established in subdivision 1.

Subd. 4. Expense reimbursement. Prohibits members of the task force from being reimbursed for expenses related to the duties of the task force.

Subd. 5. Expiration. Makes the task force expire on July 1, 2013.

Makes this section effective the day following final enactment.

Article 8: Redesigning Service Delivery

1 **Electronic verification.** Amends § 119B.09, by adding subd. 4b. Authorizes county agencies to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for the child care assistance programs. Specifies that the information is sufficient to determine eligibility.

2 **American Indian child welfare projects.** Amends § 256.01, subd. 14b, by adding paragraph (i). Allows the commissioner to authorize a test project for the White Earth Band to provide child welfare services to tribal children who are residents of Hennepin County. Requires Hennepin County to transfer the proportion of property taxes collected and used to fund child welfare services for this population to the tribe when the tribe assumes responsibility for providing services.

3 **American Indian child welfare, social, and human services project; White Earth Band of Ojibwe.** Amends § 256.01, by adding subd. 14c. Paragraph (a) instructs the commissioner to enter into a contract with the White Earth Band for the tribe to provide all human services and public assistance programs to tribal members who reside on the reservation. Requires the commissioner to seek federal approval and waivers as needed to implement this project.

Paragraph (b) instructs the commissioner to redirect all funds provided to Mahnomen County for these services to the tribe, including administrative expenses when the project is operational.

Paragraph (c) provides that in consultation with the tribe, the commissioner is to determine which programs not currently provided by the tribe will be transferred to the tribe and the process by which the programs will be transferred. States that in the case of a dispute a two-

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thirds vote of the tribal council will overrule the decision of the commissioner.

Paragraph (d) provides that when programs are transferred Mahnomen County is relieved of responsibility for providing services to tribal members who reside on the reservation. Requires Mahnomen County to transfer the proportion of property taxes allocated for funding of county social services to the tribe.

Paragraph (e) requires the tribe to comply with all federal and state reporting and record keeping requirements.

4 **Computer system simplification.** Creates § 256.0145.

Subd. 1. Reprogram MAXIS. Requires the commissioner of human services, as part of the enterprise architecture project, to reprogram the MAXIS computer system to automatically apply child support payments entered into the PRISM computer system to a MAXIS case file.

Subd. 2. Program the social service information system. Requires the commissioner of human services to require all prepaid health plans to accept a billing format identical to the MMIS billing format for payment to county agencies for mental health targeted case management claims, elderly waiver claims, and other claim categories as added to the benefit set. Requires the commissioner to make any necessary changes to the SSIS system to bill prepaid health plans for those claims.

5 **County electronic verification to determine eligibility.** Creates § 256.0147. Authorizes county agencies to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for child support enforcement, GA, MSA, and MFIP and related programs. Specifies the information is sufficient to determine eligibility. Prohibits state and county case workers from being cited in error, as part of any audit and quality review, for an incorrect eligibility determination based on current but inaccurate information received through a state-approved electronic data source. Requires reviewers to forward a corrective action notice to the caseworker for proper and immediate correction if there is a potential error. Specifies the caseworker should use the most accurate information in making eligibility determinations.

6 **Case management appeals.** Amends § 256.045, subd. 4a. Requires any recipient of case management or personal care assistance services who contests a county's action, reduction, suspension, denial, or termination of services to submit a written request for an informal conference with the recipient's case worker and county social service director or designee. Requires the county to notify the recipient of the county's action within 15 days of the conference. Requires the county to notify the recipient at the time of application and at the time of any change in services of the recipient's right to request an informal conference.

7 **Provision of required materials in alternative formats.** Amends § 256B.69, by adding subd. 30. Paragraph (a) defines the terms "alternative format," and "prepaid health plan."

Paragraph (b) allows prepaid health plans to provide in an alternative format a provider directory and certificate of coverage and other specified materials if certain conditions are

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met.

Paragraph (c) allows prepaid health plans to provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. Requires the commissioner or local agency to inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. Requires prepaid health plans to provide sufficient paper versions of the primary care network list to the commissioner and to local agencies to accommodate potential enrollee requests for paper versions of the primary care network list.

Paragraph (d) allows prepaid health plans to provide in an alternative format certain materials to specified persons as long as certain specified conditions are met.

Paragraph (e) requires the commissioner to seek any federal Medicaid waivers within 90 days after the effective date of this subdivision that are necessary to provide alternative formats of required materials to enrollees of prepaid health plans as authorized under this section.

Paragraph (f) requires the commissioner to consult with specified parties to determine how materials required to be made available to enrollees of prepaid health plans may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. Requires the commissioner to consult with specified parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

8 **Recovery of overpayments.** Amends § 256D.09, subd. 6. Exempts certain GA recipients from recovery of overpayments. Limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

9 **Overpayment of monthly grants and recovery of ATM errors.** Amends § 256D.49, subd. 3. For the MSA program, limits establishment of an overpayment to 12 months from the date of discovery due to agency error and six years due to client error. Specifies that no limit applies to the establishment period if the overpayment is due to an intentional program violation or if the client wrongfully obtained assistance.

10 **Scope of overpayment.** Amends § 256J.38, subd. 1. For the MFIP program, limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

11 **Food stamp program; Maternal and Child Nutrition Act.** Amends § 393.07, subd. 10. Limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

12 **Essential human services or essential services.** Amends § 402A.10, subd. 4. Adds tribal services to the definition of essential human services or essential services.

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13 **Service delivery authority.** Amends § 402A.10, subd. 5. Adds that the commissioner has the authority to assign a county to be a member of a service delivery authority. Adds that a tribe or group of tribes to the definition of service delivery authority.

14 **Steering committee on performance and outcome reforms.** Amends § 402A.15.

Subd. 1. Duties. Removes the requirement for the steering committee to include recommendations on resources and funding needed to achieve performance measures. Eliminates certain considerations such as geography, populations served, and administrative demands when determining performance measures and goals. Requires the steering committee to incorporate federal performance measures when federal funding is contingent on meeting these performance measures.

Subd. 2. Composition. Removes the requirement for two members of the steering committee to also serve as representatives to the redesign council.

15 **Commissioner power to remedy failure to meet performance outcomes.** Amends § 402A.18.

Subd. 1. Underperforming county; specific service. Grants the commissioner authority to adjust state and federal funds for an underperforming county.

Subd. 2. Underperforming county; more than one-half of services. Makes technical changes.

Subd. 2a. Financial responsibility of underperforming county. Requires an underperforming county to provide the nonfederal and nonstate funding needed to remedy performance deficiencies to the entity assuming administration of the essential service.

Subd. 3. Conditions prior to imposing remedies. Makes a technical change.

16 **Council.** Amends § 402A.20.

Subd. 1. Council. Clarifies that recommendations must be approved by a majority of the voting council members. There are nonvoting members of the council.

Subd. 2. Council duties. Clarifies the duties of the council. Among the duties:

- Review the service redesign process, including proposed memoranda of understanding;
- Review and make recommendations on requests for waivers of statutory or rule program requirements;
- Establish a process for public input on the scope of essential services administered by a service delivery authority;
- Serve as a forum to resolve conflicts;
- Engage in the program improvement process; and

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- Identify and recommend incentives for counties to participate in service delivery authorities.

Subd. 3. Program evaluation. Requires the council to request that the legislative auditor perform a reevaluation of human service administration that was initially reported in 2007.

17 **Designation of service delivery authority.** Creates § 402A.35.

Subd. 1. Requirements for establishing a service delivery authority. Paragraph (a) sets out the population and geographic requirements for establishing a service delivery authority.

Paragraph (b) lists the requirements for a human service authority: compliance with state and federal laws; defining the scope of essential services; designating a single administrative structure; identifying needed waivers from statutory or rule program requirements; establishing a targeted reduction of administrative expenses; establishing terms for a county to withdraw from participation.

Paragraph (c) prohibits a county or tribe that is a member of a service delivery authority from participating in another service delivery authority.

Paragraph (d) provides that nothing in this chapter limits or prohibits local governments or tribes from combining services or county boards or tribes from entering into contracts for services that are not under the jurisdiction of the service delivery authority.

Subd. 2. Relief from statutory mandates. Lists the statutory mandates. Allows the service delivery authorities to request additional waivers from other statutory and rule mandates in order to allow greater flexibility and control.

Subd. 3. Duties. Lists the duties of the service delivery authority.

Subd. 4. Process for establishing a service delivery authority. Paragraph (a) provides that a county or consortium of counties seeking to establish a service delivery authority must present a proposed memorandum of understanding, and a resolution from the board of county commissioners of each participating county. Provides that a tribe must have a resolution from tribal government stating the tribe's intent to participate.

Paragraph (b) allows the commissioner to finalize and execute the memorandum of understanding upon the recommendation of the council.

Subd. 5. Commissioner authority to seek waivers. Gives the commissioner authority to grant waivers, but they must be approved by the council.

18 **Alignment of verification and redetermination policies.** Requires the commissioner to develop recommendations to align eligibility verification procedures for all health care, economic assistance, food support, child support enforcement, and child care programs.

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Requires the commissioner to report back to the chairs of the legislative committees with jurisdiction over these issues by January 15, 2012, with recommendations and draft legislation to implement the alignment of eligibility verifications.

19 **Alternative strategies for certain redeterminations.** Requires the commissioner to develop and implement by January 15, 2012, a simplified process to redetermine eligibility for recipient populations in the MA, MSA, food support, and GRH programs who are eligible based on disability, age, or chronic medical conditions, and who are expected to experience minimal change in income or assets from month to month. Requires the commissioner to apply for any federal waivers needed to implement this section.

20 **Request for proposals; combined online application.** Paragraph (a) requires the commissioner of human services to issue a request for proposals for a contract to implement an integrated online eligibility and application portal for food support, cash assistance, child care, and health care programs. Specifies items that must be included in the system.

Paragraph (b) requires the commissioner to enter into a contract for the services specified in paragraph (a) by October 1, 2011, based on the responses to the request for proposals. Requires the contract to incorporate a performance-based vendor financing option whereby the vendor shares in the risk of the project's success.

Makes this section effective the day following final enactment.

21 **Repealer.** Repeals §§ 402A.30 (Designation of Service Delivery Authority); and 402A.45 (Essential Services Outside Jurisdiction of Service Delivery Authority).

Repeals Minn. Rules, part 9500.1243, subp. 3 (recoupment of overpayments).

Article 9: Chemical and Mental Health

1 **Liability of county; reimbursement.** Amends § 246B.10. Increases the county share for persons civilly committed to the Minnesota sex offender program from 10 percent to 30 percent.

Provides this section is effective for individuals who are civilly committed to the sex offender program on or after August 1, 2011.

2 **Minnesota extended treatment options.** Amends § 252.025, subd. 7. Prohibits mid-contract layoffs from occurring as a result of restructuring this program, but permits layoffs as a result of low census or closure of the facility due to decreased census.

3 **Commitment; Red Lake Band of Chippewa Indians; White Earth Band of Ojibwe.** Amends § 253B.212. Makes technical changes. Adds subdivision 1a. Allows the White Earth Band to enter into the same agreements as the Red Lake Band with the Indian Health Service for care and treatment of tribal members committed for care and treatment due to mental illness, developmental disability, or chemical dependency. Adds that White Earth can also contract with the commissioner of human services for treatment of tribal members who have been committed by the tribal court. Requires tribal court commitment procedures

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to comply with the provisions of section 253B.05 to 253B.10.

4 **Local agency duties.** Amends § 253B.03, subd. 1. Adds that the county requirement to provide chemical dependency treatment services is subject to the limitations imposed in section 254B.04, subd. 1.

5 **Division of costs.** Amends § 254B.03, subd. 4. Increases the county share under the consolidated chemical dependency treatment fund from 16.14 percent to 22.95 percent.

Provides that this increase is effective for claims processed beginning July 1, 2011.

6 **Eligibility.** Amends § 254B.04, subd. 1. Limits access to residential chemical dependency treatment services to no more than three treatment episodes for the same person in a four year period, and no more than four episodes in a lifetime. Provides an exception that additional placements can be made when deemed appropriate by the commissioner.

7 **Eligibility for treatment in residential settings.** Amends § 254B.04, by adding subd. 2a. Increases the assessment level score for an individual to be approved for residential chemical dependency treatment.

8 **Allocation of collections.** Amends § 254B.06, subd. 2. Increases the county share under the consolidated chemical dependency treatment fund from 16.14 percent to 22.95 percent.

Provides that this increase is effective for claims processed beginning July 1, 2011.

9 **Residential services for children with severe emotional disturbance.** Amends § 256B.0625, subd. 41. Adds that medical assistance covers services provided by a tribe for children who have a severe emotional disturbance and require residential care.

Provides that this section is effective October 1, 2011.

10 **Payment rate.** Amends § 256B.0945, subd. 4. Adds paragraph (c) which states that payment for mental health rehabilitative services provided by tribal organizations must be made according to section 256B.0625, subd. 34, (Indian health services facilities) or other federally approved methodology.

Provides that this section is effective October 1, 2011.

11 **Community mental health services; use of behavioral health hospitals.** Instructs the commissioner to issue a report to the legislature on how the community behavioral health hospitals will be utilized to meet the mental health needs of the regions in which they are located. Requires the report to address future use of the hospitals that are not certified as Medicaid eligible or have less than 65 percent licensed bed occupancy. Requires the commissioner to consult with the regional mental health authorities.

12 **Integrated dual diagnosis treatment.** Requires the commissioner to implement integrated dual diagnosis treatment for individuals with co-occurring substance abuse and mental health disorders. Requires the commissioner to seek federal waivers as necessary.

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13 **Closure of state-operated services facilities.** Instructs the commissioner to close the Willmar Community Behavioral Health Hospital by October 1, 2011. Also instructs the commissioner to close the behavioral health hospitals in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, and Rochester, and the Child and Adolescent Behavioral Health Services in Willmar, and the subacute mental health facility in Wadena by October 1, 2012. Requires the commissioner to issue a report to the legislature on how the department will accommodate the needs of the clients impacted by the closure and how the department will accommodate the needs of the adversely affected state employees.

14 **Regional treatment centers; employees; reports.** Provides that no layoffs shall occur as a result of restructuring services at the Anoka-Metro Regional Treatment Center. Requires the commissioner to issue a report which provides the number of employees in management positions at Anoka and the Minnesota Security Hospital and the ratio of management to direct care staff for each facility.

15 **Repealer.** Repeals Laws 2009, chapter 79, art. 3, sec. 18, the Anoka-Metro Regional Treatment Center redesign.

Article 10: Appropriations

See spreadsheet for details.

Article 11: Forecast Adjustments

See spreadsheet for details.