Minnesota Department of Human Services – Policy Bill
LEGISLATIVE BACKGROUND INFORMATION 2017

S.F. 1291 (Utke) **H.F. 1245 (Schomacker)** **Revisor#: 17-0004**

Background sheet for Health and Human Services Reform Committee

The Minnesota Department of Human Services (DHS) is the state's largest agency, serving well over 1 million people with an annual budget of $11 billion and more than 6,500 employees throughout the state. The department oversees a broad range of services, including health care, economic assistance, mental health and substance abuse prevention and treatment, child welfare services, and services for the elderly and people with disabilities. DHS also provides direct care and treatment to more than 12,000 clients every year. This bill contains policy only (non-budget related) provisions from the across the Department policy divisions.

While the changes here are advanced by DHS there are various stakeholders that have requested many of the clarifications. Other policy changes recommended are Department driven due to challenges with implementing previous laws passed or known areas of confusion or ambiguity that need the legislature's clarity and approval.

Article 1 CHILDREN AND FAMILY SERVICES

Eliminating Errors in Cross-References and Program Names (Sections 1, 3, 7, 8, 9, 10, 11) *(amends statutes §§ 256N.24, subd. 1 (d)(1); 256N.24, subd. 8 (b); 256N.24, subd. 11 (e); 256N.02, subd. 10; 256N.02, subd. 17; 256N.24, subd. 12 (b); and 256N.24, subd. 14)*

PROBLEM: There are numerous errors and inaccuracies in foster care and permanency sections of Minnesota Statutes, including cross-reference errors, outdated references to programs that have been phased out or no longer exist, incorrect program names, and grammatical errors.

PROPOSAL: This proposal cleans up statutory errors.

Providing Consistency in Definitions (Sections 2, 4, 5) *(amends §§ 256N.02, subd. 18; 256N.22, subd. 1 (a); and 256N.02, subd. 16)*

PROBLEM: Shared terminology among the foster care and permanency sections of Minnesota Statutes have varying definitions, which has led to confusion when attempting to determine which definition is applicable. For example, the definition of relative in Chapter 256N (Northstar Care for Children) does not currently include the legal parent, guardian, or custodian of a child's sibling, but the definition of relative in Chapter 260C (Juvenile Protection Proceedings) does. This is important because the permanency disposition for the Northstar benefit is ordered under Chapter 260C.

Additionally, the definition of transfer of permanent legal and physical custody to a relative is not clearly defined in Chapter 256N. As a result, counties and courts sometimes apply a family law lens to the legal disposition, even though the legal disposition falls under Juvenile Court and not Family Court, and order joint legal and/or physical custody between a relative custodian and a child's parent. Joint custody, either legal or physical, is a form of reunification; to be eligible for Northstar Kinship Assistance, state and federal law require that reunification be ruled out prior to proceeding with a transfer of permanent legal and physical custody to a relative.

PROPOSAL: This proposal makes shared terminology consistent across foster care and permanency sections of Minnesota Statutes. It also clarifies eligibility criteria for Northstar Kinship Assistance by providing a clearer definition of what a transfer of permanent legal and physical custody to a relative must be in order to establish eligibility for Northstar Kinship Assistance.

Removing a Contradiction in Adoption Assistance Eligibility (Section 6) *(amends § 256N.23, subd. 6 (4))*

PROBLEM: The federal Guardianship Assistance Program provides an adoption assistance eligibility path for individuals receiving Guardianship Assistance payments who are interested in adopting children in their care. This same eligibility path is not accurately reflected in Minnesota Statutes. Currently, statute excludes legal custodians and guardians from receiving adoption assistance, since they are already caring for the children in their care without receiving assistance and would therefore not meet eligibility criteria for adoption assistance. But statute also states that legal custodians receiving Northstar Kinship Assistance benefits on a child's behalf are eligible to receive Northstar Adoption Assistance as long as they meet applicable criteria and are adopting the child. It is unclear, therefore, whether a relative custodian would be eligible or not for Northstar Adoption Assistance if they decide to adopt a child in their care.

PROPOSAL: This proposal clarifies the contradiction in Northstar Adoption Assistance eligibility for relative custodians who wish to adopt the children in their care by specifying that relative custodians currently receiving Northstar Kinship Assistance are excluded from the list of individuals who are ineligible to receive Northstar Adoption Assistance on a child's behalf. This will put Minnesota state law in conformance with federal law.

Clarifying the Appeal Process for Northstar Adoption and Kinship Assistance (Section 12) *(amends § 256N.28, subd. 6 (b))*

PROBLEM: The appeals section of Northstar Care for Children contains many redundancies and has left human services judges uncertain of what actually constitutes extenuating circumstances in a benefit denial case. Each human services judge may interpret this section differently, and in some instances, the department has been asked to provide clarification of what extenuating circumstances might entail.

PROPOSAL: This proposal removes redundancy and unclear examples of extenuating circumstances for the Northstar Care for Children appeals process, simplifying the appeals process and allowing human services judges the ability to determine, based on existing statute, what may constitute extenuating circumstances.

Article 2 CHEMICAL AND MENTAL HEALTH SERVICES

Strengthen Service Standards for Mental Health Mobile Crisis Response (Sections 1-14, 17, 20-28, and 30-37) ***(§245.462, subds. 6 and 11; §245.464, subd. 2; §245.466, subd. 2; §245.470, subd. 2; §245.4871, subd. 9a, 14; §245.4875, subd. 2; §245.488, subd. 2; §245.735, subd. 3; §245.8261, subd. 1; §245.991, subds. 1-14; §245D.02, subd. 20; §253B.02, subd. 9; §256B.0623, subd. 2; §256B.0624, subds. 1-4; §256B.0625, subd. 35a; §256B.092, subd. 14; §256B.0943, subds. 1, 2, 4, and 9; §256B.0946, subds. 1, 1a, 4 and 6; §256B.0947, subds.3a and 7; §256B.84; §256B.49, subd. 25)***

PROBLEM: Mobile Crisis services assist children and adults who are experiencing a mental health crisis to cope with that crisis. Under this service model, a mental health crisis responder assesses the crisis, assists the person in coping with the crisis, and follows up with the person to assure that he or she receives longer term support and services they may need.

While Minnesota has made progress in expanding access to mental health crisis response services, the quality of crisis services still varies from region to region and county to county in a number of ways. There is also great

variation in how Mobile Crisis teams collaborate and interact with other emergency responders, including law enforcement, as well as the integration of teams with their local hospital emergency departments. If the response is uneven or unpredictable, people may cease calling if they think Mobile Crisis won't be helpful.

Crisis services require a provider to meet a client in stressful circumstances, and connect with them very quickly and effectively. Their caseload is whoever needs service at that time. Proper training and support is absolutely critical to service quality. This is especially true when meeting the needs of people who may be outside that provider's usual specialty. DHS has received significant feedback on the need for training specific to mental health needs in children, elders, and underserved communities.

Additionally, Minnesota has two separate sets of standards for Mobile Crisis teams serving children and those serving adults. While there are specific skills, knowledge, and training needed to work with children and adults, having two distinct and often overlapping sets of standards has led to confusion, especially for providers who serve both children and adults with a single Mobile Crisis team.

Currently, our statutory standards are focused on eligibility and requirements for billing Medical Assistance (256B.0624, 256B.0944). However, other funding sources are also paying for Mobile Crisis services. This leaves a grey area, particularly around individuals who are uninsured or underinsured while some of those individuals are being referred to emergency rooms, when they could be better served by a mobile team.

PROPOSAL: This proposal seeks to improve the quality and consistency of Mental Health Mobile Crisis (Mobile Crisis) services by establishing more consistent and robust service standards for crisis services, including protocols for triage and handoffs to other services. This proposal is intended to create a common expectation about what Mobile Crisis providers must offer and what recipients of service may expect.

DHS recognizes that variations in how Mobile Crisis services are delivered can have significant impact on the outcomes and safety of Minnesotans experiencing a mental health crisis. To address these issues, this proposal will:

- Improve Training: Simplify and unify standards for both children's and adults Mobile Crisis teams and implement clarified training requirements;
- Standardize Dispatch: Standardize criteria for teams in determining the need to send an immediate mobile response;
- Improved Integrations with Hospitals and 911 Response: Support better integration of Mobile Crisis teams in hospital emergency departments, and;
- Clarifications of Authority: New language is required to place Crisis standards in the Adult and Children's Mental Health Acts.

Intended Outcomes will be:

- Ensuring these services are delivered consistently throughout the state while retaining the flexibility to meet unique regional needs and accounting for the differences in working with children and adults;
- Ensuring that responding providers are knowledgeable about working with the communities and age ranges they serve;
- Ensuring that individuals, family members, and other emergency responders can rely on Mobile Crisis as a dependable, credible response;
- Providing better psychiatric care for individuals who do come to the ER, and;

- To bringing the general service standards for Mobile Crisis to the Mental Health Act will clarify that this is a statewide expectation, regardless of who is paying for the service and encourage counties to streamline the services they pay for

Implementation will occur between July 1, 2017 and June 30, 2018. Minnesota made substantial investments in the startup and operation of Mobile Crisis in 2015, and is on track to have 24/7 mobile response throughout the state by January 1, 2018.

Entry Level Mental Health Provider Services Standards, Qualifications, and Trainings (Sections 15, 16, and 29) ***(§256B.0615, subds. 1-5; §256B.0616, subds. 1-5; §256B.0943, subd. 7)***

PROBLEM: Currently there are three entry level, direct support staff positions that work in various types of mental health programs – Certified Peer Specialists, Family Peer Specialists, and Mental Health Behavioral Aids. For Certified Peer Specialists and Family Peer Specialists standards for becoming a peer specialist and the training needed, are unclear. There are several provider agencies that express frustration and confusion about training requirements. Mental Health Behavioral Aids also have training requirements that are unclear in statute. In addition, the continuing education requirements are also unclear.

Mental Health Behavioral Aides are an entry level position in the children's mental health workforce. Currently, Mental Health Behavioral Aides are required to undergo preservice training as well as continuing education. However, the statute is unclear about what topics must be covered prior to providing services and what can be covered in continuing education. In addition, the training topics do not necessarily reflect the skills and knowledge needed for individuals to fulfill this role.

PROPOSAL: This proposal clarifies and updates the qualifications for Certified Peer Specialists, Family Peer Specialists, and Mental Health Behavioral Aids. This proposal will:

- Create clear expectations about the the role of peer specialists and behavioral aids;
- Update the training requirements for behavioral aides to better align with their role in delivering services as well as provide clarity on which topics must be covered before providing services and what training may be conducted as part of continuing education. These changes are intended to provide clarity for individuals seeking to become behavioral aides as well as provider seeking to hire new behavioral aides.

Intended outcomes will be:

- Support for providers to incorporate peer specialists into their programs;
- Help providers hire and train peer specialists and behavioral aids, and;
- Providers are able to retain the ability to recruit individuals without formal educations into these roles while ensuring that they have experience that will allow them to be effective in this role.

This proposal does not make significant changes to the requirements for a Certified Peer Specialist, Family peer Specialist, and Mental health Behavioral Aids, but it does make the expectations easier to understand.

Effective Date: day following enactment.

Lead Mental Health Professional on an Assertive Community Treatment (ACT) Team Policy Correction (Section 18) (*§256B.0622, subd. 7a)*

PROBLEM: ACT provides intensive and comprehensive mental health care in the community for adults with serious and persistent mental illness. ACT services are delivered 24/7 by an inter-disciplinary team of professionals known as an "ACT Team". Currently, there are 27 ACT teams statewide with 2,079 individuals served in 2014.

A key element of the DHS 2016 Policy proposal, which was passed by the 2016 legislature, was defining the various staff who each serve a particular function on an ACT team, per the evidenced-based model. One of the staff roles that is critical to the ACT model is the "lead mental health professional". This position functions as the lead for a particular ACT client's therapy and clinical services.

A definition of this role was inadvertently omitted from last year's proposal. As DHS continues to work with ACT teams to meet the new service standards and the evidenced-based model, it's critical that all of the elements are clearly laid out in statute. Defining this role will not add the number of people working on an ACT team, it simply defines a role that certain members of the team must play. Each ACT client is assigned a lead among the mental health professionals on the ACT team.

PROPOSAL: This proposal corrects the inadvertent omission from a proposal that was included in the 2016 DHS policy to clarify and update standards for Assertive Community Treatment (ACT) services in order to enhance the quality of care for clients, improve the consistency in ACT services across the state, as well as provide clearer expectations, greater flexibility, and stronger accountability for providers.

Article 3 OPERATIONS

Enhanced Program Integrity in Recipient & Provider Investigations (Sections 1 & 35) *(amends statutes §§245.095, Subd. 1 & 2; 270B.14, Subd. 1)*

PROBLEM: There are and continue to be opportunities to improve the operational integrity of the programs DHS implements and oversees with its partners. Eligibility determinations investigations for MA could be more accurate and reliable with additional data to verify income. Providers who have been excluded from one DHS program are able to be enrolled, licensed, registered, and receive grant funds in or from another program administered by DHS. Current language prohibits new enrollments or licensures, but it is silent on those already enrolled or licensed.

PROPOSAL: This proposal provides DHS with additional tools and authority to accurately and effectively enforce eligibility requirements. It also ensures that providers who have been excluded from one DHS program may not operate as another provider or grantee during the time of the exclusion. These sections:

- Prevent any provider who has been excluded from any DHS program from enrolling, becoming licensed, registered, or receiving grant funds in or from any other program administered by DHS, and
- Allows DHS to receive the same type of income data from the DOR it receives on MinnesotaCare recipients, to verify the incomes of applicants and recipients of Medical Assistance.

Ownership Clarification for Licensed Entities (Sections 2–16, 18, 19) *(amends statutes §§245A.02 subd. 3b; 245A.02 Subd. 5a; 245A.02, Subd. 8; 245A.02 subd. 9; 245A.02 subd. 10b; 245A.02 subd. 12; 245A.02, Subd. 12a; 245A.03, Subd. 1; 245A.03, Subd. 3; 245A.04 subd. 2; 245A.04, Subd. 4; 245A.04, Subd. 6; 245A.04 subd. 7; 245A.04 subd. 7a; 245A.04 subd. 10; [245A.043]*; *245A.05 (a); 245A.07, Subd. 2)*

PROBLEM: Current law (245A) prohibits transfer of a license, requiring a new license application for every change in ownership. Changes in ownership often do not alter the staff, policies, or services of the program – diminishing the need of the Department to monitor these transactions. The current definition of "controlling individual" is confusing to stakeholders and leaves the Department and service recipients vulnerable to misrepresentation. Some bad actors have taken advantage of this confusion by intentionally obscuring the information they provide to the Department, making it difficult to identify who should be disqualified from

participating in other licensed programs if a controlling individual is associated with a license revocation.

PROPOSAL: This proposal modifies the Human Services Licensing Act (245A) to address several issues related to the ownership of licensed programs. This proposal will allow the Department to more accurately identify who should be held responsible for actions associated with a specific licensed program or service and will require license holders to notify the Department when there are changes in the people who are responsible with operating the program. The proposal will also streamline licensing applications where appropriate following changes in ownership and establish clear notification requirements following a change in ownership. Increased clarity will benefit the Department and providers by making expectations clear to license holders engaging in common business transactions.

Provisional Licensing for Directly-Licensed Programs (Sections 13, 17) *(amends statute §§245A.04 subd. 7; [245A.045])*

PROBLEM: During the application and pre-licensure process, it is often clear to licensors that a program may have difficulty complying with licensing regulations. Existing statute, however, does not give the Division an option between granting or denying a license, resulting in some providers receiving a license and struggling significantly within their first two years of licensure. Newly licensed child care centers, for example, are particularly prone to receiving a fine, conditional license, or license revocation within their first 24 months of operation.

PROPOSAL: This proposal will create authority in 245A for the Department to issue a provisional license to license applicants across all service and facilities directly licensed by the Department, including child care centers, home and community based service providers, chemical dependency treatment and detoxification programs, specifically in instances where a license applicant has demonstrated substantial compliance with applicable licensing requirements and demonstrates the ability to comply with all applicable laws and rules by the end of the provisional license term. This proposal will improve the health and safety of children and vulnerable adults receiving care through DHS-licensed services and facilities by strengthening the Department's ability to hold newly licensed providers accountable for licensing violations and provide clarity to license applicants on what standards they must meet in order to receive a full license by the end of the provisional license term.

Enhanced Program Integrity for In-Home Services (Sections 21–30) *(amends statutes §§256B.02, Subd. 7; 256B.04, Subd. 21; 256B.0625, Subd. 43; 256B.064, Subd. 1; 256B.0651, Subd. 17; 256B.0659, Subd. 3; 256B.0659, Subd. 12; 256B.0659, Subd. 14; 256B.0659, Subd. 21; 256B.4912, [Subd 11])*

PROBLEM: There are and continue to be opportunities to improve program integrity in Minnesota's Medicaid program. Gaps exist in documentations requirements in violation of Federal law. A need exists to clarify the important link between QP visits and ensuring appropriate and necessary PCA services. Service recipients cannot not be notified when their service provider's Medicaid payments will be suspended. This lack of Notification to clients prior to withholding payments limits clients' control of decisions relating to their own care and assure continued services through another provider. The proposals in this legislation address these deficiencies in law that hinder DHS/OIG's efforts to improve program integrity in Minnesota Medicaid.

PROPOSAL: The proposal will bring DHS into compliance with federal law and will strengthen oversight functions and investigative capacity within SIRS by establishing documentation requirements for all MHCP providers, strengthening sanction authority and recipient support, and increases enforcement of state and federal exclusion requirements. The sections in this bill:

- Establish service documentation and billing requirements for HCBS providers, describing manner and form of documentation including specific requirements for different types of providers (transportation, DME and Adult Day Programs).

- Require QPs to document the date, exact time (with AM and PM notations) and total amount of time, of each visit or call with the recipient.
- Require recipient identifying information, such as date of birth and/or recipient ID, on the PCA timesheet.
- Add documentation requirements consistent with transportation services, providing greater ability to oversee and ensure program integrity in paid provider travel.
- Link payments of PCA services with required QP Supervision Services. Clarifying that any payment for PCA services after the date that a required QP visit was not performed is an overpayment and subject to recovery.
- Requires that any MHCP provider convicted of a program related crime be excluded from participation as a provider in MHCP for 5 years from the date of conviction, consistent with the 5-year minimum federal exclusion for conviction of program related crimes.
- Allows DHS to exclude individuals convicted of program related crimes, who are not individually enrolled, like interpreters, drivers, nurses, many direct care workers in MH and HCBS, etc.
- Allows DHS to exclude individuals who could be subject to a permissive, but not mandatory federal exclusion, based on the terms of their criminal proceeding.
- Allows DHS to notify recipients when it suspends provider payments so they can make other arrangements.

Fair Hearing Appeals Process Improvement Updates and Clarifications (Sections 31–34) *(amends statutes §§256G.01, Subd. 4; 256G.02, Subd. 4; 256G.09, Subd. 2; 256G.10)*

PROBLEM: There are opportunities to increase compliance, increase efficiencies, better allocate resources, reduced frustration by public assistance recipients, and reduce state fair hearing delays. For example, by allowing flexibility in who takes certain actions regarding appeals, the department can better distribute administrative tasks among available resources and speed up the processing of appeals. Additionally, by clarifying the county financial dispute language, counties will be better informed of the process, which will allow for counties to resolve more cases without the need for an appeal, faster resolution for those that are appealed, and faster payment of claims.

PROPOSAL: This proposal will 1) correct citations in statute, 2) make various improvement, updates, and clarifications to the fair hearing appeals process, and 3) clarify administrative process for counties. The purpose of these corrections, updates, and clarifications are to ensure that recipients, advocates, providers, agencies and counties participating in appeals and administrative reviews understand roles and that process steps are clear. Additionally, this proposal will make the appeals process more user friendly and efficient for both the participants and the agency.

- The proposal clarifies: 1) how a child's county of residence is determined for purposes of determining financial responsibility, 2) which provisions apply to social services and which apply to financial services, and 3) what the process to follow is for each county that is part of the appeal. Many counties have little experience with this type of appeals and rely on the language found in the statute for bringing and arguing these appeals.
- The proposal clarifies that interpreter or translation services must be provided by the agency who took the action that is under appeal.

Article 4 HEALTH CARE

State Medical Review Team Cleanup (Section 1) *(256.01, subd. 29)*

PROBLEM: The State Medical Review Team (SMRT) completes disability determinations for individuals using

criteria defined by the Social Security Administration. A SMRT disability certification establishes a basis of eligibility for Medical Assistance (MA), MA for Employed People with Disabilities (MA-EPD), and children whose MA eligibility is determined under the TEFRA option. County and tribal workers submit referrals and communicate with SMRT on behalf of their clients.

The statute that governs SMRT directs the commissioner of human services to "review all medical evidence submitted by county agencies with a referral and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary."

In 2014, SMRT streamlined its disability determination process to be more efficient in response to a continuous improvement process. DHS directed counties to stop including medical evidence with their referrals and SMRT began collecting all of the medical evidence and needed information directly from providers. Prior to this change, county financial workers would submit this information and SMRT would then follow-up with the provider for additional information. This change eliminated the need to collect information from multiple sources.

PROPOSAL: This proposal would make technical changes to Minnesota statute to reflect current practice of the State Medical Review Team (SMRT) and the role of county agencies in the SMRT process. This proposal would remove the statutory language that refers to the county's role so that the statute accurately reflects the current SMRT procedure.

Personal Care Assistance Provider Enrollment (Section 2 & 3) *(256b.0659, subd. 21 and subd. 23)*

PROBLEM: The current Personal Care Assistance (PCA) provider enrollment requirements need to be streamlined and clarified. There are two main issues that this proposal seeks to address:

First, PCA provider agency staff are not clearly required to complete the required training prior to submitting an application for enrollment. This leads to Department of Human Services (DHS) staff spending time during the enrollment process working with incomplete applications or potentially ineligible applicants.

Second, if a PCA agency is "terminated" as an enrolled provider, they may not re-enroll for two years and providers could be at risk for this even for minor issues relating to the revalidation process.

PROPOSAL: This proposal would update the PCA provider enrollment requirements in order to streamline the process for both DHS and provider agencies while maintaining strong oversight of the program.

The proposal would clarify that PCA provider agency staff must complete the required training prior to submitting an application for enrollment. This is intended to reduce the time spent by DHS staff during the enrollment process working with incomplete applications or potentially ineligible applicants.

This proposal would also clarify that the two year ban does not apply to agencies terminated solely due to failing to comply with revalidation requirements in a timely and complete fashion. This would allow providers who were terminated simply for failing to complete the revalidation process to re-enroll.

Article 5 COMMUNITY SUPPORTS

Policy Implementation of the Home and Community-Based Services Rule
(Sections 1-2, 4-7, 10, 11, 13-15, 17-19, 26 Repealer) (*§144D.04, subd. 2; §144D.04, subd. 2a; §245A.04, subd. 14; §245A.11, subd. 9; §245A.11, subd. 10; §245A.11, subd. 11; §245D.071, subd. 1; §245D.071, subd 3; §245D.11, subd. 4; §245D.24, subd. 3; §256.045, subd. 3; §256B.0911, subd. 3a; §256B.092, subd. 1a; §256B.49, subd. 1; Minn. Rules, Part 9555.6255)*

PROBLEM: The Center for Medicare and Medicaid Services (CMS) issued the Home and Community Based Services (HCBS) rule on January 16, 2014, which became effective on March 17, 2014. The new rule was developed to assure that home and community-based services are provided differently than institutional services are provided, recognizing that even though the service is not provided in an institution, the setting may have qualities that feel like an institution to the person receiving the services. The rule raises expectations for what is possible for older adults and people with disabilities; our system needs to evolve to assure all people:

- Have information and experiences with which to make informed choices;
- Are provided an array of options to fully support community inclusion; and
- Have their rights protected.

If DHS does not secure legislative authority in 2017 to enhance licensing standards, there will not be a system in place to enforce new HCBS setting standards. Federal rule compliance is required for DHS to continue to renew and expand waiver services for people receiving services through the disability and elderly waivers. Failure to comply with the federal requirements, puts the state at risk of federal sanctions, including the risk of losing over $850M in federal financial participation for the aging and disability waiver services affected by this rule. The affected services account for 60-70% of all waiver spending.

PROPOSAL:
This proposal amends licensing, assessment, and support planning statute to comply with the requirements of the Home and Community Based Services (HCBS) rule. These changes:

- Repeals Adult Foster Care Rule 9555.6255 and amends MN Statutes Chapter 245A, governing Adult Foster Care under the Elderly Waiver to assure that people are supported to fully access and engage in the community, have the right to furnish and decorate their living space, have the right to have visitors, right to personal privacy and access to food at any time.
- Amend MN Statutes Chapters 144D governing Customized Living services under the waivers to assure that people are supported to fully access and engage in the community, have the right to furnish and decorate their living space and have the right to have visitors, have the right to access to food at any time and have choice of roommate.
- Amend MN Statutes Chapter 245D, governing Foster Care and Supported Living Services for children and adults on BI, CAC, CADI and DD waivers to assure that people are supported to fully access and engage in the community, have the right to furnish and decorate their living space, have the right to have visitors, right to personal privacy, access to food at any time and protection against eviction through a legally enforceable agreement.

- Amend MN Statutes Chapters 256B.0911 and 256B.092, in the areas of assessment/reassessment, and support planning to assure that people informed choice of settings includes non-disability specific residential and non-residential settings.

<u>Clarify DHS Authority to Manage Statewide Corporate Foster Care Capacity</u> (Section 3)
(§245A.03, subd. 7)

PROBLEM: This proposal specifies the commissioner's authority to manage statewide corporate foster care capacity. Minnesota Statute 245A.03, subd. 7 gives the commissioner the authority to manage statewide licensed corporate foster care capacity; however, that authority has been questioned recently and may conflict with other sections of law related to a licensed provider's legal property rights. Without more clarity, the commissioner is not able to move corporate foster care capacity to address statewide needs identified in the needs determination process conducted by the commissioner, and to better align capacity with service recipients' community of choice.

PROPOSAL: This proposal changes statute to specify the commissioner's authority to manage licensed corporate foster care, including de-licensing and relocation of capacity to address the choices individuals on the disability waivers make regarding where they wish to live.

Establish new waiver services: Individualized Home Supports (IHS) (Section 8, 20-24) *(§245D.03, subd. 1; §256B.4913, subd. 7; §256B.4914, subd. 3; §256B.4914, subd. 5; §256B.4914, subd. 8; §256B.4914, subd. 16)*

PROBLEM: DHS and stakeholders identified a significant service gap for people with disabilities to live in their own homes on the (BI), (CAC), and Inclusion (CADI) waivers. IHS fills this significant service gap to support people in their own homes promoting greater community inclusion. IHS combines training and support services into a single comprehensive service to people living in their own homes. The developmental disability (DD) waiver has access to a similar service, with the same standards, to support people to live independently in their own home but equivalent supports do not exist on the BI, CAC or CADI waivers.

PROPOSAL: IHS is a service designed to holistically support a person in their own home and within their community by providing support (e.g. supervision, cuing, and assistance) and training in four broad community living service areas. The community living service areas are (1) community participation, (2) health and safety, and wellness, (3) household management, and (4) adaptive skills. Service delivery can occur in person or through two-way real-time remote support. With multiple service delivery methods, IHS increases a person's choices and options of how and where services are delivered to meet their community living service needs.

These sections incorporate IHS into the licensing and waiver rate setting standards for home and community-based waiver services, in order to implement IHS.

Criteria for Partially Provider-Controlled Housing Where 245D Services are Provided (Section 9) *(§245D.04, subd. 3)*

PROBLEM: Partial provider control occurs when the service provider holds a master or transitional lease, controls who else lives in the unit, or otherwise has control over the unit. There are currently providers delivering services in these settings, but there are not consistent criteria to ensure that the service recipients' rights are protected and that the housing unit is safe and healthy. Because the housing setting itself is not licensed, DHS licensing does not currently have clear authority to ensure that protections are in place when the person requires protections.

PROPOSAL: This proposal establishes consistent criteria for settings where people live and receive services in an individualized living unit (e.g. an apartment) where a provider has partial control over the setting.

Alternatives for 245D Training Requirements (Section 12) *(§245D.09, subd. 5a)*

PROBLEM: Current licensing requirements for training limit the flexibility of providers to hire and train competent staff. Workers who switch jobs need to re-take training to meet hourly requirements, rather than show competency in the training modules. Additionally, several stakeholders, including people who receiving services, family members, providers, and advocates have stated that there are times when individual direct care professionals are not competent to provide supports, even after they have completed the number of training hours required by the licensure.

PROPOSAL: Section 12 creates flexibility for a provider to fulfill 245D training requirements via hourly training or competency based training.

PCA/CFSS Notice of Termination Change (Sections 16, 25) *(§256.0659, subd. 24; 256B.85, subd. 12b)*

PROBLEM: Current law allows for at least a 10-day notice of action when the person's current Personal Care Assistance (PCA) provider is discharging a person. A 10-day notice of termination does not allow enough time for program participants to find another agency and transition their workers to that agency if they want to bring their workers with them to the new agency. Due to the workforce shortage, it also takes more time to find new workers to serve a participant.

PROPOSAL: The 30-day notice will allow more time for a participant to find a new agency to meet their needs and will also allow more time both to find new workers and for current workers to be affiliated with the new agency.

This policy change will help with continuity of care as a person can continue to receive services while they are looking for a new agency. This will help to assure a participant's health and safety needs continue to be met if they continue to receive services during this longer transition period.

Article 6 TECHNICAL

This article is comprised of technical corrections to statute as recommended with the Revisor.

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Summary of Amendment

Procedural changes to SNAP Employment and Training *(amends § 256D.051)*

PROBLEM: The current process used to engage people in employment and training services for the Supplemental Nutrition Assistance Program benefits (formerly called Food Stamps) is not working. The current process creates significant administrative burden for county human services offices, competing for time with the core work of determining eligibility and ensuring that the counties issue accurate benefit amounts.

Adults receiving food benefits through the Supplemental Nutrition Assistance Program who have no disabilities and no children must meet work requirements. If they fail to do so, they lose benefits after three months and are not eligible again for three years (unless they meet some specific work requirements in the meantime).

Federal law allows states two options: one is to require all of those individuals to participate in employment services and the other option is to let them choose whether they want the services to help meet the work requirements. In 2016 more than 32,000 adults were referred to SNAP employment services. Only 6,300 enrolled and received services.

Counties have estimated that they spend more than 14,000 frontline hours in the notices, tracking of responses and no shows and case actions in the current process.

PROPOSAL: Keep the work requirements in place, as mandated by federal law. Give participants the option to engage in employment services. This would eliminate much of the administrative work for notices and tracking that counties must currently do. It would allow the publicly funded employment services providers to spend their time on individuals interested in and motivated to receive help in getting and keeping a job.

Reporting on TANF Work Participation Rates and the Self-Support Index *(amends §§ 256J.751, subd. 2, and subd. 5; adds new subd. 2a and subd. 4a)*

PROBLEM:
Current law requires DHS to report to counties data monthly on 10 specific measures and quarterly on 7 other or overlapping measures. The legislature identified most of those measures shortly after the Minnesota Family Investment Program was launched in 1998. The data is to help with county performance management. Using the existing statute to keep up with data needs has proved cumbersome. For instance, current law:

- Fails to require any data on the Diversionary Work Program (DWP) launched in 2004
- Fails to require any data for the Family Stabilization Services track launched in 2008 that serves about 40% of the families subject to work requirements.
- Requires monthly reports on data that changes very little such as the number of child only cases or average monthly gross earnings.

By holding the department accountable to provide data on a regular basis and by engaging counties, tribes and employment services agencies, the Department will provide information that will more effectively support integrating relevant data into real time performance management.

PROPOSAL:
The changes the Governor proposes still hold DHS accountable to provide monthly and quarterly data – but to have DHS work with counties, tribes and the employment services agencies to identify the data that will best support performance management. It requires quarterly reporting on racial and geographic data measuring disparities within MFIP. It also requires monthly and quarterly reporting on the self-support index, which measures the percentage of MFIP and DWP cases off cash assistance or working 30 hours or more per week at one, two, and three-year follow-up points.

Clarifying Treatment of Lump Sum Payments and ABLE Accounts for Asset Determination (*amends § 256P.02, subd. 1 and subd. 1a*)

PROBLEM:
Minnesota Statute § 256P was enacted in 2014, and implemented on October 1, 2016, to create as much consistency in eligibility for public assistance programs as possible. During the implementation process it was found that the statute required clarification of how lump sum payments are treated when determining a client's assets.

Minnesota Statute § 256Q became effective on July 1, 2015. This section created Achieving a Better Life Experience (ABLE) accounts. The ABLE accounts are intended to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life, and to provide secure funding for disability-related expenses on behalf of designated beneficiaries with disabilities that will supplement, but not supplant, benefits provided through private insurance, the Medicaid program under title XIX of the Social Security Act, the Supplemental Security Income program under title XVI of the Social Security Act, the beneficiary's employment, and other sources. During the implementation process it was found that there was no guidance in § 256P regarding how those accounts would be treated.

PROPOSAL:
This section proposes that lump sum payments shall be counted as income for two months. If the lump sum remains available to the client in the third month, it shall be counted as an asset in the asset limit. The proposed statutory change is codification of existing policy governing lump sum payments. To fulfill the intent of the

legislation establishing ABLE accounts, this section proposes that ABLE accounts be exempt from inclusion in the asset limit.

Entry Level Mental Health Provider Training and Standards *(256B.0943)*

PROBLEM: Mental Health Behavioral Aides are an entry level position in the children's mental health workforce. Currently, Mental Health Behavioral Aides are required to undergo preservice training as well as continuing education. However, the statute is unclear about what topics must be covered prior to providing services and what can be covered in continuing education. In addition, the training topics do not necessarily reflect the skills and knowledge needed for individuals to fulfill this role.

PROPOSAL: This proposal would update the training requirements to better align with the role of behavioral aides in delivering services as well as provide clarity on which topics must be covered before providing services and what training may be conducted as part of continuing education. These changes are intended to provide clarity for individuals seeking to become behavioral aides as well as provider seeking to hire new behavioral aides.

Host County Contract for Intensive Mental Health Services *(256B.0622)*

PROBLEM: DHS certifies and/or licenses intensive mental health services for adults – spefically Assertive Community Treatment (ACT) and Intensive Residential Treatment Services (IRTS) – but a host county contract is a prerequisite for certification (Minn. Statute 256B.0622).

This is an outdated requirement that creates confusion for providers seeking approval from both the state and county and creates delays in developing programs. When the requirement for a host county contract was established, counties had a much more direct role in funding and oversight of intensive mental health services but this requirement does not fit well with the mental health service system as it currently exists. Today, state and federal funding pays for the majority of these services through Medical Assistance (MA) and MinnesotaCare while state grants support counties in paying for care for individuals without adequate health care coverage.

PROPOSAL: This proposal would eliminate the requirement that intensive mental health services for ACT IRTS programs to have a host county contact. Similar children's mental health services already do not have this requirement. While this proposal would eliminate the requirement for a formal contract arrangement, it would also require providers to demonstrate that the program has an ongoing relationship with the counties it serves, as well as other levels of care, in order to facilitate access and continuity of care for clients, especially for individuals whose health care coverage may be disrupted or inadequate. To this end, the proposal would require providers to demonstrate and document:

- An ongoing relationship with counties and tribal nations serving as the local mental health authority.
- Ongoing relationships with other levels of care, to facilitate referrals to and from the proposed program.

The proposal also seeks to strengthen the DHS certification process to ensure that there is a demonstrated need for the service in a given area, as identified by the communities being served, and to mitigate against overdevelopment.