House Research Act Summary

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TOPIC: Health and Human Services Finance

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Article 1: Affordable Care Act Implementation; Better Health Care for More Minnesotans

Overview

This article contains provisions related to the MinnesotaCare program, and requirements for a basic health plan under the federal Affordable Care Act (ACA). The article eliminates the $10,000 annual limit on inpatient hospital benefits, the related coinsurance requirement, and the four-month uninsured and 18-month no access to employer subsidized insurance requirements. The article also reduces MinnesotaCare income limits, increases the MA income limit for children, establishes requirements for service delivery, and directs the commissioner of human services to seek federal authority and funding to operate a health coverage program for persons with incomes up to 275 percent of the federal poverty guidelines (FPG). The article also contains other provisions related to ACA implementation.

1 **MinnesotaCare federal receipts.** Amends § 16A.724, subd. 3. Dedicates all federal funding received for implementation and administration of MinnesotaCare as a basic health program to that program and requires this money to be deposited into the health care access fund. Allows this money to be used only for that program to: purchase health coverage for enrollees, reduce enrollee premiums and cost-sharing, or provide additional benefits. Strikes language related to the deposit of federal funds for administrative costs. Provides a January 1, 2015 effective date.

2 **Eligibility.** Amends § 254B.04, subd. 1. Strikes a cross-reference to a section repealed later in the bill (§ 256B.057, subd. 2). Provides a January 1, 2014 effective date.

3 **Federal approval.** Amends § 256.01, by adding subd. 35. (a) Requires the commissioner to seek federal authority necessary to operate a health insurance program for persons with incomes up to 275 percent of FPG. The proposal must seek to secure all federal funding available from at least the following sources:

(1) premium tax credits and cost sharing subsidies for individuals with incomes above 133 percent and at or below 275 percent of FPG, who would otherwise be enrolled in the Minnesota Insurance Marketplace;

(2) Medicaid; and

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

(b) Requires funding received to be used to design and implement a health coverage program that is streamlined and meets the needs of Minnesotans with income up to 275 percent of FPG. Specifies program criteria.

(c) Directs the commissioner to develop and submit a proposal consistent with the criteria in paragraph (b), and seek all federal authority necessary to implement the program. Requires

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the commissioner to consult with stakeholder groups and consumers in developing the proposal.

(d) Authorizes the commissioner to seek any available federal waivers and approvals prior to 2017.

(e) Requires the commissioner to report progress to the relevant legislative committees by January 15, 2015.

(f) Gives the commissioner authority to accept and spend federal funds.

4 **State agency has lien.** Amends § 256.015, subd. 1. Makes a conforming change related to participating entities, in a section of law dealing with state agency liens on health care related causes of action and recoveries.

5 **Affordable care act.** Amends § 256B.02, subd. 17. Modifies an existing definition of the ACA. Provides a July 1, 2013 effective date.

6 **Caretaker relative.** Amends § 256B.02, by adding subd. 18. Defines "caretaker relative." Provides a January 1, 2014 effective date.

7 **Insurance affordability program.** Amends § 256B.02, by adding subd. 19. Defines "insurance affordability program" as one of the following: (1) MA; (2) a program that provides advance payments of premium tax credits or cost-sharing reductions; (3) MinnesotaCare; and (4) a Basic Health Plan. Provides an immediate effective date.

8 **Applications for medical assistance.** Amends § 256B.04, subd. 18. Requires DHS to accept applications for MA by telephone, mail, in-person, online, and through other commonly available electronic means. Strikes the requirement that DHS conduct eligibility determinations for MinnesotaCare. Requires DHS to determine whether individuals found not eligible for MA are potentially eligible for other insurance affordability programs. Provides a January 1, 2014 effective date.

9 **Families with children.** Amends § 256B.055, subd. 3a. Expands MA eligibility to include children under the age of 19 (current law refers to children under age 18, with certain education-related exceptions for children under 19). Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

10 **Pregnant women; needy unborn child.** Amends § 256B.055, subd. 6. Requires the MA program, when providing coverage to pregnant women, to accept self-attestation of pregnancy, unless the agency has information not reasonably compatible with the attestation. (Current law requires written verification of pregnancy from a physician or licensed registered nurse.) Provides a January 1, 2014 effective date.

11 **Infants.** Amends § 256B.055, subd. 10. States that MA covers infants less than two years of age in a family with countable income less than the income standard. (With this change, this section will reflect coverage under current MA law.) Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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12 **Adults without children.** Amends § 256B.055, subd. 15. Modifies the definition of the adults without children under MA, to remove a requirement that the person not be an adult in a family with children and to require the person to not otherwise be eligible for MA under the aged, blind, or disabled eligibility category as a person who meets the categorical requirements of the Supplemental Security Income Program, and not be enrolled as a person who would meet these requirements except for excess income or assets. Provides a January 1, 2014 effective date.

13 **Adults who were in foster care at the age of 18.** Amends § 256B.055, by adding subd. 17. Allows MA coverage for a person under age 26 who was in foster care on the date of attaining 18 years of age, and who was enrolled in MA while in foster care. Provides a January 1, 2014 effective date.

14 **Residency.** Amends § 256B.056, subd. 1. Requires MA applicants to be residents of the state in accordance with specified federal regulations (current law requires compliance with the rules of the state agency). Provides a January 1, 2014 effective date.

15 **Families with children income methodology.** Amends § 256B.056, subd. 1c. Strikes income methodology provisions for families with children to conform to the ACA. Strikes a cross-reference to a section repealed in the bill, related to MA income eligibility for children. Provides a January 1, 2014 effective date.

16 **Asset limitations for certain individuals.** Amends § 256B.056, subd. 3. Makes a change to the subdivision headnote.

17 **Income.** Amends § 256B.056, subd. 4. Effective January 1, 2014, increases the MA income limit for children age 19 to 20 to 133 percent of FPG, and increases the MA income limit for children under age 19 to 275 percent of FPG. Also makes conforming changes. Provides a January 1, 2014 effective date.

18 **Excess income standard.** Amends § 256B.056, subd. 5c. Increases, from 100 to 133 percent of FPG, the spend-down standard that applies to parents and caretaker relatives, pregnant women, infants, and children two through 20. Also strikes outdated language. Provides a January 1, 2014 effective date.

19 **Periodic renewal of eligibility.** Amends § 256B.056, by adding subd. 7a. (a) Requires the commissioner to make annual redeterminations of eligibility based on information in the enrollee's case file and other available information, without requiring the enrollee to submit any information when sufficient data is available to renew eligibility.

(b) If eligibility cannot be renewed as provided in paragraph (a), requires the commissioner to provide the enrollee with a prepopulated renewal form, and to permit the enrollee to submit the form with any corrections or additional information, and to sign the renewal form by the allowed means of submission.

(c) Allows an enrollee terminated for failure to complete the renewal process to submit the renewal within four months of termination and if eligible, have coverage reinstated without a

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lapse (retroactive to the date of termination).

(d) Requires individuals eligible under a spend-down to renew eligibility every six months.

Provides a January 1, 2014 effective date.

20 **Eligibility verification.** Amends § 256B.056, subd. 10. Requires the commissioner to use information obtained through the electronic service established by the U.S. Department of Health and Human Services and other available electronic data sources to verify eligibility requirements. Requires the commissioner to establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees (including self-attestation), to allow real-time eligibility determinations and maintain program integrity. Provides a January 1, 2014 effective date.

21 **Infants and pregnant women.** Amends § 256B.057, subd. 1. Provides that infants less than age two are eligible for MA. (Current law in this section refers to infants less than age one.) Also removes the requirement that pregnant women have written verification of pregnancy from a physician or registered nurse. Strikes a reference to the use of existing income methodologies based on AFDC income methodology, and adds a reference to the use of an equivalent income standard based on MAGI. Provides a January 1, 2014 effective date.

22 **Children under age two.** Amends § 256B.057, subd. 8. Adds a reference to using an equivalent income standard based on MAGI, in a provision of law specifying the MA income limit for certain children under age two. Provides a January 1, 2014 effective date.

23 **Certain persons needing treatment for breast or cervical cancer.** Amends § 256B.057, subd. 10. Removes a cross-reference to a section repealed in this bill. Provides a January 1, 2014 effective date.

24 **Presumptive eligibility determinations made by qualified hospitals.** Amends § 256B.057, by adding subd. 12. Directs the commissioner to establish a process to qualify hospitals to determine presumptive eligibility for MA for applicants who may have a basis of eligibility using MAGI. Provides a January 1, 2014 effective date.

25 **Citizenship requirements.** Amends § 256B.06, subd. 4. Clarifies that MA coverage, funded through the federal Children's Health Insurance Program, is for pregnancy related services for pregnant women funded who are ineligible for federally funded MA because of immigration status (this consolidates the current law reference to persons who are undocumented, nonimmigrants, or lawfully present). Provides a January 1, 2014 effective date.

26 **Accountability.** Amends § 256B.0755, subd. 3. Requires a health care delivery system to indicate how its services will be coordinated with services provided by other providers and county agencies, how these entities will be engaged, and how these entities were consulted in developing the application. Provides that this section applies to contracts entered into or renewed on or after July 1, 2013.

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27 **Sole-source or single-plan managed care contract.** Amends § 256B.694. Allows the commissioner to consider and approve contracting on a single-plan basis with county-based purchasing plans to serve state public health care program enrollees. (Current law limits this to plans serving persons with a disability who voluntarily enroll.)

28 **Affordable Care Act.** Amends § 256L.01, by adding subd. 1b. Provides a definition of the Affordable Care Act.

29 **Family.** Amends § 256L.01, subd. 3a. Amends the definition of family, by referring to federal regulations that define the family as those individuals for whom a taxpayer claims a deduction for a personal exemption. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

30 **Income.** Amends § 256L.01, subd. 5. Defines income under MinnesotaCare as modified adjusted gross income. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

31 **Minnesota Insurance Marketplace.** Amends § 256L.01, by adding subd. 6. Defines the Minnesota Insurance Marketplace.

32 **Participating entity.** Amends § 256L.01, by adding subd. 6. Defines a participating entity as a health carrier, county-based purchasing plan, accountable care organization or other entity operating a health care delivery systems demonstration project, an entity operating a county integrated health care delivery network pilot project, or a network of health care providers established to offer services under MinnesotaCare. Provides a January 1, 2015 effective date.

33 **Commissioner's duties.** Amends § 256L.02, subd. 2. Requires payment for MinnesotaCare services to be made to all participating entities under contract with the commissioner. Requires a Web site to be used to provide information about medical programs and promote access to services. Provides that this section is effective July 1, 2014, or upon federal approval, except that the amendment related to "participating entities" is effective January 1, 2015.

34 **Federal approval.** Amends § 256L.02, by adding subd. 6. (a) Requires the commissioner of human services to seek federal approval to implement the MinnesotaCare program as a basic health program. Requires the commissioner to seek to include, in any agreement with the Centers for Medicare and Medicaid Services, procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of the program. Requires the procedures to address the timing of payments, payment reconciliation, enrollee risk adjustment, and minimizing state financial risk. Requires the commissioner of human services to consult with the commissioner of management and budget when developing the basic health plan proposal to be submitted to the federal government.

(b) Requires the commissioner of human services, in consultation with the commissioner of management and budget, to work with the CMS to establish a process for the reconciliation and adjustment of federal payments that balances state and federal liability over time.

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Requires the commissioner to request that the state and enrollees be held harmless in the reconciliation process for three years to allow the state to develop a statistically valid methodology to predict enrollment trends and their effect on federal payments.

Provides an immediate effective date.

35 **Coordination with Minnesota Insurance Marketplace.** Amends § 256L.02, by adding subd. 7. States that MinnesotaCare shall be considered a public health care program for purposes of chapter 62V. Provides a January 1, 2014 effective date.

36 **Covered health services.** Amends § 256L.03, subd. 1. Updates the listing of MinnesotaCare covered services, by striking language excluding coverage of inpatient hospital services, inpatient mental health services, and chemical dependency services. (These services are covered under current law.) Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

37 **Children; MinnesotaCare health care reform waiver.** Amends § 256L.03, subd. 1a. Removes reference to coverage of pregnant women under MinnesotaCare (these individuals are eligible for MA; another provision in this bill states that persons eligible for MA are not eligible for MinnesotaCare). Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

38 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Removes the annual inpatient hospital limit of $10,000. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

39 **Loss ratio.** Amends § 256L.03, by adding subd. 4a. Requires coverage provided through the MinnesotaCare program to have a medical loss ratio of at least 85 percent. Provides a January 1, 2015 effective date.

40 **Cost-sharing.** Amends § 256L.03, subd. 5. Eliminates the 10 percent coinsurance requirement for inpatient hospital services. Makes conforming changes related to elimination of the $10,000 annual limit on inpatient hospital costs. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

41 **Lien.** Amends § 256L.03, subd. 6. Modifies the definition of "state agency" by replacing references to prepaid health plans and county-based purchasing entities with a reference to participating entities. This amendment is to a provision that gives the state agency a lien for the cost of covered health services upon causes of action accruing to the enrollee or the enrollee's legal representative. Provides a January 1, 2015 effective date.

42 **Families with children.** Amends § 256L.04, subd. 1. Modifies MinnesotaCare income eligibility criteria, to cover families with children with incomes above 133 percent of FPG and not exceeding 200 percent of FPG and makes related changes. (Under current law, MinnesotaCare covers families with children with incomes not exceeding 275 percent of FPG, with a fixed income limit for parents of $57,500.) Allows children under age 19 with incomes at or below 200 percent of FPG to be eligible for MinnesotaCare, if they are not eligible for MA solely due to application of the federal household composition rule.

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Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

43 **General requirements.** Amends § 256L.04, by adding subd. 1c. To be eligible for the MinnesotaCare, requires a person to meet the eligibility requirements of this section. Provides that a person eligible for MinnesotaCare shall not be considered a qualified individual and is not eligible to enroll in a qualified health plan offered through the Minnesota Insurance Marketplace. Provides a January 1, 2014 effective date.

44 **Single adults and households with no children.** Amends § 256L.04, subd. 7. Modifies MinnesotaCare income eligibility criteria, to cover individuals and families with no children with incomes above 133 percent of FPG and not exceeding 200 percent of FPG. (Under current law, MinnesotaCare covers individuals and households without children with incomes not exceeding 250 percent of FPG.) Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

45 **Applicants potentially eligible for medical assistance.** Amends § 256L.04, subd. 8. Strikes language that allows potentially eligible persons to enroll in either MinnesotaCare or MA. Also makes conforming changes related to the ACA and strikes an obsolete date. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

46 **Citizenship requirements.** Amends § 256L.04, subd. 10. States that families and individuals who are lawfully present and ineligible for MA due to immigration status, with incomes not exceeding 200 percent of FPG, are eligible for MinnesotaCare. Specifies that lawfully present noncitizens are eligible for MinnesotaCare. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

47 **Persons in detention.** Amends § 256L.04, subd. 12. Specifies that enrollees and applicants residing in a correctional or detention facility are eligible for MinnesotaCare while awaiting disposition of charges. Provides a January 1, 2014 effective date.

48 **Coordination with medical assistance.** Amends § 256L.04, by adding subd. 14. (a) States that individuals eligible for MA are not eligible for MinnesotaCare.

(b) Requires the commissioner to provide seamless eligibility and access to services, for persons transitioning between MA and MinnesotaCare.

Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

49 **Application assistance and information availability.** Amends § 256L.05, subd. 1. Allows applicants to submit their applications online, in person, by mail, or by phone in accordance with the ACA, and by any other means by which MA applications may be submitted. Allows applicants to submit applications through the Minnesota Insurance Marketplace or through the MinnesotaCare program. Requires MinnesotaCare applications and application assistance to be available at locations at which MA applications must be made available (in addition to those locations already listed in law). Requires application assistance to be available for applicants filing online applications through the Minnesota Insurance Marketplace. Provides a January 1, 2014 effective date.

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50 **Commissioner's duties.** Amends § 256L.05, subd. 2. Makes conforming changes, adding references to the Minnesota Insurance Marketplace and the ACA. Provides a January 1, 2014 effective date.

51 **Effective date of coverage.** Amends § 256L.05, subd. 3. Strikes references to coverage dates for newborns and newly adoptive children. Adds a reference to the use of MAGI and makes other changes. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

52 **Retroactive coverage.** Amends § 256L.05, subd. 3c. States that provisions related to MinnesotaCare retroactive coverage do not apply and shall not be implemented, once eligibility determination for MinnesotaCare is conducted by the Minnesota Insurance Marketplace. Strikes an obsolete reference to General Assistance Medical Care. Provides a January 1, 2014 effective date.

53 **Commissioner's duties and payment.** Amends § 256L.06, subd. 3. Eliminates the four-month waiting period to re-enroll, for persons disenrolled for nonpayment of premium or who voluntarily disenroll. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

54 **General requirements.** Amends § 256L.07, subd. 1. Sets the MinnesotaCare income limit at 200 percent of FPG (the current income limit is 275 percent of FPG for families and children and 250 percent of FPG for adults without children). Also strikes references to the MinnesotaCare insurance barriers, which are modified in a later section. Makes conforming changes. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

55 **Must not have access to employer-subsidized minimum essential coverage.** Amends § 256L.07, subd. 2. Provides that persons with access to subsidized health coverage that is affordable and provides minimum value as defined in federal regulations are not eligible for MinnesotaCare. Under current law, persons must not have access to subsidized employer coverage, or have had access through the current employer for 18 months prior to application or reapplication. Subsidized coverage is that for which the employer pays at least 50 percent of the cost. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

56 **Other health coverage.** Amends § 256L.07, subd. 3. Provides that a family or individual must not have minimum essential health coverage, to be eligible for MinnesotaCare. Strikes the requirement under current law that persons must have no health coverage while enrolled, or for at least four months prior to application and renewal, and also strikes related language. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

57 **Residency requirement.** Amends § 256L.09, subd. 2. Strikes references to pregnant women and the MA residency requirement. Provides an effective date of January 1, 2104, or upon federal approval, whichever is later.

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58 **Medical assistance rate to be used.** Amends § 256L.11, subd. 1. States that payment to providers are at the same rates and conditions established under MA, except as otherwise provided. Provides an effective date of January 1, 2014.

59 **Inpatient hospital services.** Amends § 256L.11, subd. 3. Makes conforming changes to inpatient hospital rates, specifying that the rate paid is the MA rate. Provides an effective date of January 1, 2014.

60 **Selection of vendors.** Amends § 256L.12, subd. 1. Allows the commissioner to consider proposals to serve MinnesotaCare enrollees from managed care-like entities.

61 **Service delivery.** Adds § 256L.121.

Subd. 1. Competitive process. Requires the commissioner to establish a competitive process for contracting with participating entities for the offering of standard health plans. Requires coverage to be available beginning January 1, 2015. Requires each standard health plan to cover the services listed in section 256L.03 and meet the requirements of that section. States that the competitive process must meet the requirements of the ACA and be designed to increase access to high-quality health care coverage options. Requires the commissioner, to the extent feasible, to seek to ensure that enrollees have the choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, requires the commissioner to use the competitive procurement process used for the prepaid medical assistance program, except for competitive bidding.

Subd. 2. Other requirements for participating entities. Directs the commissioner to require participating entities, as a condition of contract, to document: (1) the provision of culturally and linguistically appropriate services, including marketing materials, to enrollees; and (2) the inclusion of essential community providers in provider networks.

Subd. 3. Coordination with state-administered health programs. Requires the commissioner to coordinate the administration of MinnesotaCare with medical assistance. Specifies requirements for coordination.

Provides an immediate effective date.

62 **Premium determination.** Amends § 256L.15, subd. 1. Strikes references to nonpayment of premiums for pregnant women and children. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

63 **Sliding fee scale; monthly individual or family income.** Amends § 256L.15, subd. 2. Modifies the MinnesotaCare premium scale, effective January 1, 2014, to requires persons age 21 and older to pay per-person premiums, based on a sliding scale tied to the federal poverty guidelines. Makes conforming changes. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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64 **Determination of funding adequacy for MinnesotaCare.** Requires the commissioners of revenue and management and budget, in consultation with the commissioner of human services, to conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the November 2013 forecast. Requires the commissioners to determine the amount of state funding that will be needed after December 31, 2019, in addition to federal basic health plan payments, for the MinnesotaCare program, and to evaluate the stability and likelihood of long-term federal funding. Requires the commissioners to report results to legislative chairs and ranking minority members by January 15, 2014, including recommendations for changes to state revenue for the fund, if state funding will continue to be required.

65 **State-based risk adjustment system assessment.**

(a) Requires the commissioner of health to collect from health carriers in the individual and small group markets data required for conducting risk adjustment with standard risk adjusters and specifies criteria for the data.

(b) Requires the commissioner of health to assess the extent to which the data collected are sufficient for developing and operating a state alternative risk adjustment methodology consistent with federal rules.

(c) Gives the commissioner of health the authority to use identified data to validate and audit a statistically valid sample of data for each health carrier.

(d) If the assessment finds that the data are sufficient for developing and operating a state alternative risk adjustment methodology, requires the commissioners of health and human services, in consultation with the commissioner of commerce and the MNsure board, to study whether state-based risk adjustment, using either the federal risk adjustment model or a state-based alternative, can be more cost-effective and perform better than risk adjustment conducted by federal agencies. Specifies study criteria.

(e) Specifies criteria for contracting for the study, and requires the commissioner of human services to evaluate and make recommendations for maximizing federal funding.

(f) Requires the commissioner of health to submit an interim report to the legislature by March 15, 2014, and a final report by October 1, 2015. Specifies criteria for the reports.

(g) Requires the MNsure board to apply for federal funding under the ACA, and allows the commissioners of health and human services to proceed with implementation of the section only if funding has been made available.

(f) Defines the MNsure board and the ACA.

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66 **Request for federal authority.** Requires the commissioner of human services to seek federal authority to allow persons under age 65, participating in a home and community-based services waiver, to continue to disregard spousal income and assets, in place of the spousal asset provisions under the Affordable Care Act.

67 **Revisor's instruction.** Directs the revisor to remove references to sections repealed in the bill and make conforming changes. Also directs the revisor to change the term Minnesota Insurance Marketplace to MNsure in this article and in statute.

68 **Repealer.**

(a) Repeals the following provisions, effective January 1, 2014: § 256L.01, subd. 4a (definition of gross income); 256L.031 (Healthy Minnesota Contribution Program); 256L.04, subds. 1b (children with incomes greater than 275 percent FPG), 9 (reference to General Assistance Medical Care), and 10a (deeming of sponsor income and resources); 256L.05, subd. 3b (reapplication after a lapse); 256L.07, subds. 1 (eligibility related to income and insurance barriers), 5 (voluntary disenrollment for members of the military), 8 (automatic eligibility for foster care and other children), and 9 (eligibility for firefighters and ambulance attendants); 256L.11, subds. 5 and 6 (payment for inpatient hospital services for children), and 256L.17, subds. 1, 2, 3, 4, and 5 (MinnesotaCare asset requirement).

(b) Repeals the following provisions, effective January 1, 2014: § 256B.055, subds. 3 (MA coverage until March 31, 1998, for AFDC-related dependent children), 5 (MA coverage for certain AFDC-related pregnant women), and 10b (MA for children under age two; **§** 256B**.**056, subd. 5b (requiring certain recipients not residing in a long-term care facility to verify their income every six months); and **§** 256B.057, subd. 1c (no asset test for pregnant women) and 2 (children eligible at 150 percent FPG; use of six-month budget periods).

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

Overview

This article modifies the Disability Linkage Line, the Senior Linkage Line, long-term care consultations, SAIL projects, the common entry point for reporting maltreatment of a vulnerable adult, and preadmission screening requirements.

1 **Resident assessment schedule.** Amends § 144.0724, subd. 4. Modifies the list of assessments used to determine nursing facility level of care.

2 **Balancing long-term care services and supports; report and study required.** Amends § 144A.351.

Subd. 1. Report requirements. No changes.

Subd. 2. Critical access study. Requires the commissioner of human services to conduct a onetime study to assess local capacity and availability of home and community-based services for older adults and people with disabilities and people with

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mental illnesses. Requires the study to assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. Requires the report to be submitted to the legislature no later than August 15, 2015.

3 **City, county, and state social workers.** Amends § 148E.065, subd. 4a. Exempts city, county, and state agencies employing staff designated to perform duties under the Senior Linkage Line and Disability Linkage Line from employing licensed social workers.

4 **Specific powers.** Amends § 256.01, subd. 2. Requires the commissioner to designate agencies that operate the Senior Linkage Line as the state of Minnesota Aging and Disability Resource Centers under federal law and to incorporate cost reimbursement claims from the designated centers into the federal cost reimbursement claiming processes. Requires reimbursements to be appropriated to the commissioner to be granted to the Aging and Disability Resource Center designated agencies.

5 **Disability Linkage Line.** Amends § 256.01, subd. 24. Modifies the Disability Linkage Line.

6 **Consumer information and assistance and long-term care options counseling; Senior Linkage Line.** Amends § 256.975, subd. 7. Modifies the Senior Linkage Line.

7 **Preadmission screening activities related to nursing facility admissions.** Amends § 256.975, by adding subd. 7a. Requires all individuals seeking admission to Medicaid certified nursing facilities to be screened prior to admission. States the purpose of the screening is to determine the need for nursing facility level of care and to complete federally required activities related to mental illness and developmental disabilities. Lists the criteria that apply to the preadmission screening. Allows the local county mental health authority or the state developmental disability authority to prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services. Lists the screener's duties in assessing a person's needs. Makes this section effective October 1, 2013.

8 **Exemptions and emergency admissions.** Amends § 256.975, subd. 7b. Lists exemptions from the federal screening requirements. Lists persons who are exempt from preadmission screening for purposes of level of care determination. Specifies when a screening must occur for persons admitted to a Medicaid certified nursing facility from the community on an emergency basis or from an acute care facility on a nonworking day. Allows emergency admissions to a nursing facility prior to a screening under certain conditions. Requires nursing facilities to provide written information to all persons admitted regarding a person's right to request and receive long-term care consultation services. Makes this section effective October 1, 2013.

9 **Screening requirements.** Amends § 256.975, by adding subd. 7c. Lists preadmission screening requirements. Makes this section is effective October 1, 2013.

10 **Payment for preadmission screening.** Amends § 256.975, by adding subd. 7d. Specifies funding sources for preadmission screening. Requires the Minnesota Board on Aging to

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employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding for the service. Makes this section effective October 1, 2013.

11 **Priority for other grants.** Amends § 256.9754, by adding subd. 3a. Requires the commissioner of health to give priority to community services development grantees using technology as a part of a proposal when awarding technology-related grants. Requires the commissioner of transportation to give priority to grantees creating transportation options for older adults when distributing transportation-related funds.

12 **State waivers.** Amends § 256.9745, by adding subd. 3b. Allows the commissioner of health to waive applicable state laws and rules on a time-limited basis if the commissioner determines that a participating grantee requires a waiver in order to achieve demonstration project goals.

13 **Grant preference.** Amends § 256.9754, subd. 5. Requires the commissioner to give preference when awarding community services development grants to areas with identified home and community-based services needs.

14 **Evaluation.** Amends § 256B.021, by adding subd. 4a. Requires the commissioner to evaluate certain Medicaid Reform Waiver projects and lists the information that must be included in the evaluation.

15 **Work, empower, and encourage independence.** Amends § 256B.021, by adding subd. 6. Upon federal approval, requires the commissioner to establish a demonstration project to provide navigation, employment supports, and benefits planning services to a targeted group of Medicaid recipients beginning July 1, 2014. Requires the project to promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants.

16 **Housing stabilization.** Amends § 256B.021, by adding subd. 7. Upon federal approval, requires the commissioner to establish a demonstration project to provide service coordination, outreach, in-reach, tenancy support, and community living assistance to a targeted group of Medicaid recipients beginning January 1, 2014. Requires this project to promote housing stability, reduce costly medical interventions, and increase opportunities for independent community living.

17 **Purpose and goal.** Amends § 256B.0911, subd. 1. Updates cross-references.

18 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definitions of "long-term care consultation services" and "long-term care options counseling" by updating cross-references and making conforming changes.

19 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Updates cross-references and modifies the information that must be provided to the person receiving assessment or support planning, or the person's legal representative.

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20 **Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, subd. 4d. Updates cross-references, makes conforming changes, specifies the funding source for preadmission screenings provided by the Senior Linkage Line, and requires the Disability Linkage Line to employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding. Makes this section effective October 1, 2013.

21 **Determination of institutional level of care.** Amends § 256B.0911, by adding subd. 4e. Requires the determination of the need for nursing facility, hospital, and ICF/DD levels of care to be made according to criteria developed by the commissioner. Specifies the criteria to be used in determining the need for nursing facility level of care.

22 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Makes conforming changes.

23 **Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Updates cross-references.

24 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Updates a cross-reference.

25 **Assessments and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Updates a cross-reference.

26 **Home and community-based services for older adults.** Amends § 256B.0917, by adding subd. 1a. Specifies the purpose of projects selected by the commissioner is to make strategic changes in the long-term services and supports system for older adults. States the projects are intended to create incentives for new and expanded home and community-based services in order to meet listed goals. Makes the services provided by these projects available to older adults who are eligible for MA and the elderly waiver, the alternative care program, or essential community supports grants, and to persons who have their own funds to pay for services.

27 **Definitions.** Amends § 256B.0917, by adding subd. 1b. Defines "community," "core home and community-based services provider," "eldercare development partnership," "long-term services and supports," and "older adult."

28 **Eldercare development partnerships.** Amends § 256B.0917, by adding subd. 1c. Requires the commissioner to select and contract with eldercare development partnerships. Lists the duties of the eldercare development partnerships.

29 **Caregiver support and respite care projects.** Amends § 256B.0917, subd. 6. Modifies caregiver support and respite care projects under SAIL.

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30 **Core home and community-based services.** Amends § 256B.0917, by adding subd. 7a. Requires the commissioner to select and contract with core home and community-based services providers for projects to provide services and supports to older adults. Lists criteria projects must meet.

31 **Community service grants.** Amends § 256B.0917, subd. 13. Broadens the preference for awarding community service grants to include areas with service needs identified in a needs determination process. Removes a list of services for which the commissioner must consider grants.

32 **Consumer surveys of nursing facilities residents.** Amends § 256B.439, subd. 3. Specifies consumer surveys are surveys of nursing facility residents.

33 **Home and community-based services report card in cooperation with the commissioner of health.** Amends § 256B.439, by adding subd. 3a. Requires the commissioner to work with existing advisory groups to develop recommendations for a home and community-based services report card. Lists items to be considered in developing the recommendations. Requires a report to the legislature by August 1, 2014.

34 **Dissemination of quality profiles.** Amends § 256B.439, subd. 4. Modifies requirements related to the dissemination of quality profiles.

35 **External fixed costs.** Amends § 256B.441, subd. 13. Modifies the definition of "external fixed costs."

36 **Calculation of payment rate for external fixed costs.** Amends § 256B.441, subd. 53. Modifies the calculation of payment rates for external fixed costs by removing costs for long-term care consultations beginning October 1, 2013.

37 **Informed choice.** Amends § 256B.49, subd. 12. Modifies a cross-reference.

38 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Modifies a cross-reference.

39 **Preadmission screening waiver.** Amends § 256B.69, subd. 8. Adds a cross-reference.

40 **Supplementary service rate; exemptions.** Amends § 256I.05, by adding subd. 1o. Prohibits counties from negotiating GRH supplementary service rates for certain individuals determined to be eligible for Housing Stability Services.

41 **Reporting.** Amends § 626.557, subd. 4. Modifies maltreatment of vulnerable adults reporting requirements by allowing the common entry point to accept electronic reports submitted through a Web-based reporting system established by the commissioner. Makes this section effective July 1, 2014.

42 **Common entry point designation.** Amends § 626.557, subd. 9. Removes language requiring each county board to designate a common entry point for reports of suspected maltreatment of vulnerable adults. Requires the commissioner to establish a common entry point effective July 1, 2014. Requires the common entry point to have access to the

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centralized database and to log reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation. Specifies requirements for the operation of the common entry point. Requires the commissioners of human services and health to collaborate on the creation of a system for referring reports to the lead investigative agencies.

43 **Education requirements.** Amends § 626.557, subd. 9e. Requires the commissioner of human services to conduct an outreach campaign to promote the common entry point for reporting vulnerable adult maltreatment.

44 **Federal approval.** Makes this article contingent on federal approval.

45 **Repealer.** (a) Repeals Minnesota Statutes, sections 245A.655 (federal grants to establish and maintain a single common entry point for reporting maltreatment of a vulnerable adult); and 256B.0917, subds. 1 (SAIL purpose, mission, goals and objectives), 2 (design of SAIL projects), 3 (local long-term care strategy), 4 (information, screening, and assessment function), 5 (service development and delivery), 7 (contract), 8 (living-at-home/block nurse program grant), 9 (state technical assistance center), 10 (implementation plan), 11 (SAIL evaluation and expansion), and 12 (public awareness campaign).

(b) Repeals Minnesota Statutes, section 256B.0911, subds. 4a, 4b, and 4c (preadmission screening activities related to nursing facility admissions; exemptions and emergency admissions; screening requirements) effective October 1, 2013.

Article 3: Safe and Health Development of Children, Youth, and Families

Overview

This article modifies provisions of MFIP and establishes rates and reimbursements for child care programs. It makes changes to family child care provider training and supervision requirements. Changes are made to provide services for homeless youth and sex trafficking victims. The MFIP family cap is repealed.

1 **Student parent.** Amends § 119B.011, by adding subd. 19b. Adds a definition of "student parent." Provides an effective date of November 11, 2013.

2 **Child care market rate survey.** Amends § 119B.02, by adding subd. 7. Requires the commissioner to perform a biennial survey of the prices charged by Minnesota child care providers to determine the 75th percentile for like arrangements in county price clusters. Provides a February 3, 2014, effective date.

3 **Factors which must be verified.** Amends §119B.025, subd. 1. Adds that when a family has completed a redetermination form and all verifications are received by the county agency within 30 days of the date the forms were due, then the family has met the redetermination eligibility requirements. Provides an effective date of August 4, 2014.

4 **Funding priority.** Amends § 119B.03, subd. 4. Adds student parents as a priority for BSF child care. Provides a November 11, 2013, effective date.

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5 **Eligible participants.** Amends § 119B.05, subd. 1. Makes student parents eligible for child care assistance under the MFIP child care program. Provides a November 11, 2013, effective date.

6 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Establishes the maximum rate for child care assistance. Requires the maximum registration fees in effect on January 1, 2013, to remain in effect notwithstanding any rules to the contrary.

7 **Legal nonlicensed family child care provider rates.** Amends § 119B.13. Adds county price clusters as a consideration in determining maximum rates for legal nonlicensed family child care providers. Makes this section effective February 3, 2014.

8 **Provider rate differential for accreditation.** Amends § 119B.13, subd. 3a. Requires the commissioner in conjunction with the commissioners of health and education to accept applications from accreditation organizations beginning July 1, 2013. Instructs the commissioner to pay a provider rate differential to centers that are accredited by an approved accreditation organization.

9 **Provider rate differential for Parent Aware.** Amends § 119B.13, by adding subd. 3b. Allows a family child care provider or child care center to receive a 15 percent rate differential if they have a three star Parent Aware rating and a 20 percent rate differential with a four star rating. Provides an effective date of March 3, 2014.

10 **Weekly rate paid for children attending high-quality care.** Amends §119B. 13, by adding subd. 3c. Allows a licensed provider or license-exempt center to be paid up to the weekly maximum rate, but not in excess of the provider's actual charge, when specified conditions are met. Provides an effective date of August 4, 2014.

11 **Provider payments.** Amends § 119B.13, subd. 6. Allows a county to withhold a provider's authorization or payment for not more than three months after the provider has corrected an intentional violation of program rules. Provides an effective date of February 3, 2014.

12 **Absent days.** Amends § 119B.13, subd. 7. Modifies reimbursement provided under state child care assistance programs to child providers and license-exempt centers, to:

- raise the limit, from ten to 25, on the number of days per year that providers can be reimbursed for full-day absent days of a child;
- retain a ten day limit for consecutive full-day absent days; and
- establish an exemption from the limit for some documented medical conditions.

The changes would have the effect of restoring reimbursement limits and a medical conditions exemption that had been in place prior to a 2011 legislative change. Provides an effective date of February 1, 2014.

13 **Immediate suspension expedited hearing.** Amends § 245A.07, subd. 2a. Allows the commissioner, with a determination of reasonable cause, to order the temporary immediate suspension of a license based on a violation of safe sleep requirements without demonstrating an infant died or was injured as a result of the violation.

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14 **Reduction of risk of sudden unexpected infant death in licensed programs.** Amends § 245A.1435. Paragraph (a) requires a licensed child care provider to place an infant to sleep on the infant's back unless a signed statement is on file from the infant's physician directing an alternate sleep position. Allows an infant who is able to roll over independently to remain on its stomach after being placed to sleep on its back if the infant is at least six months old or the parents have signed a statement that the infant rolls over at home.

Paragraph (b) requires a crib to have a firm mattress covered by a tight fitted sheet that overlaps the underside of the mattress. Prohibits anything from being placed in the crib with an infant except for a pacifier. Defines "pacifier."

Paragraph (c) provides that if an infant falls asleep before being placed in the crib, the license holder must move the infant to a crib as soon as practical.

Paragraph (d) allows swaddling of an infant under specified conditions.

15 **Training on risk of sudden unexpected infant death and abusive head trauma for child foster care providers.** Amends § 245A.144. Changes the term "shaken baby syndrome" to "abusive head trauma." Changes "sudden infant death" to "sudden unexpected infant death."

16 **Training on risk of sudden unexpected infant death and abusive head trauma by other programs.** Amends § 245A.1444. Changes the term "shaken baby syndrome" to "abusive head trauma." Changes "sudden infant death" to "sudden unexpected infant death."

17 **Family child care diapering area disinfection.** Creates § 245A.1446. Allows family child care providers to use disinfecting agents other than bleach to disinfect diapering areas. Lists the criteria these agents must meet in order to be used as a substitute.

18 **Family child care infant sleep supervision requirements.** Amends §245A.147.

Subd. 1. In-person checks on infants. Encourages license holders to monitor sleeping infants in-person every 30 minutes. For infants in their first four months of care and infants who have an upper respiratory infection, the license holder is encouraged to make these checks every 15 minutes.

Subd. 2. Use of audio or visual monitoring devices. Encourages license holders to use and maintain an audio or visual monitoring device to monitor each sleeping infant in care during all hours of sleep.

19 **Child care license holder insurance.** Creates § 245A.152. Paragraph (a) requires license holders to provide written notice to parents whether the license holder has liability insurance.

Paragraph (b) provides that if the license holder has insurance the parents must be informed that they can inspect the certificate of insurance, the date of expiration or next renewal of the policy, and upon the policy expiration date, whether the policy has lapsed or been renewed. If the policy was renewed, the license holder is required to inform the parents of the new expiration date.

Paragraph (c) requires a license holder who does not have liability insurance to inform parents annually of this fact.

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Paragraph (d) requires license holders to notify parents of any change in insurance status.

Paragraph (e) requires the license holder to make the certificate of insurance available to the commissioner and to county licensors.

Paragraph (f) instructs license holders to document, with a signature of the parent or guardian, that the parent or guardian received the notices required by this section.

20 **Sudden unexpected infant death and abusive head trauma training.** Amends § 245A.40, subd. 5. Adds that volunteers must receive instruction in safe sleep requirements. Changes the term "sudden infant death syndrome" to "sudden unexpected infant death" and "shaken baby syndrome" to "abusive head trauma."

21 **Family child care training requirements.** Amends § 245A.50.

Subd. 1. Initial training. No changes.

Subd. 2. Child growth and development and behavior guidance training. Changes the training requirement for child growth and development from two hours of training to four hours of child growth and development and behavior guidance training prior to initial licensure and before caring for children. Defines "behavior guidance training." Requires annual child growth and development and behavior guidance training.

Subd. 3. First aid. Requires first aid training to be repeated every two years.

Subd. 4. Cardiopulmonary resuscitation. Requires CPR training to include CPR techniques for infants and children. Requires training to be repeated every two years; the current requirement is every three years. Strikes the option of video CPR training and requires in-person, hands-on training developed by the American Heart Association or American Red Cross, or nationally recognized, evidence based guidelines.

Subd. 5. Sudden unexpected infant death and abusive head trauma training. Updates terminology. Strikes the option of video training. Requires in-person training to occur every two years; in alternate years video training is required. Currently training is required every five years.

Subd. 6. Child passenger restraint systems; training requirements. No changes.

Subd. 7. Training requirements for family and group family child care. Changes the requirement for annual training from eight to 16 hours. Clarifies that the training requirements in subdivisions 2 to 6 count toward the 16-hour training requirement.

Subd. 8. Other required training requirements. No changes.

Subd. 9. Supervising for safety; training requirements. Adds that effective July 1, 2014, all family child care license holders and adult caregivers must have at least six

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hours of training on supervising for safety prior to licensure and before caring for children. At least two hours of this training must be repeated annually.

Subd. 10. Approved training. Requires county licensing staff to accept training from the Minnesota Center for Professional Development.

Subd. 11. Provider training. Requires the commissioner to establish statewide accessible training before imposing new training requirements on providers.

22 **Contribution amount.** Amends §252.27, subd. 2a. Modifies the TEFRA parental fee. Provides an effective date of January 1, 2014 for paragraph (b).

23 **Disqualification from program.** Amends §256.98, subd. 8. Lengthens the disqualification period when a family member is found to be guilty of wrongfully obtaining child care assistance. Provides a February 3, 2014, effective date.

24 **Disregard.** Amends § 256J.08, subd. 24. Modifies the definition of "disregard." Provides an effective date of October 1, 2014, or upon USDA approval, whichever is later.

25 **Income exclusions.** Amends § 256J.21, subd. 2. Excludes housing assistance grants from income.

26 **Initial income test.** Amends § 256J.21, subd. 3. Strikes "transition standard of assistance" and inserts "family wage level." Provides an effective date of October 1, 2014, or upon USDA approval, whichever is later.

27 **MFIP transitional standard.** Amends § 256J.24, subd. 5. Strikes a cross reference to the family cap. Provides an effective date of January 1, 2015.

28 **Family wage level.** Amends § 256J.24, subd. 7. Provides that earned income is subtracted from the family wage level to determine the amount of the assistance payment. Provides an effective date of October 1, 2014, or upon USDA approval, whichever is later.

29 **Amount of assistance payment.** Amends § 256J.35. Adds that beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing assistance grant of $100 per month unless the assistance unit is a child-only case, or the assistance unit is receiving public and assisted rental subsidies through HUD.

30 **Work participation cash benefits.** Amends § 256J.621. Makes formatting changes to this section. Adds subdivision 2 which suspends the work participation cash benefits program effective December 1, 2014. Allows the commissioner to reinstate the program, but requires the commissioner to notify the legislature before reinstating the program.

31 **Performance base funds.** Amends § 256J.626, subd. 7. Readjusts the performance base fund allocations and criteria for decreased funds due to below average performance.

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32 **TANF demonstration projects or waiver from federal rules and regulations.** Creates § 256J.78. Allows the commissioner to pursue TANF demonstration projects or waivers in order to improve performance of the MFIP program and improve outcomes for participants. Requires the commissioner to report progress of the waiver or demonstration project to the legislature by March 1, 2014. Provides an immediate effective date.

33 **Homeless Youth Act.** Amends § 256K.45.

Subd. 1. Grant program established. Instructs the commissioner to establish a fund and from that fund provide grants to providers serving homeless youth and youth at risk of homelessness.

Subds. 1a and 4. No changes.

Subds. 3 and 5. Strikes "prostitution" and substitutes "sexual exploitation"

Subd. 2. Homeless youth report. Requires the commissioner to prepare a biennial report for the legislature that addresses enumerated issues.

Subd. 6. Funding. Strikes the distribution formula and instructs the commissioner to expend funds to meet the greatest need on a statewide basis.

34 **Formula.** Amends § 256M.40, subd. 1. Freezes the grant allocation formula at the 2013 level. Requires public review and input before the commissioner is allowed to make changes to the formula or recommend a change to the legislature.

35 **Creation.** Amends § 257.0755, subd. 1. Clarifies that each ombudsperson appointed by a community-specific board is to operate independently but in collaboration with the appointing board.

36 **Reimbursement for special nonmedical expenses.** Amends § 259A.20, subd. 4. Allows reimbursements for child care expenses when an adoptive parent is unemployed due to a disability. Documentation of the disability must be provided to verify the disability.

37 **Delinquent child.** Amends § 260B.007, subd. 6. Provides that a child up to age 18 who has engaged in conduct that violates laws related to prostitution is not considered a delinquent child.

Effective date. Makes this section effective August 1, 2014. Applies to offenses committed on or after that date.

38 **Juvenile petty offender; juvenile petty offense.** Amends § 260B.007, subd. 16. Adds that a juvenile petty offense does not include violation of § 609.324, subdivisions 2 or 3 (prostitution in public places or general prostitution crimes).

Effective date. Makes this section effective August 1, 2014. Applies to offenses committed on or after that date.

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39 **Child in need of protection or services.** Amends § 260C.007, subd. 6. Adds sexually exploited youth to the definition of a child in need of protection or services. Strikes language related to prostitution.

Effective date. Provides an effective date of August 1, 2014.

40 **Sexually exploited youth.** Amends § 260C.007, subd. 31. Adds that a youth who has been the victim of a third degree sexual offense crime is a sexually exploited youth.

Effective date. Provides an immediate effective date.

41 **Collection; arrears only.** Amends § 518.60. Allows the public authority to close a child support case when all children of the order are emancipated and the arrearage is under $500, or the arrearage is considered unenforceable because there have been no collections in three years and all administrative and legal remedies are ineffective. Requires the public authority to mail a notice to the last known address for the obligee and obligor at least 60 calendar days prior to case closure. Requires the public authority to keep the case open if the obligee responds before case closure and is able to provide information that could lead to collection of the arrears.

42 **EBT transaction costs.** Amends Laws 1998, ch. 407, art. 6, § 116. Prohibits the commissioner from subsidizing retailers for EBT SNAP transactions.

Effective date. Makes this section effective 30 days after the commissioner notifies retailers of the termination of their agreement with the state.

43 **Effective date.** Amends Laws 2011, First Special Session chapter 9, article 1, section 3. Changes the effective date of this section from January 1, 2013 to July 1, 2014, and makes this section effective retroactively from January 1, 2013. This section limits child care assistance payments when a child in care is related to an employee of the provider or to the provider.

44 **Direction to commissioners; income and asset exclusion.** Paragraph (a) prohibits the commissioner of human services from considering conditional cash transfers made to families participating in a family independence project as income or assets for purposes of determining eligibility for specified public assistance programs.

Paragraph (b) prohibits the commissioner of human services from considering conditional cash transfers made to families participating in a family independence project as income or assets for purposes of determining medical assistance or MinnesotaCare eligibility. An exception is made for individuals whose eligibility is calculated using modified adjusted gross income.

Paragraph (c) prohibits the MHFA commissioner from considering conditional cash transfers made to families participating in a family independence project as income or assets for purposes of determining eligibility for housing assistance programs.

Paragraph (d) defines "conditional cash transfer" and "family independence demonstration."

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Paragraph (e) requires the citizens league to provide a report to the legislature on the progress and outcomes of this demonstration project.

45 **Reduction of youth homelessness.** Instructs the Minnesota Interagency Council on Homelessness to recommend strategies to reduce youth homelessness.

46 **Housing assistance grants; forecasted program.** Provides, effective July 1, 2015, that housing assistance grants must be a forecasted program.

47 **Plan for group residential housing specialty rate and banked beds.** Requires the commissioner, in consultation and with the cooperation of the counties, to conduct a statewide review of the number and status of GRH beds with rates in excess of the MSA equivalent rate. Instructs the commissioner to develop a plan for rate setting criteria and efficient use of beds. Requires that all beds must address critical service needs and must establish quality performance requirements in order to receive supplemental services rates. Instructs the commissioner to issue a written plan no later than February 1, 2014.

48 **Repealer.** Paragraph (a) repeals §§ 256J.24, the MFIP family cap.

Paragraph (b) repeals § 609.093 (juvenile prostitutes; diversion or child protection proceedings. Provides an immediate effective date for this paragraph.

Article 4: Strengthening Chemical and Mental Health Services

Overview

This article modifies various provisions of the Adult Mental Health and the Children's Mental Health Act. It increases the county share for the care of residents at the Minnesota Security Hospital and a regional treatment center or state nursing home. The chemical health care pilot project is continued and a continuum of care pilot project for chemical health is created. Medical assistance coverage is provided for certified family peer specialists, mental health consultation, family psychoeducation, and medical service coordination.

1 **Mental illness.** Amends § 245.462, subd. 20. Adds schizoaffective disorder as one of the diagnoses for purposes of determining whether an adult has a serious and persistent mental illness.

2 **Planning for pilot projects.** Amends § 245.4661, subd. 5. Excludes placement and establishment of IRTS facilities from the local mental health authority planning process. Requires the commissioner to identify the need for IRTS services and issue a request for proposal.

3 **Duties of commissioner.** Amends § 245.4661, subd. 6. Allows the commissioner to use funds from the state-operated services account for grants to providers to participate in mental health specialty treatment services.

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4 **General provisions.** Amends § 245.4682, subd. 2. Strikes references to children's mental health in this section on reform of the mental health system.

5 **Mental health practitioner.** Amends § 245.4871, subd. 26. Strikes an outdated requirement for mental health practitioners. This change allows individuals with more than 4,000 of post-master's experience to continue to work as a mental health practitioner.

6 **Transition services.** Amends § 245.4875, subd. 8. Allows a county board to continue providing mental health services to youth over 18 but under 21 if the person requests services and the services are medically necessary.

7 **Availability of case management services.** Amends §245.4881, subd. 1. Requires counties to offer case management services to a youth over age 18 who has a serious emotional disturbance. Requires counties, before discontinuing case management services for children between the ages of 17 and 21, to develop a transition plan with the child.

8 **State-operated services account.** Amends § 246.18, subd. 8. Adds paragraph (b) which allows the commissioner to access funds in the state-operated services account to provide transition services to individuals leaving institutional settings, to make grant funds available to providers participating in mental health specialty treatment services, and to fund operation of the IRTS program in Willmar.

9 **Transfers.** Amends § 246.18, by adding subd. 9. Allows the commissioner to transfer state mental health grant funds to the state-operated services account for noncovered costs of a state-operated services IRTS provider.

10 **Liability of county; reimbursement.** Amends § 246.54.

Subd. 1. County portion for cost of care. Increases the county portion for the cost of care at a regional treatment center or state nursing home for a county resident from 50 percent to 75 percent for any days over 60.

Subd. 2. Exceptions. Excludes services at the Minnesota Security Hospital from subdivision 1. Adds that for state-operated forensic transition services at the security hospital, the county share is 50 percent of the cost of care, unless the state receives payments from other sources in excess of 50 percent of the cost of care. In those cases, a county is responsible for only the remaining amount.

11 **Administrative requirements.** Amends § 253B.10, subd. 1. Adds paragraph (b) which requires the commissioner to give priority to patients being admitted from a jail or correctional facility who are:

- (1) ordered to be examined in a state hospital;
- (2) under civil commitment for competency treatment;
- (3) found not guilty by reason of mental illness; or
- (4) committed to the commissioner after dismissal of criminal charges.

Requires the commissioner to place these individuals in a state-operated services facility within 48 hours.

Section

12 Pilot projects; chemical health care. Amends § 254B.13.

Subd. 1. Authorization for navigator pilot projects. Makes technical changes by adding the term "navigator."

Subd. 2. Program design and implementation. Deletes obsolete language and adds the term "navigator."

Subd. 2a. Eligibility for navigator pilot program. Lists the eligibility criteria a prospective client must meet in order to participate in a navigator program.

Subd. 3. Program evaluation. Adds the term "navigator."

Subd. 4. Notice of navigator program discontinuation. Allows either party to discontinue participation for any reason after 30 days written notice to the other party.

Subd. 5. Duties of the commissioner. Paragraph (a) allows the commissioner to authorize navigator programs to use the CCDTF for nontreatment services.

Paragraph (b) defines "nontreatment services."

Paragraph (c) limits state expenditures for services provided through the navigator programs to no more than the CCDTF expected share in the absence of the programs.

Paragraph (d) allows the commissioner to waive administrative rules, except the rule requiring a licensed treatment provider to provide chemical dependency treatment.

Paragraph (e) prohibits the commissioner from entering into any agreement that puts federal funding at risk.

Paragraph (f) requires the commissioner to provide participating counties with specified data at least once every six months so that the counties can assess and measure outcomes.

Subd. 6. Duties of the county board. Requires the county board in participating counties to administer the program consistent with this section, ensure that no one who is otherwise eligible for chemical dependency services is denied services, and provide the commissioner with information as negotiated in the navigator agreement.

Subd. 7. Managed care. Excludes navigator participants from mandatory enrollment in managed care until services are included in the health plan's benefit set.

Subd. 8. Authorization for continuation of navigator pilots. Allows navigator pilots already in existence to continue under existing operating agreements.

Effective date. Provides that subdivision 1 to 6 and 8 are effective August 1, 2013, and subdivision 7 is effective July 1, 2013.

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13 **Continuum of care pilot projects; chemical health care.** Creates § 254B.14.

Subd. 1. Authorization for continuum of care pilot projects. Instructs the commissioner to establish pilot projects to implement measures to improve effectiveness and efficiency of the service continuum for chemically dependent individuals.

Subd. 2. Program implementation. Paragraph (a) instructs the commissioner, in coordination with specified entities, to identify and select interested counties and providers for participation in one of three pilot projects.

Paragraph (b) requires the commissioner and entities participating in the pilots to enter into operating agreements.

Paragraph (c) allows counties participating in the navigator pilot to participate in a continuum of care pilot.

Paragraph (d) allows the commissioner to waive administrative rules that are incompatible with the pilot projects.

Paragraph (e) allows the commissioner to designate noncounty entities to complete chemical use assessments and placement authorizations.

Subd. 3. Program design. Lists the elements that must be included in the design of the pilot projects.

Subd. 4. Notice of project discontinuation. Allows a participating entity or the commissioner to discontinue participation with 30 days written notice to the other party.

Subd. 5. Duties of the commissioner. Paragraph (a) allows the commissioner to authorize the expenditure of CCDTF funds for payment of nontreatment services.

Paragraph (b) limits county expenditures to their expected share of forecasted expenditures.

Subd. 6. Managed care. Excludes individuals eligible for the pilot project from mandatory enrollment in managed care until these services are included in the plan's benefit set.

Effective date. Provides an August 1, 2013 effective date.

14 **Home and community-based services transition grants.** Creates § 256.478. Requires the commissioner to make available home and community-based services transition grants to serve individuals who do not meet MA eligibility criteria, but who otherwise meet the criteria established for people being discharged from Anoka Metro Regional Treatment Center or the Minnesota Security Hospital in St. Peter. Authorizes the commissioner to transfer funds between certain accounts.

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Makes this section effective July 1, 2013.

15 **Mental health certified family peer specialist.** Creates § 256B.0616.

Subd. 1. Scope. Imposes the requirement for medical assistance coverage, subject to federal approval, of mental health certified family peer specialists for individuals who have an emotional disturbance or severe emotional disturbance. Requires services to be provided by a certified family peer specialist. Prohibits reimbursement when a certified specialist provides services to a family member.

Subd. 2. Establishment. Instructs the commissioner to establish a certified family peer specialist program. Lists the services provided by a certified family peer specialist.

Subd. 3. Eligibility. Lists the settings in which family peer specialists may be located.

Subd. 4. Peer specialist program providers. Requires the commissioner to develop a certification program that providers must complete in order to bill for services. Requires peer specialist programs to operate within an existing mental health community provider or center.

Subd. 5. Certified family peer specialist training and certification. Instructs the commissioner to develop a training and certification process and continuing education workshops for family peer specialists. Lists the criteria that must be met for an individual to qualify as a peer specialist.

16 **Definitions.** Amends § 256B.0623, subd. 2. Adds parenting skills to the list of approved adult mental health treatment services.

17 **Psychiatric consultation to primary care practitioners.** Amends § 256B.0625, subd. 48. Requires medical assistance coverage of consultation provided by psychologists and advance practice registered nurses.

18 **Medical service coordination.** Amends §256B.0625, subd. 56. Adds medical service coordination as a covered service when performed by an eligible provider through a hospital emergency department, inpatient psychiatric unit, residential treatment center, community mental health center, children's therapeutic services and support provider, or juvenile justice facility and the service recipient is a child or young adult up to age 26 with a serious emotional disturbance. Lists the types and continuum of community-based services a worker will access.

19 **Family psychoeducation services.** Amends § 256B.0625, by adding subd. 61. Provides family psychoeducation services, provided by a licensed mental health professional, as a component of an individual treatment plan for a child up to age 21 is covered by medical assistance. Defines "family psychoeducation services." Provides that this section is effective July 1, 2013, or upon federal approval, whichever is later.

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20 **Mental health clinical care consultation.** Amends § 256B.0625, by adding subd. 62. Provides that mental health clinical care coordination as a component of an individual treatment plan for a child up to age 21 and provided by a licensed mental health professional is a covered medical assistance service. Defines "clinical care coordination." Provides an effective date of July 1, 2013, or upon federal approval, whichever is later.

21 **Waiver allocations for transition populations.** Amends § 256B.092, by adding subd. 13. Requires the commissioner to make available additional DD waiver allocations and additional necessary resources to assure timely discharge from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for people who meet specified criteria. Specifies additional waiver allocations must meet federal cost-effectiveness requirements and any corporate foster care home developed under this subdivision must be considered an exception within the foster care moratorium.

Makes this section effective July 1, 2013.

22 **Definitions.** Amends §256B.0943, subd. 1. Adds the definition of mental health service plan development.

23 **Covered service components of children's therapeutic services and supports.** Amends §256B.0943, subd. 2. Adds as covered service components of CTSS: mental health service plan development, clinical care consultation, family psychoeducation, and certified peer specialist services.

24 **Qualifications of individual and team providers.** Amends § 256B.0943, subd. 7. Allows a level II mental health behavioral aide to complete a certificate program established under subdivision 8a.

25 **Level II mental health behavioral aide.** Amends § 256B.0943, by creating subd. 8a. Instructs the commissioner of human services to collaborate with children's mental health providers and MnSCU to develop a certificate program for Level II behavioral aides.

26 **Intensive treatment in foster care.** Amends § 256B.0946.

Subd. 1. Required covered service components. Requires, for eligible children with mental illness who reside in family foster care settings, medical assistance to cover specified intensive treatment services: psychotherapy, crisis assistance, psychoeducation services, clinical care consultation, and certain service delivery payment requirements.

Subd. 1a. Definitions. Defines the terms used in this section.

Subd. 2. Determination of client eligibility. Defines an eligible recipient as an individual, from birth through age 20, who is placed in a licensed foster home and has received a diagnostic assessment and an evaluation of level of care needed.

Subd. 3. Eligible mental health services providers. Requires providers to be certified by the state, have a service provision contract with a county board or

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reservation tribal council, and demonstrate the ability to provide services.

Subd. 4. Service delivery payment requirements. Lists the service delivery requirements a provider must meet in order to be reimbursed for services.

Subd. 5. Service authorization. No changes.

Subd. 6. Excluded services. Paragraph (a) lists the services that are not covered by medical assistance as components of intensive treatment in foster care. Permits these services to be billed separately.

Paragraph (b) lists the services not eligible for medical assistance reimbursement while the child is receiving intensive treatment in foster care.

Subd. 7. Medical assistance payment and rate setting. Requires the commissioner to establish a single per-client encounter rate for intensive treatment in foster care services.

27 **Waiver allocations for transition populations.** Amends § 256B.49, by adding subd. 24. Requires the commissioner to make available additional waiver allocations and additional necessary resources to assure timely discharge from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for people who meet specified criteria. Specifies additional waiver allocations must meet federal cost-effectiveness requirements and any corporate foster care home developed under this subdivision must be considered an exception within the foster care moratorium.

Makes this section effective July 1, 2013.

28 **Reimbursement for mental health services.** Amends § 256B.761. Adjusts payment rates to improve access to adult rehabilitative mental health services and related mental health support services.

29 **Child and adolescent behavioral health services.** Requires the commissioner to consult with stakeholders to develop recommendations and legislation, if necessary, for state-operated child and adolescent behavioral health services that meet the needs of children with a wide range of diagnoses and disorders, have qualified staff, and provide high-quality, effective treatment.

30 **Pilot provider input survey.** Paragraph (a) requires the commissioner of human services to initiate a pilot provider survey of providers of pediatric services and children's mental health services to evaluate the performance of medical assistance management contractors.

Paragraph (b) lists the components of the survey and requires the commissioner to consider the survey results when renewing medical assistance management contracts.

Paragraph (c) requires the commissioner to report the results of the survey to the chairs of the Health and Human Services policy and finance committees and make recommendations on whether the survey should be continued as a component of the medical assistance quality improvement system.

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31 **Mentally ill and dangerous commitments stakeholders group.** Requires the commissioner of human services in consultation with the state court administrator to convene a stakeholders working group to develop recommendations to address the concerns identified in the February 2013 OLA report on state-operated services. Requires the commissioner to submit recommendations to the legislature by January 15, 2014.

32 **State assistance to counties; transitions for high needs populations.** Paragraph (a) requires the commissioner to assist counties to assure timely discharge of patients from AMRTC and the MSH when a county does not have provider resources or appropriate placement available. Requires the commissioner to give special consideration to uninsured individuals with complex needs.

Paragraph (b) instructs the commissioner to offer metropolitan area residents about their geographic placement preferences before making a placement.

Article 5: Department of Human Services Program Integrity and Office of Inspector General

Overview

This article amends statutes related to the commissioner's access to the predatory offender registry and criminal history information from the Minnesota court information system for purposes of background studies. It also authorizes the commissioner to undertake various fraud prevention and investigation activities, and modifies statutes related to county performance standards in the provision of human services.

1 **Child care provider and recipient fraud investigations.** Amends § 13.461, by adding subd. 7b. Provides that data related to child care fraud and recipient fraud investigations are governed by section 245E.01, subd. 15.

2 **Use of data.** Amends § 243.166, subd. 7. Allows the commissioner of human services to have access to the predatory offender registry for purposes of completing background studies under chapter 245C.

3 **Agency background studies.** Amends § 245C.04, by adding subd. 4a. Paragraph (a) requires the commissioner to develop an electronic system to access new criminal history information from the Minnesota court information system. The commissioner must limit access to review only information that related to individuals who have been the subject of a background study and are affiliated with the agency that initiated the study.

Paragraph (b) requires the commissioner to develop an online system for agencies that initiate background studies to access and maintain records of background studies initiated by that agency. Requires that agencies notify the commissioner when an individual is no longer affiliated with the agency.

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4 **Background studies conducted by Department of Human Services.** Amends § 245C.08, subd. 1. Requires the commissioner to review information from the predatory offender registry when performing a background study. Allows the commissioner to review criminal history information from the Minnesota court information system that relates to individuals who have already been studied under this chapter and remain affiliated with the agency that initiated the background study.

5 **Child care provider and recipient fraud investigations within the child care assistance program.** Creates § 245E.01.

Subd. 1. Definitions. Provides the meaning of terms used in this section.

Subd. 2. Investigating provider or recipient financial misconduct. Requires the department to investigate allegations of financial misconduct.

Subd. 3. Scope of investigations. Paragraph (a) authorizes the department to contact any person, agency, organization, or other entity necessary to an investigation.

Paragraph (b) allows the department to examine and interview individuals, documents, and evidence. Provides a non-exhaustive list of examples.

Subd. 4. Determination of investigation. Lists the determinations available to the department at the conclusion of the investigation.

Subd. 5. Actions or administrative sanctions. Lists the sanctions and actions available to the department at the conclusion of an investigation.

Subd. 6. Duty to provide access. Imposes an affirmative duty on providers, license holders, controlling individuals, employees, staff persons, and recipients to grant the commissioner access to specified information or the program facility. Requires access to be allowed during normal business hours and any other time the program is in operation. Provides penalties and sanctions for failure to allow access.

Subd. 7. Honest and truthful statements. Makes it unlawful to provide false or misleading information to the commissioner.

Subd. 8. Record retention. Establishes the record retention schedules for providers within the child care assistance program.

Subd. 9. Factors regarding imposition of administrative sanctions. Lists the factors that must be considered by the department when determining whether to impose sanctions on a provider.

Subd. 10. Written notice of department sanction. Requires the department to give mailed written notice to a person of an administrative sanction that is to be imposed. Lists the information that must be provided in the notice. Allows the adversely affected party to submit documents to dispute the department's allegations, to request an informal meeting to resolve the matter, or to request an appeal.

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Subd. 11. Appeal of department sanctions under this section. Allows an adversely affected person to appeal an administrative sanction when the department is not pursuing criminal charges. Requires the appeal to be filed within 30 days of receipt of the notice of a department sanction. Allows the department to deny or terminate payments to the provider when the department determines this is necessary to protect the public or the interests of CCAP.

Subd. 12. Consolidated hearings with licensing sanctions. Specifies when an adversely affected person can request a consolidated hearing.

Subd. 13. Grounds for and methods of monetary recovery. Paragraph (a) allows the commissioner to seek monetary recovery from a provider who has been improperly paid.

Paragraph (b) lists the mechanisms by which the commissioner can seek to recover improperly paid funds.

Subd. 14. Reporting of suspected fraudulent activity. Provides the requirements that must be met in order for a reporter of suspected fraud to have immunity from civil or criminal liability.

Subd. 15. Data privacy. Classifies data gathered during investigations the same as licensing data under section 13.46.

Subd. 16. Monetary recovery; random sample extrapolation. Allows the department to use random sample extrapolation to calculate the amount of monetary recovery from a provider who has been improperly paid.

Subd. 17. Effect of department's monetary penalty determination. Provides that unless there is a timely appeal filed, the department's administrative determination or sanction is considered a final agency determination.

Subd. 18. Office of Inspector General recoveries. Excludes recoveries from investigations initiated by the OIG from the county recovery provisions in section 119B.11, subd. 3.

6 **Provider enrollment.** Amends § 256B.04, subd. 21. Requires the commissioner to publish a list of provider types designated "limited," "moderate," or "high risk" based on federal criteria. Requires suppliers of durable medical equipment, prosthetics, orthotics, and supplies operating in Minnesota to name the department, in addition to CMS, as an obligee on surety bonds. Allows the department to require a provider to purchase a performance bond as a condition of enrollment, reenrollment, reinstatement, or continued enrollment under specified circumstances. The amount of the surety bond is dependent on the provider's annual medical assistance revenue.

Provides an immediate effective date.

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7 **Application fee.** Amends § 256B.04, by adding subd. 22. Authorizes the commissioner to collect and retain federally required application fees for screening and enrollment of medical assistance providers. Imposes an application fee of $532 for calendar year 2013 and provides the fee calculation for the following years. Excludes certain providers from the fees imposed in this subdivision.

Provides an immediate effective date.

8 **Grounds for sanctions against vendors.** Amends § 256B.064, subd. 1a. Adds that the commissioner may impose sanctions against a vendor of medical care for failure to correct errors in the maintenance of records for which a fine was imposed or after a warning was issued by the commissioner.

9 **Sanctions available.** Amends § 256B.064, subd. 1b. Allows the commissioner to impose a fine. Requires the commissioner, when imposing sanctions under this section, to consider the certain factors.

10 **Imposition of monetary recovery and sanctions.** Amends § 256B.064, subd. 2. Adds paragraph (f) which allows the commissioner to impose a fine on a vendor for incomplete documentation in a health service or financial record.

Adds paragraph (g) which requires the vendor to pay the fine on or before the payment date specified. If payment is not made, allows the commissioner to withhold or reduce payments to recover the amount of the fine.

11 **Requirements for initial enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. Increases surety bond coverage amount for PCA provider agencies if the agency has medical assistance revenue in excess of $300,000 a year. Requires annual renewal of the bond.

Provides an immediate effective date.

12 **Database of registered predatory offenders.** Amends § 299C.093. Allows the commissioner of human services to have access to the predatory offender registry when conducting background studies.

13 **Definitions.** Amends §402A.10. Adds definitions of "balanced set of program measures," "essential human services program," "measure," "performance improvement plan," and "performance management system for human services."

14 **Establishment of a performance management system for human services.** Creates § 402A.12. Requires the commissioner to implement a performance management system for essential human services by January 1, 2014.

15 **Human services performance council.** Creates § 402A.16.

Subd. 1. Establishment. Requires the commissioner to convene the council by October 1, 2013.

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Subd. 2. Duties. Lists the duties that must be performed by the council.

Subd. 3. Membership. Paragraph (a) requires that five specified stakeholder groups be equally represented on the council. Provides that minimum council membership is 15 individuals and the maximum is 20.

Paragraph (b) requires members to be appointed for at least two years. Allows additional years of service at the discretion of the appointing authority.

Paragraph (c) provides member receive no compensation.

Paragraph (d) requires a commissioner appointee and an MACSSA appointee to co-chair the council.

Subd. 4. Commissioner duties. Lists the duties that must be performed by the commissioner.

Subd. 5. County or service delivery authority duties. Requires county or service delivery authorities to report performance data and provide training to staff on performance measurement and improvement.

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

Subds. 1, 2, 2a include technical changes.

Subd. 3. Conditions prior to imposing remedies. Strikes the language in this subdivision and inserts new language. Paragraph (a) requires the commissioner to notify a county or service delivery authority that it must submit a performance improvement plan under specified circumstances.

Paragraph (b) provides that the commissioner must notify the county or service delivery authority that fiscal penalties may result if performance outcomes do not improve.

Paragraph (c) establishes the requirements for submitting a performance improvement plan and the timeframe in which the commissioner must approve the plan.

Paragraph (d) requires the department to monitor the plan for two years. Allows extension of the plan under certain circumstances.

Paragraph (e) provides that if the county or service delivery authority fails to meet the minimum performance standard and the improvement target after two years of monitoring, the commissioner may impose additional remedies.

Paragraphs (f) to (h) details actions the commissioner or council must take when a county fails to meet the goals in the performance improvement plan.

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17 **Instructions to the commissioner.** Requires the commissioner, in collaboration with labor organizations, to develop clear and consistent standards for state-operated services programs to address staffing shortages, resolve workplace safety issues, and evaluate overtime use.

Article 6: Health Care

Overview

This article contains provisions related to the Medical Assistance (MA) program, emergency medical assistance, and health care provider surcharges. The article modifies MA payments rates and covered services, allows a Hennepin County demonstration project to waive copayments and include additional enrollees, increases the amount of MA capitation payments transferred to MERC, modifies payments and criteria for critical access dental providers, and makes other changes related to MA.

1 **Establishment.** Amends § 245.03, subd. 1. Allows the commissioner of human services to appoint up to two deputy commissioners.

2 **Surcharge on HMOs and community integrated service networks.** Amends § 256.9657, subd. 3. Modifies the procedures used to calculate the surcharge in cases of mergers or consolidation.

3 **Payments into the account.** Amends § 256.9657, subd. 4. Requires the hospital surcharge to be paid in 9 monthly installments due on the 15th of the month, beginning October 15, 2014 through June 15 of the following year. Requires HMO surcharge payments due in July through September 2014 for CY 2012 revenue to be paid in a lump sum on June 15, 2014. Requires a lump sum payment on June 15, 2014 for revenue earned in CY 2013. Requires lump sum payments on June 15 for future years.

4 **Reimbursement for the fee increase for the early hearing detection and intervention program.** Amends § 256.969, subd. 29. Requires hospital payment rates to be adjusted, for admissions occurring on or after July 1, 2013, to include the fee increase for the early hearing detection and intervention program paid by the hospital for public program recipients. Requires the increase to be in effect until it is fully recognized in the base year cost, and requires the payment to be included in payments to contracted managed care organizations.

5 **MA costs for certain inmates.** Amends § 256B.04, by adding subd. 22. Directs the commissioner of human services to execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to MA eligibility for inmates of public institutions. Specifies criteria for the agreement.

6 **Persons detained by law.** Amends § 256B.055, subdivision 14. Provides that an inmate of a public institution (such as a correctional facility), who meets MA eligibility criteria, is eligible for MA coverage of services received while an inpatient in a medical institution. Under current law, inmates of public institutions are not eligible for MA. States that security

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issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate. Provides a January 1, 2014 effective date.

7 **Citizenship requirements.** Amends § 256B.06, subd. 4. Classifies the following as services for the treatment of emergency medical conditions, and therefore eligible for coverage under emergency medical assistance: (1) dialysis services provided in a hospital or freestanding dialysis facility; and (2) surgery and the administration of chemotherapy, radiation, and related services to treat cancer, if the recipient has cancer that is not in remission and these services are required. (Under current law, these services are covered for the period May 1, 2013 through June 30, 2013.)

A new paragraph (l) provides that recipients of EMA are eligible for coverage of elderly waiver and nursing facility rehabilitative services, effective July 1, 2013. States that initial and continued enrollment for these services is subject to the availability of funding. Provides an effective date of July 1, 2013.

8 **Dental services.** Amends § 256B.0625, subd. 9. Expands MA dental coverage for adults, to include:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management, when additional staff time is required and sedation is not used;

(3) oral or IV sedation, if the covered service cannot be performed safely without it or would need to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an individualized treatment plan, but no more than four times per year.

9 **Drugs.** Amends § 256B.0625, subd. 13. States that MA covers drugs acquired through the federal 340B program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the covered entity. States that MA does not cover 340B drugs dispensed by 340B contract pharmacies.

10 **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) requires the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program to be estimated, effective January 1, 2014, at wholesale acquisition cost minus 40 percent, for purposes of MA payment.

The amendment to paragraph (d) allows payment for drugs administered in an outpatient setting to be at the lower of the specialty pharmacy rate or the maximum allowable cost (in addition to the lower of the usual and customary cost or 106 percent of the average sales price, as under current law). Requires the commissioner to discount the payment rate for drugs obtained through the federal 340B Drug Discount Program by 20 percent, effective January 1, 2014. Requires payment for drugs administered in an outpatient setting to be made to the administering facility or the practitioner. Provides that a retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

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Provides an effective date of January 1, 2013.

11 **Doula services.** Amends § 256B.0625, by adding subd. 28b. Provides that MA covers doula services provided by a certified doula of the mother's choice. Defines doula services. Provides an effective date of January 1, 2014, or upon federal approval.

12 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Provides that an electronic tablet may be considered durable medical equipment if it will be used as an augmentative and alternative communication system and other requirements are met.

13 **Preferred diabetic testing supply program.** Amends § 256B.0625, by adding subd. 31b. Requires the commissioner to implement a point of sale preferred diabetic testing supply program by January 1, 2014. Allows the commissioner to contract with a vendor to participate in a preferred diabetic testing supply list and supplemental rebate program and specifies related requirements. Provides that reimbursement for supplies not on the preferred supply list may be subject to prior authorization. Requires the commissioner to seek any federal waivers and approvals necessary for implementation.

14 **Childhood immunizations.** Amends § 256B.0625, subd. 39. Strikes language that specifies how much MA will pay per dose for the administration of vaccine to children.

15 **Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, subd. 58. Provides that payment for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider.

16 **Payment for multiple services provided on the same day.** Amends § 256B.0625, by adding subd. 61. States that the commissioner shall not prohibit payment, including supplemental payments, for mental health or dental services provided to a patient by a clinic or health care professional, solely because the services were furnished on the same day as other covered services furnished by the same provider.

17 **Cost-sharing.** Amends § 256B.0631, subd. 1. Directs the commissioner of human services, as part of the contracting process for the pilot program to test alternative and innovative health care delivery networks, to allow the Hennepin County pilot program to waive copayments. Provides that the value of the copayments shall not be included in the capitation payment to the integrated health care delivery network participating in the program.

18 **Hennepin and Ramsey Counties pilot program.** Amends § 256B.0756. Modifies the criteria governing a pilot program operated by Hennepin County to test alternative and innovative health care delivery networks, by:

(1) allowing the program to serve MA enrollees beyond those who are adults without children;

(2) removing the enrollment cap of 7,000 enrollees; and

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(3) striking language that allows the county to transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks.

This section also allows the commissioner to identify individuals to be enrolled in the pilot program, based on Hennepin County zip code or whether individuals would benefit from an integrated health care delivery network.

19 **Commissioner's duties.** Amends § 256B.196, subd. 2. Requires the commissioner to determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center or the city of St. Paul, that is based on the average commercial rate or determined using another method acceptable to the Centers for Medicare and Medicaid Services. Requires the commissioner to inform Hennepin County and the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available in order to make supplemental payments to HCMC and the city of St. Paul, equal to the difference between the established MA payment for ambulance services and the upper payment limit. Requires the commissioner to make supplemental payments upon receipt of the periodic transfers.

20 **Medical education and research fund.** Amends § 256B.69, subd. 5c. For FY 2014 and thereafter, increases from $36,744,000 to $49,552,000 the amount transferred from MA capitation payments to the medical education and research fund.

21 **Administrative expenses.** Amends § 256B.69, subd. 5i. Expands the list of expenses that are not allowable administrative expenses for purposes of managed care and county-based purchasing plan rate setting for public health care programs.

22 **Managed care financial reporting.** Amends § 256B.69, subd. 9c. Requires managed care and county-based purchasing plans, effective January 1, 2014, to report additional financial information on state public programs to the commissioner, and requires this reporting on a quarterly rather than annual basis. Also limits the role of the plans in determining what data are to be collected.

23 **Payment reduction.** Amends § 256B.69, subd. 31. Requires the commissioner, for CY 2014, to reduce maximum aggregate trend increases in payment rates to managed care and county-based purchasing plans by $47 million in state and federal funds, to account for the reduction in administrative expenses in section 256B.69, subd. 5i.

24 **Supplemental recovery program.** Amends § 256B.69, subd. 35. Requires the commissioner to conduct a supplemental recovery program for third-party liabilities not recovered by managed care and county-based purchasing plans for state public health care programs. Specifies program criteria.

25 **Physician reimbursement.** Amends § 256B.76, subd. 1. Effective September 1, 2014, increases payment rates for physician and professional services by five percent. In calculating the increase, requires the commissioner to exclude from the base the rate increase provided under § 256B.76, subd. 7. Provides that the increase does not apply to federally qualified health centers, rural health centers, and Indian health services, nor to payments to managed care and county-based purchasing plans.

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26 **Dental reimbursement.** Amends § 256B.76, subd. 2. Effective January 1, 2014, increases payment rates for dental services by five percent. Provides that the increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, and Indian health services. Requires payments to managed care and county-based purchasing plans to be adjusted to reflect this payment increase.

27 **Critical access dental providers.** Amends § 256B.76, subd. 4. Increases critical access dental provider payments by five percentage points (to 35 percent above the regular rate), beginning July 1, 2013. Modifies the definition of critical access dental provider. The amendment to clause (3) includes city owned and operated hospital-based dental clinics. A new clause (6) classifies private practicing dentists as critical access dental providers, if the office is located in a health professional shortage area, over 50 percent of patient encounters are with the uninsured or MA or MinnesotaCare enrollees, and other criteria are met. Also strikes language that allows the commissioner to designate dental providers as critical access providers if they provide care to state public health care program enrollees at a level that significantly increases access.

28 **Payment for certain primary care services and immunization administration.** Amends § 256B.76, by adding subd. 7. Requires payment for certain primary care services and immunization administration services provided January 1, 2013 through December 31, 2014, to be made in accordance with § 1902(a)(13) of the Social Security Act (this provision requires primary care services to be paid at a rate not less than Medicare rates for 2013 and 2014).

29 **Reimbursement for family planning services.** Amends § 256B.764. Effective July 1, 2013, increases payment rates for family planning services provided by a community clinic by 20 percent. Requires capitation rates to managed care and county-based purchasing plans to be adjusted to reflect this increase, and requires plans to pass on the full amount of the increase to community clinics.

30 **Reimbursement for basic care services.** Amends § 256B.766. Effective September 1, 2014, increases payments for specified basic care services by three percent. States that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this increase.

31 **Medicare payment limit.** Amends § 256B.767. For the period July 1, 2013 through June 30, 2014, sets payment rates for durable medical equipment, prosthetics, orthotics, and supplies subject to rates established under the Medicare National Competitive Bidding Program at the rate that applies to the same item when not subject to the Medicare competitive bidding rate. States that this paragraph does not apply to mail order diabetic supplies nor to items provided to dually eligible recipients when Medicare is the primary payer.

32 **Transfer.** Amends Laws 2013, chapter 1, section 6. Specifies the procedures used to determine the cost to MA of adding 19 and 20 year olds and parents and caretakers with income between 100 and 138 percent of FPG. Requires the commissioner of management and budget, no less than three weeks before the release of the forecast, to reduce the health

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care access fund transfer for this group by any difference between actual and forecasted costs for this group.

33 **Request for information; EMA and the uninsured study.** Requires the commissioner of human services, in consultation with specified entities, to identify alternatives and make recommendations for providing coordinated and cost-effective care and coverage to individuals who meet eligibility standards for emergency medical assistance or are uninsured and ineligible for other public health care programs, have incomes below 400 percent of FPG, and are ineligible for premium credits through the Minnesota Insurance Marketplace. Requires the commissioner to issue a request for information by August 1, 2013 and specifies criteria. Requires the commissioner to submit recommendations to the chairs and ranking minority members of legislative committees with jurisdiction over health and human services, by January 15, 2014.

34 **Request for information; emergency medical assistance.** Requires the commissioner of human services to issue a request for information (RFI) to identify and develop options for a program to provide emergency medical assistance recipients with coverage for medically necessary services not eligible for federal financial participation. Requires the RFI to be issued by August 1, 2013, and specifies criteria for the RFI. Requires the commissioner, based on responses to the RFI, to submit recommendations on providing this coverage for emergency medical assistance recipients to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2014.

35 **Dental access and reimbursement report.** Requires the commissioner of human services to study and make recommendations to the legislature on the current oral health and dental services delivery system for state public health care programs, to improve access and ensure cost-effective delivery of services. The study must include modifying the delivery of services and reimbursement methods, including modifications to critical access dental provider payments. Requires a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 15, 2013.

Article 7: Continuing Care

Overview

This article contains provisions modifying continuing care programs and services including statewide HCBS waiver capacity management, ICF/DD license surcharge, elderly waiver by creating individual community living supports, essential community supports, the quality assurance system, nursing facilities, development of quality profiles, and continuing care provider rates and grant increases. This article also contains provisions creating an autism early intensive intervention benefit and community first services and supports.

1 **Penalties for late or nonsubmission.** Amends § 144.0724, subdivision 6. Allows nursing facilities to apply for a reduction in their penalty amount (for not submitting assessment data,

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or submitting it late) if the penalty is one percent or more of the facility's total operating costs.

2 **Licensed beds on layaway status.** Amends § 144A.071, subdivision 4b. Modifies the time period for nursing facilities to place beds on layaway status from one year to six months.

3 **Licensing moratorium.** Amends § 245A.03, subd. 7. Modifies the exceptions to the corporate foster care moratorium. Removes obsolete language. Authorizes the commissioner to manage statewide capacity, including adjusting the capacity available to each county, and adjusting statewide available capacity to meet statewide needs. Changes the annual due date of certain information regarding overall capacity the commissioner is required to provide. Modifies exemptions from decreased licensed capacity for certain residential settings.

4 **Nicollet county facility project.** Amends § 252.291, by adding subdivision 2b. Directs the Minnesota Department of Health (MDH) to certify one additional bed in an ICF/DD in Nicollet County.

5 **ICF/DD license surcharge.** Amends § 256.9657, subd. 3a. Modifies the ICF/DD license surcharge effective July 1, 2013.

6 **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Makes conforming cross-reference changes and specifies the monthly cost limit of elderly waiver services for individuals who are ventilator-dependent. Requires this monthly limit to be increased annually.

7 **Individual community living support.** Amends § 256B.0915, by adding subd. 3j. Establishes a new service under the elderly waiver called individual community living support (ICLS). Specifies where services may be delivered. Requires case managers or care coordinators to develop individual ICLS plans with the client using a tool developed by the commissioner. Requires the commissioner to establish payment rates and mechanisms to align payments with the type and amount of service provided, assure statewide uniformity for payment rates, and assure cost-effectiveness. Requires licensing standards for ICLS to be reviewed to avoid conflict with provider regulatory standards.

8 **Excess spending.** Amends § 256B.0916, by adding subd. 11. Makes county and tribal agencies responsible for spending in excess of the home and community-based waiver allocation made by the commissioner. Requires agencies that spend in excess of the allocation made by the commissioner to submit a corrective action plan to the commissioner. Specifies the information that must be included in the plan.

9 **Screening teams.** Amends § 256B.092, subd. 7. Requires case managers to help DD waiver recipients develop plans to transition to appropriate less restricted settings if a recipient is determined to be able to have service needs met through alternative services in a less restrictive setting. Makes this section effective January 1, 2014.

10 **Residential support services.** Amends § 256B.092, subd. 11. Corrects a cross-reference.

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11 **Waivered services statewide priorities.** Amends § 256B.092, subd. 12. Modifies the statewide priorities for the developmental disabilities home and community-based waiver. Authorizes the commissioner to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, or tribe. Removes obsolete language.

12 **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** Amends § 256B.092, by adding subd. 14. Requires certain HCBS recipients to receive a consultation with a mental health professional or a behavioral professional within 30 days of discharge. Lists duties of the mental health or behavioral professional. Defines "institution."

13 **Essential community supports.** Creates § 256B.0922.

Subd. 1. Essential community supports. Specifies the purpose of the essential community supports program. Limits essential community supports to $400 per person per month. Lists eligibility criteria. Requires a person receiving any of the essential community supports to also receive service coordination as part of their community support plan. Requires essential community supports grant recipients to be reassessed annually. Authorizes the commissioner to use federal matching funds for essential community supports.

Subd. 2. Essential community supports for people in transition. Makes certain individuals affected by the implementation of the nursing facility level of care changes eligible for essential community supports. Allows for additional onetime case management services to be available for participants.

Makes this section effective January 1, 2014.

14 **Autism early intensive intervention benefit.** Creates § 256B.0949.

Subd. 1. Purpose. Creates a new benefit under the MA state plan to provide early intensive intervention to a child with an ASD diagnosis. Specifies the coverage that must be provided under this benefit.

Subd. 2. Definitions. Defines the terms "autism spectrum disorder diagnosis," "child," "commissioner," "early intensive intervention benefit," "generalizable goals," and "mental health professional."

Subd. 3. Initial eligibility. Specifies eligibility criteria for the autism early intensive intervention benefit.

Subd. 4. Diagnosis. Specifies the requirements for an ASD diagnosis.

Subd. 5. Diagnostic assessment. Lists the information and assessments that must be relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development.

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Subd. 6. Treatment plan. Specifies requirements related to a child's treatment plan.

Subd. 7. Ongoing eligibility. Requires a child receiving this benefit to receive an independent progress evaluation by a licensed mental health professional every six months, or more frequently as determined by the commissioner, to determine if progress is being made toward goals contained in the treatment plan. Specifies the information to be included in the progress evaluation, allows the observation component of the progress evaluation to be performed by a child's licensed special education staff, and requires progress evaluations to be submitted to the commissioner in a manner determined by the commissioner. Makes children who continue to achieve treatment plan goals eligible to continue receiving this benefit. Allows treatment to continue during an appeal.

Subd. 8. Refining the benefit with stakeholders. Requires the commissioner to develop the implementation details of the benefit in consultation with stakeholders and to consider recommendations of specified councils and task forces. Requires the commissioner to release the implementation details for a 30-day public comment period prior to submission to the federal government for approval. Lists items that must be included in the implementation details.

Subd. 9. Revision of treatment options. Allows the commissioner to revise covered treatment options based on outcome data and other evidence.

Subd. 10. Coordination between agencies. Requires the commissioners of human services and education to coordinate services and information including diagnostic, functional, developmental, medical and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. Federal approval of the autism benefit. Requires federal approval to allow children eligible for MA to qualify.

Makes this option available upon federal approval, but not earlier than March 1, 2014.

15 **Quality assurance system established.** Amends § 256B.095. Removes the June 30, 2014 expiration date for the quality assurance system. Effective July 1, 2013, allows a provider of service located in a non-opted-in county to opt-in to the quality assurance system provided the county where services are provided indicates its agreement with a county with an agreement with DHS. Makes this section effective July 1, 2013.

16 **Membership.** Amends § 256B.0951, subd. 1. Removes language making the quality assurance commission expire on June 30, 2014.

17 **Commission's authority to recommend variances of licensing standards.** Amends § 256B.0951, subd. 4. Expands the alternative licensing system from programs for persons with developmental disabilities to programs for persons with disabilities.

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18 **Notification.** Amends § 256B.0952, subd. 1. Makes conforming changes related to allowing providers to opt-in to the quality assurance system.

19 **Quality assurance teams.** Amends § 256B.0952, subd. 5. Modifies phrasing and removes language specifying counties will pay team members for time spent on quality assurance.

20 **Duties of the commissioner of human services.** Amends § 256B.0955. Broadens the scope of the alternative quality assurance licensing system for those with all disabilities, not just developmental disabilities, effective July 1, 2013.

21 **Scope.** Amends § 256B.097, subd. 1. Modifies the list of disability services eligible to be part of the quality assurance system by including services licensed under section 245D (home and community-based services standards).

22 **State quality council.** Amends § 256B.097, subd. 3. Modifies provisions related to the State Quality Council.

23 **Property rate increases for certain nursing facilities.** Amends § 256B.431, subd. 44. Paragraph (b) increases the replacement-cost-new limit by $1.13 million for a nursing facility in McCleod County licensed for 110 beds. Specifies that money available from expired and cancelled nursing facility moratorium exception projects shall be used to reduce the fiscal impact to the MA budget for the increase in the replacement-cost-new limit. Makes paragraph (b) effective retroactively from June 1, 2012.

Paragraph (c) increases the replacement-cost-new limit by $1.4 million for a nursing facility in Dakota County licensed for 61 beds. Effective September 1, 2013, increases the replacement-cost-new limit by $1.2 million. Specifies that money available from expired and cancelled nursing facility moratorium exception projects shall be used to reduce the fiscal impact to the MA budget for the increase in the replacement-cost-new limit. Makes paragraph (c) effective retroactively from July 1, 2012.

Paragraph (d) allows a boarding care facility in Hennepin County to qualify for nursing facility moratorium exception funding for an elevator upgrade project.

24 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Suspends the nursing facility property-related payment rate adjustments for rate years beginning on October 1, 2013, October 1, 2014, October 1, 2015, and October 1, 2016.

25 **Nursing facility rate adjustments beginning September 1, 2013.** Amends § 256B.434, by adding subd. 19a. Requires the commissioner to provide a 5 percent average operating payment rate increase to nursing facilities for the rate year beginning September 1, 2013 (includes a 3.75 percent operating payment rate increase and a 1.25 percent quality add-on). Requires nursing facilities to use 75 percent of the money resulting from the rate adjustments for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, with certain exceptions. Specifies the items included in compensation-related costs. Specifies the process for nursing facilities to apply for the rate adjustments. Requires the commissioner to ensure that cost

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increases comply with certain requirements. Specifies how the increases shall be applied to operating payment rates in effect on August 31, 2013.

26 **Nursing facility rate adjustments beginning October 1, 2015.** Amends § 256B.434, by adding subd. 19b. Requires the commissioner to provide a 3.2 percent average operating payment rate increase to nursing facilities for the rate year beginning October 1, 2015 (includes a 2.4 percent operating payment rate increase and a 0.8 percent quality add-on). Requires nursing facilities to use 75 percent of the money resulting from the rate adjustments for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, with certain exceptions. Specifies the items included in compensation-related costs. Specifies the process for nursing facilities to apply for the rate adjustments. Requires the commissioner to ensure that cost increases comply with certain requirements. Specifies how the increases shall be applied to operating payment rates in effect on September 30, 2015.

27 **Planned closure rate adjustment.** Amends § 256B.437, subd. 6. Removes obsolete language. Reinstates planned closure rate adjustments beginning July 1, 2013, and makes the rate adjustment part of a facility's external fixed payment rate (previously it was part of a facility's total operating payment rate).

28 **Development and implementation of quality profiles.** Amends § 256B.439, subd. 1. Requires development of quality profiles for home and community-based services providers beginning not later than July 1, 2014. Defines home and community-based providers for purposes of this section. Specifies how and for whom the quality profiles must be developed.

29 **Quality measurement tools for nursing facilities.** Amends § 256B.439, subd. 2. Limits the quality measurement tools to nursing facilities and makes a technical change.

30 **Quality measurement tools for home and community-based services.** Amends § 256B.439, by adding subd. 2a. Requires the commissioners to identify and apply quality measurement tools for specified purposes. Requires the tools to include surveys of consumers of home and community-based services and to be identified and applied, to the extent possible, without requiring providers to supply information beyond state and federal requirements.

31 **Consumer surveys for home and community-based services.** Amends § 256B.439, by adding subd. 3a. Requires the commissioner to conduct surveys of home and community-based services consumers to develop quality profiles of providers. To the extent possible, requires surveys to be conducted face-to-face by state employees or contractors, but allows surveys to be conducted by an alternative method at the discretion of the commissioner. Requires surveys to be conducted periodically to update quality profiles of providers.

32 **Implementation of home and community-based services performance-based incentive payment system.** Amends § 256B.439, by adding subd. 5. Requires the commissioner to develop incentive-based grants for home and community-based services providers for achieving outcomes specified in a contract. Allows the commissioner to solicit proposals from home and community-based services providers. Requires the commissioner to

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determine the types of home and community-based services providers that will participate in the program. Allows the determination of the participating provider types to be revised annually by the commissioner. Requires the commissioner to limit the amount and number of grants in order to operate the incentive payments within funds appropriated for this purpose. Requires the commissioner to consider specified policy objectives in establishing the outcomes and related criteria.

33 **Calculation of home and community-based services quality score.** Amends § 256B.439, by adding subd. 6. Requires the commissioner to determine a quality score for each participating home and community-based services provider using quality measures according to methods determined by the commissioner in consultation with stakeholders and experts. Exempts these methods from rulemaking requirements in Minnesota Statutes, chapter 14. Specifies how scores will be determined for each quality measure and allows the commissioner to annually revise the methods for calculating scores.

34 **Calculation of home and community-based services quality add-on.** Amends § 256B.439, by adding subd. 7. Effective July 1, 2015, requires the commissioner to determine the quality add-on payment for participating home and community-based services providers. Requires the payment rate for the quality add-on to be a variable amount based on each provider's quality score. Requires the commissioner to limit the types of home and community-based services providers that may receive the quality add-on and the amount of the quality add-on payments to operate the quality add-on within funds appropriated for this purpose.

35 **Calculation of a quality score.** Amends § 256B.441, subd. 44. Removes obsolete language related to making revisions to the nursing facility quality measures. Beginning July 1, 2013, specifies the method for calculating nursing facility quality scores. Allows the commissioner to adjust the formula or the methodology for computing the total quality score, effective July 1 of any year and with five months advance public notice. In changing the formula, requires the commissioner to consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

36 **Calculation of quality add-on, with an average value of 1.25 percent, effective September 1, 2013.** Amends § 256B.441, by adding subd. 46b. Specifies the method for calculating the quality add-on effective September 1, 2013.

37 **Quality improvement incentive system beginning October 1, 2015.** Amends § 256B.441, by adding subd. 46c. Requires the commissioner to develop a quality improvement incentive program in consultation with stakeholders. Sets the annual funding pool available for quality improvement incentive payments at 0.8 percent of all operating payments, with certain exceptions. Beginning October 1, 2015, annual rate adjustments provided under the quality improvement incentive system are effective for one year, starting October 1 and ending the following September 30.

38 **Waivered services statewide priorities.** Amends § 256B.49, subd. 11a. Modifies the list of statewide priorities for the CAC, CADI, and BI waivers. Allows the commissioner to transfer funds between counties, groups of counties, and tribes to accommodate statewide

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priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe. Removes obsolete language.

39 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Removes language requiring reassessments of certain waiver recipients every six months.

40 **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Updates a cross-reference.

41 **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** Amends § 256B.49, by adding subd. 25. Requires certain HCBS recipients to receive a consultation with a mental health professional or a behavioral professional within 30 days of discharge. Lists duties of the mental health or behavioral professional. Defines "institution."

42 **Excess allocations.** Amends § 256B.49, by adding subd. 25. Makes county and tribal agencies responsible for spending in excess of the home and community-based waiver allocation made by the commissioner. Requires agencies that spend in excess of the allocation made by the commissioner to submit a corrective action plan to the commissioner. Specifies the information that must be included in the plan.

43 **Home and community-based settings for people with disabilities.** Amends § 256B.492. Modifies language limiting the number of individuals receiving home and community-based services that may live in the same community living setting.

44 **Planned closure process needs determination.** Amends § 256B.493, subd. 2. Corrects cross-references.

45 **Rate adjustment for ICF/DD in Cottonwood County.** Amends § 256B.501, by adding subd. 14. Decertifies three beds in an ICF/DD in Cottonwood County and provides for a rate increase.

46 **Rate increase effective June 1, 2013.** Amends § 256B.5012, by adding subd. 14. Requires the commissioner to increase the total operating payment rate for each ICF/DD facility by $7.81 per day. Prohibits the increase from being subject to any annual percentage increase. Makes this section effective June 1, 2013.

47 **ICF/DD rate increases effective April 1, 2014.** Amends § 256B.5012, by adding subdivision 15. Increases operating payment rates for ICFs/DD by one percent for the rate period beginning on April 1, 2014. Specifies the manner in which the commissioner must apply the rate increase.

48 **Initiatives to improve early screening, diagnosis, and treatment of children with ASD and other developmental conditions.** Amends § 256B.69, by adding subd. 32a. Requires managed care plans and county-based purchasing plans, as a condition of contract under PMAP, to implement strategies that facilitate access for young children to have periodic developmental screenings and that those who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, with the goal of meeting milestones by age five. Specifies data the commissioner must report on the DHS

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public Web site. Requires the managed care plans and county-based purchasing plans to report on barriers to providing certain services and strategies implemented to address those barriers.

49 Community first services and supports. Creates § 256B.85.

Subd. 1. Basis and scope. Requires the commissioner to establish a MA state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)," upon federal approval. Specifies program features. Makes CFSS replace the PCA program upon federal approval.

Subd. 2. Definitions. Defines "activities of daily living," "agency-provider model," "behavior," "complex health-related needs," "community first services and supports," "community first services and supports service delivery plan," "critical activities of daily living," "dependency," "extended CFSS," "financial management services contractor or vendor," "budget model," "health-related procedures and tasks," "instrumental activities of daily living," "legal representative," "medication assistance," "participant's representative," "person-centered planning process," "shared services," "support specialist," "support worker," and "wages and benefits."

Subd. 3. Eligibility. Lists eligibility requirements in order to receive CFSS services.

Subd. 4. Eligibility for other services. Prohibits selection of CFSS by a participant from restricting access to other medically necessary care and services furnished under the state plan MA benefit or other services available through alternative care.

Subd. 5. Assessment requirements. Specifies requirements related to the assessment of functional needs. Allows a participant who is residing in a facility to be assessed and choose CFSS for the purpose of using CFSS to return to the community. Requires assessment results and recommendations and authorizations for CFSS to be determined and communicated in writing by the lead agency's certified assessor to the participant and the participant's chosen provider within 40 calendar days. Allows a lead agency assessor to request a temporary authorization for CFSS services. Limits temporary authorization of services to 45 days.

Subd. 6. Community first services and support service delivery plan. Requires the CFSS service delivery plan to be developed, implemented, and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a support specialist. Requires the service delivery plan to reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the support plan. Requires the commissioner to establish the format and criteria for the CFSS service delivery plan. Lists requirements for the CFSS service delivery plan. Allows the amount of funds used each month to vary, but additional funds must not be provided above the annual service authorization amount

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unless a change in condition is assessed, authorized, and documented.

Subd. 7. CFSS; covered services. Lists the services and supports covered under CFSS.

Subd. 8. Determination of CFSS service methodology. Requires all CFSS services to be authorized by the commissioner before services begin except for certain assessments. Requires authorizations to be completed no later than 40 calendar days from the date of the assessment. Requires the amount of CFSS authorized to be based on the recipient's home care rating. Specifies how the home care rating is determined. Specifies the methodology for determining the total service units of CFSS to authorize.

Subd. 9. Noncovered services. Lists services and supports that are not eligible for payment under CFSS.

Subd. 10. Provider qualifications and general requirements. Lists requirements for agency-providers delivering services under the agency-provider model and financial management service contractors.

Subd. 11. Agency-provider model. Limits the agency-provider model to the services provided by support workers and support specialists who are employed by an agency-provider. Requires the agency-provider to allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the service delivery plan. Allows participants to use authorized units of CFSS services as needed within a service authorization that is not greater than 12 months. Allows participants to share services. Requires agency-providers to use a minimum of 72.5 percent of the revenue generated by MA payment for CFSS for support worker wages and benefits. Requires the agency-provider model to be used by individuals who have been restricted by the Minnesota restricted recipient program.

Subd. 12. Requirements for enrollment of CFSS provider agencies. Lists information and documentation CFSS provider agencies must provide to the commissioner at the time of enrollment, reenrollment, and revalidation. Requires all CFSS provider agencies to require all employees in management and supervisory positions and owners to complete mandatory training as determined by the commissioner. Requires CFSS provider agency billing staff to complete training about CFSS program financial management. Exempts CFSS provider agencies certified for participation in Medicare as home health agencies from these training requirements.

Subd. 13. Budget model. Allows participants to exercise more responsibility and control over services and supports under the budget model. Lists functions of the budget model. Lists service functions that must be provided by the financial management services contractor. Lists duties of the commissioner related to financial management services contractors. Specifies participants who are disenrolled from this model are transferred to the agency-provider model. Specifies appeal rights for participants who are disenrolled or transferred from this model.

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Subd. 14. Participant's responsibilities under the budget model. Lists participant responsibilities under the budget model.

Subd. 15. Documentation of support services provided. Establishes documentation requirements for all support services provided to CFSS participants in both agency-provider and budget models.

Subd. 16. Support workers requirements. Lists requirements for support workers. Specifies circumstances under which the commissioner may terminate a support worker's provider enrollment. Allows support workers to appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment.

Subd. 17. Support specialist requirements and payments. Requires the commissioner to develop qualifications, scope of functions, and payment rates and service limits for a support specialist that may provide additional or specialized assistance necessary to plan, implement, arrange, augment, or evaluate services and supports.

Subd. 18. Service unit and budget allocation requirements and limits. Specifies how services are authorized for the agency-provider model and the budget model.

Subd. 19. Support system. Requires the commissioner to provide information, consultation, training, and assistance to ensure the participant is able to manage the services and supports and budgets, if applicable. Requires the commissioner to provide assistance with the development of risk management agreements.

Subd. 20. Service-related rights. Requires participants to be provided with adequate information, counseling, training, and assistance to ensure that the participant is able to choose and manage services, models, and budgets. Lists information that must be provided. Requires the commissioner to ensure that the participant has a copy of the most recent community support plan and service delivery plan. Specifies appeal rights. Specifies notification requirements if services or the budget allocation is reduced, denied, or terminated.

Subd. 21. Development and Implementation Council. Requires the commissioner to establish a Development and Implementation Council. Requires the commissioner to consult and collaborate with this council when developing and implementing CFSS for at least the first five years of operation. Requires the commissioner, in consultation with the council, to provide the legislature with specified recommendations related to the quality and integrity of CFSS by February 1, 2014.

Subd. 22. Quality assurance and risk management system. Requires the commissioner to establish quality assurance and risk management measures for use in developing and implementing CFSS. Requires the commissioner to provide ongoing technical assistance and resource and educational materials for CFSS participants.

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Requires performance assessment measures and ongoing monitoring of health and well-being to be identified in consultation with the Development and Implementation Council.

Subd. 23. Commissioner's access. Requires the commissioner to be given immediate access without prior notice to documentation and records related to services provided and submission of claims for services provided when the commissioner is investigating a possible overpayment of MA funds. States that denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment or the financial management services contract.

Subd. 24. CFSS agency-providers; background studies. Specifies background study requirements for CFSS agency providers.

Subd. 25. Commissioner recommendations required. The commissioner, in consultation with the Development and Implementation Council and other stakeholders, must develop recommendations for revisions to CFSS provider agency enrollment requirements, documentation requirements, and support worker requirements that promote self-direction in specified areas. Requires the recommendations to be provided to the legislative committees with jurisdiction over health and human services policy and finance by November 15, 2013.

Makes this section effective upon federal approval, but no earlier than April 1, 2014. States that service will begin 90 days after federal approval or April 1, 2014, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when this occurs.

50 **Special needs.** Amends § 256D.44, subd. 5. Exempts individuals receiving MSA shelter needy assistance who are in the Housing Opportunities for Persons with AIDS Program from residency ratio restrictions in community living settings.

51 **Forecasted programs.** Amends Laws 2011, First Special Session ch. 9, art. 10, § 3, subd. 3, as amended by Laws 2012, ch. 247, art. 4, § 43. Specifies that a provision reducing rates for congregate living for individuals with lower needs does not apply to individuals whose primary diagnosis is mental illness and who are living in foster care settings where the license holder is also (1) a provider of assertive community treatment or adult rehabilitative mental health services, (2) a certified mental health center or a certified mental health clinic, or (3) a provider of intensive residential treatment services. Makes this section effective August 1, 2013.

52 **Board of nursing home administrators.** Amends Laws 2012, ch. 247, art. 6, § 4. Specifies that an appropriation to the Board of Nursing Home Administrators was onetime.

53 **Recommendations for concentration limits on home and community-based settings.** Requires the commissioner to consult with specified stakeholders to develop recommendations on concentration limits on HCBS settings. Requires the recommendations to be consistent with Minnesota's Olmstead Plan. Requires the recommendations and

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proposed legislation to be submitted to the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

54 **Training of autism service providers.** Requires the commissioners of health and human services to ensure that autism service providers receive training in culturally appropriate approaches to serving certain minority communities, and other cultural groups experiencing a disproportionate incidence of autism.

55 **Direction to commissioner; spousal disregard.** Directs the commissioner of human services to seek a federal approval to allow HCBS waiver recipients under age 65 to continue to use the disregard of the nonassisted spouse's income and assets, instead of the spousal impoverishment provisions in the Affordable Care Act.

56 **Direction to commissioner; ABA.** Requires the commissioner of human services to apply to CMS, by January 1, 2014, for a waiver to provide applied behavioral analysis services to children with ASD and related conditions under the MA program.

Makes this section effective the day following final enactment.

57 **Recommendations on raising the asset limits for seniors and persons with disabilities.** Requires the commissioner to develop recommendations and a request for a federal waiver to increase the asset limit for individuals eligible for MA due to disability or age who are not residing in a nursing facility or an institution whose costs for room and board are covered by MA or state funds. Requires recommendations to be provided to the legislature by February 1, 2014.

58 **Nursing home level of care report.** Requires the commissioner of human services to report on the impact of the nursing facility level of care to be implemented January 1, 2014. Specifies the information that must be included in the report. Requires the commissioner to report to the legislative committees with jurisdiction over health and human services policy and finance with a preliminary report on October 1, 2014, and a final report on February 15, 2015.

59 **Assistive technology equipment for home and community-based services waivers funding development.** Defines "assistive technology equipment." Requires the commissioner of human services to develop recommendations for assistive technology equipment funding. Lists services the commissioner shall consider funding in developing the funding for assistive technology equipment. Requires the commissioner to report to the Legislature on recommendations for implementing an assistive technology equipment program by February 1, 2014.

60 **Provider rate and grant increase effective April 1, 2014.** Increases reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by one percent on April 1, 2014, for a variety of continuing care providers. Requires managed care plans receiving state payments for the services in this section to include these increases in their payments to providers. Requires counties to increase the budget for each recipient of consumer-directed community supports by one percent on April 1, 2014.

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61 **Safety net for home and community-based services waivers.** Requires the commissioner of human services to submit for federal approval by December 31, 2013, permission to modify the financial management of HCBS waivers to provide a state-administered safety net when costs for an individual increase above an identified threshold.

62 **Shared living model.** Requires the commissioner of human services to develop and promote a shared living model option for HCBS waiver recipients who require 24-hour assistance, with any required federal approval submitted by December 31, 2013.

63 **Money follows the person grant.** Requires the commissioner of human services to submit all necessary waiver amendments to implement the Money Follows the Person federal grant by December 1, 2013.

64 **Repealer.** Repeals Minnesota Statutes, sections 256B.0917, subd. 14 (essential community supports grants); 256B.096, subds. 1 (scope), 2 (stakeholder advisory group), 3 (annual survey of service recipients), and 4 (improvements for incident reporting, investigation, analysis, and follow-up); 256B.14, subd. 3a (spousal contribution); 256B.5012, subd. 13 (ICF/DD rate decrease effective July 1, 2013); and Laws 2011, First Special Session ch. 9, art. 7, section 54, as amended by Laws 2012, ch. 247, art. 4, section 42, and Laws 2012, ch. 298, section 3 (contingency provider rate and grant reductions).

Article 8: Waiver Provider Standards

Overview

This article modifies human services licensing provisions, modifies home and community-based services (HCBS) standards, and establishes licensing fees for the new HCBS licensing standards.

1 **Human services license holders.** Amends § 13.461, by adding subd. 7c. Adds the recording-keeping requirements of home and community-based services waivers license holders under Minnesota Statutes, chapter 245D, subject to certain provisions in the Government Data Practices chapter.

2 **Health care facility.** Amends § 145C.01, subd. 7. Adds community residential settings licensed under chapter 245D to the definition of "health care facility."

3 **Health care facility; notice of status.** Amends §243.166. Broadens the definition of "health care facility" by including residential services to persons with any disabilities, not just developmental disabilities.

4 **Positive support strategies and emergency manual restraint; licensed facilities and programs.** Creates § 245.8251.

Subd. 1. Rules. Requires the commissioner to adopt rules on the use of positive support strategies, safety interventions, and emergency use of manual restraints in programs licensed under chapter 245D.

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Subd. 2. Data collection. Requires the commissioner to consult with stakeholders and develop data collection elements specific to incidents of emergency use of manual restraint and positive support transition plans for persons receiving services from providers who will be licensed under chapter 245D. Specifies reporting requirements for providers.

5 **Emergency use of manual restraint.** Amends § 245.91, by adding subd. 3a. Defines "emergency use of manual restraint."

6 **Matters appropriate for review.** Amends § 245.94, subd. 2. Adds reports of emergency use of manual restraint to the list of items to which the Ombudsman for Mental Health and Developmental Disabilities shall give particular attention.

7 **Mandatory reporting.** Amends § 245.94, subd. 2a. Requires the emergency use of manual restraints to be reported to the Ombudsman for Mental Health and Developmental Disabilities.

8 **Nonresidential program.** Amends § 245A.02, subd. 10. Strikes obsolete language from the definition of nonresidential program. Adds language and cross reference to chapter 245D.

9 **Residential program.** Amends § 245A.02, subd. 14. Strikes obsolete language from the definition of residential program. Adds language and cross reference to chapter 245D.

10 **Licensing moratorium.** Amends § 245A.03, subd. 7. Adds community residential setting licenses to the list of exceptions to the moratorium. Adds references to community residential settings. Limits the decrease of certain foster care beds to adult foster care beds.

11 **Excluded providers seeking licensure.** Amends § 245A.03, subd. 8. Corrects a cross reference.

12 **Permitted services by an individual who is related.** Amends § 245A.03, subd. 9. Modifies the list of supported living services that may be provided by an individual who is related to the recipient to include any successor licensing requirements to chapter 245B.

13 **Implementation.** Amends § 245A.042, subd. 3. Corrects a cross reference. Clarifies language related to the commissioner's authority to issue correction orders.

14 **Consolidated contested case hearings.** Amends § 245A.08, subd. 2a. Requires the county attorney to defend the commissioner's orders for sanctions in consolidated contested case hearings involving community residential settings.

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15 **Fees.** Amends § 245A.10.

Subd. 1. Application or license fee required, programs exempt from fee. States that no application or license fee will be charged for community residential settings, except as provided in subdivision 2.

Subd. 2. County fees for background studies and licensing inspections. Allows a county agency to charge a fee to recover the actual cost of inspection for licensing the physical plant of a community residential setting.

Subd. 3. Application fee for initial license or certification. Requires an applicant for an initial day services facility license to submit a $250 application fee with each new license. Allows applicants for a license to provide HCBS waiver services to persons with disabilities or to persons age 65 and older to submit an application to provide services statewide. Specifies the application fee. Adds that initial application fees in this subdivision do not include the temporary license surcharge under section 16E.22. Strikes obsolete language.

Subd. 4. License or certification fee for certain programs. Strikes obsolete language and fees. Establishes new license fees for programs licensed under chapter 245D.

Effective date. Makes this section effective July 1, 2013.

16 **Adult foster care and community residential setting license capacity.** Amends § 245A.11, subd. 2a. Makes technical changes so that this section applies to community residential settings.

17 **Adult foster care; variance for alternate overnight supervision.** Amends § 245A.11, subd. 7. Requires transfer of a variance granted under this subdivision when an adult foster care home license holder converts to a community residential setting license under chapter 245D.

18 **Alternate overnight supervision technology; adult foster care and community residential setting licenses.** Amends § 245A.11, subd. 7a. Updates terminology and strikes obsolete language.

19 **Adult foster care data privacy and security.** Amends § 245A.11, subd. 7b. Updates terminology and strikes obsolete language.

20 **Community residential setting license.** Amends § 245A.11, subd. 8. Strikes references to child foster care and to residential support services. Adds a cross reference to the definition of community residential setting.

21 **Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Prohibits county agencies from granting variances for community residential setting licenses. During implementation of chapter 245D, requires the commissioner to consider the role of counties in quality assurance, the duties of county licensing staff, and the possible use of joint powers

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agreements with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

22 **Definitions.** Amends § 245D.02. Modifies definitions in the home and community-based services standards by adding definitions of "authorized representative," "aversive procedure," "aversive stimulus," "certification," "chemical restraint," "community residential setting," "coordinated service and support plan," "coordinated service and support plan addendum," "corporate foster care," "cultural competence or culturally competent," "day services facility," "deprivation procedure," "direct support staff or staff," "emergency use of manual restraint," "expanded support team," "family foster care," "intermediate care facility for persons with developmental disabilities or ICF/DD," "least restrictive alternative," "manual restraint," "mechanical restraint," "most integrated setting," "outcome," "physician," "positive support transition plan," "self-determination," "semi-independent living services," "supervised living facility," "supervision," "time out," and "treatment." Removes definitions for "medication administration," "medication assistance," "medication management," "service plan," "staff," and "unit of government." Modifies definitions of "emergency," "home and community-based services," "incident," "legal representative," "mental health crisis intervention team," "prescriber," "prescription drug," "restraint," "seclusion," and "service." Makes this section effective January 1, 2014.

23 **Applicability and effect.** Amends § 245D.03.

Subd. 1. Applicability. Modifies the list of services governed by the licensing standards in this chapter.

Subd. 2. Relationship to other standards governing home and community-based services. Modifies standards related to foster care services. Exempts license holders providing (1) services in supervised living facilities, (2) residential services to person in an ICF/DD, and (3) homemaker services from certain standards. Specifies nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 or older, provided all relevant standards are met.

Subd. 3. Variance. Corrects a cross-reference.

Subd. 4. License holders with multiple 245D licenses. Repeals this subdivision.

Subd. 5. Program certification. Allows license holders to apply for adult mental health certification.

Makes this section effective January 1, 2014.

24 **Service recipient rights.** Amends § 245D.04.

Subd. 1. License holder responsibility for individual rights of persons served by the program. Modifies terminology.

Subd. 2. Service-related rights. Modifies a person's service-related rights.

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Subd. 3. Protection-related rights. Modifies a person's protection-related rights.

Makes this section effective January 1, 2014.

25 Health services. Amends § 245D.05.

Subd. 1. Health needs. Modifies terminology and phrasing related to license holder responsibilities for meeting health service needs of recipients.

Subd. 1a. Medication setup. Defines "medication setup" and lists information the license holder must document in the person's medication administration record.

Subd. 1b. Medication assistance. Defines "medication assistance" and specifies requirements that must be met by the license holder when staff provides medication assistance.

Subd. 2. Medication administration. Lists medication administration procedures that must be implemented by the license holder to ensure a person takes medications and treatments as prescribed. Modifies requirements that must be met before administering medication or treatment. Modifies the list of information that must be included in the person's medication administration record.

Subd. 3. Medication assistance. Repeals this subdivision.

Subd. 4. Reviewing and reporting medication and treatment issues. Modifies provisions related to reviewing and reporting medication and treatment issues.

Subd. 5. Injectable medications. No changes.

Makes this section effective January 1, 2014.

26 Psychotropic medication use and monitoring. Creates § 245D.051.

Subd. 1. Conditions for psychotropic medication administration. Lists requirements that must be met when the license holder is assigned responsibility for administering a person's psychotropic medication. Defines "target symptom."

Subd. 2. Refusal to authorize psychotropic medication. Specifies license holder duties when the person or the person's legal representative refuses to authorize the administration of a psychotropic medication ordered by the prescriber.

Makes this section effective January 1, 2014.

27 Protection standards. Amends § 245D.06.

Subd. 1. Incident response and reporting. Specifies the requirements that must be met when responding to incidents that occur while providing services to protect the health and safety of the person. Makes technical and conforming changes. Specifies when incident reports must be made and reviews must be conducted and what must be included in the review. Requires license holders to report the emergency use of

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manual restraint of a person to DHS within 24 hours of the occurrence.

Subd. 2. Environment and safety. Modifies the list of duties license holders must perform related to environment and safety.

Subd. 3. Compliance with fire and safety codes. Repeals this subdivision.

Subd. 4. Funds and property. Specifies when authorization must be received and other license holder duties when the license holder assists a person with the safekeeping of funds or other property. Removes language prohibiting license holders from being appointed a guardian or conservator of a person receiving services from the license holder. Specifies license holder duties upon the transfer or death of a person.

Subd. 5. Prohibited procedures. Prohibits license holders from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure as a substitute for adequate staffing, a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Subd. 6. Restricted procedures. Lists allowed but restricted procedures.

Subd. 7. Permitted actions and procedures. Specifies the use of instructional techniques and intervention procedures is permitted, but must be addressed in a person's coordinated service and support plan addendum when used on a continuous basis. Requires physical contact or instructional techniques to use the least restrictive alternative possible to meet the needs of the person and lists when these techniques may be used. Lists circumstances under which restraints may be used. Specifies the use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not constitute the use of mechanical restraint.

Subd. 8. Positive support transition plan. Requires license holders to develop a positive support transition plan for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. Specifies timelines for the positive support transition plan to phase out any existing plans for the emergency or programmatic use of aversive or deprivation procedures prohibited under this chapter.

Makes this section effective January 1, 2014.

28 Emergency use of manual restraints. Creates § 245D.061.

Subd. 1. Standards for emergency use of manual restraints. Specifies standards for emergency use of manual restraints.

Subd. 2. Conditions for emergency use of manual restraint. Lists the conditions that must be met for emergency use of manual restraint.

Subd. 3. Restrictions when implementing emergency use of manual restraint.

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Lists prohibitions regarding emergency use of manual restraint procedures.

Subd. 4. Monitoring emergency use of manual restraint. Requires the license holder to monitor a person's health and safety during an emergency use of manual restraint. Requires the license holder to complete a monitoring form for each incident involving the emergency use of manual restraint.

Subd. 5. Reporting emergency use of manual restraint incident. Requires staff to report each incident involving the emergency use of manual restraint. Specifies the information that must be included in the incident report. Requires each single incident of emergency use of manual restraint to be reported separately.

Subd. 6. Internal review of emergency use of manual restraint. Requires license holders to complete an internal review of each report of emergency use of manual restraint, lists the information that must be evaluated as part of the review, and requires a corrective action plan to be developed and implemented if any lapses in performance are found. Requires the license holder to maintain a copy of the internal review and corrective action plan, if any, in the person's service recipient record.

Subd. 7. Expanded support team review. Requires license holders to consult with the expanded support team following the emergency use of manual restraint.

Subd. 8. External review and reporting. Requires the license holder to submit certain information to DHS and the Ombudsman for Mental Health and Developmental Disabilities within five working days of the expanded support team review.

Subd. 9. Emergency use of manual restraints policy and procedures. Requires license holders to develop, document, and implement a policy and procedures for the emergency use of manual restraints. Specifies the information that must be included in the policy and procedures.

Makes this section effective January 1, 2014.

29 Service planning and delivery. Amends § 245D.07.

Subd. 1. Provision of services. Makes technical changes to phrasing.

Subd. 1a. Person-centered planning and service delivery. Requires the license holder to provide services in response to the person's identified needs and preferences as specified in the coordinated service and support plan, the plan addendum, and with provider standards. Lists the principles that must guide provision of services.

Subd. 2. Service planning requirements for basic support services. Specifies timelines for developing the service plan based on the coordinated service and support plan. Makes conforming changes.

Subd. 3. Reports. No changes.

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Makes this section effective January 1, 2014.

30 Service planning and delivery; intensive support services. Creates § 245D.071.

Subd. 1. Requirements for intensive support services. Specifies the requirements license holders providing intensive support services must meet.

Subd. 2. Abuse prevention. Requires license holders to develop, document, and implement an abuse prevention plan prior to or upon initiating services.

Subd. 3. Assessment and initial service planning. Specifies the timelines and processes a license holder must follow for developing the service plan for a person.

Subd. 4. Service outcomes and supports. Requires service outcomes and supports to be developed by the license holder and included in the coordinated service and support plan addendum. Requires the license holder to document the supports and lists the information that must be included in the documentation. Requires the license holder to obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and plan addendum.

Subd. 5. Progress reviews. Specifies the process for progress reviews.

Makes this section effective January 1, 2014.

31 Program coordination, evaluation, and oversight. Creates § 245D.081.

Subd. 1. Program coordination and evaluation. Lists license holder responsibilities related to program coordination and evaluation.

Subd. 2. Coordination and evaluation of individual service delivery. Requires delivery and evaluation of services provided by the license holder to be coordinated by a designated staff person. Lists activities for which the designated coordinator must provide supervision, support, and evaluation. Lists education and training requirements for designated coordinators.

Subd. 3. Program management and oversight. Requires the license holder to designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. Lists the responsibilities of the designated manager. Specifies the education, training, and supervisory experience necessary to be a designated manager.

Makes this section effective January 1, 2014.

32 Staffing standards. Amends § 245D.09.

Subd. 1. Staffing requirements. Modifies staffing requirements.

Subd. 2. Supervision of staff having direct contact. Makes conforming changes

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by modifying terminology.

Subd. 3. Staff qualifications. Makes conforming changes by modifying terminology and modifies staff qualifications.

Subd. 4. Orientation to program requirements. Modifies orientation requirements.

Subd. 4a. Orientation to individual service recipient needs. Modifies requirements related to orientation to individual service recipient needs.

Subd. 5. Annual training. Modifies annual training requirements for direct support staff.

Subd. 5a. Alternative sources of training. Allows alternative sources of training and specifies requirements for license holders related to documenting alternative sources of training.

Subd. 6. Subcontractors and temporary staff. Modifies license holder requirements related to subcontractors and temporary staff.

Subd. 7. Volunteers. Modifies terminology and requires license holders to ensure that a background study has been completed and to maintain documentation that applicable requirements have been met.

Subd. 8. Staff orientation and training plan. Requires license holders to develop a staff orientation and training plan documenting when and how compliance with orientation and training requirements will be met.

Makes this section effective January 1, 2014.

33 Intervention services. Creates § 245D.091.

Subd. 1. Licensure requirements. Specifies certain employees of licensed programs providing specified services do not have to hold a separate license under this chapter. Individuals who are not providing services as an employee of a licensed program must obtain a license according to this chapter.

Subd. 2. Behavior professional qualifications. Lists qualifications for behavior professionals, as defined in the BI and CADI waiver plans.

Subd. 3. Behavior analyst qualifications. Lists qualifications for behavior analysts, as defined in the BI and CADI waiver plans.

Subd. 4. Behavior specialist qualifications. Lists qualifications for behavior specialists, as defined in the BI and CADI waiver plans.

Subd. 5. Specialist services qualifications. Lists qualifications for an individual providing specialist services, as defined in the DD waiver plan.

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Makes this section effective January 1, 2014.

34 Record requirements. Creates § 245D.095.

Subd. 1. Record-keeping systems. Requires license holders to ensure that certain records are uniform and legible.

Subd. 2. Admission and discharge register. Requires the license holder to keep a written or electronic register listing the dates and names of all persons served by the program who have been admitted, discharged, or transferred.

Subd. 3. Service recipient record. Requires license holders to maintain a record of current services provided to each person on the premises where the services are provided or coordinated. Lists the information that must be maintained for each person.

Subd. 4. Access to service recipient records. Requires license holders to ensure that certain people have access to service recipient records in accordance with applicable state and federal law, regulation, or rule.

Subd. 5. Personnel records. Requires the license holder to maintain a personnel record of each employee to document and verify staff qualifications, orientation, and training. Lists the information that must be included in the personnel record.

Makes this section effective January 1, 2014.

35 Policies and procedures. Amends § 245D.10.

Subd. 1. Policy and procedure requirements. Modifies license holder policy and procedure requirements.

Subd. 2. Grievances. Requires the complaint process to promote service recipient rights.

Subd. 3. Service suspension and service termination. Modifies requirements related to policies and procedures for service suspension and service termination.

Subd. 4. Availability of current written policies and procedures. Modifies license holder requirements related to making available current written policies and procedures.

Makes this section effective January 1, 2014.

36 Policies and procedures; intensive support services. Creates § 245D.11.

Subd. 1. Policy and procedure requirements. Requires license holders providing intensive support services to establish, enforce, and maintain required policies and procedures.

Subd. 2. Health and safety. Requires license holders to establish policies and

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procedures that promote health and safety.

Subd. 3. Data privacy. Requires license holders to establish policies and procedures that promote service recipient rights by ensuring data privacy according to the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Subd. 4. Admission criteria. Requires license holders to establish policies and procedures that promote continuity of care by ensuring certain admission or service initiation criteria are met.

Makes this section effective January 1, 2014.

37 Facility licensure requirements and application process. Creates § 245D.21.

Subd. 1. Community residential settings and day service facilities. Defines "facility."

Subd. 2. Inspections and code compliance. Specifies requirements related to inspections and code compliance.

Makes this section effective January 1, 2014.

38 Facility sanitation and health. Creates § 245D.22.

Subd. 1. General maintenance. Requires license holders to maintain the interior and exterior of buildings used by the facility in good repair and in a sanitary and safe condition. Requires license holders to correct building and equipment deterioration, safety hazards, and unsanitary conditions.

Subd. 2. Hazards and toxic substances. Requires license holders to ensure that service sites owned or leased by the license holder are free from hazards that would threaten the health or safety of a person receiving services. Lists requirements that must be met.

Subd. 3. Storage and disposal of medication. Requires certain controlled substances to be stored in a locked storage area permitting access only by persons and staff authorized to administer the medication. Requires medications to be disposed of according to EPA recommendations.

Subd. 4. First aid. Requires staff people to be trained in first aid and, when required in a person's coordinated service and support plan, cardiopulmonary resuscitation. Requires facilities to have first aid kits readily available. Specifies the items with which first aid kits must be equipped.

Subd. 5. Emergencies. Requires license holders to have a written plan for responding to emergencies to ensure the safety of persons in the facility and lists information that must be included in the plan.

Subd. 6. Emergency equipment. Requires each facility to have a flashlight and a

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portable radio or TV that do not require electricity and can be used if a power failure occurs.

Subd. 7. Telephone and posted numbers. Requires each facility to have a non-coin operated telephone that is readily accessible. Requires a list of emergency numbers to be posted in a prominent location. Specifies the numbers that must be included on the list of emergency numbers. Requires the names and telephone numbers of each person's representative, physician, and dentist to be readily available.

Makes this section effective January 1, 2014.

39 Community residential settings; satellite licensure requirements and application process. Creates § 245D.23.

Subd. 1. Separate satellite license required for separate sites. Requires license holders providing residential support services to obtain a separate satellite license for each community residential setting located at separate addresses when the settings are to be operated by the same license holder. Specifies a community residential setting is a satellite of the HCBS license. Specifies community residential settings are permitted single-family use homes. Requires the commissioner to notify the local municipality where the residence is located of the approved license.

Subd. 2. Notification to local agency. Requires license holders to notify the local agency within 24 hours of the onset of changes in a residence resulting from construction, remodeling, or damages requiring repairs that require a building permit or may affect a licensing requirement.

Subd. 3. Alternate overnight supervision. Specifies requirements for license holders who have been granted an alternate overnight supervision technology adult foster care license.

Makes this section effective January 1, 2014.

40 Community residential settings; physical plant and environment. Creates § 245D.24.

Subd. 1. Occupancy. Requires the residence to meet the definition of a dwelling unit in a residential occupancy.

Subd. 2. Common area requirements. Requires the living area to be provided with an adequate number of furnishings for the usual functions of daily living and social activities. Requires the dining area to be furnished to accommodate meals shared by all persons living in the residence. Requires furnishings to be in good repair and functional to meet the daily needs of the persons living in the residence.

Subd. 3. Bedrooms. Requires persons receiving services to mutually consent to sharing a bedroom with one another. Specifies no more than two people receiving services may share one bedroom. Specifies size, furnishings, and other requirements bedrooms must meet.

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Makes this section effective January 1, 2014.

41 Community residential settings; food and water. Creates § 245D.25.

Subd. 1. Water. Requires potable water from private wells to be tested annually to verify safety. Authorizes the health authority to require retesting and corrective measures under certain circumstances. Prohibits water temperature of faucets from exceeding 120 degrees Fahrenheit.

Subd. 2. Food. Requires food served to meet any dietary needs of a person as prescribed by the person's physician or dietician. Requires three nutritionally balanced meals to be served or made available per day, and requires nutritious snacks to be available between meals.

Subd. 3. Food safety. Requires food to be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to the health of a person.

Makes this section effective January 1, 2014.

42 Community residential settings; sanitation and health. Creates § 245D.26.

Subd. 1. Goods provided by the license holder. Specifies the household goods that must be made available by the license holder.

Subd. 2. Personal items. Requires personal health and hygiene items to be stored in a safe and sanitary manner.

Subd. 3. Pets and service animals. Requires pets and service animals housed in the residence to be immunized and maintained in good health. Requires license holders to ensure that the person and person's representative are notified before admission of the presence of pets in the residence.

Subd. 4. Smoking in the residence. Requires license holders to comply with the requirements of the Minnesota Clean Indoor Air Act, when smoking is permitted in the residence.

Subd. 5. Weapons. Requires weapons and ammunition to be stored separately in locked areas that are inaccessible to a person receiving services. Defines "weapons."

Makes this section effective January 1, 2014.

43 Day services facilities; satellite licensure requirements and application process. Creates § 245D.27. Requires license holders providing day services to apply for separate licenses for each facility-based service site when the license holder is the owner, lessor, or tenant of the service site at which services are provided more than 30 days within any 12-month period. Allows a day services program to operate multiple licensed day service facilities in one or more counties in the state. Defines "adjoining lot." Makes this section effective January 1, 2014.

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44 **Day services facilities; physical plant and space requirements.** Creates § 245D.28.

Subd. 1. Facility capacity and useable space requirements. Specifies facility capacity and useable space requirements for day services facilities.

Subd. 2. Individual personal articles. Requires each person to be provided space for storage of personal items for the person's own use while receiving services at the facility.

Makes this section effective January 1, 2014.

45 **Day services facilities; health and safety requirements.** Creates § 245D.29.

Subd. 1. Refrigeration. Requires refrigeration to have a temperature of 40 degrees Fahrenheit or less if refrigeration is provided by the license holder.

Subd. 2. Drinking water. Requires drinking water to be available to all persons receiving services and to be provided in single-service containers or from drinking fountains accessible to all persons.

Subd. 3. Individuals who become ill during the day. Requires there to be an area in which a person receiving services can rest under certain circumstances.

Subd. 4. Safety procedures. Requires the license holder to establish general written safety procedures and specifies the information that must be included in the safety procedures.

Makes this section effective January 1, 2014.

46 **Day services facilities; staff ratio and facility coverage.** Creates § 245D.31.

Subd. 1. Scope. Makes this section apply only to facility-based day services.

Subd. 2. Factors. Lists factors that affect the number of direct support staff members a license holder is required to have on duty at the facility at a given time. Requires the commissioner to consider these factors in determining a license holder's compliance with staffing requirements and whether the staff ratio requirement for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. Staff ratio requirement for each person receiving services. Specifies the process for the case manager to determine the staff ratio assigned to each person receiving services and requires documentation of how the ratio was determined.

Subd. 4. Person requiring staff ratio of one to four. Specifies the conditions under which a person must be assigned a staff ratio of one to four.

Subd. 5. Person requiring staff ratio of one to eight. Specifies the conditions under which a person must be assigned a staff ratio of one to eight.

Subd. 6. Person requiring staff ratio of one to six. Requires a person who does

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not have any of the characteristics described in subdivisions 4 and 5 to be assigned a staff ratio of one to six.

Subd. 7. Determining number of direct support service staff required. Specifies the steps for determining the number of direct support service staff required to meet the combined staff ratio requirements of the persons present at any one time.

Subd. 8. Staff to be included in calculating minimum staffing requirement. Requires only direct support staff to be counted as staff members in calculating the staff to participant ratio. Allows volunteers to be counted under certain circumstances. Prohibits persons receiving services from being counted as or substituted for a staff member in calculating the staff to participant ratio.

Subd. 9. Conditions requiring additional direct support staff. Requires the license holder to increase the number of direct support staff persons present at any one time beyond the number required if necessary under specified circumstances.

Subd. 10. Supervision requirements. Prohibits one direct support staff member from being assigned responsibility for supervision and training of more than 10 persons receiving supervision and training, except as otherwise stated in each person's risk management plan. Requires a direct support staff member to be assigned to supervise the center in the absence of the director or a supervisor.

Subd. 11. Multifunctional programs. Allows multifunctional programs to count other employees of the organization besides direct support staff of the day service facility in calculating the staff to participant ratio if the employee is assigned to the day services facility for a specified amount of time, during which the employee is not assigned to another organization or program.

Makes this section effective January 1, 2014.

47 Alternative licensing inspections. Creates § 245D.32.

Subd. 1. Eligibility for an alternative licensing inspection. Allows community residential setting and day services facility license holders to request approval for an alternative licensing inspection when all services provided under the license holder's license are accredited and certain other requirements are met. Defines "substantial and consistent compliance."

Subd. 2. Qualifying accreditation. Requires the commissioner to accept a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities as a qualifying accreditation.

Subd. 3. Request for approval of an alternative inspection status. Specifies the process for requesting approval of an alternative inspection.

Subd. 4. Programs approved for alternative licensing inspection; deemed compliance licensing requirements. Requires license holders approved for alternative licensing inspection to maintain compliance with all licensing standards,

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prohibits the commissioner from performing routine licensing inspections, and requires the commissioner to investigate complaints and take action as provided for in human services licensing statutes.

Subd. 5. Investigations of alleged or suspected maltreatment. Specifies the commissioner retains the responsibility to investigate alleged or suspected maltreatment of a minor or a vulnerable adult.

Subd. 6. Termination or denial of subsequent approval. Allows the commissioner to terminate or deny subsequent approval of an alternative licensing inspection if the commissioner makes certain determinations.

Subd. 7. Appeals. Prohibits appeals of the commissioner's decision that the conditions for approval for an alternative licensing inspection have not been met.

Subd. 8. Commissioner's programs. Excludes certain licensed HCBS providers from being approved for an alternative licensing inspection.

Makes this section effective January 1, 2014.

48 **Adult mental health certification standards.** Creates § 245D.33. Requires the commissioner to issue a mental health certification for services licensed under this chapter when a license holder is determined to have met certain requirements. Makes this certification voluntary for license holders. Requires the certification to be printed on the license and identified on the commissioner's public Web site. Lists the requirements for certification. Requires license holders seeking this certification to request it on forms and in the manner prescribed by the commissioner. Allows the commissioner to issue correction orders, orders of conditional license, or sanctions if the commissioner finds that a license holder has failed to comply with the certification requirements. Prohibits appeals when a certification is denied or removed based on a determination that the certification requirements have not been met. Makes this section effective January 1, 2014.

49 **Case management services.** Amends § 256B.092, subd. 1a. Modifies DD waiver case management services by adding requirements related to positive support transition plans.

50 **Residential support services.** Amends § 256B.092, subd. 11. Allows residential support services to be provided by foster care settings. Modifies the list of criteria residential support services must meet.

51 **Case management.** Amends § 256B.49, subd. 13. Modifies CAC, CADI, and BI waiver case management services by adding requirements related to positive support transition plans.

52 **Provider qualifications.** Amends § 256B.4912, subd. 1. Adds cross-references and modifies elderly and disability waiver provider qualifications beginning January 1, 2014.

53 **Applicant and license holder training.** Amends § 256B.4912, subd. 7. Adds cross-references and requires newly enrolled HCBS providers to ensure that at least one controlling individual has completed training on waiver and related program billing within six months of

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enrollment. Allows the commissioner to grant exemptions to new waiver provider training requirements.

54 **Data on use of emergency use of manual restraint.** Amends § 256B.4912, by adding subd. 8. Requires facilities and services licensed under chapter 245D to submit data to the commissioner regarding the use of emergency use of manual restraint.

55 **Definitions.** Amends §256B.4912, by adding subd. 9. Defines "controlling individual," "managerial official," and "owner" for purposes of HCBS waivers.

56 **Enrollment requirements.** Amends § 256B.4912, by adding subd. 10. Lists information and documentation all HCBS waiver providers must provide to the commissioner at the time of enrollment and within 30 days of a request.

57 **Evaluation and referral of reports made to common entry point unit.** Amends § 626.557, subd. 9a. Strikes the requirement for the common entry point to report allegations of maltreatment to the county when the report involves services licensed under chapter 245D.

58 **Lead investigative agency.** Amends § 626.5572, subd. 13. Provides that the Department of Human Services is the lead investigative agency for reports involving vulnerable adults who are receiving HCBS subject to chapter 245D.

59 **Report on transfer of vulnerable adult maltreatment investigation duties.** Requires the commissioner of human services to provide a follow-up report on the collection of fees and actual licensing and maltreatment investigation costs resulting from the reform of the standards and oversight of HCBS waiver services. Specifies information and recommendations that must be included in the report and requires the commissioner to submit the report with draft legislation to the legislative committees with jurisdiction over health and human services policy and finance by July 1, 2015.

60 **Integrated licensing system for home care and home and community-based services.** Requires the Departments of Health and Human Services to jointly develop an integrated licensing system for providers of both home care services and HCBS. Lists components that must be included in the integrated licensing system. Requires recommendations for legislative changes to implement the integrated licensing system to be submitted to the legislature by February 15, 2014. Before implementation of the integrated licensing system, allows licensed home care providers to provide HCBS without obtaining a HCBS license. Lists conditions that apply to these providers.

61 **Repealer.** (a) Repeals Minnesota Statutes, sections 245B.01 (rule consolidation); 245B.02 (definitions); 245B.03 (applicability and effect); 245B.031 (accreditation, alternative inspection, and deemed compliance); 245B.04 (consumer rights); 245B.05, subd. 1, 2, 3, 5, 6, and 7 (consumer protection standards); 245B.055 (staffing for DT&H services); 245B.06 (service standards); 245B.07 (management standards); and 245B.08 (compliance strategies), effective January 1, 2014.

(b) Repeals Minnesota Statutes, section 245D.08 (record requirements).

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Article 9: Waiver Provider Standards Technical Changes

Overview

This article provides technical changes related to the new waiver provider standards established in chapter 245D.

1 **Specific purchases.** Amends § 16C.10, subd. 5. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

2 **Service contracts.** Amends § 16C.155, subd. 1. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

3 **Housing with services establishment or establishment.** Amends § 144D.01, subd. 4. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

4 **Applicability.** Amends § 174.30, subd. 1. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

5 **Scope.** Amends § 245A.02, subd. 1. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

6 **License holder.** Amends § 245A.02, subd. 9. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

7 **Permitted services by an individual who is related.** Amends § 245A.03, subd. 9. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

8 **Funds and property; other requirements.** Amends § 245A.04, subd. 13. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

9 **License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

10 **Personal care.** Amends § 256B.0625, subd. 19c. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

11 **Contract provisions.** Amends § 256B.5011, subd. 2. Makes technical and conforming

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changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

12 **Agreement.** Amends § 471.59, subd. 1. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

13 **Definitions.** Amends § 626.556, subd. 2. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

14 **Persons mandated to report.** Amends § 626.556, subd. 3. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

15 **Notification of neglect or abuse in facility.** Amends § 626.556, subd. 10d. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.

16 **Repealer.** Repeals Minnesota Statutes, section 256B.49, subd. 16a (MA reimbursement), effective January 1, 2014.

Article 10: Health-Related Licensing Boards

Overview

This article modifies provisions related to the regulation of pharmacies, drug wholesalers, and drug manufacturers. It imposes criminal history check requirements on applicants for licensure with one of the health-related licensing boards. Fees for individuals licensed by the Board of Marriage and Family Therapy are decreased.

1 **Licensure and application fees.** Amends §148B.17, subd. 2. Decreases fees charged to individuals who are licensed by the Board of Marriage and Family Therapy.

2 **Pharmacy licensure requirements.** Amends §151.19, subd. 1. Paragraph (a) requires pharmacies to be licensed by the board.

Paragraph (b) requires applications to be made in a manner specified by the board.

Paragraph (c) requires all licensed pharmacies to comply with federal laws and state laws and rules related to operation of a pharmacy. Requires out-of-state pharmacies dispensing drugs to residents of Minnesota to comply with federal laws related to operation of a pharmacy.

Paragraph (d) provides that an out-of-state pharmacy must provide proof of licensure or registration by the state in which it is physically located before the board will issue a license.

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Paragraph (e) provides that a separate license is required for each pharmacy at which any portion of the dispensing process occurs for drugs dispensed to residents of Minnesota.

Paragraph (f) prohibits the board from issuing a pharmacy license unless the pharmacy passes an inspection. For out-of-state pharmacies, a report issued by the regulatory authority of the state in which the pharmacy is located satisfies this requirement.

Paragraph (g) lists the requirements that must be met by an out-of-state pharmacy in order to be licensed or have its license renewed.

3 **Sale of federally restricted medical gases.** Amends § 151.19, subd. 3. Paragraph (a) requires pharmacies to be licensed by the board.

Paragraph (b) requires applications to be made in a manner specified by the board.

Paragraph (c) requires all licensed pharmacies to comply with federal laws and state laws and rules related to operation of a pharmacy. Requires out-of-state pharmacies dispensing drugs to residents of Minnesota to comply with federal laws related to operation of a pharmacy.

Paragraph (d) provides that an out-of-state pharmacy must provide proof of licensure or registration by the state in which it is physically located before the board will issue a license.

Paragraph (e) provides that a separate license is required for each pharmacy at which any portion of the dispensing process occurs for drugs dispensed to residents of Minnesota.

Paragraph (f) prohibits the board from issuing a pharmacy license unless the pharmacy passes an inspection. For out-of-state pharmacies, a report issued by the regulatory authority of the state in which the pharmacy is located satisfies this requirement.

Paragraph (g) lists the requirements that must be met by an out-of-state pharmacy in order to be licensed or have its license renewed.

4 **Licensing of drug manufacturers; fees; prohibitions.** Amends §151.252.

Subd. 1. Requirements. Paragraph (a) requires drug manufacturers to be licensed by the board.

Paragraph (b) requires applications to be made in a manner specified by the board.

Paragraph (c) requires licensed drug manufacturers to comply with federal law and state law and rules.

Paragraph (d) provides that drug manufacturers that are required to be registered pursuant to federal law must be registered before they can be licensed by the board. Allows the board to establish standards for the licensure of drug manufacturers that are not required to be registered by federal law.

Paragraph (e) provides that out-of-state drug manufacturers must be licensed or registered by the state in which they are physically located. Allows the board to establish standards for the licensure of a drug manufacturer that is not required to be

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licensed or registered by the state in which it is located.

Paragraph (f) requires a separate license for each facility where drug manufacturing occurs.

Paragraph (g) prohibits the board from issuing a license unless the drug manufacturer passes an inspection. For an out-of-state drug manufacturer, a report issued by the regulatory authority of the state in which the facility is located or by the USFDA satisfied the inspection requirement

Subd. 2. Prohibition. Makes it unlawful for a drug manufacturer to sell legend drugs to anyone located in this state except as provided in this chapter.

Subd. 3. Payment to practitioner; reporting. Requires drug manufacturers, unless prohibited under the provisions of the Affordable Care Act, to file a report with the board annually identifying payments, honoraria, reimbursement, or other compensation paid to practitioners in Minnesota during the previous calendar year.

5 **Research.** Amends § 151.37, subd. 4. Adds paragraph (b). Allows a pharmacy to dispense drugs for use by patients enrolled in a bona fide research study being conducted pursuant to an investigational new drug application or that has been approved by an institutional review board. Provides that a prescription drug order is not required, allows a research drug to be labeled according to study protocol, and clarifies that dispensing and distribution of research drugs is not considered compounding, manufacturing, or wholesaling.

Adds paragraph (c). Provides that an entity under contract to a federal agency to distribute drugs for bona fide research studies are exempt from wholesaler licensing requirements. Exempts out-of-state entities, licensed by the state in which they are located, to distribute drugs to patients enrolled in bona fide research studies of investigational new drugs approved by the USFDA or an IRB.

6 **Requirements.** Amends §151.47, subd. 1. Makes technical changes. Adds that wholesale drug distributors must be licensed or registered by the state in which it is physically located. Allows the board to establish standards for the licensure of a drug wholesaler if licensure or registration is not required by the state in which the wholesaler is located.

Adds that a separate license is required for each wholesale distribution facility from which drugs are shipped into the state or to which drugs are reverse distributed.

Adds that a distribution facility must pass an inspection or be accredited by an accreditation program approved by the board before the board will issue a license. For out-of-state facilities, an inspection report issued by the regulatory authority of the state in which the facility is located or proof of accreditation will satisfy this requirement.

7 **Prohibition.** Amends §151.47, by adding subdivision 3. Makes it unlawful for a wholesale distributor to sell drugs to anyone located in the state or to receive drugs in reverse distribution from anyone located within the state except as provided in this chapter.

8 **License renewal application procedures.** Amends §151.49. Makes technical changes.

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9 Health-related licensing boards; criminal background checks. Creates § 214.075.

Subd. 1. Applications. By January 1, 2018, requires all applicants for initial licensure, licensure by endorsement, or reinstatement to submit to a criminal history check of state and national data. Requires completion of a criminal history check if more than one year has elapsed since the applicant last submitted a background check to the board.

Subd. 2. Investigations. Allows a board to require a licensee to submit to a criminal history record check if the board has reasonable cause to believe the licensee has been charged with or convicted of a crime.

Subd. 3. Consent form; fees; fingerprints. Paragraph (a) requires the applicant to submit a completed consent form for a criminal background check and a full set of fingerprints. Holds the applicant responsible for payment of all fees.

Paragraph (b) places responsibility for payment of all fees association with the criminal background check on the applicant or licensee. Requires the fees to be set by the BCA and FBI. Requires fees to be submitted to the respective licensing board.

Paragraph (c) requires the boards to deposit funds received under this subdivision in a dedicated fund and appropriated to the administrative services unit to pay the criminal background check fees to the BCA and FBI.

Subd. 4. Refusal to consent. Prohibits a board from issuing a license to any applicant who refuses to consent to a background check or fails to submit fingerprints within 90 days after an application is submitted. Provides that failure to submit to a criminal background check as required in subdivision 3 is grounds for disciplinary action.

Subd. 5. Submission of fingerprints to the Bureau of Criminal Apprehension. Requires the board to submit applicant fingerprints to the BCA. Requires the BCA to perform a check of state criminal justice information and to forward the fingerprints to the FBI for a check of national criminal justice information. Instructs the BCA to report findings back to the entity that initiated the background study.

Subd. 6. Alternatives to fingerprint-based criminal background checks. Allows a board to require an alternative method of criminal history checks under specified circumstances.

Subd. 7. Opportunity to challenge accuracy of report. Establishes the process and procedure for an applicant or licensee to challenge the accuracy of the criminal history information reported to the board or the commissioner.

Subd. 8. Instructions to the board; plans. Requires the boards to collaborate with DHS and the BCA to establish a plan for completing criminal background checks of all licensees who were licensed before the effective date requirement under subdivision 1.

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10 **Parental depression.** Amends § 214.12, by adding subd. 4. Requires specified health-related licensing boards to provide educational information to regulated individuals on the subject of parental depression and its effect on children.

11 **Definitions.** Amends § 214.40, subd. 1. Makes technical changes and adds dental therapists and advanced dental therapists to the definition of "health care provider" for purposes of the volunteer health care provider program.

12 **Inclusion of other health-related occupations to criminal background checks.** Requires the commissioner of health, if not reviewed by the Sunset Advisory Commission, to require all applicants for licensure in one of the specified occupations to submit to criminal background checks as required under section 214.075.

13 **Repealer.** Repeals §§151.19, subd. 2 (nonresident pharmacies; registration and fees); 151.25 (registration of manufacturers); 151.45 (wholesale drug distributor advisory task force); 151.47, subd. 2 (wholesale drug distributor licensing requirements); and 151.48 (out-of-state wholesale drug distributor licensing).

Article 11: Home Care Providers

Overview

This article modifies regulation of home care providers. It classifies certain data collected by the commissioner of health; establishes two levels of home care licensure; codifies home care provider regulation in statute; increases fees; and requires the commissioner to inspect all licensees.

1 **Health occupations data.** Amends § 13.381, subd. 2. Makes a conforming cross-reference change.

2 **Homecare and hospice provider.** Amends § 13.381, subd. 10. Specifies that data regarding home care and hospice providers background studies are governed by section 144A.476, subdivision 1.

3 **Data classification; private data.** Amends § 144.051 by adding subdivision 3. Classifies certain data collected, created or maintained by the commissioner of health as "private data" as defined in Minnesota Statutes, chapter 13.

4 **Data classification; public data.** Amends § 144.051, by adding subdivision 4. Classifies certain data collected, created or maintained by the commissioner of health as "public data" as defined in Minnesota Statutes, chapter 13.

5 **Data classification; confidential data.** Amends § 144.051, by adding subdivision 5. Classifies certain data collected, created or maintained by the commissioner of health as "confidential data" as defined in Minnesota Statutes, chapter 13.

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6 **Release of private or confidential data.** Amends § 144.051, by adding subdivision 6. Permits the Department of Health to release private or confidential data, except for social security numbers, to state, federal or local agencies and law enforcement to enhance investigate or enforcement efforts or to further public health protection.

7 **Definitions.** Amends § 144A.43. Modifies definitions of terms applicable to regulation of home care services as provided in Minnesota Statutes, §§ 144.699, subdivision 2, and 144A.43 to 144A.482.

8 **Home care bill of rights.** Amends § 144A.44. Makes technical changes and updates terminology. Combines enumerated rights related to being told provider charges for services and the extent to which, if known, payment can be expected from insurance, public programs or other sources. Adds to the list of enumerated rights: the right to be free from neglect, financial exploitation and other forms of maltreatment covered by the Vulnerable Adults Act and the Maltreatment of Minors Act; and the right to know a provider's reason for terminating services. Modifies exceptions that apply to the right to 10-day advanced notice of termination of services.

Provides that all home care providers must comply with the home care bill of rights and requires the commissioner to enforce the bill of rights against all home care providers regardless of licensure.

9 **Regulation of home care services.** Amends § 144A.45. Makes technical changes and updates terminology. Modifies listed purposes of the commissioner's regulation of home care providers. Makes conforming changes related to repeal of Minnesota Rules, chapter 4668. Requires the commissioner to inspect temporary licensees within one year of issuance of a temporary license and requires inspection of licenses at an interval that will promote the health and safety of clients. Removes provision related to Medicaid reimbursement for Class F providers. Removes provision related to licensed home care providers who provide Alzheimer's disease services.

10 **Home care provider and home care services.** Adds § 144A.471. Requires home care providers to be licensed by the commissioner of health. Defines the phrases "direct home care service" and "regularly engaged" for purposes of license requirements. Establishes a misdemeanor for a home care provider who operates without a license. Establishes two categories of home care provider licensure: basic and comprehensive. Provides exemptions and exclusions from licensure, but specifies that exempted providers must still comply with the home care bill of rights.

11 **Home care provider license; application and renewal.** Adds § 144A.472. Specifies information that must be provided to the commissioner by applicants for a home care provider license. Requires applicants for a comprehensive home care license to provide verification of certain policies and procedures. Includes license renewal provisions and requires licensees with multiple units to obtain separate licenses for each unit that cannot share supervision and administration. Prohibits transfer of any home care license. Sets fee schedule for initial licensure and license renewal fees.

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12 **Issuance of temporary license and license renewal.** Adds § 144A.473. Provides a process for temporary licensure, which is effective for one year, and requires inspection during that first year.

13 **Surveys and investigations.** Adds § 144A.474. Requires the commissioner to conduct inspections of each home care provider, describes types of surveys to be conducted and the survey process, and requires that surveys and investigations be conducted without advance notice. Requires home care providers to provide accurate and truthful information and specifies certain information that must be provided upon request. Provides a process for correction orders, reconsideration and assessing fines. Specifies training requirements for surveyors.

14 **Enforcement.** Adds § 144A.475. Sets out enforcement provisions. Provides reasons for which the commissioner may refuse to grant or renew or may suspend or revoke a license. Requires that providers must request an appeal no later than 15 days after receipt of notice of an action. Restricts eligibility for certain licenses for certain providers after a license is revoked or not renewed for noncompliance.

15 **Background studies.** Adds § 144A.476. Requires background studies for owners and managers of home care provider services and for employees, contractors and volunteers.

16 **Compliance.** Adds § 144A.477. Provides that the commissioner shall survey licensees under this chapter at the same time as for certification under Medicare, to the extent feasible. Provides that certain state regulations are equivalent to federal requirements for providers that are certified for participation in Medicare as a home health agency.

17 **Innovation variance.** Adds § 144A.478. Defines "innovation variance" for purposes of this section. Establishes a process by which a provider may apply for and the commissioner may grant an innovation variance from requirements of this chapter.

18 **Home care provider responsibilities; business operation.** Adds § 144A.479. Requires certain actions of home care providers with regard to business operations. Restricts non-governmental licensees from accepting powers-of-attorney from clients and from serving as a client's representative. Requires home care providers to report maltreatment of minors or vulnerable adults and must report suspected maltreatment. Requires each licensee to have an individual abuse prevention plan for vulnerable minors and adults for whom they provide services. Requires certain information to be kept as part of employee records.

19 **Home care provider responsibilities with respect to clients.** Adds § 144A.4791. Requires providers to give clients notice of their rights under the home care bill of rights. Provides special requirements for home care providers that serve clients with dementia. Sets out requirements for licensees related to only accepting clients for which the provider is qualified to provide services; making referrals when the provider reasonably believes medical services from another health care provider are required; assessment and monitoring of services provided under a basic- or comprehensive-level of licensure; actions required in response to a request to discontinue life-sustaining treatment; termination of services plans; emergency preparedness; and client complaint processes.

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20 **Medication management.** Adds § 144A.4792. Prohibits medication management under a basic home care license. Provides requirements for medication management under a comprehensive home care license.

21 **Treatment and therapy management services.** Adds § 144A.4793. Prohibits treatment and therapy management under a basic home care license. Provides requirements for treatment and therapy management under a comprehensive home care license.

22 **Client record requirements.** Adds §144A.4794. Regulates licensee maintenance of client records, including disclosure and access requirements; content requirements; and the duration of retention of records after client discharge or termination.

23 **Home care provider responsibilities; staff.** Adds § 144A.4795. Provides requirements for the training and competency of staff providing home care services, including licensed health professionals and unlicensed personnel. Lists requirements for staff instructors and competency evaluators.

24 **Orientation and annual training requirements.** Adds § 144A.4796. Requires staff who provide or supervise direct home care services to complete certain orientation requirements. Requires special training for providers who provide services for clients with Alzheimer's disease. Requires certain annual training for all staff who provide direct home care services.

25 **Provision of services.** Adds § 144A.4797. Requires licensees to make available a contact person for staff consultations, and under a comprehensive license, that person must be a registered nurse. Provides supervision requirements for staff who perform basic home care services and for staff who perform delegated nursing or therapy tasks.

26 **Employee health status.** Adds § 144A.4798. Requires licensees to have in place a TB prevention and control program and requires providers to follow guidelines for prevention and control of other communicable diseases.

27 **Department of Health licensed home care provider advisory council.** Adds § 144A.4799. Requires the commissioner of health establish a home care provider advisory council to advise the commissioner on home care provider regulation including, but not limited to, regulation of community standards, enforcement of licensing standards and training standards.

28 **Home care licensing implementation for new licensees and transition period for current licensees.** Adds § 144A.481. Requires temporary license applications to begin January 1, 2014. Provides that home care providers licensed under the current structure must apply for either a basic or comprehensive home care license beginning July 1, 2014. Requires that all home care providers have either a basic or comprehensive home care license by June 30, 2015. Specifies requirements for renewal licenses during transition period. Specifies how change of ownership applications will be handled during the transition period.

29 **Registration of home management providers.** Adds § 144A.482. Sets out requirements and regulation provisions for home management providers. Requires entities that operate home management services, such as housekeeping or meal preparation, to be registered with

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the commissioner of health. Provides an annual fee for this required registration.

30 **Agency quality improvement program.** Adds § 144A.483. Requires the commissioner to establish a quality improvement program and submit an annual report to the legislature on home care licensing and regulatory activities. Specifies the commissioner shall study whether to add a correction order appeals process by an independent reviewer.

31 **Integrated licensing system for home care and home and community-based services.** Requires the Department of Health's compliance and monitoring division and the Department of Human Services' licensing division to develop an integrated licensing system for providers who provide both home care services subject to licensure under Minnesota Statutes, chapter 144A and home and community-based services subject to licensure under Minnesota Statutes, chapter 245D.

32 **Study of correction order appeal process.** Requires MDH to study the correction order appeal process with a report due to the legislature by February 1, 2016.

33 **Repealer.** (a) Repeals Minnesota Statutes §§ 144A.46 and 144A.461 (licensure and registration of home care services).

(b) Repeals Minnesota Rules, chapter 4668 (home care licensure and class F home care providers). Repeals Minnesota Rules, chapter 4669 (home care licensure fees).

34 **Effective Date.** Provides an immediate effective date for this article.

Article 12: Health Department

Overview

This article modifies provisions related to the department of health. The article includes changes to the MERC program; a requirement for certain coverage of autism spectrum disorders; and an increase in the fee for newborn screening, as well as added conditions for which screening is required. Among other changes, this article also modifies the department's statewide health improvement program (SHIP); mortuary science provisions related to alkaline hydrolysis; and the activities conducted by the Office of Vital Records.

1 **Transfers.** Amends § 16A.724, subd. 2. Transfers $1,000,000 each year from the health care access fund to the medical education and research costs (MERC) fund.

2 **Coverage for autism spectrum disorders.** Amends § 43A.23, subd. 4. Requires that the participants in the state employee group insurance program (SEGIP) receive the same benefit as is required in section 3. Provides an effective date of January 1, 2016, or the date of the next collective bargaining agreement.

3 **Coverage for autism spectrum disorders.** Adds § 62A.3094.

Subd. 1. Definitions. Defines the term "autism spectrum disorders" to include

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autism and related conditions. Defines "medically necessary care" for purposes of this section. Defines "mental health professional" for purposes of this section.

Subd. 2. Coverage required. Requires health plans issued by a large employer to provide benefits related to autism spectrum disorders for children under 18 years.

Lists services and therapies that must be included in a plan. Requires the plan to include a treatment plan recommended by the enrollee's treating physician or mental health professional.

Prohibits health carriers from refusing to renew, issue, or otherwise terminating an enrollee's insurance coverage due to the enrollee having an autism spectrum disorder.

Prohibits health plans from requiring an updated treatment plan more often than every six months, unless the health carrier and treating provider agree to a more frequent schedule for updates. Requires independent progress evaluation.

Subd. 3. No effect on other law. Provides that nothing in this section limits mental health coverage required under Minnesota Statutes, section 62Q.47.

Subd. 4. State health care programs. Provides that the coverage requirements in this section do not affect the benefits available under medical assistance, and MinnesotaCare.

Effective date: Makes the law effective January 1, 2014, and applies to coverage issued, sold, renewed, or continued on or after that date.

4 **Definitions.** Amends § 62J.692, subd. 1. Expands the definition of clinical medical education program to include dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

5 **Application process.** Amends § 62J.692, subd. 3. Expands the definition of clinical medical education program to include dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers

6 **Distribution of funds.** Amends § 62J.692, subd. 4. Modifies the distribution formula by phasing out the supplemental public program volume factor, limiting eligibility to training sites with more than 0.1 FTEs, and raising the minimum grants from $1000 to $5000. Limits the use of the funds to expenses related to the clinical training program costs. Requires that $1,000,000 each year of available MERC funding be distributed each year for grants to family medicine residency programs located outside of the seven-county metro area. Specifies certain eligibility requirements.

7 **Report.** Amends § 62J.692, subd. 5. Requires the training sites to include in the grant verification report a training site expenditure report and removes a reference to the advisory committee.

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8 **Review of eligible providers.** Amends § 62J.692, subd. 9. Removes a reference to the advisory committee.

9 **Distribution of funds.** Amends § 62J.692, by adding subd. 11. Specifies that if federal approval is not granted for the changes to the distribution formula in subd. 4, then the supplemental public program volume factor will continue to be used.

10 **Designation.** Amends § 62Q.19, subd. 1. Adds certain hospitals and affiliated specialty clinics whose inpatients are mostly under age 21 to a list of essential community providers. Provides an immediate effective date.

11 **Bored geothermal heat exchanger.** Amends § 103I.005, by adding subd. 1a. Adds a definition of "bored geothermal heat exchanger."

12 **Fees.** Amends § 103I.521. Directs fees collected by the commissioner under Minnesota Statutes, chapter 103I (wells, borings, and underground uses), to be credited to the state government special revenue fund.

13 **Who must pay.** Amends § 144.123, subd. 1. Modifies the provision for collecting a fee for diagnostic laboratory services by permitted the commissioner to contract for the costs of analysis rather than charge a flat handling fee. Specifies that funds collected under contracts pursuant to this section must be deposited into a special account and appropriated to the commissioner. (Minn. Stat. § 144.123, subd. 2 is repealed in this article.)

14 **Duty to perform testing.** Amends § 144.125, subd. 1. Increases the fee for the newborn screening programs to $135. Increases the fee for early hearing detection to $15 and specifies that it must be deposited into the general fund for the support services required under the early hearing detection and intervention program. The remaining fee amount must be credited to the state government special revenue fund.

15 **Newborn screening for critical congenital heart disease (CCHD).** Adds § 144.1251.

Subd. 1. Required testing and reporting. Requires hospitals, birthing centers, and facilities that provide maternity and newborn care to screen newborns for congenital heart disease using pulse oximetry screening. Indicates that this screening should be done before the infant is discharged from the nursery but after 24 hours of age. Requires that results must be reported to the state Department of Health. Specifies that for premature infants and others admitted for intensive care, the screen should be performed when medically appropriate.

Subd. 2. Implementation. Provides a list of responsibilities for the Department of Health related to this screening program, including the following:

- communicate screening protocol and requirements;
- make information and forms available to persons with a duty to perform testing and reporting, health care providers, parents of newborns, and the public;
- provide training to ensure compliance and implementation of this screening;
- establish data collection and reporting system;

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- coordinate implementation of universal standardized screening;
- provide assistance to providers as this screening program is implemented and develop and implement early medical and developmental intervention services for children with CCHD and their families; and
- comply with sections 144.125 to 144.128, the current sections of statute governing the Department of Health's newborn screening program.

16 **Definitions.** Amends § 144.212. Adds the following definitions: authorized representative; certification item; correction; court of competent jurisdiction; disclosure; legal representative; local issuance office; record; and verification.

17 **Office of Vital Records.** Amends § 144.213. Changes the name of the office of the state registrar to the office of vital records. Specifies that local issuance offices that fail to comply with statutes or rules or to properly train employees may have their issuance privileges and access to the vital records system revoked. Specifies that the state registrar is authorized to prepare typewritten, photographic, electronic or other reproductions of original records and fillies to preserve vital records. Requires the state registrar to establish, designate, and eliminate offices; direct the activities of all persons engaged in the activities pertaining to the operation of vital statistics; develop and conduct training programs to promote uniformity of policy and procedure; and prescribe, furnish and distribute all required forms and prescribe other means for transmission of data that will accomplish the purpose of complete, accurate and timely reporting and registration.

18 **Security of vital records system.** Adds § 144.2131. Specifies the duties for the state registrar to provide security of the vital records system.

19 **Father's name; child's name.** Amends § 144.215, subd. 3. Removes reference to a declaration of parentage.

20 **Social security number registration.** Amends § 144.215, subd. 4. Changes the reference to vital records.

21 **Reporting a foundling.** Amends § 144.216, subd. 1. Changes the reference to vital records.

22 **Court petition.** Amends § 144.217, subd. 2. Specifies that a person may petition the appropriate court in the county in which the birth allegedly occurred if a delayed record of birth is rejected.

23 **Replacement of vital records.** Amends § 144.218, subd. 5. Removes reference to a declaration of parentage.

24 **Amendment and correction of vital records.** Adds § 144.2181. Specifies the process to amend or correct a vital record.

25 **Public information; access to vital records. Amends § 144.225, subd. 1. R**emoves reference to local registrar.

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26 **Access to records for research purposes.** Amends § 144.225, subd. 4. Makes a technical change.

27 **Certified birth or death record.** Amends § 144.225, subd. 7. Changes reference from local registrar to local issuance officer.

28 **Standardized format for certified birth and health records.** Amends § 144.225, subd. 8. Changes reference from local registrant to local issuance office.

29 **Which services are for fee.** Amends § 144.226. Specifies that a fee may be charged for the administrative review and processing of a request for a certified record. Requires the fees to be payable at the time of application. Specifies that the fee is for reviewing and processing a request. Makes other minor technical changes.

30 **Definitions.** Adds § 144.492. Defines terms for purposes of this act: "commissioner" as commissioner of health; and "stroke" as the sudden death of brain cells in a localized area due to inadequate blood flow.

31 **Criteria.** Adds § 144.493. Sets out criteria for hospitals based on different levels of stroke care capability: comprehensive stroke center; primary stroke center; and acute stroke ready hospital.

32 **Designating stroke hospitals.** Adds § 144.494. Provides that no hospital can use the term "stroke center" or "stroke hospital" in its name unless it has been designated as such.

Permits a hospital that meets certain criteria to apply for designation as a stroke center or stroke hospital. Provides such designation would apply for a three-year period.

33 **Health facilities construction plan submittal and fees.** Adds § 144.554. Requires the commissioner to collect a fee for review of the construction plan submitted for approval from hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities. Provides a fee schedule based on total estimated cost of the project.

34 **Newborn Hearing Screening Advisory Committee.** Amends § 144.966, subd. 2. Extends expiration of the committee by six years.

35 **Support services to families.** Amends § 144.966, subd. 3a. Modifies the family support services requirement by specifying that family participation in the services is voluntary. Requiring the commissioner to contract for hearing loss specific parent-to-parent assistance and certain individualized deaf or hard of hearing mentors.

36 **Annual fees.** Amends § 144.98, subd. 3. Reduces fees for environmental lab accreditation.

Provides an immediate effective date.

37 **State government special revenue fund.** Amends § 144.98, subd. 5. Specifies that the fees collected under this program must be credited to the state government special revenue fund.

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Provides an immediate effective date.

38 **Establishing a selection committee.** Amends § 144.98 by adding subd. 10. Requires the commissioner to establish a selection committee to recommend approval of qualified lab assessors and assessment bodies. Provides required membership and structure of the committee.

39 **Activities of the selection committee.** Amends § 144.98 by adding subd. 11. Sets out duties of the selection committee established under subd. 10, including that the committee will determine assessor and assessment body application requirements and consider submitted applications.

40 **Commissioner approval of assessors and scheduling of assessments.** Amends § 144.98 by adding 12. Provides criteria for assessors to meet in order to be approved by the commissioner.

41 **Laboratory requirements for assessor selection and scheduling assessments.** Amends § 144.98 by adding subd. 13. Requires accredited labs or those seeking accreditation that need an assessment by the commissioner to select from a list of approved assessors. Limits the number of times a lab can select the same assessor to not more than twice in succession. Provides other requirements for labs relative to selecting an assessor. Specifies that the fees collected under this section are deposited in a special account and appropriated to the commissioner for assessment activities.

42 **Administrative penalty orders.** Amends § 144.99, subd. 4. Provides the commissioner authority to issue certain specified administrative penalty orders for violations of the Lead Poisoning Prevention Act, Minnesota Statutes, sections 144.9501 to 144.9512. Specifies that revenue collected from these penalties must be credited to the state government special revenue fund.

43 **Safe harbor for sexually exploited youth.** Adds § 145.4716. Directs the commissioner of health to establish a director of child sex trafficking prevention. Outlines the duties of the director, including providing training, maintaining information, applying for federal funding, managing grants, providing oversight, conducting evaluations, and developing policies.

44 **Regional navigator grants.** Adds § 145.4717. Directs the commissioner of health, through the director of child sex trafficking prevention, to provide grants for regional navigators serving six regions of the state to coordinate resources and services for sexually exploited youth. Provides that each regional navigator must develop and annually submit a work plan to the director outlining a needs and resource assessment, grant goals and outcomes, and grant activities.

45 **Program evaluation.** Adds § 145.4718. Requires the director to conduct or contract for a comprehensive evaluation of the statewide program for sexually exploited youth. The first evaluation must be completed by June 30, 2015, and submitted to MDH by September 1, 2015, and then be conducted every two years thereafter.

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46 **Postpartum depression education and information.** Amends § 145.906. Requires the commissioner to review the materials and information related to postpartum depression to determine their effectiveness in a way that reduces racial health disparities as reported in postpartum information reported in surveys of maternal attitudes and experiences. The commissioner shall make necessary changes and ensure that women of color receive the information.

47 **Maternal depression; definition.** Adds § 145.907. Defines maternal depression.

48 **Statewide health improvement program.** Amends § 145.986.

Subd. 1. Purpose. Adds a purpose statement for the statewide health improvement program (SHIP).

Subd. 1a. Grants to local communities. Requires that grants be awarded to all community health boards and tribal governments that demonstrate the ability to implement programs designed to achieved the purpose of the program. Requires grantees to address health disparities and inequities in their community. Removes obsolete language.

Subd. 2. Outcomes. Makes no changes.

Subd. 3. Technical assistance and oversight. Requires the commissioner to contract for technical assistance to grantees.

Subd. 4. Evaluation. Requires grantees to collect, monitor, and submit certain data to the commissioner. Requires the commissioner to contract for designing and implementing evaluation systems.

Subd. 5. Report. Requires certain reporting related to each grantee's progress toward measurable outcomes, and reports on any corrective action plans required by the commissioner. Removes obsolete language. Requires reporting on contracts entered under this section.

Subd. 6. Supplantation of existing funds. Makes no changes.

49 **Establishment; goals.** Amends § 145A.17, subd. 1. Expands the targeted families in the family home visiting programs to include families with a serious mental health disorder, including maternal depression.

50 to 96 **Alkaline hydrolysis.** Amends §§ 149A.02 to 149A.96. Modifies mortuary science provisions. Includes alkaline hydrolysis as a means of final disposition of dead human bodies and requires the commissioner of health to enforce all laws and adopt rules related to licensing and operation of alkaline hydrolysis facilities. Provides that fees collected by the commissioner shall be credited to the state government special revenue fund.

97 **Hospital and department of health; recognition form.** Amends § 257.75, subd. 7. Changes the office of the state registrar to the office of vital records.

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98 **Legal effect.** Amends § 260C.635, subd. 1. Changes the office of the state registrar to the office of vital records.

99 **Definition.** Amends § 517.001. Specifies the definition of local registrar in chapter 517 (marriage).

100 **Minnesota Task Force on Prematurity.** Amends Laws 2011, first special session. Modifies the duties of the task force by removing certain items that the task force was required to consider. Extends the deadline for submission of the final report and expiration of the task force from January 2013 to January 2015. Makes technical changes.

101 **Funeral establishments; branch locations.** Requires the commissioner to review requirements relative to preparation and embalming rooms and propose legislation for changes to branch establishments.

102 **Health equity report.** Requires the commissioner to consult with certain stakeholders and submit a report by February 1, 2014, on a plan to advance health equity in Minnesota.

Eliminating health disparities grants; organizations with limited fiscal capacity. (Note: This section was left out of the conference committee report in error. It was enacted as part of the Revisor's corrections bill (Laws 2013, chapter 144.)) Permits the commissioner of health to provide working capital advanced to grantees for certain grants awarded under the general fund.

103 **Guaranteed renewability study.** Requires the commissioner of commerce, with the commissioner of health and representatives of the health carriers and consumer advocates, to study guaranteed renewability of health plans and consider statutory provisions. Requires recommendations be reported to the legislature by February 1, 2014.

104 **Capital reserves limits study.** Requires the commissioner of health to study methods for determining appropriate levels for capital reserves for health maintenance organizations. Requires the commissioner to make recommendations to the legislature by February 1, 2014.

105 **Study and recommendations regarding MCHA.** Requires the department of commerce to study and report to the legislature as to options for coverage for high-quality, medically necessary, evidence-based treatment of autism spectrum disorders for children up to age 18, including whether MCHA could provide coverage through January 1, 2016.

106 **Attorney general legal opinion required.** Requires the attorney general, no later than October 1, 2013, to provide a written legal opinion on whether a health plan is required to provide coverage of treatment for mental health and mental health-related illnesses, including autism spectrum disorders.

107 **Revisor's instruction.** Instructs the Revisor to replace the term "vertical heat exchanger" with "bored geothermal heat exchanger."

108 **Repealer.** (a) Repeals Minnesota Statutes, § 103I.005, subd. 20. (Definition of "vertical heat exchanger.)

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Repeals Minnesota Statutes, §§ 149A.025 (alkaline hydrolysis regulation); 149A.20, subd. 8 (mortuary science fee); 149A.30, subd. 2 (mortuary science fee); 149A.40, subd. 8 (mortuary science fee); 149A.45, subd. 6 (mortuary science fee); 149A.50, subd. 6 (mortuary science fee); 149A.51, subd. 7 (mortuary science fee); 149A.52, subd. 5a (mortuary science fee); and 149A.53, subd. 9 (mortuary science fee).

Repeals Minnesota Statutes, § 485.14 (Receipt of vital statistics records by district court for preservation of records).

(b) Effective July 1, 2014, repeals Minnesota Statutes, § 144.123, subd. 2 (fees for diagnostic lab services).

Article 13: Payment Methodologies for Home and Community-Based Services

Overview

This article provides for a statewide payment methodology for home and community-based services.

1 **Day training and habilitation services for adults with developmental disabilities.** Amends § 252.41, subd. 3. Removes language related to county contracts. Makes this section effective January 1, 2014.

2 **Service principles.** Amends § 252.42. Removes a cross-reference related to the establishment of rates. Makes this section effective January 1, 2014.

3 **Commissioner's duties.** Amends § 252.43. Removes a reference to payment rates established by a county and adds a cross-reference to the new HCBS waivers rate-setting section. Makes this section effective January 1, 2014.

4 **County board responsibilities.** Amends § 252.44. Removes county board authority to contract with certain vendors and set payment rates. Makes this section effective January 1, 2014.

5 **Vendor's duties.** Amends § 252.45. Removes language related to county contracts. Makes this section effective January 1, 2014.

6 **Day training and habilitation rates.** Amends § 252.46, subd. 1a. Adds a cross-reference to the HCBS waiver rate-setting section. Makes this section effective January 1, 2014.

7 **Payment methodologies.** Amends § 256B.4912, subd. 2. Adds a cross-reference to the new rate setting methodology.

8 **Payment requirements.** Amends § 256B.4912, subd. 3. Modifies the list of items the payment methodology must accommodate.

9 **Rate stabilization adjustment.** Amends § 256B.4913, by adding subd. 4a. Defines "implementation period." Specifies banding values. Requires the commissioner to adjust

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individual reimbursement rates within specified amounts. Specifies this subdivision does not apply to rates for recipients served by providers new to a given county after January 1, 2014.

10 **Stakeholder consultation.** Amends § 256B.4913, subd. 5. Modifies stakeholder consultation to allow for an existing stakeholder group and others to assist in the full implementation of the new payment system. Removes obsolete language.

11 **Implementation.** Amends § 256B.4913, subd. 6. Makes conforming changes. Implements the new payment rate methodology for HCBS waivers beginning January 1, 2014. Requires data for all recipients to be entered into the disability waiver rates system by December 31, 2014.

12 **Home and community-based services waivers; rate setting.** Creates § 256B.4914.

Subd. 1. Application. Makes the payment methodologies apply to the CAC, CADI, DD, and BI home and community-based services (HCBS) waivers.

Subd. 2. Definitions. Defines the terms "commissioner," "component value," "customized living tool," "disability waiver rates system," "lead agency," "median," "payment or rate," "rates management system," and "recipient."

Subd. 3. Applicable services. Lists the applicable services authorized under the state's home and community-based waivers for persons with disabilities.

Subd. 4. Data collection for rate determination. Specifies rates for applicable home and community-based waiver services are set by the rates management system. Specifies data that must be collected for rate determinations under the rates management system. Specifies the information needed to update individual data.

Subd. 5. Base wage index and standard component values. Establishes a base wage index to determine staffing costs associated with providing services to individuals receiving HCBS waiver services. Specifies the method by which the commissioner must calculate the base wage index. Defines the values for other components for calculating rates.

Subd. 6. Payments for residential support services. Specifies how payments for residential support services are calculated.

Subd. 7. Payments for day programs. Specifies how payments for services with day programs, including adult day care, day treatment and habilitation, prevocational services, and structured day services are calculated.

Subd. 8. Payments for unit-based services with programming. Specifies how payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, hourly supported living services, and supported employment provided to an individual outside of any day or residential service plan are calculated.

Subd. 9. Payments for unit-based services without programming. Specifies

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how payments for unit-based services without programming including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan are calculated.

Subd. 10. Updating payment values and additional information. Requires the commissioner to develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates. Requires the commissioner to conduct research, gather data, and review specified data. Requires the commissioner to report to the legislature with proposed changes for component values. Requires the commissioner to report to the legislature by January 15, 2015, with recommendations, and periodically through January 15, 2019, and every four years thereafter. Requires the commissioner to implement a regional adjustment factor to all rate calculations no later than January 1, 2015. Requires the commissioner to provide public notice in October of each year detailing certain legislatively approved changes.

Subd. 11. Payment implementation. Makes the payments established under the payment methodology supersede rates established in county contracts for recipients receiving HCBS waiver services.

Subd. 12. Customization of rates for individuals. Requires direct care costs to be increased by an adjustment factor for persons determined to have higher needs based on being deaf or hard-of-hearing. Specifies the customization rate for deaf or hard-of-hearing persons. Defines "deaf and hard-of-hearing."

Subd. 13. Transportation. Requires the purchase of transportation services to be cost-effective and limited to market rates where the transportation mode is generally available and accessible.

Subd. 14. Exceptions. Specifies a process for establishing exceptions to payment rates determined under subdivisions 6 to 9.

Subd. 15. County or tribal allocations. Requires the commissioner to establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on lead agencies. Requires the commissioner to make annual adjustments to lead agencies' HCBS budget allocations to adjust for rate differences and the resulting impact on county allocations.

Subd. 16. Budget neutrality adjustment. Requires the commissioner to use specified adjustments to rates to assure budget neutrality.

13 **Federal approval.** Authorizes the commissioner to manage the HCBS waiver programs within federally required parameters. Allows the commissioner to negotiate an agreement with CMS for the implementation of the disability waivers payment methodology system to prevent federal action that would withhold or disallow federal funding for waiver recipients. Specifies the process for making changes to the implementation plan for the disability waivers payment rate system.

14 **Repealer.** (a) Repeals Minn. Stat. §§ 252.40 (service principles and rate-setting procedures);

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252.46, subds. 1 to 11 and 16 to 21 (payment rates); 256B.4913, subds. 1 to 4 (payment methodology development); 256B.501, subd. 8 (payment for persons with special needs), effective January 1, 2014.

(b) Repeals Minn. Rules, part 9525.1860, subp. 3, items B and C (billing for services), and 4, item D (service limitations), effective January 1, 2014.

Article 14: Health and Human Services Appropriations

Overview

See spreadsheet for details.

Article 15: Reform 2020 Contingent Appropriations

Overview

See spreadsheet for details.

Article 16: Human Services Forecast Adjustments

Overview

See act for details.

Article 17: Northstar Care for Children

1 **Contracts for child foster care services.** Amends § 256.0112, by adding subd. 10. Requires local agencies to follow the provisions of chapter 256N when negotiating contracts for child foster care services.

2 **Foster care maintenance payments.** Amends § 256.82, subd. 2. Strikes obsolete language.

3 **Setting foster care standard rates.** Amends § 256.82, subd. 3. Establishes child foster care payments during the transition to Northstar Care for Children under chapter 256N.

4 **Citation.** Creates § 256N.001. Cites §§ 256N.001 to 256N.28 as the "Northstar Care for Children Act." The act provides certain benefits for children who are in foster care, the permanent care of a relative, or in the care of adoptive parents.

5 **Public policy.** Creates § 256N.01. Paragraph (a) provides that it is the state's policy to keep children safe from harm, and if they do suffer harm, to make appropriate services immediately available to them.

Paragraph (b) states that children do best in permanent homes, and if that home cannot be

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with their parents, then an alternative permanent home must quickly be made available.

Paragraph (c) provides that in achieving permanency for a child, stable benefits must be available for caregivers without consideration of the placement setting.

6 **Definitions.** Creates § 256N.02. Defines the terms used in this chapter.

7 **Northstar Care for children; generally.** Creates §256N.20

Subd. 1. Eligibility. Provides that a child is eligible for Northstar Care if the child is eligible for foster care, guardianship assistance, or adoption assistance.

Subd. 2. Assessments. Requires each eligible child receive an assessment.

Subd. 3. Agreements. For children eligible for guardianship assistance or adoption assistance, requires negotiations and the development of a written, binding agreement with the caregivers of the child.

Subd. 4. Benefits and payments. Benefits are based primarily on assessments, and, if appropriate, negotiations and agreements. Although the benefits are paid to the caregiver, the benefits are considered the benefits of the child.

Subd. 5. Federal, state, and local shares. Requires Northstar costs to be shared by the federal government, state, counties of financial responsibility, and tribes.

Subd. 6. Administration and appeals. Provides that administration and appeals are governed by section 256N.28.

Subd. 7. Transition. Provides that children in foster care or receiving relative custody assistance or adoption assistance prior to January 1, 2015, who remain with the same caregivers will generally continue to receive benefits under programs preceding Northstar. Specifies the sections of this act dealing with the transition to Northstar Care for foster children, children in relative custody, and children in adoptive placements.

8 **Eligibility for foster care benefits.** Creates § 256N.21.

Subd. 1. General eligibility requirements. Establishes criteria for a child's eligibility for foster care benefits.

Subd. 2. Placement in foster care. Requires that a child to be placed away from the child's parent or guardian and that the following criteria are met:

- the legally responsible agency has placement authority and care responsibility for the child; and
- the child is placed in an emergency relative placement, a licensed foster placement, or, for a child 18 or older and under age 21, a supervised independent living setting.

Subd. 3. Minor parent. Clarifies that when a minor parent is in foster care with

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the child and both are in the same placement, the foster care benefit is limited to the minor parent, unless the agency has separate legal responsibility for the minor parent's child.

Subd. 4. Foster children ages 18 up to 21 placed in an unlicensed supervised independent living setting. Provides that a child between the ages of 18 and 21 who has maintained eligibility for foster care is entitled to benefits.

Subd. 5. Excluded activities. States that foster care benefits represent costs for activities similar to those expected of parents. Provides that the agency may pay an additional fee for specific services provided by the foster parent.

Subd. 6. Transition from pre-Northstar Care for Children program. Provides that children in family foster care on December 31, 2014, will continue to receive benefits under pre-Northstar Care criteria. Establishes the bases for transition from pre-Northstar Care to Northstar Care.

9 Guardianship assistance eligibility. Creates § 256N.22.

Subd. 1. General eligibility requirements. Establishes the eligibility criteria for payment of guardianship assistance to a relative who has accepted permanent legal and physical custody of a child.

Subd. 2. Agency determinations regarding permanency. Lists determinations that must be made by the legally responsible agency prior to the transfer of permanent legal and physical custody.

Subd. 3. Citizenship and immigration status. Requires the child to be a citizen or otherwise eligible for federal public benefits in order to be eligible for guardianship assistance.

Subd. 4. Background study. Requires completion of a background study on each prospective relative custodian and any other adult residing in the household. Provides that if the background study reveals a conviction of specified felony offense, then the relative custodian is prohibited from receiving guardianship assistance.

Subd. 5. Responsibility for determining guardianship assistance eligibility. Requires the commissioner to determine a child's eligibility for guardianship assistance.

Subd. 6. Exclusions. Paragraph (a) makes a child with a guardianship assistance agreement ineligible for the MFIP child-only grant.

Paragraph (b) prohibits the commissioner from entering into a guardianship assistance agreement with a child's biological parent, an individual who has assumed legal and physical custody of a child under tribal code without child welfare system involvement, or for a child who was placed in Minnesota by another state or tribe outside Minnesota.

Subd. 7. Guardianship assistance eligibility determination. Requires the

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financially responsible agency to determine whether a child is eligible for guardianship assistance and submit this determination to the commissioner for final approval.

Subd. 8. Termination agreement. Lists the conditions under which a guardianship assistance agreement must be terminated.

Subd. 9. Death of relative custodian or dissolution of custody. Requires termination of the agreement upon the death or dissolution of custody of both relative custodians when custody has been assigned to two individuals, or the sole relative custodian in the assignment of custody to one individual.

Subd. 10. Assigning a child's guardianship assistance to a court-appointed guardian or custodian. Allows the commissioner to consent to the continuation of guardianship assistance to an individual who is a guardian or custodian appointed by a court upon the death of the relative custodian. The temporary assignment may be approved for a maximum of six months.

Subd. 11. Extension of guardianship assistance after age 18. Allows the commissioner to extend guardianship assistance beyond the date the child turns 18, up to the date the child turns 21, when specified conditions and criteria are met.

Subd. 12. Beginning guardianship assistance component of Northstar Care for Children. Effective November 27, 2014, allows a child who meets eligibility criteria for guardianship assistance to have the agreement negotiated under the Northstar Care criteria.

Subd. 13. Transition to guardianship assistance under Northstar Care for Children. Lays out the procedure for executing guardianship assistance agreements for a child who has a relative custody assistance agreement in effect on or before November 26, 2014.

10 Adoption assistance eligibility. Creates § 256N.23.

Subd. 1. General eligibility requirements. Lists the criteria for adoption assistance eligibility.

Subd. 2. Special needs determination. Lists the requirements for a child to be considered a child with special needs.

Subd. 3. Citizenship and immigration status. Requires the child to be a citizen or otherwise eligible for federal public benefits to be eligible for IV-E adoption assistance. To be eligible for non IV-E adoption assistance, a child must be a citizen or meet the qualified alien requirements.

Subd. 4. Background study. Requires completion of a background study on each prospective adoptive parent. Provides that if the background study reveals a conviction of specified felony offense, then the adoptive parent is prohibited from receiving adoption assistance.

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Subd. 5. Responsibility for determining adoption assistance eligibility. Requires the commissioner to determine the child's eligibility for adoption assistance.

Subd. 6. Exclusions. Lists the individuals the commissioner must exclude from receiving adoption assistance on behalf of a child.

Subd. 7. Adoption assistance eligibility determination. Requires the financially responsible agency to determine whether a child is eligible for adoption assistance and submit this determination and supporting documentation to the commissioner for final approval.

Subd. 8. Termination of agreement. Lists the conditions under which an adoption assistance agreement must be terminated.

Subd. 9. Death of adoptive parent or adoption dissolution. State that the adoption assistance agreement ends upon the death or termination of parental rights of the adoptive parent, if sole adoptive parent, or parents, in the case of a two-parent adoption.

Subd. 10. Continuing a child's title IV-E adoption assistance in a subsequent adoption. Lists the conditions under which adoption assistance continues in a subsequent adoption and the conditions in which it will not continue.

Subd. 11. Assigning a child's adoption assistance to a court-appointed guardian or custodian. Allows the commissioner to consent to the continuation of adoption assistance to an individual who is a guardian or custodian appointed by a court upon the death of the adoptive parent or parents. The temporary assignment may be approved for a maximum of six months.

Subd. 12. Extension of adoption assistance agreement. Allows continuation of an adoption assistance agreement beyond the date the child turns 18 up until the child turns 21 under certain limited circumstances.

Subd. 13. Beginning adoption assistance under Northstar Care for Children. Effective November 27, 2014, allows a child who meets eligibility criteria for adoption assistance to have the agreement negotiated under the Northstar Care criteria.

Subd. 14. Transition to adoption assistance under Northstar Care for Children. Lays out the procedure for executing adoption assistance agreements under this chapter to a child with an adoption assistance agreement under chapter 259A.

11 Assessments. Creates § 256N.24.

Subd. 1. Assessment. Requires an assessment of each child eligible for foster care, guardianship, or adoption assistance to determine the level of benefits the child may receive.

Subd. 2. Establishment of assessment tool, process, and requirements. Requires the commissioner to develop an assessment tool and process to be used for

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performing assessments required in subdivision 1.

Subd. 3. Child care allowance portion of assessment. Establishes the criteria and considerations for providing a child care allowance to caregivers.

Subd. 4. Extraordinary levels. Requires the assessment to provide five levels to the difficulty of care rating for a particular child. Lists the circumstances that must be met in order to consider an extraordinary level of care.

Subd. 5. Timing of initial assessment. For children entering Northstar Care, requires completion of the initial assessment within 30 days after the child is placed in foster care.

Subd. 6. Completion of initial assessment. Establishes agency responsibilities for completion of the assessment.

Subd. 7. Timing of special assessment. Establishes criteria for performing a special assessment as part of a negotiation for guardianship assistance, adoption assistance, or when a child transitions from pre-Northstar Care to Northstar Care.

Subd. 8. Completing the special assessment. Requires the special assessment to be completed in consultation with the child's caregivers. If the caregivers refuse to participate, then establishes the level of care that will be assigned to the child.

Subd. 9. Timing of and requests for reassessments. Lists the events that trigger the requirement for a reassessment. Requires the reassessment to be conducted within 30 days of the event.

Subd. 10. Caregiver requests for reassessments. Allows a caregiver to submit a written request for reassessment if at least six months have passed since a previously requested review. Allows a request in less than six months if there has been a significant change in the child's needs.

Subd. 11. Completion of reassessment. Requires the reassessment to be completed in consultation with the child's caregivers. If the caregivers refuse to participate, then establishes the level of care that will be assigned to the child.

Subd. 12. Approval of initial assessments, special assessments, and reassessments. Identifies agency personnel who must approve assessments completed by others in the agency. Establishes when the commissioner must approve the assessments.

Subd. 13. Notice for caregiver. Requires the agency to provide written notice to the caregiver of the results of the assessment or reassessment. Lists the information that must be provided to the caregiver.

Subd. 14. Assessment tool determines rate of benefits. Provides that the assessment tool determines the monthly benefit level for children in foster care. For guardianship assistance or adoption assistance, the monthly payment may be

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negotiated up to the monthly benefit level under foster care.

12 Agreements. Creates § 256N.25.

Subd. 1. Agreement; guardianship assistance; adoption assistance. Establishes the requirements for the written, binding agreement between the caregivers and the agency.

Subd. 2. Negotiation of agreement. Requires the agency and caregivers to negotiate the assistance agreement and submit the finalized agreement to the commissioner for approval. Provides that the benefit rate must be negotiated and included in the agreement.

Subd. 3. Renegotiation of agreement. Allows a relative caregiver or adoptive parent to request renegotiation of the agreement when there is a change in the needs of the child or the family's circumstances. Provides that the agreement must be renegotiated if the child receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits.

13 Benefits and payments. Creates § 256N.26.

Subd. 1. Benefits. Identifies three potential benefits: medical assistance, basic payment, and supplemental difficulty of care payment.

Subd. 2. Medical assistance. States that eligibility is determined according to section 256B.055.

Subd. 3. Basic monthly rate. Lists the monthly rates based on age ranges for the period from January 1, 2015, to June 30, 2016. Rates range from $565 to $790 per month.

Subd. 4. Difficulty of care supplemental monthly rate. Lists the supplemental rates for the period from January 1, 2015, to June 30, 2016. Rates range from $60 to $600 per month.

Subd. 5. Alternate rates for preschool entry and certain transitioned children. Establishes that a child subject to a guardianship or adoption assistance agreement before the age of six shall receive 50 percent of the basic rate and supplemental rate.

Subd. 6. Emergency foster care rate for initial placement. Establishes the formula for determining the emergency foster care rate when a child is placed in an emergency foster care placement. Sets out the conditions that must exist for application of this payment rate.

Subd. 7. Special at-risk monthly payment for at-risk children in guardianship assistance and adoption assistance. Establishes a payment rate for children who are considered at-risk of developing a disability.

Subd. 8. Daily rates. Instructs the commissioner to establish prorated rates to be used when a partial month is involved in foster care, guardianship assistance, and

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adoption assistance.

Subd. 9. Revision. Requires the commissioner to make biennial adjustments to the rates in subdivisions 3 through 7 based on the USDA Estimates of the Cost of Raising a Child. Limits the adjustment to no more than three percent per annum.

Subd. 10. Home and vehicle modification. Allows reimbursement for vehicle and home modifications to accommodate the needs of a child eligible for adoption assistance. Requires the reimbursement to be negotiated as part of the adoption assistance agreement.

Subd. 11. Child income or income attributable to the child. Provides that the monthly guardianship or adoption assistance payments made on behalf of the child are considered income and resources available to the child. In some cases, the receipt of other income on behalf of the child may impact the amount of the monthly assistance payments received by the adoptive parent or relative custodian.

Subd. 12. Treatment of Supplemental Security Income. Permits the county of financial responsibility to apply to be the payee for a foster child for the duration of the child's foster care placement. Sets out the requirements for adoptive parents and relative caregivers to receive SSI payments on behalf of the child.

Subd. 13. Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits. Permits the county of financial responsibility to apply to be the payee for a foster child for the duration of the child's foster care placement. Sets out the requirements for adoptive parents and relative caregivers if a child becomes eligible for one of these benefits after placement.

Subd. 14. Treatment of child support and Minnesota family investment program. Provides that child support may be redirected to the county of financial responsibility when a child is in foster care. For a child eligible for adoption or guardianship assistance, court-ordered child support cannot have any impact on the Northstar Care monthly payment. A child eligible for Northstar Care payments is excluded from an MFIP assistance unit.

Subd. 15. Payments. Requires monthly payments to caregivers. Establishes which agency must make the monthly payment.

Subd. 16. Effect of benefit on other aid. Northstar Care payments are not considered income for child care assistance or any other financial benefit. Children receiving a payment under Northstar Care are excluded from an MFIP assistance unit.

Subd. 17. Home and community-based services waiver for persons with disabilities. Allows a foster child to qualify for HCBS waiver services. Clarifies that HCBS waiver services cannot substitute for foster care.

Subd. 18. Overpayments. Authorizes the commissioner to collect any amount of foster care, adoption assistance, or guardianship assistance paid in excess of payment

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due. Requires the commissioner to provide written notification to the caregiver.

Subd. 19. Payee. Requires adoption and guardianship assistance payments to be made to the caregiver specified in the agreement. When there is more than one adoptive parent or relative caregiver, both must be listed on the agreement. Sets out the procedure if there is a divorce, separation, or death.

Subd. 20. Notification of change. Requires caregivers to notify the commissioner of specified changes in status or circumstances.

Subd. 21. Correct and true information. Requires the commissioner to initiate a fraud investigation against the caregiver under specified circumstances.

Subd. 22. Termination notice for caregiver. Requires the agency that makes the maintenance payment to provide 15 days notice to the caregiver when benefits will be terminated. Lists information that must be included in the notice.

14 Federal, state, and local shares. Creates § 256N.27.

Subd. 1. Federal share. Requires the county of financial responsibility to determine IV-E eligibility for children in foster care and for children who qualify for guardianship assistance or adoption assistance.

Subd. 2. State share. Establishes the formula for the commissioner to pay the state share of the maintenance payments.

Subd. 3. Local share. Requires the county of financial responsibility to pay the local share of maintenance payments. In cases of federally required adoption assistance where there is no financially responsible agency, the commissioner must pay the local share. For an Indian child who is IV-E eligible, the agency or entity assuming responsibility for the child is responsible for the nonfederal share.

Subd. 4. Nonfederal share. Sets out the calculations for establishing state and local shares.

Subd. 5. Adjustments for proportionate shares among financially responsible agencies. Requires the commissioner to adjust the nonfederal share expenditures so that the relative share for each agency is proportional to its foster care expenditures before Northstar Care.

15 Administration and appeals. Creates § 256N.28.

Subd. 1. Responsibilities. Describes the responsibilities of the financially responsible agency and the commissioner

Subd. 2. Procedures, requirements, and deadlines. Requires the commissioner to specify procedures, requirements, and deadlines for administration of Northstar Care, including the transition.

Subd. 3. Administration of title IV-E programs. Requires the IV-E programs to

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comply with federal law and regulations.

Subd. 4. Reporting. Instructs the commissioner to identify required fiscal and statistical reports that must be completed.

Subd. 5. Promotion of programs. Requires the commissioner to actively promote the guardianship and adoption assistance programs. Instructs the commissioner to inform families of the adoption tax credit when they adopt a child under the commissioner's guardianship.

Subd. 6. Appeals and fair hearings. Sets out a caregiver's appeal rights.

Subd. 7. Transitions from pre-Northstar Care for Children programs. Establishes the transition processes, priorities, and considerations.

Subd. 8. Purchase of child-specific adoption services. Allows the commissioner to reimburse a placing agency for adoption services.

16 **Scope.** Amends § 257.85, subd. 2. Limits applicability of relative custody assistance to district court or tribal court ordered placements made on or before November 26, 2014.

17 **Relative custody assistance agreement.** Amends § 257.85, subd. 5. Limits applicability of relative custody assistance to those placements in which the agreement is signed on or before November 26, 2014.

18 **Eligibility criteria.** Amends § 257.85, subd. 6. Prohibits execution of new relative custody assistance agreements after November 26, 2014. Requires renegotiation of agreements signed before this date if the transfer of custody did not occur before this date.

19 **No new execution of adoption assistance agreements.** Creates § 259A.12. Prohibits execution of new adoption assistance agreements after November 26, 2014. Requires renegotiation of agreements signed before this date if the adoption was not finalized before this date.

20 **Pre-Northstar Care for Children foster care program.** Creates § 260C.4411.

Subd. 1. Pre-Northstar Care for Children foster care program. Establishes county of financial responsibility and tribal agency duties for children placed in family foster care on or before December 31, 2014.

Subd. 2. Consideration of other programs. Provides that if a child is eligible for funds through RSDI, SSI, or IV-E, those funds must be used to meet the needs of the child. Provides that if a child is eligible for HCBS waiver programs, these programs are not a substitute for foster care.

21 **Payment for residential placements.** Creates § 260C.4412. Provides that when a foster child is placed in a group residential setting, foster care maintenance payments must be made on behalf of the child. Provides an effective date of January 1, 2015.

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22 **Initial clothing allowance.** Creates § 260C.4413. Requires an initial clothing allowance for children placed in foster care under pre-Northstar and Northstar Care. Provides an effective date of January 1, 2015.

23 **Distribution of funds recovered for assistance furnished.** Amends § 260C.446. Strikes the cross-reference to a statutory section that is being repealed in this article. Provides an effective date of January 1, 2015.

24 **Repealer.** (a) Repeals Minnesota Statutes §§ 256.82, subd. 4 (foster care payments) and 260C.441 (county payments to commissioner) effective January 1, 2015.

(b) Repeals Minnesota Rules, parts 9560.0650, subps. 1 (foster care maintenance payments), 3 (agency contract care), and 6 (reassessments); 9560.0651 (difficulty of care payments); and 9560.0655 (difficulty of care rates), effective January 1, 2015.