House Research Act Summary

CHAPTER: 71 **SESSION:** 2015 Regular Session

TOPIC: Health and Human Services Omnibus Finance Bill

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Section

Article 1: Child and Family Services

Overview

This article makes changes to provisions related to the child care assistance programs, FAIM, MFIP, and the Homeless Youth Act; reforms the GRH program; modifies child protection statutes; and provides for federal compliance with the Uniform Interstate Family Support Act.

1 **Failure to comply with attendance record requirements.** Amends § 119B.125, subd. 7. Establishes overpayment claim procedures with regard to failure to comply with child care attendance record requirements.

2 **Provider payments.** Amends § 119B.13, subd. 6. Modifies the commissioner's authority related to child care authorizations.

3 **Providers of group residential housing or supplementary services.** Amends § 245C.03, by adding subd. 10. Requires the commissioner to conduct background studies on any individual required under the GRH statute. Makes this section effective July 1, 2016.

4 **Child protection workers or social services staff having responsibility for child protective duties.** Amends § 245C.03, by adding subd. 11. Paragraph (a) requires the commissioner to complete background studies on county child protection staff when the study is initiated by the county agency.

Paragraph (b) provides that the commissioner cannot make the disqualification determination, but must send the background study information to the county that initiated the study.

5 **Child protection workers or social services staff having responsibility for child protective duties.** Amends § 245C.04, by adding subd. 10. Requires the commissioner to conduct background studies of county child protection staff.

6 **Providers of group residential housing or supplementary services.** Amends § 245C.10, by adding subd. 11. Requires the commissioner to recover the cost of background studies initiated by GRH or supplementary services providers through a fee of no more than $20 per study. Appropriates the background study fees to the commissioner for the purpose of conducting background studies. Makes this section effective July 1, 2016.

7 **Child protection workers or social services staff having responsibility for child protective duties.** Amends § 245C.10, by adding subd. 12. Authorizes the commissioner to collect a fee of not more than $20 for conducting background studies on county child protection staff. Appropriates the fees to the commissioner for the purpose of conducting background studies.

8 **Department of Human Services child fatality and near fatality review team.** Amends § 256.01, by adding subd. 12a. Requires the commissioner to establish a child fatality and near child fatality review team to review fatalities and near fatalities due to maltreatment, and those that occur in licensed facilities and are not due to natural causes. Provides that

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department staff shall lead the reviews. Requires summary reports of each review to be submitted to the state child mortality review panel.

9 **Authority and purpose.** Amends § 256.017, subd. 1. Adds the GRH program to the DHS compliance system.

10 **Definitions.** Amends § 256.741, subd. 1. Modifies the definition of public assistance, by removing MinnesotaCare and plans supplemented by tax credits from the definition, for purposes of child support.

11 **Assignment of support and maintenance rights.** Amends § 256.741, subd. 2. Strikes MinnesotaCare from the definition of public assistance.

12 **Child protection grants to address child welfare disparities.** Adds § 256E.28.

Subd. 1. Child welfare disparities grant program established. Allows the commissioner to award grants for development, implementation, and evaluation of activities to address racial disparities in the child welfare system. Provides a list of the issues that must be addressed.

Subd. 2. State-community partnerships; plan. Requires the commissioner to consult with culturally based community organizations; various cultural councils; counties; tribal governments; and the legislative task force on child protection when developing the plan for awarding grants.

Subd. 3. Measurable outcomes. Requires the commissioner to establish measurable outcomes before distributing any grants.

Subd. 4. Process. Establishes the process for providing grants. Limits a county grantee to spending no more than 3 percent of the grant for administrative costs. Requires the commissioner to establish an administrative cost limit with all other grantees. Prohibits a grantee from using grant funds to supplant existing federal and state funds received for child protection purposes.

Subd. 5. Grant program criteria. Provides that the commissioner shall award competitive grants to eligible applicants. Establishes the groups and entities that may be eligible for grants. Specifies the priorities that must be considered by the commissioner in awarding grants.

Subd. 6. Evaluation. Requires the commissioner to conduct biennial evaluations of the programs operated by the grantees. Requires the commissioner to consult with the legislative task force on the protection of children and provide the biennial report to the task force and the legislature.

Subd. 7. American Indian child welfare projects. Requires the commissioner to award $75,000 to each tribe authorized to provide child welfare services under section 256.01, subd. 14b. An eligible tribe is not required to apply for these funds, and may apply for a competitive grant under this section.

13 **Definitions.** Amends § 256E.35, subd. 2. Modifies definitions under the FAIM program by moving definitions within the definitions section and adding a definition for "financial coach."

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14 **Financial coaching.** Amends § 256E.35, subd. 4a. Lists services financial coaches must provide to FAIM program participants.

15 **Group residential housing.** Amends § 256I.03, subd. 3. Modifies the definition of "group residential housing."

16 **Countable income.** Amends § 256I.03, subd. 7. Modifies the definition of "countable income."

17 **Direct contact.** Amends § 256I.03, by adding subd. 9. Adds a definition of "direct contact."

18 **Habitability inspection.** Amends § 256I.03, by adding subd. 10. Adds a definition of "habitability inspection."

19 **Long-term homelessness.** Amends § 256I.03, by adding subd. 11. Adds a definition of "long-term homelessness."

20 **Professional statement of need.** Amends § 256I.03, subd. 12. Adds a definition of "professional statement of need."

21 **Prospective budgeting.** Amends § 256I.03, by adding subd. 13. Adds a definition of "prospective budgeting."

22 **Qualified professional.** Amends § 256I.03, by adding subd. 14. Adds a definition of "qualified professional."

23 **Supportive housing.** Amends § 256I.03, by adding subd. 15. Adds a definition of "supportive housing."

24 **Individual eligibility requirements.** Amends § 256I.04, subd. 1. Modifies individual eligibility requirements under the GRH program. Makes this section effective September 1, 2015.

25 **County approval.** Amends § 256I.04, subd. 1a. Modifies the county approval process for supplementary service payments.

26 **License required; staffing qualifications.** Amends § 256I.04, subd. 2a. Modifies the requirements that must be met for a county to enter into an agreement with an establishment to provide GRH. Beginning July 1, 2016, prohibits agencies from having an agreement with a GRH or supplementary services provider unless all staff members who have direct contact with recipients meet certain requirements.

27 **Group residential housing agreements.** Amends § 256I.04, subd. 2b. Requires agreements between agencies and GRH providers to be in writing on a form developed and approved by the commissioner. Requires providers to verify certain minimum requirements in the agreement.

28 **Background study requirements.** Amends § 256I.04, subd. 2c. Effective July 1, 2016, requires GRH or supplementary service providers to initiate background studies on certain individuals. Requires GRH or supplementary services providers to maintain compliance with all requirements established for entities initiating background studies. Effective July 1, 2017, requires GRH or supplementary services providers to demonstrate that all individuals required to have a background study have received a certain notice.

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29 **Conditions of payment; commissioner's right to suspend or terminate agreement.** Amends § 256I.04, subd. 2d. Requires GRH or supplementary services to be provided to the satisfaction of the commissioner and in accordance with all applicable federal, state, and local laws, ordinances, rules, and regulations. Prohibits providers from receiving payment for services for housing found by the commissioner to be performed or provided in violation of federal, state, or local law, ordinance, rule, or regulation. Gives the commissioner the authority to suspend or terminate the agreement immediately when the commissioner determines the health or welfare of the housing or service recipients is endangered, or when the commissioner has reasonable cause to believe that the provider has breached a material term of the agreement. Requires the commissioner to provide the provider with a written notice of a curable material breach of the agreement and allow ten days to cure the breach.

30 **Providers holding health or human services licenses.** Amends § 256I.04, subd. 2e. Specifies the minimum staff qualifications and background study requirements that must be met when the GRH or supplementary service staff are operating under certain licenses.

31 **Required services.** Amends § 256I.04, subd. 2f. Lists required services under the GRH program.

32 **Crisis shelters.** Amends § 256I.04, subd. 2g. States that secure crisis shelters for battered women and their children designated by the Minnesota Department of Corrections are not group residences under the GRH statute. (This language was moved from another location within this section.)

33 **Moratorium on development of GRH beds.** Amends § 256I.04, subd. 3. Makes technical and conforming changes.

34 **Rental assistance.** Amends § 256I.04, subd. 4. Removes obsolete language.

35 **Rate increases.** Amends § 256I.05, subd. 1c. Makes technical and conforming changes.

36 **Supplementary service rate for certain facilities.** Amends § 256I.05, subd. 1g. Modifies language related to providing a supplementary service rate for facilities providing services to homeless individuals.

37 **Time of payment.** Amends § 256I.06, subd. 2. Removes language limiting county agencies to only providing advance GRH payments for individuals who do not expect to receive countable earned income during the month for which payment is made and requiring payment for individuals with countable earned income to be made only after a household report form is received. Makes this section effective April 1, 2016.

38 **Reports.** Amends § 256I.06, subd. 6. Modifies reporting requirements for recipients with countable earned income by requiring recipients with countable earned income to complete a household report form at least once every six months rather than monthly. Makes this section effective April 1, 2016.

39 **Determination of rates.** Amends § 256I.06, subd. 7. Makes technical and conforming changes.

40 **Amount of GRH payment.** Amends § 256I.06, subd. 8. Requires prospective budgeting to be used to determine the amount of the GRH payment for individuals with earned income. Prohibits an increase in income from affecting an individual's eligibility or payment amount

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until the month following the reporting month. Requires a decrease in income to be effective the first day of the month after the month in which the decrease is reported. Makes this section effective April 1, 2016.

41 **Income exclusions.** Amends § 256J.21, subd. 2. Modifies the list of items that must be excluded from income under MFIP to include child support payments of up to $100 for an assistance unit with one child and up to $200 for an assistance unit with two or more children.

42 **Food portion of MFIP transitional standard.** Amends § 256J.24, subd. 5a. Adds language requiring that the food portion of the MFIP transitional standard comply with federal waivers.

43 **Monthly income test.** Amends § 256J.33, subd. 4. Modifies the list of items applied against the MFIP monthly income test.

44 **Definitions.** Amends § 256K.45, subd. 1a. Modifies the definitions of "homeless youth" and "youth at risk of homelessness" under the Homeless Youth Act to increase the age limit from age 21 to age 24.

45 **Funding.** Amends § 256K.45, subd. 6. Adds language requiring the commissioner to provide outreach, technical assistance, and program development to increase capacity to better meet the needs of homeless youth statewide.

46 **Child protection grant allocation.** Creates § 256M.41.

Subd. 1. Formula for county staffing funds. Establishes the formula for allocation of funds to county boards.

Subd. 2. Prohibition on supplanting existing funds. Provides that counties must not use grant funds to supplant current county expenditures for child protection staffing or child protection services, but must use the funds to increase staff and expand services.

Subd. 3. Payments based on performance. Requires 80 percent of a county's allocation to be paid on or before July 10 of each year. An additional 10 percent of the allocation is based on meeting certain performance standards related to timely contact with child victims, and an additional 10 percent of the allocation is based on meeting certain performance standards related to timely and consistent caseworker contact with children in out of home placement or under supervision in their homes, except in 2015 this applies only to contacts with children placed outside their homes.

47 **Death or incapacity of relative custodian or modification of custody.** Amends § 256N.22, subd. 9. Clarifies the process of modifying custody when a relative custodian dies or becomes incapacitated or custody is removed from the relative custodian. These changes are made to comply with changes to federal law on successor guardians for families receiving kinship assistance.

48 **Assigning a successor relative custodian for a child's Northstar kinship assistance.** Amends § 256N.22, subd. 10. Paragraph (a) states that a kinship assistance benefit agreement remains valid if a successor is named in the benefit agreement. Allows the benefit to be paid even if the successor is not a relative.

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Paragraph (b) lists the requirements the successor must meet in order to receive kinship assistance benefits.

Paragraph (c) allows temporary approval of kinship assistance payments until the successor completes all of the requirements in paragraph (b).

Paragraph (d) allows kinship assistance benefits to be paid to a guardian or custodian appointed by the court upon the death of the relative custodian when no successor guardian has been named in the kinship assistance agreement.

Paragraph (e) allows kinship assistance benefits to be approved for a maximum of six months following the death or incapacity of the relative custodian. Provides that if the court has not appointed a permanent legal guardian for the child in that time, the kinship assistance benefits end.

Paragraph (f) provides that if benefits are paid under paragraphs (d) and (e), the benefits must be paid from funds other than federal IV-E funds.

49 **Extraordinary levels.** Amends § 256N.24, subd. 4. Adds that enhanced difficulty of care payments can be made for children who live in a foster residence settings. Current law allows these payments when a child lives in a family foster home or lives with an adoptive parent or relative custodian.

50 **Agreement; Northstar kinship assistance; adoption assistance.** Amends § 256N.25, subd. 1. Adds a cross-reference to clarify that renegotiation of kinship assistance or adoption assistance agreements must be conducted with the caregivers.

Adds that successor relative custodians must be named in the kinship assistance agreement, when applicable. Provides that a successor custodian may be added or changed when the agreement is renegotiated.

51 **State share.** Amends § 256N.27, subd. 2. Strikes a sentence allowing the commissioner to transfer funds in case of deficit. By striking this sentence, Northstar Care becomes a forecasted program.

52 **Effect of recognition.** Amends § 257.75, subd. 3. Makes structural changes to this subdivision. Clarifies that signing a recognition of parentage does not establish the father's custody or parenting time unless an action is commenced under chapter 518. But by signing a recognition of parentage, the father has a basis for bring an action to determine custody and parenting time and establishing a child support obligation, among other things. Provides a March 1, 2016, effective date.

53 **Recognition form.** Amends § 257.75, subd. 5. Lists the specific information that must be included in the recognition of parentage form and requires verification that the parents have seen the educational materials contained on the form and received oral notice of the information on the form. Provides a March 1, 2016, effective date.

54 **Reimbursement of certain agency costs; purchase of service contracts and tribal customary adoptions.** Amends § 259A.75. Makes changes to conform with newly created subdivision 7 on tribal customary adoptions.

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Adds subdivision 7 requiring the commissioner to enter into grant contracts with tribal social services agencies to provide recruitment and adoption placement for Indian children under the jurisdiction of tribal courts.

55 **Relative.** Amends § 260C.007, subd. 27. Adds a relative includes the legal parent, guardian, or custodian of the child's siblings. This change is made to allow children to maintain contact with siblings who have been separated and who have only one parent in common and to broaden possible placement options for children who may be placed outside of the home.

56 **Sibling.** Amends § 260C.007, subd. 32. To the definition of "sibling," adds that a sibling includes an individual who would have been considered a sibling but for termination of parental rights of one or both parents, suspension of parental rights under tribal code, or other disruption of parental rights, such as death of a parent. This change is made to allow children to maintain contact with siblings who have been separated.

57 **Administrative or court review of placements.** Amends § 260C.203. Lowers the age at which a child who is in an out-of-home placement must have an independent living plan developed. Current law requires an independent living plan to be developed for children 16 and older. This amendment requires a plan for children 14 and older. Adds that Indian children must be provided with their tribal enrollment identification card when preparing for independent living.

58 **Out-of-home placement plan.** Amends § 260C.212, subd. 1. Allows a child who is 14 or older to designate two other individuals to help prepare the child's out-of-home placement plan.

Requires the out-of-home placement plan to document steps to finalize a transfer of permanent legal and physical custody to a relative as the permanency plan for a child who cannot be returned to the care of either parent. Provides a list of issues that must be addressed in the plan.

Provides that an independent living plan should identify opportunities for the child to engage in activities appropriate for the child's age group.

59 **Protecting missing and runaway children and youth at risk of sex trafficking.** Amends § 260C.212, by adding subd. 13. Paragraph (a) requires local social services agencies to begin immediate efforts to locate any child who is missing from foster care.

Paragraph (b) requires the local social services agency to report information on the missing child immediately to local law enforcement and to the National Center for Missing and Exploited children. For purposes of this paragraph, "immediately" means within 24 hours.

Paragraph (c) prohibits the agency from discharging a missing child from foster care or closing the case until diligent efforts to locate the child have been exhausted and the court terminates the agency's jurisdiction.

Paragraph (d) requires the agency to determine the factors that contributed to the child running away or being absent from care.

Paragraph (e) requires the agency to evaluate the child to determine happened to the child while absent from care and whether the child may have been a sex trafficking victim.

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Paragraph (f) instructs the agency to notify law enforcement if there is cause to believe a child is, or is at risk of being, a sex trafficking victim.

Paragraph (g) requires the agency to determine appropriate services for any child for whom the agency has responsibility for placement, care, or supervision when the agency believes the child is, or is at risk of being, a sex trafficking victim.

60 **Support age-appropriate and developmentally appropriate activities for foster children.** Amends § 260C.212, by adding subd. 14. Requires social services agencies and child-placing agencies to permit children to participate in activities or events suitable for children of the same age. Instructs foster parents and facility staff to allow children to participate in extracurricular, social, or cultural activities typical for the child's age.

61 **Relative search.** Amends § 260C.221. Requires the relative search to include all adult grandparents; all legal parents, guardians or custodians; the child's siblings; and any adult relatives suggested by the child's parents. Makes an exception when there is documented family violence.

62 **Care, examination, or treatment.** Amends § 260C.331, subd. 1. Corrects a cross-reference.

63 **Independent living plan.** Amends § 260C.451, subd. 2. Corrects a cross-reference.

64 **Reentering foster care and accessing services after age 18.** Amends § 260C.451, subd. 6. Corrects a cross-reference.

65 **Permanent custody to agency.** Amends § 260C. 515, subd. 5. Requires consultation with a child age 16 and older before the court orders the child to be placed in the permanent custody of a social services agency.

66 **Child in permanent custody of responsible social services agency.** Amends § 260C.521, subd. 1. Requires consultation with a child age 16 and older before the court orders the child to be placed in the permanent custody of a social services agency.

67 **Modifying order of permanent legal and physical custody to a relative.** Amends § 260C.521, subd. 2. Allows the successor custodian named in the kinship placement agreement to file a request to modify the order for permanent and legal custody to name the successor custodian as the permanent physical and legal custodian of the child. Instructs the court to modify the order if modification is in the child's best interest and upon review of the background study of the successor custodian.

68 **Content of review.** Amends § 260C.607, subd. 4. Requires the court to review the independent living plan for youth who are age 14 and older. Updates a cross-reference.

69 **Obligor.** Amends § 518A.26, subd. 14. Strikes the presumption that the parent who has primary physical custody is not an obligor.

70 **Methods.** Amends § 518A.32, subd. 2. For purposes of determining potential income when calculating child support, makes a change from the amount a parent could earn working full time at 150 percent of minimum wage to the amount a parent could earn working 30 hours per week at 100 percent of the minimum wage. This change is being made to conform with changes in federal law.

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71 **Authority.** Amends § 518A.39, subd. 1. Clarifies that the court has the authority modify medical support orders.

72 **Medical support only modification.** Amends § 518A.39, by adding subd. 8. Paragraph (a) establishes the basis for modification of the medical support terms of a child support order.

Paragraph (b) provides that the terms of a medical support modification are retroactive only from the date of service of the notice on the responding party and the public authority.

Paragraph (c) states that an evidentiary hearing is not needed for modifications under this subdivision.

Paragraph (d) identifies the statutes governing attorney fees for motions under this subdivision.

Paragraph (e) provides that the parental income for purposes of child support in the original order shall be used to determine the modified medial support order.

73 **Definitions.** Amends § 518A.41, subd. 1. Changes the definition of "public coverage." Provides that public coverage does not include MinnesotaCare or federally subsidized medical plans.

74 **Determining the appropriate health care coverage.** Amends § 518A.41, subd. 3. Adds that health care coverage is determined comprehensive if it meets the minimum essential coverage definition in the ACA.

75 **Ordering health care coverage.** Amends § 518A.41, subd. 4. Establishes the parental contribution for health care coverage when neither parent has appropriate health care coverage available.

Provides an August 1, 2015 effective date.

76 **Child support enforcement services.** Amends § 519A.41, subd. 14. Clarifies that the public authority, in addition to establishing medical support orders, must enforce and modify medical support orders when a party applies for services or when a joint child receives public assistance.

Provides a January 1, 2016 effective date.

77 **Enforcement.** Amends § 518A.41, subd. 15. Establishes the basis for modifying a medical support order when a party fails to carry court ordered coverage or provide other medical support.

Provides a January 1, 2016 effective date.

78 **Income disparity between parties.** Amends § 518A.43, by adding subd. 1a. Allows the court not to order a party who has between 10 and 45 percent parenting time to pay basic support when there is a significant disparity in income and the order to pay support would be detrimental to the child.

Provides a March 1, 2016 effective date.

79 **Contents of pleadings.** Amends § 518A.46, subd. 3. Strikes MinnesotaCare as a form of public assistance for purposes of child support determinations.

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80 **Contents of pleadings for medical support modifications.** Amends § 518A.46, by adding subd. 3a. Paragraph (a) lists the information that must be included in the pleadings when requesting a modification of medical support.

Paragraph (b) lists the information that must be provided to the court and the parties for cases scheduled in the expedited process.

Provides a January 1, 2016 effective date.

81 **Fees for IV-D services.** Amends § 518A.51. Removes the $25 application fee for individuals applying for child support and maintenance collection services.

Strikes Minnesota Care as a public assistance program.

Provides that this section is effective July 1, 2016, except that the amendments striking MinnesotaCare are effective July 1, 2015.

82 **Definitions.** Amends § 518A.53, subd. 1. Modifies the definition of arrears.

Provides a July 1, 2016 effective date.

83 **Collection services.** Amends § 518A.53. Strikes a cross-reference to the application fee for IV-D services. Allows income withholding for arrears collection to be in the specific amount ordered by the court.

Provides a July 1, 2016 effective date.

84 **Arrearage order.** Amends § 518A.53, subd. 10. Requires an employer, in addition to withholding the amount of a support order from an obligor's income, to withhold from an obligor's income the specific amount of arrears ordered by the court.

Provides a July 1, 2016 effective date.

85 **Collection; arrears only.** Amends § 518A.60. Strikes an obsolete cross-reference.

Provides a July 1, 2016 effective date.

86 **Consumer reporting agency; reporting arrears.** Amends § 518A.685. Requires the public authority to report arrears information to a consumer reporting agency when an obligor is in arrears in an amount greater than three times the monthly court ordered support obligation. Provides that before making a report, the public authority must mail the obligor written notice at least 30 days prior to making the report. Allows the obligor, within 21 days of receipt of the notice, to pay the arrears in full or request an administrative review. If the public authority has reported the obligor to a consumer reporting agency and determines the obligor has paid arrears in full or is paying current monthly support plus the required arrearage payment, the public authority must report this to the consumer reporting agency. Requires the public authority to make monthly reports to the consumer reporting agency if the authority has reported arrearage information under this section.

Provides a July 1, 2016 effective date.

87 **Condition of rendition.** Amends § 518C.802. Strikes obsolete language from the Uniform Interstate Family Support Act.

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88 **Public policy.** Amends § 626.556, subd. 1, as amended by Laws 2015, ch. 4, § 1. Modifies the public policy statement to reflect that when reports alleging child abuse or neglect are received, the health and safety of the children are the primary consideration. (Current law focuses on engaging the family's protective capabilities while addressing child safety and risk.)

Strikes the requirement that a family assessment shall be the preferred response for all reports except those alleging substantial child endangerment. Provides that all reports alleging sexual abuse and substantial child endangerment must be handled as investigations and not accepted as family assessment.

Makes technical changes to the structure of this subdivision.

89 **Definitions.** Amends § 626.556, subd. 2. Removes sexual abuse from the definition of "substantial child endangerment" since this subdivision already contains a definition of "sexual abuse."

Amends the definition of physical abuse. Clarifies that certain actions are not considered reasonable and moderate physical discipline, and adds striking a child age one to under age four on the face or head which results in an injury to this list. (Current law provides that these actions are not reasonable or moderate physical discipline when done in anger or without regard to the safety of the child. This is the language that was stricken.)

Clarifies the definition of "report" to specify that a report is a community that describes maltreatment of a child and contains sufficient information to identify the child and the alleged abuser.

90 **Persons mandated to report; persons voluntarily reporting.** Amends § 626.556, subd. 3. Adds tribal social services agencies and tribal police as agencies that can accept reports of child maltreatment from voluntary and mandated reporters.

Strikes the cross reporting requirements for county social services agencies and law enforcements. This language has been moved to another subdivision. Also strikes requirements related to providing information to mandated and voluntary reporters and moves this language to another subdivision.

91 **Failure to notify.** Amends § 626.556, subd. 6a. Changes cross-references so that all reports are referred to law enforcement by the receiving social service agency.

92 **Report; information provided to parent; reporter.** Amends § 626.556, subd. 7, as amended by Laws 2015, ch. 4, sec. 2. In making screening decisions, requires the county agency to consider all relevant history, including screened-out reports. Allows the agency to communicate with specified professionals and individuals.

Adds stricken language from subdivision 3 on providing information to mandated and voluntary reporters.

Allows the agency to use information in a screened-out report to offer social services to the family.

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93 **Guidance for screening reports.** Amends § 626.556, by adding subd. 7a. Paragraph (a) requires staff, supervisors, and other involved in child protection screening to follow guidance issued by the commissioner of human services and immediately implement updated policies and procedures when notified by the commissioner.

Paragraph (b) provides that the county agency must consult with the county attorney before proposing modification of the guidelines to the commissioner. Requires the commissioner to preapprove all modifications before the modifications can be implemented by the county. States that the guidelines may provide additional protections, but must not be less protective of children.

94 **Duties of local welfare agency and local law enforcement agency upon receipt of report; mandatory notification between police or sheriff and agency.** Amends § 626.556, subd. 10. Adds the cross reporting requirements stricken from subdivision 3. Makes technical changes to conform to changes made in definitions in subdivision 2.

Adds that information relevant to an investigation or assessment includes maltreatment reports that were screened out.

95 **Determinations.** Amends § 626.556, subd. 10e. Strikes paragraph (k) which provides counties with the discretion to modify definitions and criteria associated with determining which allegations of abuse and neglect to investigate as long as the policies are consistent with statutes and rules and approved by the county board.

96 **Release of data to mandated reporters.** Amends § 626.556, subd. 10j. Paragraph (a) requires the local agency to provide information to the mandated reporter who made the report and has an ongoing responsibility for the child, unless providing the information is not in the best interests of the child. Allows the agency to provide the information to other mandated reports who have ongoing responsibility for the health, education, or welfare of the child.

Adds paragraph (b) requiring reporters to treat data they receive as private data and imposes the remedies and penalties available under sections 13.08 and 13.09 if a reporter releases data in violation of this section.

97 **Provision of child protective services; consultation with county attorney.** Amends § 626.556, subd. 10m. Requires the county agency to consult with the county attorney to determine whether a CHIPS petition should be filed if a family does not accept or fails to comply with a plan for protective services; if voluntary services may not provide adequate protection for the child; or the family is not cooperating with the investigation or assessment.

98 **Welfare, court services agency, and school records maintained.** Amends § 626.556, subd. 11c. Adds reports alleging child maltreatment that were not accepted for assessment or investigation to the record retention requirements of this paragraph. Requires those reports, family assessment cases, and cases in which an investigation determines there has been no maltreatment or need for protective services to be retained for five years. Requires that records of screened-out reports must contain sufficient information to identify the subjects of the reports, the alleged maltreatment, and the reasons the report was not accepted.

Clarifies that retained records can be used in future screening decisions and risk and safety assessments.

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Strikes paragraph (e) which required reports that were not accepted for assessment or investigation to be retained for 365 days.

99 **Commissioner's duty to provide oversight; quality assurance reviews; annual summary of reviews.** Amends § 626.556, by adding subd. 16. Paragraph (a) instructs the commissioner to develop a plan for quality assurance reviews of local agency screening practices. Requires the commissioner to oversee and provide guidance to counties so that screening decisions are consistent throughout the state. Requires the reviews to begin no later than September 30, 2015.

Paragraph (b) requires the commissioner to issue an annual report with summary results of the reviews. Specifies that the report must contain aggregate data and must not include data that could be used to identify any subject whose data is included in the report. Provides that the report must be classified as public information and be provided to designated members of the legislature.

100 **Background studies.** Amends § 626.559, by adding subd. 1b. Requires background studies to be completed on child protection staff hired on or after July 1, 2015, or current county employees who are assigned to child protection duties on or after July 1, 2015. Allows counties to use the commissioner's NetStudy system or to use an alternate process. Requires counties to initiate a background study before an individual begins a position allowing direct contact with persons served by the agency.

101 to 119 **Uniform Interstate Family Support Act.** Chapter 518C. These sections make technical amendments to various sections the Uniform Interstate Family Support Act, chapter 518C, to conform to changes in federal law.

120 **GRH report on program improvements.** Requires the commissioner, in coordination with stakeholders and advocates, to build on the GRH reforms made this session, and propose modifications that will result in a more cost-effective GRH program, and report to the legislative committees having jurisdiction over GRH issues by December 15, 2016. The working group shall examine the feasibility of restructuring service rates, develop a plan to fund only those services that are not funded by other programs based on individual need, and explore and recommend appropriate and effective assessment tools.

121 **Child support work group.** Paragraph (a) establishes the work group to review the child support parenting expense adjustment and to identify and recommend changes to the adjustment.

Paragraph (b) identifies stakeholders and legislators who will be members of the work group.

Paragraph (c) authorizes the work group to contract with an economist to assist in creating an equitable parent expense adjustment formula.

Paragraph (d) requires the work group to submit a report to the legislature and to the commissioner of human services by January 15, 2016. Requires the report to include recommendations for changes to the computation of child support and recommendations on the composition of a permanent child support task force.

Paragraph (e) provides that terms, compensation, removal of group members, and filling of vacancies are governed by Minnesota Statutes, section 15.059.

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Paragraph (f) provides that the work group expires January 16, 2016.

122 **Instructions to the commissioner; screening guidelines.** Paragraph (a) instructs the commissioner to update the child maltreatment screening guidelines no later than October 1, 2015, to reflect changes in the use of screened out reports and the emphasis on child health and safety. Requires the commissioner to consult with a diverse group of community representatives while developing the updated guidelines.

Paragraph (b) instructs the commissioner to publish and distribute the updated guidelines no later than November 1, 2015.

Paragraph (c) requires county staff to implement the guidelines on January 1, 2016.

123 **Commissioner's duty to provide training to child protection supervisors.** Requires the commissioner to establish requirements for initial training and continuing education for child protection supervisors. Requires the training to be competency based.

124 **Child protection updated formula.** Instructs the commissioner to evaluate the formula established in section 256M.41 to determine whether it is equitable or whether modifications are needed to the distribution formula.

125 **Legislative task force on child protection.** Establishes the legislative task force and lists its duties. Allows the task force to provide oversight and monitoring of specified executive agencies, counties, and tribes in their efforts to assure the safety and well-being of children at risk of harm or children who are involved in the child welfare system. Requires the task force to issue a report to the legislature and governor. Provides that the task force expires the last day of the 2016 legislative session.

Provides an immediate effective date.

126 **Revisor's instruction.** Instructs the revisor to alphabetize the definitions in section 626.556, subdivision 2 and correct cross-references.

Article 2: Chemical and Mental Health Services

Overview

This article establishes emergency services for children and adults. It requires the commissioner of health to improve the collection of suicide data so that it is more usable in determining trends and establishing strategies to prevent suicides. It increase rates for chemical dependency providers and provides for MA coverage for young adults who receive services at a psychiatric residential treatment facility.

1 **General.** Amends § 13.46, subd. 2. Adds that welfare data (private data on individuals) may be disclosed to other personnel in the welfare system for the purpose of coordinating services for an individual or family. (Welfare data can presently be shared with personnel in the welfare system to verify an individual's identity, determine eligibility and the need to provide services to an individual or family across programs, assess parental contributions, and investigate suspected fraud.)

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Adds that welfare data can be disclosed to a health care provider as defined in the Minnesota Health Records Act to the extent necessary to coordinate services, provided that a health record is disclosed only as allowed under sections 144.291 to 144.298.

2 **Mental health data.** Amends § 13.46, subd. 7. Adds that mental health data (private data on individuals) may be disclosed to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record is disclosed only as allowed under section 144.293.

Adds that mental health data (private data on individuals) may be disclosed to a health care provider as defined in the Minnesota Health Records Act if the patient to the extent necessary to coordinate services.

3 **Emergency services.** Amends § 62Q.55, subd. 3. Adds emergency mental health services for children and adults to the definition of "emergency services" in the chapter on health plan companies.

4 **Consent does not expire.** Amends § 144.293, subd. 6. Makes changes to conform to amendments in earlier sections. Adds that consent does not expire to the release of health records to a program in the welfare system to the extent necessary to coordinate services for the patient.

5 **Restricted construction or modification.** Amends § 144.551, subd. 1. Provides a moratorium exception to 20-bed psychiatric hospital, within an existing facility, for patients under 21 years of age, if the commissioner of health finds the project is in the public interest. Requires the project to serve patients in need of extended acute psychiatric care. Provides contingencies if the project ceases to provide extended acute psychiatric care.

6 **Community-based programs.** Amends § 145.56, subd. 2. Instructs the commissioner of health, within available appropriations, to establish grants for community-based programs to provide evidence based suicide prevention and intervention training to education, public safety, and health professionals and to provide postvention training to mental health professionals.

7 **Collection and reporting suicide data.** Amends § 145.56, subd. 4. Adds paragraphs (b) and (c) which require the commissioner of health to issue a report to the legislature by February 1, 2016, with a plan to identify methods to improve the gathering of suicide-related data. Requires the plan to address how this data can help identify the scope of the suicide problem, identify high risk groups, establish priority prevention activities, and monitor the effects of suicide prevention programs.

8 **Planning for pilot projects.** Amends § 245.4661, subd. 5. Corrects a reference to intensive residential treatment services (IRTS).

9 **Duties of commissioner.** Amends § 245.4661, subd. 6. Strikes language that allows the transfer of funds from a state-operated services account for mental health specialty treatment services. (Related to section 246.18, subdivision 8.)

10 **Services and programs.** Amends § 245.4661, by adding subd. 9. Lists the services and programs adult mental health grants may fund.

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11 **Commissioner duty to report on use of grant funds biennially.** Amends § 245.4661, by adding subd. 10. Requires the commissioner to report biennially on the amount of funding from adult mental health grants provided to mental health initiatives, the programs and services funded, service gaps, and outcome data related to those services and programs.

12 **Restricted access to data.** Amends § 245.467, subd. 6. Requires county boards to have a procedure in place to allow personnel of the welfare system and health care providers who have access to mental health data under section 13.46, subdivision 7 (amended in section 2 of this article), to have access to the names and addresses of persons who are receiving mental health services through the county. (Current law allows certain county employees and staff who provide mental health treatment to have access to this data.)

13 **Restricted access to data.** Amends § 245.4876, subd. 7. Requires county boards to have a procedure in place to allow personnel of the welfare system and health care providers who have access to mental health data under section 13.46, subdivision 7 (amended in section 2 of this article), to have access to the names and addresses of children who are receiving mental health services through the county. (Current law allows certain county employees and staff who provide mental health treatment or case management to have access to this data.)

14 **Establishment and authority.** Amends § 245.4889, subd. 1. Lists the services and programs that children's mental health grants may fund.

15 **Commissioner duty to report on use of grant funds biennially.** Amends § 245.4889, by adding subd. 3. Requires the commissioner to report biennially on the amount of funding from children's mental health grants provided to mental health initiatives, the programs and services funded, service gaps, and outcome data related to those services and programs.

16 **Excellence in mental health demonstration project.** Creates § 245.735.

Subd. 1. Excellence in Mental Health demonstration project. Allows the commissioner of human services to participate in the demonstration project.

Subd. 2. Federal proposal. Allows the commissioner to submit a proposal of the project, including state plan amendments and waiver requests, to the United States Department of Health and Human Services.

Subd. 3. Reform projects. Allows the commissioner to establish standards for certification of behavioral health clinics. Lists the required standards. Requires the commissioner to establish standards and methodologies for a payment system.

Subd. 4. Public participation. Requires the commissioner to consult with stakeholders, recipients of mental health services, and mental health professionals.

Subd. 5. Information systems support. Requires the commissioner and the state chief information officer to provide information systems support to the projects.

17 **State-operated services account.** Amends § 246.18, subd. 8. Strikes language that allows the transfer of funds from a state-operated services account for mental health specialty treatment services. (Related to section 245.4661, subd. 6.)

18 **Special review board.** Amends § 253B.18, subd. 4c. Makes structural changes to create new paragraph (b) which requires the special review board to review each petition for a reduction in custody from a person who has been committed as mentally ill and dangerous to

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determine if barriers and obstacle prevent a patient from progressing in treatment. Requires the board to report trends in barriers and obstacles noted in the previous year to the commissioner.

Provides a January 1, 2016 effective date.

19 **Petition; notice of hearing; attendance; order.** Amends § 253B.18, subd. 5. Requires the head of the treatment facility to schedule a hearing before the special review board for any patient who has not appeared before the board in the previous three years to ensure each patient has a hearing.

Provides that this section is effective January 1, 2016, and requires hearings to start no later than February 1, 2016.

20 **Rate requirements.** Amends § 254B.05, subd. 5, as amended by Laws 2015, ch. 21, art. 1, sec. 52. Requires the commissioner to establish a rate for high-intensity residential treatment services for clients who have been committed to the commissioner and who have complex and difficult needs, and pose a potential threat to the community. This section affects CARE programs, which will remain open, transition to 16 bed facilities, and become eligible for federal funds.

21 **Payment methodology for highly specialized vendors.** Amends § 254B.12, subd. 2. Strikes the requirement that the commissioner receive legislative approval before implementing the payment methodology for highly specialized vendors.

22 **Eligibility.** Amends § 256B.0615, subd. 3. Corrects a cross-reference to intensive residential treatment services (IRTS).

23 **Scope.** Amends § 256B.0622, subd. 1. Updates the names of two treatment services to assertive community treatment (ACT) and intensive residential treatment services.

24 **Definitions.** Amends § 256B.0622, subd. 2. Replaces the definition of intensive nonresidential rehabilitative mental health services with the definition of "assertive community treatment." Strikes outdated language.

25 **Eligibility.** Amends § 256B.0622, subd. 3. Modifies eligibility for ACT and IRTS by striking the requirement of two or more inpatient hospitalizations in the past year to recurring or prolonged inpatient hospitalizations in the past year.

26 **Provider certification and contract requirements.** Amends § 256B.0622, subd. 4. Updates references to ACT and IRTS.

27 **Standards applicable to both assertive community treatment and residential providers.** Amends § 256B.0622, subd. 5. Updates standards for ACT and IRTS providers by changing when the functional assessment must be updated and when the individual treatment plan must be completed and updated.

28 **Additional standards for assertive community treatment.** Amends § 256B.0622, subd. 7. Updates the program name to ACT.

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29 **Medical assistance payments for intensive rehabilitative mental health services.** Amends § 256B.0622, subd. 8. Allows physicians to deliver services via telemedicine. Strikes obsolete references to county rate setting. Establishes rate-setting requirements for new programs.

30 **Provider enrollment; rate setting for county-operated entities.** Amends § 256B.0622, subd. 9. Strikes obsolete reference to county rate setting.

31 **Provider enrollment; rate setting for specialized program.** Amends § 256B.0622, subd. 10. Strikes obsolete reference to county rate setting, and adds language that a county contract is not required under certain conditions.

32 **Sustainability grants.** Amends § 256.0622, by adding subd. 11. Authorizes the commissioner to disburse grant funds directly to ACT and IRTS providers.

33 **Crisis stabilization services.** Amends § 256B.0624, subd. 7. Clarifies staffing requirements for adult crisis stabilization services.

34 **Psychiatric residential treatment facility services for persons under 21 years of age.** Amends § 256B.0625, by adding subd. 45a. Paragraph (a) provides MA coverage of psychiatric residential treatment facility services for persons under age 21. Allows persons who reach age 21 at the time they are receiving services to continue to receive services until the services are no longer required, or they reach age 22, whichever occurs first.

Paragraph (b) defines "psychiatric residential treatment facility" as a facility other than a hospital that provides psychiatric services, as defined in federal regulations, to individuals under age 21 in an inpatient setting.

Paragraph (c) requires the commissioner to develop admissions and discharge procedures and to establish rates consistent with federal guidelines.

Paragraph (d) instructs the commissioner to enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. Requires the commissioner to issue an RFP and allows state-operated services to respond to the RFP.

Provides an effective date of July 1, 2017, or upon federal approval, whichever is later.

35 **Psychiatric consultation to primary care practitioners.** Amends § 256B.0625, subd. 48. Allows medical assistance coverage for psychiatric consultation provided by a licensed independent clinical social worker or a licensed marriage and family therapist.

36 **Chemical dependency provider rate increase.** Adds § 256B.7631. Effective July 1, 2015, increases MA payment rates for chemical dependency services by 2 percent over the rates in effect on January 1, 2014.

37 **Clubhouse program services.** Allows the commissioner of human services to develop service standards and a payment methodology for Clubhouse program services to be covered under medical assistance. Allows the commissioner to seek federal approval for the services and medical assistance reimbursement. Upon federal approval, requires the commissioner to obtain legislative approval to implement the services and payment system.

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38 **Excellence in mental health demonstration project.** Requires the commissioner of human services to report to the legislature on the progress of the Excellence in Mental Health demonstration project by January 15, 2016. Instructs the commissioner to include recommendations for legislative changes needed to implement the reform projects.

39 **Rate-setting methodology for community-based mental health services.** Instructs the commissioner of human services to conduct a comprehensive analysis of the current rate-setting methodology for community-based mental health services for children and adults. Requires the commissioner to issue a report to the chairs of legislative committees with jurisdiction over health and human services finance by January 1, 2017.

40 **Report on human services data sharing to coordinate services and care of a patient.** Requires the commissioner to report, by January 1, 2017, on the fiscal impact, including estimated savings, resulting from the modifications to the data practices act permitting the sharing of private data for care coordination.

41 **Comprehensive mental health program in Beltrami County.** Instructs the commissioner to award a grant to Beltrami County for the planning and development of a comprehensive mental health program if Beltrami County submits a formal commitment and plan to fund, operate, and sustain the program and services after the onetime state grant is expended. Requires the plan to include an integrated care model for mental health and co-occurring disorders for individuals who are under arrest, under a civil commitment transport hold, or in need of mental health crisis services. Requires the commissioner, in consultation with Beltrami County, to issue a progress report to the legislature by November 1, 2017.

42 **Mental health crisis services.** Directs the commissioner to increase access to mental health crisis services for children and adults. Provides a list of actions to be taken by the commissioner that will result in increased access. Requires the commissioner to give priority to regions unable to meet the needs of the residents in the region and to distribute at least 50 percent of the grant funds to programs in rural Minnesota.

43 **Instructions to the commissioner.** Requires the commissioner, in consultation with stakeholders, to develop recommendations for children's crisis mental health residential services that will allow for timely direct access to care.

Article 3: Withdrawal Management Programs

Overview

This article creates a new chapter of law containing the licensing standards for withdrawal management programs.

1 **Purpose.** Creates § 245F.01. Makes a statement of public policy regarding the establishment of withdrawal management services for persons in need of detoxification, assessment, intervention, and referral services.

2 **Definitions.** Creates § 245F.02. Defines the following terms as used in this chapter: "administration of medications," "alcohol and drug counselor," "applicant," "care coordination," "chemical," "clinically managed program," "commissioner," "department,"

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"direct patient contact," "discharge plan," "licensed practitioner," "medical director," "medically monitored program," "nurse," "patient," "peer recovery support services," "program director," "protective procedure," "recovery peer," "responsible staff person," "substance," "substance use disorder," "technician," and "withdrawal management program."

3 **Application.** Creates § 245F.03. Provides that this chapter applies to withdrawal management programs licensed by the commissioner of human services. States that this chapter does not apply to programs licensed as a hospital, but allows programs located in a hospital to be licensed if they choose to be licensed under this chapter.

4 **Program licensure.** Creates § 245F.04.

Subd. 1. General application and license requirements. Requires an applicant seeking licensure as a clinically managed withdrawal program or medically monitored withdrawal program to meet federal and state requirements. Requires the program to be located in a licensed hospital or a licensed supervised living facility.

Subd. 2. Contents of application. Lists the documentation that must be provided by the applicant to the commissioner.

Subd. 3. Changes in license terms. Requires a license holder to notify the commissioner if one of the list events occurs.

Subd. 4. Variances. Allows the commissioner to grant variances to the requirements of this chapter.

5 **Admission and discharge policies.** Creates § 245F.05.

Subd. 1. Admission policy. Requires each license holder to have a written admission policy that is approved and signed by the medical director and posted in the admission area of the facility. Prohibits admission of a person who does not meet the admission policy criteria.

Subd. 2. Admission criteria. Requires the program to determine if the program services are appropriate for the needs of the individual. Establishes the required admission criteria.

Subd. 3. Individuals denied admission by program. Requires each license holder to have a written policy for addressing the needs of individuals who are denied admission. Requires programs to document denied admissions.

Subd. 4. License holder responsibilities; denying admission or terminating services. Requires the license holder to make alternate treatment arrangements at a facility capable of caring for and admitting a patient who is denied admission or whose treatment is terminated when denial or termination poses an immediate threat to the patient or requires immediate medical intervention. Requires the license holder to make a report to law enforcement of all admission denials and terminations of service that involve the commission of a crime.

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Subd. 5. Discharge and transfer policies. Requires each license holder to have a written discharge and transfer policy and procedure that is signed by the medical director. Lists the procedures and guidelines that must be addressed in the policy.

6 **Screening and comprehensive assessment.** Creates § 245F.06.

Subd. 1. Screening for substance use disorder. Requires a nurse or alcohol and drug counselor to screen each patient at admission to determine whether a comprehensive assessment is needed.

Subd. 2. Comprehensive assessment. Requires a comprehensive assessment to be completed for each patient who has a positive screening for a substance use disorder prior to discharge, but not later than 72 hours following admission. If a patient's medical condition prevents a comprehensive assessment from being conducted, that must be documented in the patient's file. Allows a previously completed assessment to be used if it is accurate and current.

7 **Stabilization planning.** Creates § 245F.07.

Subd. 1. Stabilization plan. Requires completion of an individualized stabilization plan for each patient within 12 hours of admission.

Subd. 2. Progress notes. Requires at least daily entry of progress notes in the patient's file. Lists the information to be included in progress notes.

Subd. 3. Discharge plan. Requires the license holder to conduct discharge planning with the patient prior to discharge, document the planning in the patient's record, and provide the patient with a copy of the discharge plan. Lists the information that must be addressed in the plan.

8 **Stabilization services.** Creates § 245F.08.

Subd. 1. General. Instructs license holders to encourage patients to remain in care and to participate in programs for ongoing recovery services. Lists the services that must be offered unless clinically inappropriate. Requires documentation in the patient's record.

Subd. 2. Care coordination. Requires care coordination for each patient. Lists the components of care coordination.

Subd. 3. Peer recovery support services. Describes the support services that may be provided by peers in recovery. Requires the support services to be supervised by a staff person.

Subd. 4. Patient education. Lists the issues that must be addressed with each patient.

Subd. 5. Mutual aid, self-help, and support groups. Requires the license holder to refer patients to available groups when clinically indicated.

9 **Protective procedures.** Creates § 245F.09.

Subd. 1. Use of protective procedures. Specifies the situations in which protective procedures may be used, the situations in which these procedures are

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prohibited, and the observation requirements when a client is subject to protective procedures.

Subd. 2. Protective procedures plan. Requires each license holder to have a written policy and procedure on when protective procedures may be implemented when a patient poses an imminent danger of harming self or others. Lists the issues that must be included in the protective procedures policy.

Subd. 3. Records. Requires detailed documentation in the patient record when a protective procedure is used.

Subd. 4. Use of law enforcement. Requires each program to maintain a central log to document each incident involving the use of law enforcement.

Subd. 5. Administrative review. Requires each license holder to maintain a record of all patient incidents and protective procedures use. Requires an administrative review of each use of protective procedures within 72 hours by an individual who was not involved in the use of the procedure. Requires the license holder to conduct a quarterly review of the use of protective procedures with the goal of reducing the use of these procedures.

10 **Patient rights and grievance procedures.** Creates § 245F.10.

Subd. 1. Patient rights. Provides that each patient, at the time of admission, must be given a written statement of patient rights.

Subd. 2. Grievance procedure. Provides that each patient or patient's representative, at the time of admission, must be informed of the facility's grievance procedure. Lists information that must be included in the written grievance procedure. Requires this to be posted in a conspicuous location and to be made available to patients.

11 **Patient property management.** Creates § 245F.11. Lists the requirements the license holder must meet for handling patient funds and property.

12 **Medical services.** Creates § 245F.12.

Subd. 1. Services provided at all programs. Lists the required service components common to all licensed withdrawal management programs.

Subd. 2. Services provided at clinically managed programs. Lists the required medical services that must be provided at the program, in addition to the requirements in subdivision 1.

Subd. 3. Services provided at medically monitored programs. Lists the required medical services and medical staff that must be provided at the program, in addition to the requirements in subdivision 1.

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13 **Medications.** Creates § 245F.13.

Subd. 1. Administration of medications. Requires a registered nurse to develop the written policies and procedures for medication administration. Lists the issues that must be addressed in the policies and procedures.

Subd. 2. Control of drugs. Provides that the license holder must have written policies and procedures developed by a registered nurse relating to the control of drugs. Lists issues that must be addressed in the policies and procedures. Requires the license holder to implement these procedures.

14 **Staffing requirements and duties.** Creates § 245F.14.

Subd. 1. Program director. Requires a license holder to employ or contract with a person on a full-time basis to serve as program director. This person may serve as program director for more than one program owned by the same license holder.

Subd. 2. Responsible staff person. Requires a staff member, designated by the license holder, to be present and awake during all hours of program operation.

Subd. 3. Technician required. Provides that one technician for every ten patients must be awake and on duty at all times, except when specified conditions are present.

Subd. 4. Registered nurse required. Provides that a registered nurse must be available 24 hours a day by telephone or in person for consultation. Lists the duties of the registered nurse.

Subd. 5. Medical director required. Provides that a license holder must have a medical director available to ensure accurate and safe provision of all health services.

Subd. 6. Alcohol and drug counselor. Requires each licensed program to have one full-time equivalent alcohol and drug counselor for every 16 patients.

Subd. 7. Ensuring staff-to-patient ratio. Provides that the responsible staff person must ensure the program does not exceed the required staff-to-patient ratios.

15 **Staff qualifications.** Creates § 245F.15.

Subd. 1. Qualifications for all staff who have direct patient contact. Requires staff with direct patient contact to be at least 18 years old and be free of substances use problems for a specified time based on their profession. For program directors, supervisors, nurses, and alcohol and drug counselors—free of substances for at least two years. For recovery peers—free of substances for at least one year. For technicians and other support staff—free of substances for at least six months.

Subd. 2. Continuing employment; no substance use problems. Provides that license holders must require staff to be free from substance use problems as a condition of employment.

Subd. 3. Program director qualifications. Provides the educational and work experience requirements for a program director.

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Subd. 4. Alcohol and drug counselor qualifications. Provides that alcohol and drug counselors must meet the requirements found in Minnesota Rules, part 9530.6450, subpart 5.

Subd. 5. Responsible staff person qualifications. Establishes qualifications for the responsible staff person based on the whether the program is licensed as a clinically managed program or a medically monitored program.

Subd. 6. Technician qualifications. Lists the areas in which a technician must display competency prior to direct patient contact.

Subd. 7. Recovery peer qualifications. Requires recovery peers to be at least 21 years old and have a high school diploma or equivalent, be free of substances for at least one year, have completed a training curriculum designed by the commissioner, and receive supervision by supervisory staff.

Subd. 8. Personal relationships. Provides that a license holder must have a written policy addressing personal relationships between patients and staff. Lists the prohibited conduct and actions that must be addressed in the policy.

16 **Personnel policies and procedures.** Creates § 245F.16.

Subd. 1. Policy requirements. Provides that license holders must have written personnel policies and make the policies available to staff members. Lists what must be included in the personnel policy.

Subd. 2. Staff development. Requires the license holder to provide staff orientation prior to patient contact, and at least 30 hours of continuing education every two years.

17 **Personnel files.** Creates § 245F.17. Provides that a license holder must maintain a separate personnel file for each staff member. Lists the minimum information that must be retained in the file.

18 **Policy and procedures manual.** Creates § 245F.18. Provides the requirements for the format and information that must be contained in the manual.

19 **Patient records.** Creates § 245F.19.

Subd. 1. Patient records required. Provides that current patient records must be maintained on site where treatment is provided. Requires entries to be signed and dated by the staff member making the entry.

Subd. 2. Records retention. Requires that records be maintained in compliance with chapter 245A, Human Services Licensing.

Subd. Contents of records. Lists the information that must be included in patient records.

20 **Data collection required.** Creates § 245F.20. Requires the license holder to participate in the drug and alcohol normative evaluation system (DAANES).

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21 **Payment methodology.** Creates § 245F.21. Instructs the commissioner to develop a payment methodology, seek federal approval for the methodology, and upon federal approval, seek legislative approval for the methodology.

Article 4: Direct Care and Treatment

Overview

This article extends insurance coverage for employees who, as a result of an assault by a patient at a DHS institution, are totally and permanently disabled. It increase the county share of cost for individuals who receive inpatient care at a regional treatment center when such care is not clinically necessary.

1 **Insurance contributions; former employees.** Amends § 43A.241. A 2014 law requires the commissioner of corrections to continue to make the employer contribution for insurance coverage for any former Department of Corrections employee who was a member of the Minnesota State Retirement System (MSRS) general plan who was assaulted by an inmate at a state correctional institution and was determined to be totally and permanently disabled under MSRS laws.

This bill extends the law to apply to positions covered by either the MSRS correctional plan or the general state employee's retirement plan and to former employees assaulted by either patients at institutions under control of the commissioner of human services or inmates at state prisons.

Provides that this section is effective the day following final enactment and applies to persons assaulted on or after that date.

2 **County portion for cost of care.** Amends § 246.54, subd. 1. Increases the county share of cost for individuals who are receiving care in a regional treatment center. Requires the county to pay 100 percent of the cost of care for each day, including the day of admission, when the facility determines the client is clinically appropriate for discharge.

Article 5: Simplification of Public Assistance Programs

Overview

This article simplifies the treatment of income, the requirements for reporting income and changes in circumstances, and the process for correcting overpayments and underpayments for various public assistance programs.

1 **Income.** Amends § 119B.011, subd. 15. Modifies the definition of "income" under the child care assistance program and ties it to the definitions of "earned income" and "unearned income" in Minnesota Statutes, chapter 256P, Economic Assistance Program Eligibility and Verification.

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2 **Factors which must be verified.** Amends § 119B.025, subd. 1. Requires changes in eligibility factors to be reported according to the requirements under chapter 256P. Specifies the effective date of a change in income for purposes of the CCAP programs.

3 **Assistance.** Amends § 119B.035, subd. 4. Requires families participating in the at-home infant child care program to report income and other family changes according to the requirements under chapter 256P.

4 **Eligibility; annual income; calculation.** Amends § 119B.09, subd. 4. Requires lump sum payments to be annualized over 12 months.

5 **Standards.** Amends § 256D.01, subd. 1a. Requires countable income under the GA program to be calculated according to the requirements under chapter 256P.

6 **Assistance unit.** Amends § 256D.02, by adding subd. 1a. Defines "assistance unit" under the GA program.

7 **Cash assistance benefit.** Amends § 256D.02, by adding subd 1b. Defines "cash assistance benefit."

8 **Income.** Amends § 256D.02, subd. 8. Modifies the definition of "income" under the GA program and ties it to the definitions of "earned income" and "unearned income" under chapter 256P.

9 **Eligibility; amount of assistance.** Amends § 256D.06, subd. 1. Modifies the calculation of income under the GA program and requires countable income to be calculated according to chapter 256P.

10 **Reports.** Amends § 256D.405, subd. 3. Requires MSA participants to report changes in circumstances according to the requirements under chapter 256P.

11 **Assistance unit.** Amends § 256I.03, by adding subd. 1b. Defines "assistance unit" under the GRH program.

12 **Countable income.** Amends § 256I.03, subd. 7. Ties the definition of "countable income" under the GRH program to the definition of "countable income" under chapter 256P.

13 **Individual eligibility requirements.** Amends § 256I.04, subd. 1. Requires countable income under the GRH program to be determined according to the requirements under chapter 256P.

14 **Reports.** Amends § 256I.06, subd. 6. Requires GRH recipients to report changes in circumstances according to the requirements under chapter 256P.

15 **Earned income.** Amends § 256J.08, subd. 26. Modifies the definition of "earned income" under the MFIP program and ties it to the definition of "earned income" under chapter 256P.

16 **Unearned income.** Amends § 256J.08, subd. 86. Modifies the definition of "unearned income" under the MFIP program and ties it to the definition of "unearned income" under chapter 256P.

17 **Applicant reporting requirements.** Amends § 256J.30, subd. 1. Modifies MFIP applicant reporting requirements and requires applicants to meet the reporting requirements under chapter 256P.

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18 **Changes that must be reported.** Amends § 256J.30, subd. 9. Modifies MFIP participant reporting requirements and requires participants to meet the reporting requirements under chapter 256P.

19 **Amount of assistance payment.** Amends § 256J.35. Modifies recoupment of MFIP overpayments by cross-referencing recoupment of overpayments in chapter 256P.

20 **Fair hearings.** Amends § 256J.40. Changes the cross-reference related to recoveries of overpayments under the MFIP program. The new cross-reference is to section 256P.08, Correction of Overpayments and Underpayments.

21 **DWP overpayments and underpayments.** Amends § 256J.95, subd. 19. Changes the cross-reference specifying how ATM errors under the DWP program must be recovered by referencing the language in chapter 256P related to recovering ATM errors.

22 **Applicability.** Amends § 256P.001. Applies chapter 256P to the child care assistance programs.

23 **Assistance unit.** Amends § 256P.01, by adding subd. 2a. Defines "assistance unit" under the Economic Assistance Program Eligibility and Verification chapter.

24 **Earned income.** Amends § 256P.01, subd. 3. Modifies the definition of "earned income" for purposes of the GA, MSA, CCAP, GRH, and MFIP programs.

25 **Unearned income.** Amends § 256P.01, by adding subd. 8. Defines "unearned income" for purposes of the GA, MSA, CCAP, GRH, and MFIP programs.

26 **Exemption.** Amends § 256P.02, by adding subd. 1a. Exempts CCAP participants from the personal property limitations in the Economic Assistance Program Eligibility and Verification chapter.

27 **Exempted programs.** Amends § 256P.03, subd. 1. Exempts CCAP participants from the earned income disregard under the Economic Assistance Program Eligibility and Verification chapter because the child care programs contain specific policies that are unique to that program, which include different documentation requirements related to authorized hours of care and authorized activities, and the use co-pays instead of income disregards.

28 **Exemption.** Amends § 256P.04, subd. 1. Exempts CCAP participants from the documentation, verification, and recertification requirements under the Economic Assistance Program Eligibility and Verification chapter. The Child Care Assistance chapter of statutes contains separate documentation, verification, and recertification requirements for these programs.

29 **Factors to be verified.** Amends § 256P.04, subd. 4. Adds nonrecurring income to the list of factors that must be verified at the time of application.

30 **Exempted programs.** Amends § 256P.05, subd. 1. Exempts CCAP participants from self-employment earnings requirements under the Economic Assistance Program Eligibility and Verification chapter.

31 **Income calculations.** Creates § 256P.06.

Subd. 1. Reporting of income. Requires the county agency to evaluate income received by members of the assistance unit, or by others whose income is considered

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available to the assistance unit, and to only count income that is available to the assistance unit to determine eligibility.

Subd. 2. Exempted individuals. Exempts certain members of an assistance unit under the CCAP and MFIP programs from having their earned income count toward the income of the assistance unit.

Subd. 3. Income inclusions. Lists the items that must be included in determining the income of an assistance unit.

32 Reporting of Income and Changes. Creates § 256P.07.

Subd. 1. Exempted programs. Exempts MSA and GRH participants who qualify on the basis of eligibility for SSI from the requirements of this section.

Subd. 2. Reporting requirements. Requires applicants or participants to provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. Requires applicants or participants to report changes according to the requirements of this section. Allows benefits to be delayed or denied when information or documentation is not provided, depending upon the type of information required and its effect on eligibility.

Subd. 3. Changes that must be reported. Requires assistance units to report certain changes within ten days of the date they occur, at the time of recertification, or within eight calendar days of a reporting period, whichever occurs first. Requires assistance units to report other changes at the time of recertification of eligibility or at the end of a reporting period, as applicable. Specifies the manner in which delays in reporting are handled. Lists the changes an assistance unit must report within ten days.

Subd. 4. MFIP-specific reporting. Lists the additional changes in circumstances MFIP assistance units must report within ten days.

Subd. 5. DWP-specific reporting. Lists additional information DWP participants must report on an application.

Subd. 6. CCAP-specific reporting. Lists the additional changes in circumstances CCAP assistance units must report within ten days of the change.

Subd. 7. MSA-specific reporting. Requires MSA shelter needy participants to report shelter expenses within ten days of a change.

33 Correction of Overpayments and Underpayments. Creates § 256P.08.

Subd. 1. Exempted programs. Exempts CCAP and GRH participants from this section.

Subd. 2. Scope of overpayment. Specifies the process for recouping or recovering overpayments. Limits establishment of overpayments to six years prior to the month of discovery due to client error or an intentional program violation. Prohibits participants or former participants from being responsible for agency errors.

Subd. 3. Notice of overpayment. Requires county agencies to notify participants or former participants of overpayments in writing. Lists the information that must be

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included in the notice. Specifies no limit applies to the period in which the county agency is required to recoup or recover an overpayment.

Subd. 4. Recovering GA and MSA overpayments. Specifies the process counties must follow when recovering GA or MSA overpayments.

Subd. 5. Recovering MFIP overpayments. Specifies the process counties must follow when recovering MFIP overpayments.

Subd. 6. Recouping overpayments from MFIP participants. Allows a participant to voluntarily repay, in part or in full, an overpayment even if assistance is reduced, until the total amount of the overpayment is repaid. Specifies the process counties must follow when recovering overpayments due to fraud and nonfraud.

Subd. 7. Recovering automatic teller machine errors. For recipients receiving benefits by electronic benefit transfer, allows county agencies to recover ATM errors by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error, if the overpayment is the result of an ATM dispensing funds in error to the recipient.

Subd. 8. Scope of underpayments. Requires a county agency to issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Limits corrective payments to 12 months prior to the month of discovery. Specifies the manner in which corrective payments must be issued.

Subd. 9. Identifying the underpayment. Allows an underpayment to be identified by a county agency, participant, former participant, or person who would be a participant except for agency or client error.

Subd. 10. Issuing corrective payments. Requires county agencies to correct underpayments within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment of the participant, issuing a separate payment to a participant or former participant, or reducing an existing overpayment balance. Lists the methods the county agency must use to correct underpayments. Excludes corrective payments when determining income and resources for the month of payment.

Subd. 11. Appeals. Allows a participant to appeal an underpayment, an overpayment, or a reduction in an assistance payment made to recoup an overpayment. Requires the participant's appeal of each issue to be timely according to the human services appeals process. Prohibits the fact or amount of an overpayment to be considered as part of a later appeal when an appeal is not timely.

34 **Repealer.** Paragraph (a) repeals Minn. Stat. §§ 256D.0513 (budgeting lump sums); 256D.06, subd. 8 (recovery of ATM errors); 256D.09, subd. 6 (recovery of overpayments); 256D.49 (payment correction); and 256J.38 (correction of overpayments and underpayments).

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Paragraph (b) repeals Minn. Rules, part 3400.0170, subp. 5 (earned income of wage and salary employees), 6 (excluded income), 12 (determination of unearned income), and 13 (treatment of lump sum payments).

35 **Effective date.** Makes this article effective August 1, 2016.

Article 6: Nursing Facility Payment Reform and Workforce Development

Overview

This article provides for nursing home payment reform and long-term care workforce development, modifies an exception to the nursing facility bed moratorium, and provides construction project rate adjustments for certain facilities.

1 **Home and community-based services employee scholarship program.** Creates § 144.1503.

Subd. 1. Creation. Establishes the home and community-based services employee scholarship grant program to assist qualified provider applicants to fund employee scholarships for education in nursing and other health care fields.

Subd. 2. Provision of grants. Requires the commissioner to make grants available to qualified providers of older adult services. Specifies how grants must be used.

Subd. 3. Eligibility. Specifies provider eligibility requirements and limitations on the use of grant funds.

Subd. 4. Home and community-based services employee scholarship program. Requires qualifying providers to propose a home and community-based services employee scholarship program. Requires providers to establish criteria by which funds are distributed among employees. Specifies minimum requirements scholarship programs must meet.

Subd. 5. Participating providers. Requires the commissioner to publish a request for proposals in the State Register, and lists the information that must be included in the request. Requires the commissioner to publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. Application requirements. Requires eligible providers seeking a grant to submit an application to the commissioner and lists the information that must be included in the application.

Subd. 7. Selection process. Specifies the process the commissioner must follow in making grant selections.

Subd. 8. Reporting requirements. Specifies provider reporting requirements. Allows the commissioner to require and collect from grant recipients other information necessary to evaluate the program.

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2 **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Modifies the moratorium on the creation of new nursing home beds and construction projects greater than $1,000,000, by modifying an exception for a facility in Polk County. Allows the project to construct 25 beds in Polk County and distributes 104 beds among up to three other counties. The other counties must have fewer than the median number of age-intensity adjusted beds published by the commissioner. Requires the commissioner to approve the location of the beds if distributed outside of Polk County. Allows the licensee to combine the additional beds with beds relocated from other facilities that were approved under the moratorium exception process.

Requires the commissioner to calculate the property-related reimbursement rates for the construction projects using existing rules and statutes governing property reimbursement rates. If the replacement beds are combined with beds from other facilities, the commissioner must calculate the property rate as a weighted average of the rates.

3 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Modifies monthly limits under the Alternative Care program to be consistent with the elderly waiver monthly limits.

4 **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Modifies adjustments to the elderly waiver cost limits and removes obsolete language. Makes this section effective July 1, 2016.

5 **Customized living service rate.** Amends § 256B.0915, subd. 3e. Modifies adjustments to elderly waiver customized living service rates and removes obsolete language. Makes this section effective July 1, 2016.

6 **Service rate limits; 24-hour customized living services.** Amends § 256B.0915, subd. 3h. Modifies adjustments to elderly waiver 24-hour customized living services rate limits. Makes this section effective July 1, 2016.

7 **Operating costs after July 1, 1985.** Amends § 256B.431, subd. 2b. Removes language related to special dietary needs (this language is moved to § 256B.441, subd. 51b).

8 **Employee scholarship costs and training in English as a second language.** Amends § 256B.431, subd. 36. Allows nursing facilities with no employee scholarship cost per diem to request a scholarship cost per diem between October 1, 2015, and December 31, 2017. Reduces the average number of hours worked per week necessary to qualify, expands eligible professions, and includes additional eligible costs. Specifies that this rate increase is an optional rate add-on that a facility must request from the commissioner and that the rate increase must be used for scholarships.

9 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Removes obsolete language in paragraphs (a), (b), and (e). Extends the suspension of automatic inflationary adjustments for two rate years. Removes language in paragraph (d) related to the performance-based incentive payment program (this language is moved to § 256B.441, subd. 46d).

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10 **Construction project rate adjustments for certain nursing facilities.** Amends § 256B.434, by adding subd. 4i. Paragraph (a) provides property rate increases to nursing facilities with more than 120 active beds as of January 1, 2015, and with construction projects approved in 2015 under the nursing facility moratorium exception process.

In addition to property rate adjustments they would normally receive under section 256B.434, subdivision 4f, facilities with 120 to 149 active beds will receive an additional property rate adjustment of $4. Facilities with between 150 and 160 beds will receive an additional $12.50 property rate adjustment.

Paragraph (b) specifies that money available from moratorium exception project appropriations shall be used to reduce the fiscal impact to the MA budget for the increases allowed under paragraph (a).

11 **Calculation of nursing facility operating payment rates.** Amends § 256B.441, subd. 1. Specifies how the commissioner of human services must calculate nursing facility operating payment rates beginning January 1, 2016. Removes obsolete language related to the phase-in of rebased operating payment rates and language related to rebasing of property rates.

12 **Administrative costs.** Amends § 256B.441, subd. 5. Modifies the definition of "administrative costs" by including property insurance.

13 **Allowed costs.** Amends § 256B.441, subd. 6. Modifies the definition of allowed costs by specifying the process by which wage and benefit costs are approved for facilities in which employees are represented by collective bargaining agents.

14 **Employer health insurance costs.** Amends § 256B.441, by adding subd. 11a. Defines "employer health insurance costs."

15 **External fixed costs.** Amends § 256B.441, subd. 13. Modifies the definition of "external fixed costs" by removing obsolete language and adding property assessments and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments; performance-based incentive payments; and special dietary needs.

16 **Facility average case mix index.** Amends § 256B.441, subd. 14. Modifies the definition of "facility average case mix index" by removing obsolete language and specifying that resource utilization group (RUG) weights used shall be based on the case mix system prescribed in statute.

17 **Fringe benefit costs.** Amends § 256B.441, subd. 17. Modifies the definition of "fringe benefit costs" by removing health insurance and excluding the Public Employees Retirement Association (PERA) and employer health insurance costs.

18 **Median total care-related cost per diem and other operating per diem determined.** Amends § 256B.441, subd. 30. Removes language related to peer groups and requires the commissioner to determine the median total care-related cost per diem and other operating cost per diem using the cost reports from nursing facilities in the seven county metro area.

Paragraph (b) specifies how the median total care-related per diem is calculated.

Paragraph (c) specifies how the median other operating per diem is calculated.

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19 **Prior system operating cost payment rate.** Amends § 256B.441, subd. 31. Updates the date of the prior cost operating payment rate to be the rate in effect on December 31, 2015, removes obsolete language, and clarifies the items included in the prior system operating cost.

20 **Rate year.** Amends § 256B.441, subd. 33. Modifies the definition of "rate year" to conform to the change in the timing of the rate year.

21 **Reporting period.** Amends § 256B.441, subd. 35. Modifies the definition of "reporting period" to include parameters for interim and settle-up periods.

22 **Standardized days.** Amends § 256B.441, subd. 40. Modifies the definition of "standardized days" to specify how resident days at a penalty classification are treated.

23 **Calculation of a quality score.** Amends § 256B.441, subd. 44. Removes obsolete language and makes technical and conforming changes to the statute governing the calculation of nursing facility quality scores.

24 **Quality improvement incentive system beginning October 1, 2015.** Amends § 256B.441, subd. 46c. Makes conforming changes to the quality improvement incentive system to reflect the new rate year timeline. Specifies that quality improvement incentive rate adjustments must be included in the external fixed payment rate.

25 **Performance-based incentive payments.** Amends § 256B.441, by adding subd. 46d. Moves the performance-based incentive payment language from § 256B.434, subdivision 4, paragraph (d), to this new subdivision and specifies that these payments are included in the external fixed payment rate.

26 **Calculation of care-related per diems.** Amends § 256B.441, subd. 48. Removes language listing the items included in the other operating per diem (this language is moved to subd. 30).

27 **Determination of total care-related limit.** Amends § 256B.441, subd. 50. Describes the formula used to calculate the limit on a facility's reimbursement for care-related costs. The commissioner must calculate a facility's care-related limit using the facility's quality score and the metro median care related per diem. Facilities with higher quality scores are subject to higher limits. The table below shows example limits for a number of different facility quality scores.

Facility Quality Score	**Care-related Limit** (percent of metro median care-related per diem)
0	89.375%
10	90
25	103.4375
50	117.5
75	131.5625
90	140
100	145.625

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Paragraph (d) specifies that a facility which has costs that exceed its care-related limit shall have its total care-related per diem reduced to its limit.

28 **Determination of other operating price.** Amends § 256B.441, subd. 51. Modifies the existing limit on operating costs. Limits a facility's other operating per diem to 105 percent of the metro median other operating per diem.

29 **Exception for specialized care facilities.** Amends § 256B.441, subd. 51a. Removes the commissioner's authority to negotiate certain increases for nursing facilities that provide specialized care. Beginning January 1, 2016, increases the care-related limit for specialized care facilities by 50 percent. Defines "specialized care facilities."

30 **Special dietary needs.** Amends § 256B.441, by adding subd. 51b. Moves a provision related to special dietary needs from § 256B.431, subd. 2b, paragraph (h), to a new subdivision and removes this amount from allowable raw food per diem costs and includes it in the external fixed per diem rate.

31 **Calculation of payment rate for external fixed costs.** Amends § 256B.441, subd. 53. Modifies the calculation of external fixed costs by removing obsolete language and reordering some of the paragraphs, removing property insurance from external fixed costs, and adding calculations for employer health insurance costs, quality improvement incentive payment rate adjustments, performance-based incentive payments, and special dietary needs.

32 **Determination of total payment rates.** Amends § 256B.441, subd. 54. Removes obsolete language and makes conforming changes.

33 **Alternative to phase-in for publicly owned nursing facilities.** Amends § 256B.441, subd. 55a. Makes conforming changes.

34 **Hold harmless.** Amends § 256B.441, subd. 56. Paragraph (a) removes obsolete language related to the phase-in of the rebased operating payment rates and updates hold harmless language, effective for the rate year beginning January 1, 2016, to specify that no nursing facility will receive an operating payment rate less than its operating payment rate as of December 31, 2015.

Paragraph (b) prohibits facilities from being subject to a care-related payment rate limit reduction greater than 5 percent of the median total care-related per diem for rate years beginning on or after January 1, 2016.

35 **Critical access nursing facilities.** Amends § 256B.441, subd. 63. Suspends the critical access nursing facility program from January 1, 2016, to December 31, 2017.

36 **Nursing facility in Golden Valley.** Amends § 256B.441, by adding subd. 65. Requires the operating payment rate for a specified facility located in Golden Valley to be calculated without the application of the total care-related limit and the determination of the other operating price, effective for the rate year beginning on January 1, 2016.

37 **Nursing facilities in border cities.** Amends § 256B.441, by adding subd. 66. Effective January 1, 2016, increases the operating payment rate for nonprofit nursing facilities in the city of Breckenridge. Nonprofit facilities in Breckenridge will receive an operating payment

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rate that the commissioner will calculate based upon the operating rates received in nonprofit facilities in adjacent cities located in another state.

Exempts facilities from certain nursing facility payment rate limits if the adjustments under this subdivision result in a rate that exceeds those limits. The new operating rate will only apply if it results in a higher operating payment rate than would otherwise be determined.

38 **Nursing facility; contract with insurance provider.** Amends § 256B.441, by adding subd. 67. Allows facilities that don't provide employee health insurance coverage as of May 1, 2015, to be reimbursed for employer health insurance costs if the facility has a signed contract with a health insurance provider beginning January 1, 2016.

39 **Scope.** Amends § 256B.50, subd. 1. Modifies the scope of MA appeals to include allowable costs under the nursing facility payment system. Makes this section effective January 1, 2016, and apply to appeals filed on or after that date.

40 **Monthly rates; exemptions.** Amends § 256I.05, subd. 2. Adds a cross-reference to the current nursing facility payment system in the GRH statute.

41 **Direction to commissioner; nursing facility payment reform report.** By January 1, 2017, requires the commissioner of human services to evaluate and report to the legislature on several items related to nursing facility payment reform including the impact of the quality adjusted care limits and the ability of nursing facilities to attract and retain employees under the new payment system.

42 **Property rate setting.** Requires the commissioner to conduct a study, in consultation with stakeholders and experts, of property rate setting, based on a rental value or other approach for Minnesota nursing facilities and to report to the legislature by March 1, 2016, for a system implementation date of January 1, 2017. Lists actions the commissioner must take, including contracting with at least two firms to conduct appraisals of all nursing facilities in the MA program and using the information from the appraisals to complete the design of a rental value or other system and calculate a replacement value and an effective age for each nursing facility.

43 **Revisor's instruction.** Instructs the Revisor of Statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, Department of Human Services, and stakeholders, to prepare legislation for the 2016 legislative session to recodify laws governing nursing home payments and rates. Makes this section effective the day following final enactment.

44 **Repealer.** Repeals Minnesota Statutes, § 256B.434, subd. 19b (nursing facility rate adjustments beginning October 1, 2015); and § 256B.441, subds. 14a (facility group types), 19 (hospital-attached nursing facility status), 50a (determination of proximity adjustments), 52 (determination of efficiency incentive), 55 (phase-in of rebased operating payment rates), 58 (implementation delay), and 62 (repeal of rebased operating payment rates).

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Article 7: Continuing Care

Overview

This article contains provisions related to background studies, home and community-based service standards, TEFRA parental fees, local and regional dementia grants, MA-EPD, disability waiver rate setting, home and community-based settings, and ABLE accounts.

1 **ABLE accounts and designated beneficiaries.** Amends § 13.461, by adding subd. 32. Specifies how data on ABLE accounts and designated beneficiaries is treated.

2 **Background studies required.** Amends § 144.057, subd. 1. Requires DHS, when conducting background studies of non-Minnesota residents who provide direct-care services in nursing homes, home care agencies, or boarding care homes, to (1) check for substantiated findings of maltreatment in the individual's state of residence whenever the study subject's state of residence makes that information available, and (2) check the national Crime Information Center database.

3 **Correction orders and conditional licenses for programs licensed as home and community-based services.** Amends § 245A.06, by adding subdivision 1a. Paragraph (a) requires the commissioner to limit adverse licensing actions to the service site at which the licensing violations occurred unless the commissioner articulates a basis for applying the adverse action to other sites.

Paragraph (b) provides that if a license holder has been issued more than one license, adverse action must be limited to the license for the program at which the licensing violations occurred if other programs, for which there are separate licenses, are being operated in substantial compliance with law and rules.

4 **Settlement agreement.** Creates § 245A.081. Paragraph (a) allows a license holder or the commissioner to initiate a discussion about a possible settlement agreement related to an adverse licensing action. Provides that if the parties enter into a settlement agreement, then the agreement constitutes a full agreement between the parties. Requires the agreement to identify the actions the license holder has taken or will take to remedy the violation.

Paragraph (b) provides that neither party is required to initiate a settlement discussion.

Paragraph (c) requires the commissioner to respond within 14 days to a settlement request.

Paragraph (d) allows the commissioner to withdraw from settlement agreement negotiations at any time.

5 **Licensed foster care and respite care.** Amends § 245A.155, subd. 1. Clarifies that this section applies to foster care agencies and providers that care for individuals who rely on medical monitoring equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment.

6 **Foster care agency requirements.** Amends § 245A.155, subd. 2. Makes conforming changes.

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7 **Abuse prevention plans.** Amends § 245A.65, subd. 2. Adds language allowing a governing body's delegated representative to review and revise abuse prevention plans.

8 **Background studies conducted by DHS.** Amends § 245C.08, subd. 1. Provides a cross-reference to section 144.057, subdivision 1, thereby requiring DHS to review information from the national Crime Information System when conducting background studies of any non-Minnesota resident who performs direct-care services in a nursing home, home care agency, or boarding care home. This section also permits DHS to inform any entity that initiated a background study of the status of processing the study subject's fingerprints.

9 **Background study; tribal organizations.** Amends § 245C.12. Requires DHS, when it contracts with tribes to conduct background studies for staff working in tribal nursing homes, to obtain criminal history data from the National Criminal Records Repository.

10 **Working day.** Amends § 245D.02, by adding subd. 37. Defines "working day."

11 **Health needs.** Amends § 245D.05, subd. 1. Allows for some flexibility in the timing of when the license holder must notify the person's legal representative and others of changes in the person's physical and mental health needs affecting health service needs assigned to the license holder.

12 **Medication administration.** Amends § 245D.05, subd. 2. Removes language requiring the license holder to obtain annual reauthorization from the person or the person's legal representative to administer medication or treatment.

13 **Incident response and reporting.** Amends § 245D.06, subd. 1. Makes a technical and conforming change.

14 **Environment and safety.** Amends § 245D.06, subd. 2. Removes a requirement that CPR training include in-person instruction.

15 **Permitted actions and procedures.** Amends § 245D.06, subd. 7. Modifies allowable uses of restraint performed by a licensed health care professional.

16 **Service planning requirements for basic support services.** Amends § 245D.07, subd. 2. Clarifies timelines for completing, reviewing, and revising the preliminary coordinated service and support plan addendum.

17 **Service plan review and evaluation.** Amends § 245D.071, subd. 5. Modifies license holder requirements related to providing a written status report prior to a progress review meeting and coordinated service and support plan addendum within ten working days of the meeting. Deems the license holder's submission of the coordinated service and support plan or plan addendum approved under certain circumstances and makes the plan or plan addendum effective until the legal representative or case manager submits a written request to revise the addendum.

18 **Staff qualifications.** Amends § 245D.09, subd. 3. Allows competency in certain areas to be determined through testing or observed skill assessment conducted by the trainer or instructor or by an individual previously deemed competent by the trainer or instructor.

19 **Annual training.** Amends § 245D.09, subd. 5. Exempts direct support staff from annual basic first aid training if the direct support staff has a current first aid certification.

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20 **First aid must be available on site.** Amends § 245D.22, subd. 4. Removes a requirement that CPR training include in-person instruction.

21 **Staff ratio requirement for each person receiving services.** Amends § 245D.31, subd. 3. Removes language requiring certain documentation to be recorded on a standard assessment form required by the commissioner.

22 **Person requiring staff ratio of one to four.** Amends § 245D.31, subd. 4. Modifies the list of criteria a person must meet to be assigned a staff ratio requirement of one to four.

23 **Person requiring staff ratio of one to eight.** Amends § 245D.31, subd. 5. Modifies the list of criteria a person must meet to be assigned a staff ratio requirement of one to eight.

24 **Contribution amount.** Amends § 252.27, subd. 2a. Reduces TEFRA parental fees by 10 percent.

25 **HCBS transitions grants.** Amends § 256.478. Removes the commissioner's authority to transfer funds between the MA account and the HCBS transitions grants account.

26 **Regional and local dementia grants.** Amends § 256.975, by adding subd. 11. Paragraph (a) requires the Minnesota Board on Aging to award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

Paragraph (b) lists the project areas for the regional and local grants.

Paragraph (c) lists the eligible applicants for the regional and local dementia grants.

Paragraph (d) lists the information that must be included in grant applications.

Paragraph (e) lists the priorities the board must consider when awarding grants.

Paragraph (f) requires the board to divide the state into specific geographic regions and allocate a percentage of the money available for the regional and local dementia grants to projects or initiatives aimed at each geographic region.

Paragraph (g) requires the board to award any available grants by January 1, 2016, and each July 1 thereafter.

Paragraph (h) specifies reporting requirements grant recipients must meet.

Paragraph (i) lists the duties of the Minnesota Board on Aging in administering these grants.

Makes this section effective July 1, 2015.

27 **Excess income standard.** Amends § 256B.056, subd. 5c. Effective July 1, 2016, increases the spenddown standard for persons who are aged, blind, or disabled, from 75 to 80 percent of FPG.

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28 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Reduces the MA-EPD premium from $65 to $35 and reduces the amount of unearned income MA-EPD enrollees must pay in addition to the premium from 5 percent to 0.5 percent. Makes this section effective September 1, 2015.

29 **Asset availability.** Amends § 256B.059, subd. 5. Removes language that prohibits under any circumstances a married couple from converting assets to income in order to avoid being subject to the asset limit for the purposes of determining an institutionalized spouse's eligibility for long-term care under medical assistance. This change is required to bring Minnesota into compliance with the 2013 federal *Geston* decision, in which the Eighth Circuit Court held that federal Medicaid law does not permit treating certain income streams as an asset for the purposes of determining Medicaid eligibility for long-term care.

30 **Distribution of funds; partnerships.** Amends § 256B.0916, subd. 2. Requires the commissioner to manage waiver allocations to fully use available waiver appropriations. Makes this section effective the day following final enactment.

31 **Excess spending.** Amends § 256.0916, subd. 11. Modifies county and commissioner duties related to HCBS waiver overspending. Makes this section effective the day following final enactment.

32 **Use of waiver allocations.** Amends § 256B.0916, by adding subd. 12. Specifies county and commissioner duties related to HCBS waiver allocations. Makes this section effective the day following final enactment.

33 **Excess allocations.** Amends § 256B.49, subd. 26. Modifies the provision related to excess allocations of certain MA home and community-based waiver funds.

34 **Use of waiver allocations.** Amends § 256B.49, by adding subd. 27. Modifies county and commissioner duties related to HCBS waivers.

35 **Rate stabilization adjustment.** Amends § 256B.4913, subd. 4a. Modifies the banding period. Prohibits the commissioner from enforcing any rate decrease or increase that would otherwise result from the end of the banding period.

36 **Stakeholder consultation and county training.** Amends § 256B.4913, subd. 5. Requires the commissioner to (1) train county personnel responsible for administering the rate-setting framework and (2) maintain an online instruction manual explaining the rate-setting framework. Prohibits the commissioner from deferring to the county or tribal agency on matters of technical application of the rate-setting framework. Prohibits county and tribal agencies from setting rates in a manner that conflicts with the rate-setting framework.

37 **Definitions.** Amends § 256B.4914, subd. 2. Modifies the definition of "individual staffing."

38 **Payments for residential support services.** Amends § 256B.4914, subd. 6. Removes language requiring the commissioner to establish a Monitoring Technology Review Panel. Makes technical and conforming changes.

39 **Payments for unit-based services with programming.** Amends § 256B.4914, subd. 8. Makes technical and conforming changes.

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40 **Updating payment values and additional information.** Amends § 256B.4914, subd. 10. Clarifies the information the commissioner must gather related to the underlying costs for services provided by a license holder. Modifies the list of items the commissioner must review and evaluate. By January 1, 2016, requires the commissioner to develop a methodology to determine shared staffing levels. Requires individual staffing hours to be used when the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment. Makes this section effective the day following final enactment.

41 **Exceptions.** Amends § 256B.4914, subd. 14. Modifies the process for requesting and determining rate exceptions under the disability waiver rate system.

42 **County or tribal allocations.** Amends § 256B.4914, subd. 15. Modifies the provision related to excess allocations by requiring lead agencies that exceed their waiver allocations to submit a corrective action plan to the commissioner. Under current law, lead agencies that exceed their waiver allocations are responsible for the overspending.

43 **Home and community-based settings for people with disabilities.** Amends § 256B.492. Modifies the settings in which persons receiving services under an MA disability waiver may receive services. Makes this section effective July 1, 2016.

44 **Plan established.** Creates § 256Q.01. Establishes a savings plan known at the Minnesota ABLE plan. States the purposes of this plan are to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life, and to provide secure funding for disability-related expenses on behalf of designated beneficiaries with disabilities that will supplement, but not supplant, other specified benefits.

45 **Citation.** Creates § 256Q.02. Allows this chapter to be cited as the "Minnesota Achieving a Better Life Experience Act."

46 **Definitions.** Creates § 256Q.03.

Subd. 1. Scope. States for the purposes of this section, the terms defined in this section have the meanings given them.

Subd. 2. ABLE account. Defines "ABLE account."

Subd. 3. ABLE plan or plan. Defines "ABLE plan" or "plan."

Subd. 4. Account. Defines "account."

Subd. 5. Account owner. Defines "account owner."

Subd. 6. Annual contribution limit. Defines "annual contribution limit."

Subd. 7. Application. Defines "application."

Subd. 8. Board. Defines "board."

Subd. 9. Commissioner. Defines "commissioner."

Subd. 10. Contribution. Defines "contribution."

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Subd. 11. Department. Defines "department."

Subd. 12. Designated beneficiary or beneficiary. Defines "designated beneficiary" or "beneficiary."

Subd. 13. Earnings. Defines "earnings."

Subd. 14. Eligible individual. Defines "eligible individual."

Subd. 15. Executive director. Defines "executive director."

Subd. 16. Internal Revenue Code. Defines "Internal Revenue Code."

Subd. 17. Investment in the account. Defines "investment in the account."

Subd. 18. Member of the family. Defines "member of the family."

Subd. 19. Participation agreement. Defines "participation agreement."

Subd. 20. Person. Defines "person."

Subd. 21. Plan administrator. Defines "plan administrator."

Subd. 22. Qualified disability expense. Defines "qualified disability expense."

Subd. 23. Qualified distribution. Defines "qualified distribution."

Subd. 24. Rollover distribution. Defines "rollover distribution."

Subd. 25. Total account balance. Defines "total account balance."

47 ABLE plan requirements. Creates § 256Q.04.

Subd. 1. State residency requirement. Requires the designated beneficiary of any ABLE account to be a resident of Minnesota, or the resident of a state that has entered into a contract with Minnesota to provide its residents access to the Minnesota ABLE plan.

Subd. 2. Single account requirement. Limits ABLE accounts to one account per beneficiary, except as permitted under certain IRS regulations.

Subd. 3. Accounts-type plan. Requires the plan to be operated as an accounts-type plan. Requires a separate account to be maintained for each beneficiary for whom contributions are made.

Subd. 4. Contribution and account requirements. Subjects contributions to an ABLE account to certain IRS requirements prohibiting noncash contributions and contributions in excess of the annual contribution limit. Limits the total account balance to the maximum account balance limit under section 529 college savings plans.

Subd. 5. Limited investment direction. Prohibits designated beneficiaries from directing the investment of assets in their accounts more than twice in any calendar year.

Subd. 6. Security for loans. Prohibits an interest in an account from being used as security for a loan.

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48 **ABLE Plan Administration.** Creates § 256Q.05.

Subd. 1. Plan to comply with federal law. Requires the commissioner to ensure that the plan meets the federal requirements for an ABLE account. Allows the commissioner to request a private letter ruling or rulings from the IRS or Secretary of Health and Human Services. Requires the commissioner to take any necessary steps to ensure that the plan qualifies under relevant provisions of federal law.

Subd. 2. Plan rules and procedures. Requires the commissioner to establish the rules, terms, and conditions for the plan, subject to the requirements of this chapter and IRS regulations.

Subd. 3. Consultation with other state agencies; annual fee. Requires the commissioner of human services to consult with the executive director of the State Board of Investment and the commissioner of the Office of Higher Education in designing and establishing the plan's requirements and in negotiating or entering into contracts with third parties. Requires the commissioner and executive director to establish an annual fee, equal to a percentage of the average daily net assets of the plan, to be imposed on account owners to recover the costs of administration, record-keeping, and investment management.

Subd. 4. Administration. Requires the commissioner to administer the plan, including accepting and processing applications, verifying state residency, verifying eligibility, maintaining account records, making payments, and undertaking any other necessary tasks to administer the plan. Requires DHS to adopt rules for the purposes of implementing and administering the plan. Allows DHS to contract with one or more third parties to carry out some or all of these administrative duties, including providing incentives. Allows DHS and the board to jointly contract with third-party providers, if DHS and the board determine that it is desirable to contract with the same entity or entities for administration and investment management.

Subd. 5. Authority to impose fees. Allows the commissioner, or the commissioner's designee, to impose annual fees on account owners to recover the costs of administration. Requires the commissioner to keep the fees as low as possible, consistent with efficient administration, so that the returns on savings invested in the plan are as high as possible.

Subd. 6. Federally mandated reporting. Paragraph (a) requires the commissioner to submit a notice to the Secretary of the Treasury upon the establishment of each ABLE account as required in federal law. Specifies the information that must be included in the notice.

Paragraph (b) requires the commissioner to electronically submit to the Commissioner of Social Security monthly statements on relevant distributions and account balances from all ABLE accounts as required under federal law.

Subd. 7. Data. Paragraph (a) makes data on ABLE accounts and designated beneficiaries of ABLE accounts private data on individuals or nonpublic data under the Government Data Practices statute.

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Paragraph (b) allows the commissioner to share or disseminate data classified as private or nonpublic under certain circumstances.

49 **Plan accounts.** Creates § 256Q.06.

Subd. 1. Contributions to an account. Allows any person to make contributions to an ABLE account on behalf of a beneficiary. States that contributions to an account made by persons other than the account holder become the property of the account owner. Specifies that a person does not acquire an interest in an ABLE account by making contributions to an account. Requires contributions to be made in cash, by check, or other commercially acceptable means, as permitted by the IRS and approved by the plan administrator in cooperation with the commissioner and the board.

Subd. 2. Contribution and account limitations. Subjects contributions to an ABLE account to certain IRS requirements. Prohibits the maximum balance of an ABLE account from exceeding the limit imposed under the Minnesota section 529 college savings plan. Requires any portion of a contribution to an account to be rejected if the contribution exceeds the annual contribution limit or would cause the total account balance to exceed the maximum account balance limit.

Subd. 3. Authority of account owner. Specifies the authority the account owner has over the account.

Subd. 4. Effect of plan changes on participation agreement. States that amendments to this statute automatically amend the participation agreement and any amendments to the operating procedures and policies of the plan automatically amend the participation agreement after adoption by DHS or the board.

Subd. 5. Special account to hold plan assets in trust. States that all assets of the plan, including contributions to accounts, are held in trust for the exclusive benefit of account owners. Requires assets to be held in a separate account in the state treasury to be known as the Minnesota ABLE plan account or in accounts with the third-party provider. States that plan assets are not subject to claims by creditors of the state, are not part of the general fund, and are not subject to appropriation by the state. Requires payments from the Minnesota ABLE plan account to be made under this chapter.

50 **Investment of ABLE Accounts.** Creates § 256Q.07.

Subd. 1. State Board of Investment to invest. Requires the State Board of Investment to invest the money deposited in accounts in the plan.

Subd. 2. Permitted investments. Allows the board to invest the accounts in any permitted investment under certain retirement plans, with certain exceptions.

Subd. 3. Contracting authority. Allows the board to contract with one or more third parties for investment management, record-keeping, or other services in connection with investing the accounts. Allows the board and DHS to jointly contract with third-party providers, if the commissioner and board determine that it is desirable to contract with the same entity or entities for administration and investment management.

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51 **Account Distributions.** Creates § 256Q.08.

Subd. 1. Qualified distribution methods. Specifies how qualified distributions may be made.

Subd. 2. Distributions upon death of a beneficiary. Requires the amount remaining in the beneficiary's account to be distributed pursuant to IRS regulations upon the death of a beneficiary.

Subd. 3. Nonqualified distribution. Allows an account owner to request a nonqualified distribution from an account at any time. Specifies the manner in which nonqualified distributions must be withdrawn. Subjects the earnings portion of a nonqualified distribution to a federal additional tax pursuant to IRS regulations. Defines "earnings portion" for purposes of this subdivision.

52 **Individual Providers of Direct Support Services.** Ratifies the direct support services contract between SEIU Healthcare Minnesota and the state of Minnesota. Makes this section effective July 1, 2015.

53 **Rate increase for direct support services providers workforce negotiations.** Increases the reimbursement rate by 1.53 percent on July 1, 2015, and by an additional 0.2 percent on July 1, 2016, for direct support services provided through a covered program if the legislature ratifies the contract negotiated between the state and SEIU Healthcare Minnesota. Covered programs include PCA Choice, Consumer-Directed Community Supports, home and community-based waivered services, alternative care, consumer support grant, and Community First Services and Supports.

54 **Consumer-directed community supports budget methodology exception.** Directs the commissioner of human services to submit an amendment to the federal Centers for Medicare and Medicaid Services for the HCBS waivers to establish an exception to the CDCS budget methodology for certain participants. Makes the exception under this section effective October 1, 2015, or upon federal approval, whichever is later. Requires the commissioner to notify the revisor of statutes when this occurs.

55 **Home and community-based services incentive pool.** Requires the commissioner to (1) develop an initiative to provide incentives for innovation in achieving integrated competitive employment, living in the most integrated setting, and other outcomes determined by the commissioner; and (2) seek requests for proposals and contract with one or more entities to provide incentive payments for meeting identified outcomes. Requires the initial requests for proposals to be issued by October 1, 2016.

56 **Direction to commissioner; reports required.** Directs the commissioner to develop and submit reports to the legislature on the implementation of certain disability waiver overspending provisions by February 15, 2018, and February 15, 2019.

57 **Instructions to the commissioner.** Requires the commissioner to determine the number of people who were determined ineligible for CFSS because they did not require constant supervision and cuing in order to accomplish activities of daily living. Instructs the commissioner to issue a report with the findings to the legislature.

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58 **Repealer.** Repeals Laws 2012, ch. 247, art. 4, § 47, as amended by Laws 2014, ch. 312, art. 27, § 72, (commissioner to seek amendment exception to consumer-directed community supports budget methodology) upon the effective date of section 54.

Article 8: Health Department and Public Health

1 **Transfers.** Amends § 16A.724, subdivision 2. Strikes the transfer from the health care access fund to the medical education and research costs fund that currently occurs if resources in the health care access fund exceed expenditures.

2 **Health Information Exchange.** Amends § 62J.498. Updates definitions and specifies that portions of the application for certification classified as public data shall be made available to the public for at least ten days while an application is under consideration and upon the request of the commissioner. At the request of the commissioner, the applicant must participate in a public hearing by presenting an overview of the application and responding to questions from the public.

3 **Certificate of authority to provide health information exchange services.** Amends § 62J.4981. Modifies the certificate of authority requirements for health data intermediaries and health information organizations.

4 **Coordination.** Amends § 62J.4982, subdivision 4. Removes obsolete language relating to a report the commissioner completed in 2011.

5 **Fees and monetary penalties.** Amends § 62J.4982, subdivision 5. Reduces fees paid by health information exchange service providers and specifies the fees shall be deposited in the state government special revenue fund.

6 **Distribution of funds.** Amends § 62J.692, subdivision 4. Strikes the $1,000,000 from the health care access fund for grants to family medicine residency programs.

7 **Definitions.** Amends § 62Q.37, subdivision 2. Adds the Accreditation Association for Ambulatory Health Care (AAAHC) to the list of nationally recognized independent organizations for purposes of audits conducted by the commissioner of commerce on certain health plan companies. Under current law, if the audit has been conducted by a nationally recognized independent organization and meets certain standards, the commissioner shall accept the audit in lieu of conducting the commissioner's own audit.

8 **Restricted uses of the all-payer claims data.** Amends § 62U.04, subdivision 11. Allows the Commissioner of Health to compile public use files of summary data or tables from the all-payer claims data submitted under section 62U.04 (encounter data and pricing data) that (1) are available to the public by March 1, 2016, at no or at a minimal cost and available by web-based electronic data download by June 30, 2019; (2) do not identify individual patients, providers, or payers; (3) are updated by the commissioner at least annually with the most current data available; (4) contain clear and conspicuous explanations of the characteristics of the data; and (5) not lead to the collection of additional data elements beyond what is authorized as of June 30, 2015. This section also requires the commissioner to consult with the all-payer claims database work group when creating these public use summary files.

Section

9 **Projected spending baseline.** Amends § 62U10 by adding subdivision 6. Requires the commissioner to submit a yearly report, beginning February 15, 2016, on the project impact on spending from specified health indicated related to a list of preventable illnesses and death.

10 **Outcomes reporting; savings determination.** Amends § 62U.10 by adding subdivision 7. Requires the commissioner to annually determine, beginning November 1, 2016, the actual total private and public health care and long-term care spending for health indicators project in section 9 of this article.

11 **Transfers.** Amends § 62U.10 by adding subdivision 8. Requires the commissioner to annually notify the commissioner of management and budget if savings under section 10 of this article meet or exceed $50,000,000 for all health indicators in aggregate statewide. Requires the commissioner of MMB to transfer that savings from the general fund to the health care access fund.

12 **Definitions.** Amends § 144.1501, subdivision 1. Adds definitions for advanced dental therapists, dental therapists, mental health professionals, and public health nurses.

13 **Creation of account.** Amends § 144.1501, subdivision 2. Adds mental health professional to the loan forgiveness program if they work in a designated rural area or other specified areas. Adds advanced dental therapists, dental therapists, and public health nurses to the loan forgiveness program if they work in a designated rural area. Extends the loan forgiveness program to nurses who agree to practice in a hospital that owns or operates a nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home.

14 **Eligibility.** Amends § 144.1501, subdivision 3. Extends the loan forgiveness program to eligible practitioners who are in training or education to become an eligible practitioner and adds the list of practitioners for which definitions were added under section 12 of this article.

15 **Loan forgiveness.** Amends § 144.1501, subdivision 4. Requires the commissioner to give preference to loan forgiveness applications who document diverse cultural competencies.

16 **Primary care residency expansion grant program.** Adds § 144.1506.

Subd. 1. Defines terms.

Subd. 2. Expansion grant program. (a) Requires the commissioner of health to award primary care residency expansion grants to eligible programs to plan and implement new residency slots. Caps grant amount for certain activities.

(b) Lists what the grant funds may be used for, including, but not limited to, planning related to establishing an accredited primary care residency program, recruitment, and training site improvements.

Subd. 3. Applications for expansion grants. States requirements for the grant applications for eligible applicants.

Subd. 4. Consideration of expansion grant applications. Requires the commissioner to review each application and requires specific awards for certain practices.

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Subd. 5. Program oversight. Allows the commissioner to require grantees to submit information during the grant period for evaluation of the program.

17 **International medical graduates assistance program.** Adds § 144.1911.

Subd. 1. Establishment. Establishes the international medical graduates assistance program.

Subd. 2. Definitions. Defines terms.

Subd. 3. Program administration. Requires the commissioner to, among other things, coordinate integration of qualified immigrant international medical graduates into the Minnesota health care system, develop a system to assess and certify the clinical readiness of those graduates, and study and submit a report on changes necessary to ensure full utilization of those graduates by January 15, 2017.

Subd. 4. Career guidance and support services. Requires the commissioner to award grants to eligible nonprofit organizations to provide career guidance to international medical graduates and specifies eligible grant activities.

Subd. 5. Clinical preparation. Requires the commissioner to award grants to support clinical preparation for international medical graduates and specifies grant program requirements.

Subd. 6. International medical graduate primary care residency grant program and revolving account. Requires the commissioner to award grants to support primary care residency positions for immigrant physicians willing to serve in rural or underserved areas of the state and specifies grant requirements.

Subd. 7. Voluntary hospital program. Permits a hospital to establish residency programs for foreign trained physicians to become candidates for licensure to practice medicine in Minnesota.

Subd. 8. Board of Medical Practice. States that this section do not alter the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. Consultation with stakeholders. Requires the commissioner to administer the international graduates assistance program in consultation with specified stakeholders.

Subd. 10. Report. Requires the commissioner to submit and annual report to the legislature on the progress of the integration of international medical graduates into the Minnesota health care delivery system.

18 **Definitions.** Amends § 144.291, subdivision 2. Adds a definition of patient information service to the Health Records Act.

19 **Exceptions to consent requirement.** Amends § 144.293, subdivision 5. Permits a provider to release a deceased patient's health care records to another provider for the purposes of diagnosing or treating the deceased patient's surviving adult child.

Effective date. This section is effective the day following final enactment.

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20 **Record locator or patient information service.** Amends § 144.293, subdivision 8. Adds "patient information service" to allowable release of information and exclusions of information for record locator services.

21 **Liability of provider or other person.** Amends § 144.298, subdivision 2. Adds "patient information service" to liability that exists for record locator services.

22 **Liability for record locator or patient information service.** Amends § 144.298, subdivision 3. Adds "patient information service" to liability that exists for record locator services.

23 **Early dental prevention initiative.** Adds § 144.3875. Requires the commissioner of health, in collaboration with the commissioner of human services, to implement a statewide initiate to increase awareness among communities of color and recent immigrants on the importance of early dental intervention for infants and toddlers. Requires the commissioner to, among other things, develop educational materials, develop a distribution plan, and work with stakeholders.

24 **Minnesota radon licensing act.** Adds § 144.4961.

Subd. 1. Citation. Provides this section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. Definitions. Defines terms.

Subd. 3. Rulemaking. Requires the commissioner of health to adopt rules for licensure related to indoor radon in dwellings and other buildings.

Subd. 4. System tag. Requires any radon mitigation system installed in Minnesota on or after October 1, 2017 to have a radon mitigation system tag provided by the commissioner.

Subd. 5. License required annually. Requires an annual license for any person, firm, or corporation that sells devices or performs services for compensation to detect the presence of radon.

Subd. 6. Exemptions. Provides an exemption to the requirements of this section for newly constructed Minnesota homes that installed a radon system prior to the issuance of a certificate of occupancy.

Subd. 7. License applications and other reports. Requires the entities listed in subdivision 8 to submit applications for licenses, system tags, and other reporting required by the commissioner.

Subd. 8. Licensing fees. Describes the type of license and the fees to be charged for each type of license.

Subd. 9. Enforcement. Requires the commissioner to enforce this section.

Effective date. States this section is effective July 1, 2015, except subdivision 4 and 5, which are effective October 1, 2017.

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25 **Violence against health care workers.** Adds § 144.566.

Subd. 1. Definitions. Defines terms.

Subd. 2. Hospital duties. Requires hospitals to design and implement preparedness and incident response action plans to acts of violence by January 15, 2016 and conduct an annual review. Requires the hospital to designate a committee to develop the plan and provide training to all health care workers employed or contracted with the hospital. Also requires the hospital to make the plans available to law enforcement and prohibits a hospital from interfering or discouraging a health care worker from contacting law enforcement. Allows the commissioner to impose an administrative fine for noncompliance.

26 **Requirements for certain notices and discharge planning.** Adds § 144.586.

Subd. 1. Observation stay notice. (a) Requires a hospital to provide oral and written notice to every patient placed in observation status about the placement not later than 24 hours after the placement. Requires the notice to include, among other things, a recommendation that the patient contact certain persons.

(b) Requires the hospital to document the date of the notice in the patient's record.

Subd. 2. Postacute care discharge planning. Requires a hospital to comply with federal hospital requirements for discharge planning and lists federal requirements. Federal requirements include, but are not limited to, conducting a discharge planning evaluation and a list of Medicare eligible home care agencies or skilled nursing facilities. Requires the hospital to document in the patient's record that the list was presented to the patient.

27 **Certified lead firm.** Amends § 144.9501, subdivision 6d. Amends the definition of certified lead firm.

28 **Certified renovation firm.** Amends § 144.9501, by adding subdivision 6e. Adds a definition for certified renovation firm.

29 **Lead sampling technician.** Amends § 144.9501, subdivision 22b. Amends the definition for lead sampling technician by removing the requirement that the technician be registered with the commissioner under section 144.9505.

Effective date. The effective date for this section is July 1, 2016.

30 **Renovation.** Amends § 144.9501, subdivision 26b. Amends the definition of renovation.

Effective date. The effective date for this section is July 1, 2016.

31 **Lead renovator.** Amends § 144.9501 by adding subdivision 26c. Adds a definition of lead renovator.

Effective date. The effective date for this section is July 1, 2016.

32 **Credentialing of lead firms and professionals.** Amends § 144.9505. Modifies the credentialing requirements for lead firms and professionals. Requires, among other things, that lead renovation firms be licensed by the commissioner, that certain firms employing persons performing work requiring credentials obtain certifications from the commissioner,

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and that persons performing training for lead renovation work receive a permit from the commissioner.

Effective date. The effective date for this section is July 1, 2016.

33 **Rules.** Amends § 144.9508. States that notwithstanding sections 14.125 and 14.128, the authority of the commissioner to adopt rules relating to lead standards does not expire.

Effective date. This section is effective the day following final enactment.

34 **Life-saving allergy medication.** Adds § 144.999.

Subd. 1. Definitions. Defines terms, including authorized entity.

Subd. 2. Commissioner duties. Allows the commissioner to identify additional categories of entities or organizations where individuals may come in contact with allergens capable of causing anaphylaxis.

Subd. 3. Obtaining and storing epinephrine auto-injectors. Allows authorized entities to obtain, possess, and use epinephrine auto-injectors. Requires the auto-injectors to be stored in a specific manner and obtained from a pharmacy or manufacturer after an authorized person of the entity shows certification of having completed training. Allows administration of epinephrine if, in good faith, it is believed the individual is experiencing anaphylaxis, even if that individual does not have a prescription.

Subd. 4. Use of epinephrine auto-injectors. Permits any owner, manager, employee, or agent of an authorized entity who has completed the training program to either provide an epinephrine auto-injector to an individual, or the individual's parent, legal guardian or caretaker, or administer an epinephrine auto-injector to the individual if the employee or agent believes in good faith the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy. Specifies that an authorized entity is not required to maintain a stock of epinephrine auto-injectors.

Subd. 5. Training. (a) Requires an employee or agent of an authorized entity to complete a training program every two years that is either nationally recognized or has been approved by the commissioner. The training must include how to recognize signs and symptoms of allergic reactions, standards and procedures for storage and administration of auto-injectors, and emergency follow-up procedures.

(b) Requires the training entity to issue a certificate to a person who successfully completes the training.

Subd. 6. Good Samaritan protections. States that an authorized entity that possesses and makes available auto-injectors and its employees, a pharmacy, or a manufacturer that dispenses auto-injectors to an authorized entity, or a training entity, is considered "emergency care, advice, or assistance" under section 604A.01 (Good Samaritan Law).

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35 **Supplemental nursing services agency.** Amends § 144A.70, subdivision 6. Includes hiring or temporarily contracting with other licensed health professionals in the definition of supplemental nursing services agency.

36 **Oversight.** Amends § 144.70 by adding subdivision 7. States that the commissioner of health is responsible for the oversight of supplemental nursing services and states how the oversight is to be conducted.

37 **Supplemental nursing services agency registration.** Amends § 144A.71. Specifies the fees to be collected by the commissioner to register a supplemental nursing services agency and specifies that the fees must be collected annually and deposited in the state government special revenue fund.

38 **Registration requirements; penalties.** Amends § 144A.72. Requires nursing services agencies to retain all records for five calendar years and, in order to retain registration, must provide services to a health care facility during the year preceding the supplemental nursing services agency's registration renewal date. Modifies hearing requirements for revocation of an agency's registration.

39 **Complaint system.** Amends § 144A.73. Requires that complaints against a supplemental nursing services agency be investigated by the Office of Health Facility Complaints.

40 **Residential hospice facility.** Amends § 144A.75, subdivision 13. Modifies the definition of residential hospice facility to also include a facility that:

(1) directly provides 24-hour residential and support services for hospital patients;

(2) houses no more than 21 hospice patients;

(3) meets federal hospice certification regulations; and

(4) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a 40-bed non-Medicare certified nursing home as of January 1, 2015.

Effective date. This section is effective the day following final enactment.

41 **Direct-care staff.** Amends § 144D.01 by adding subdivision 3a. Defines direct-care staff for purposes of the housing with services chapter.

42 **Enforcement of dementia care training requirements.** Adds § 144D.066.

Subd. 1. Enforcement. Requires the commissioner of health to enforce dementia care training standards for staff working in housing with services settings and for housing managers and specifies the training requirements.

Subd. 2. Fines for noncompliance. Allows the commissioner to impose a fine for every staff person who is required to obtain training that does not have proper certification, beginning January 1, 2017. Requires the housing with services registrant and home care provider to allow the required training as part of employee and staff duties.

Subd. 3. Technical assistance. Requires the commissioner to provide technical assistance instead of imposing fines for noncompliance between January 1, 2016 and December 31, 2016.

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43 **Forms.** Amends § 145.4131, subdivision 1. Adds to the list of required information on form provided to the commissioner of health by an abortion provider. Addition includes whether the abortion resulted in a born alive infant, medical actions taken to preserve the life of the born alive infant, whether the born alive infant survived, and the status, if known, of the born alive infant if the infant did survive.

44 **Abortion; live births.** Amends § 145.423 by making conforming changes and adding subdivisions 4 to 8.

Subd. 1. Recognition; medical care. Makes conforming changes to "born alive infant." The law as written requires all reasonable measures be taken to preserve the life and health of a child born alive as a result of an abortion.

Subd. 2. Physician required. Makes conforming changes to "born alive infant." The law as written requires a physician, other than the physician performing the abortion, to be immediately accessible when an abortion is being performed after the twentieth week of pregnancy in order to take appropriate measures to preserve the life and health of a born alive infant.

Subd. 3. Death. Makes conforming changes to "born alive infant." The law as written requires certain procedures for disposal of a body of a born alive child who has died.

Subd. 4. Definition of born alive infant. (a) States that any infant human who is born alive at any stage of development must be included in the determination of any Minnesota law or ruling with the words "person," "human being," "child," and "individual."

(b) States that "born alive" means, regardless of how the human was extracted or whether the umbilical cord has been cut, any human who (1) breathes, (2) has a beating heart, (3) has pulsation of the umbilical cord, or (4) has definite movement of voluntary muscles.

(c) Prohibits anything in this section from being construed to affirm, deny, expand, or contract any legal status or legal right to a human prior to being born alive.

Subd. 5. Civil and disciplinary actions. (a) Creates a cause of action against the abortion provider by the person upon whom an abortion was performed, or the parent or guardian of the mother if the mother is a minor, for death of or injury to a born alive infant if the death or injury was caused by simple negligence, gross negligence, wantonness, willfulness, intentional conduct, or another violation of the legal standard of care.

(b) Allows suspension or revocation of a medical personnel's professional license if that person does not take all reasonable measures to preserve the life and health of a born alive infant as required by subdivision 1. Requires an automatic suspension of a person's medical license for one year if the person performed an abortion and had judgment rendered against them under paragraph (a) and states reinstatement requirements.

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(c) Prohibits this section from being construed to create a cause of action against the mother of a born alive infant, civilly or criminally, for the actions of medical personnel in violation of this section for which she did not give her consent.

Subd. 6. Protection of privacy in court proceedings. Requires a court to rule if the anonymity of any female upon whom an abortion was performed or attempted should be preserved from the public if the female does not consent to disclosure. Provides requirements for the court if the court determines anonymity should be preserved. Requires any person who is not a public official to use a pseudonym if bringing an action under subdivision 5 if there is no written consent from the female upon whom the abortion was performed or attempted.

Subd. 7. Status of born alive infant. States that a born alive infant will be an abandoned ward of the state and the parents will have no parental rights unless the abortion was performed to save the life of the woman or fetus or unless one or both parents agree within 30 days of birth to accept the parental rights and responsibilities for the child.

Subd. 8. Severability. Allows for severability of any one or more provisions of this section if any part is found to be unconstitutional.

Subd. 9. Short title. States this act may be cited as the "Born Alive Infants Protection Act."

45 **Reports.** Amends § 145.928, subdivision 13. Requires the commissioner of health to submit an annual report to the legislature on grants made to decrease racial and ethnic disparities in infant mortality rates. States specifications for the report and requires the first report be issued by January 15, 2016.

46 **Promising strategies.** Amends § 145.928 by adding subdivision 15. Requires the commissioner when considering grant applications for health disparities grants to give equal weight to a promising strategy as given to a research or evidence-based strategy.

47 **Grants to local communities.** Amends § 145.986, subdivision 1a. Requires the commissioner, beginning November 1, 2015, to offer grant recipients the option of using a grant to implement health improvement strategies that improve the health status, delay the expression of dementia, or slow the progression of dementia. States requirements for the grants.

48 **Outcomes.** Amends § 145.986, subdivision 2. Requires the commissioner, for grants awarded on or after July 1, 2016, to identify the geographic area targeted, the policy, systems, or environmental strategy used, and the selected outcomes and evaluation measures for the grant.

49 **Evaluation.** Amends § 145.986, subdivision 4. Adds information on the impact on the health indicators listed in section 62U.10, subdivision 6 to the information used by the commissioner to conduct a biennial evaluation of the statewide health improvement program funded under this section.

50 **Funding formula for community health boards.** Amends § 145A.131. Provides an increase in the local public health grant for community health boards that are all or a portion is located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti,

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Ramsey, Scott, Sherburne, Washington, and Wright equal to ten percent of the grant award to the community health board. The amount distributed shall be adjusted each year based on available funding and the number of eligible community health boards.

51 **Examinations.** Amends § 149A.20, subdivision 5. Requires an individual who did not obtain a passing score for mortuary science to wait two weeks before retaking the examination.

52 **Internship.** Amends § 149A.20, subdivision 6. Requires that an internship in mortuary science must, at a minimum, be 2,080 hours completed within a three-year period, and that the commissioner may waive up to 520 hours upon the satisfactory completion of a clinical or practicum in mortuary science through a program approved by the commissioner. Requires an intern to complete 25 case reports in the areas of embalming arrangements and services. Requires case reports be completed by the intern and filed with the commissioner before completion of the internship.

53 **Continuing education.** Amends § 149A.40. Requires the commissioner to require 15 hours of continuing educations house for renewal of a license to practice mortuary science and specifies what those hours must include.

54 **Fees.** Amends § 149A.65. Increases the fees relating to mortuary science.

55 **Establishment update.** Amends § 149A.92, subdivision 1. Allows funeral establishments that use one preparation and embalming room for all establishments to bring the other establishment locations not used for those purposes into compliance with this section by July 1, 2017.

56 **Reports to commissioner.** Amends § 149A.97, subdivision 7. Allows the commissioner to require a funeral provider reporting preneed rust accounts to arrange for and pay an independent third-party auditing firm to complete an audit of the trust account every other year. Requires the funeral provider to report the findings of the audit to the commissioner in additional to the annual report.

57 **Lodging establishment.** Amends § 157.15, subdivision 8. Adds a second definition to be included as a lodging establishment. The definition includes a building, structure, or enclosure located within ten miles distance from a hospital or medical center and is used or held out to be a place where exclusively patients, their families, and caregivers can sleep while the patient is receiving treatment for periods of one week or more. Specifically excludes places providing health or home care services.

Effective date. States this section is effective the day following final enactment.

58 **Working group on violence against Asian women and children.** Requires the commissioner of health to create a multidisciplinary working group to address violence against Asian women and children by July 1, 2015 and specifies the membership of the working group, the duties of the group, and group management. Provides that the group sunsets the day after the Council on Asian-Pacific Minnesotans submits the report required under this section.

Effective date. This section is effective the day following final enactment.

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59 **Health equity grants.** Requires the commissioner to consider applicants who present evidence of a promising strategy to accomplish the applicant's objective for grants awarded under Laws 2014, chapter 312, article 30, section 3, subdivision 2. States a promising strategy must be given the same weight as research or evidence-based strategies.

Article 9: Health Care Delivery

1 **Short title.** Adds § 62A.67. States that sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

Effective date. This section is effective January 1, 2016.

2 **Definitions.** Adds § 62A. 671. Defines terms for the Minnesota Telemedicine Act.

Effective date. This section is effective January 1, 2016.

3 **Coverage of telemedicine services.** Adds § 62A.672.

Subd. 1. Coverage of telemedicine services. (a) Requires health plans to cover telemedicine benefits in the same manner as any other benefits covered under the plan.

(b) States that this section shall not be construed to (1) requires a health carrier to provide coverage for services that are not medically necessary; (2) prohibit a health carrier from establishing criteria that a health care provider must meet for the delivery of telemedicine, so long as the criteria is not unduly burdensome or unreasonable; or (3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices, so long as they are not unduly burdensome or unreasonable.

Subd. 2. Parity between telemedicine and in-person services. Prohibits a health carrier from excluding a service for coverage solely because the service is provided via telemedicine and not provided through in-person consultation or contact.

Subd. 3. Reimbursement for telemedicine services. Requires the health carrier to reimburse the distant site provider for services delivered via telemedicine on the same basis and at the same rate as would apply to the services, consultation, or contacts if provided in person. Permits the health carrier to require a deductible, co-payment, or coinsurance for services provided by telemedicine so long as the deductible, co-payment, or coinsurance does not exceed the deductible, co-payment, or coinsurance applicable if the service is provided through in-person contact.

Effective date. This section is effective January 1, 2016.

4 **Development.** Amends § 62U.02, subdivision 1. Requires the commissioner of health, starting January 1, 2016, to stratify quality measures by race, ethnicity, preferred language, and country of origin. Allows the commissioner to require measures be stratified by other sociodemographic factors on or after January 1, 2018, and provides guidance for the determination of those factors.

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5 **Quality incentive payments.** Amends § 62U.02, subdivision 2. Adds risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors to the list of variations a payment system must adjust for, to the extent possible, to reduce incentives to health care providers to avoid high-risk patients.

6 **Quality transparency.** Amends § 62U.02, subdivision 3. Requires the risk adjustment system to adjust for patient characteristics established under section 4 of this article beginning July 1, 2017.

7 **Contracting.** Amends § 62U.02, subdivision 4. Includes providers serving high concentrations of patients and communities impacted by health disparities in the group that the commissioner may contract with to complete tasks.

8 **Community medical response emergency medical technician.** Amends § 144E.001 by adding subdivision 5h. Adds a definition of community medical response emergency technician, or CEMT.

9 **Definition.** Amends § 144E.275, subdivision 1. Adds that medical response units may also provide CEMT services as permitted under section 10 of this article.

10 **Community medical response emergency medical technician.** Amends § 144E.275 by adding subdivision 7. . (a) States eligibility to be certified as a CEMT, including, but not limited to, current certification as an EMT or AEMT, two years of service as an EMT or AEMT, and successful completion of a CEMT training program.

(b) Requires a CEMT to practice in accordance with standards established by the medical response unit medical director.

(c) Allows a CEMT to provide services approved by the medical response unit medical director.

(d) Limits when a CEMT may provide episodic individual patient education and prevention education and states limitations.

(e) Subjects a CEMT to the same certification, disciplinary, complaint, and other regulations as applied to EMTs.

(f) Prohibits a CEMT from providing services defined in section 144A.471, subdivision 6 and 7 (basic and comprehensive home care) with limited exceptions.

11 **Definitions.** Amends § 151.58, subdivision 2. Includes a boarding care home that provides centralized storage of medications in the definition of "health care facility," for purposes of the use of automated drug distribution systems.

12 **Operation of automated drug distribution systems.** Amends § 151.58, subdivision 5. Provides an exemption from the requirement that a pharmacist employed by and working at the managing pharmacy certify the accuracy of the filling of any cassettes, canisters, or containers of drugs that will be loaded into the automated drug distribution system. This requirement would not apply if the filled cassettes, canisters, or containers have been provided by a repackager registered with the FDA, and licensed by the board as a manufacturer.

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13 **Telemedicine services.** Amends § 256B.0625, subdivision 3b. (a) States that medical assistance covers medically necessary services provided via telemedicine in the same manner as in-person.

(b) Requires the commissioner of human services to establish a criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine and states what the attestation may include.

(c) Requires providers to document each occurrence of services provided by telemedicine as a condition of payment and statement documentation requirements.

(d) Requires the commissioner to make a facility fee payment to the originating site equal to the amount of the originating site fee paid by Medicare. Prohibits a facility fee from being paid to a health care provider that is being paid under a cost-based methodology or if Medicare has already paid the facility fee.

(e) Cross-references other sections for definitions.

Effective date. This section is effective January 1, 2016.

14 **Drugs.** Amends § 256B.0625, subdivision 13. Modifies the procedure used to calculate the number of dosage units of an over-the-counter medication that can be dispensed under MA. Current law requires this quantity to be the lowest of the number of dosage units in the manufacturer's original package or the number dosage units required to complete the patient's course of therapy. This section adds to this list the number of dosage units dispensed from a system using retrospective billing.

Effective date. This section is effective January 1, 2016, or upon federal approval, whichever is later.

15 **Payment rates.** Amends § 256B.0625, subdivision 13e. The amendment to paragraph (a) specifies the pharmacy dispensing fee for over-the-counter drugs that applies when a retrospectively billing pharmacy bills for quantities less than the number of units in the manufacturer's original package.

A new paragraph (b) allows pharmacies dispensing prescriptions to residents of long-term care facilities, that use an automated drug distribution system, or a packaging system that meets the standards in rule that allow drugs to be returned, to use retrospective billing. Requires claims to be submitted only for the quantity of medication used during a defined billing period, and requires a retrospectively billing pharmacy to use a billing period not less than one calendar month or 30 days.

The amendment to paragraph (c) exempts pharmacies that use a packaging system that allows drugs to be returned from the requirement to credit DHS for the acquisition cost of all unused drugs, if that pharmacy uses retrospective billing.

Effective date. This section is effective January 1, 2016, or upon federal approval, whichever is later.

16 **Performance reporting and quality improvement system.** Amends § 256B.072. Requires that the measures used in the performance reporting system established by the Commissioner of Human Services for health care providers who provide services to public program

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recipients must be stratified by race, ethnicity, preferred language, and country of origin and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

17 **Proposal for child protection focused "community medical response emergency medical technician" (CEMT) model.** Requires the commissioner to develop a proposal for a pilot program to coordinate services between child protective services and CEMTs.

18 **Community medical response emergency medical technician services covered under the medical assistance program.** (a) Requires the commissioner of human services, in consultation with other specified persons, to determine services and payment rates for CEMTs to be covered by medical assistance.

(b) Requires payment for services provided by a CEMT to meet certain conditions, including, but not limited to, having been part of a patient care plan and billed by an eligible medical assistance enrolled provider.

(c) Requires the commissioner of human services to submit the list of services to certain members of the legislature by February 15, 2016. States that no services will be covered until legislation providing coverage is enacted.

19 **Evaluation of community medical response emergency medical technician services.** Requires the commissioner of human services, if medical assistance coverage legislation is enacted, to evaluate the effect on medical assistance and MinnesotaCare and reporting findings to certain members of the legislature by December 1, 2017.

Article 10: Health Licensing Boards

Overview

This article amends the optometry, pharmacy, and social work practice acts. It modifies licensing fees for dental professionals, optometrists, pharmacy professionals, and social workers.

1 **Board of optometry.** Amends § 148.52. Clarifies that optometrists who are appointed to the board must be licensed in Minnesota.

2 **Board; seal.** Amends § 148.54. Adds the offices of vice president and secretary to the board.

3 **Examination.** Amends § 148.57, subd. 1. Strikes the $87 application fee and creates a cross-reference to section 148.59, the section in which all fees are listed.

4 **Endorsement.** Amends § 148.57, subd. 2. Strikes the $87 application fee and creates a cross-reference to section 148.59, the section in which all fees are listed.

5 **Change of address.** Amends § 148.57, by adding subd. 5. Requires a regulated person to maintain a current name and address with the board and notify the board in writing within 30 days of any change. Requires a regulated person to request revised credentials from the board when the person has a name change. Establishes requirements for reissuance of lost, stolen, or destroyed credentials.

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6 **Prohibitions relating to legend drugs.** Amends § 148.574. Strikes references to sections repealed in this article.

7 **Requirements defined.** Amends § 148.575, subd. 2. Strikes obsolete language related to board certification for use of legend drugs since the use of legend drugs is now part of the curriculum in optometric training.

8 **Standard of care.** Amends § 148.577. Strikes reference to a section repealed in this article.

9 **License renewal; license registration fees.** Amends § 148.59. Establishes fees. Provides that fees may not exceed the listed amounts, but may be adjusted lower by the board.

10 **Grounds for disciplinary action.** Amends § 148.603. Establishes the conduct that may be the basis for disciplinary action.

11 **Reporting obligations.** Creates § 148.604.

Subd. 1. Permission to report. Allows any person to report conduct constituting grounds for discipline to the board.

Subd. 2. Institutions. Requires health care institutions and organizations to notify the board if the entity has taken action to revoke, suspend, restrict, or condition the optometrists practice privileges. Requires the institutions or organizations to notify the board if an optometrist has resigned prior to the conclusion of disciplinary proceedings.

Subd. 3. Licensed professionals. Requires licensed optometrists to report conduct constituting grounds for disciplinary action to the board.

Subd. 4. Self-reporting. Requires an optometrist to report to the board any personal conduct that constitutes grounds for disciplinary action.

Subd. 5. Deadlines; forms; rulemaking. Requires reports to be made to the board within 30 days after occurrence of the reportable event. Allows the board to provide forms for submission of reports and to adopt rules.

Subd. 6. Subpoenas. Allows the board to issue subpoenas for production of reports required by subdivisions 2 to 4.

12 **Immunity.** Creates § 148.605.

Subd. 1. Reporting. Provides that any individual or entity making a report under section 148.604 in good faith and in exercise of reasonable care is immune from criminal and civil liability.

Subd. 2. Investigation; indemnification. Paragraph (a) provides that members and employees of the board, and consultants retained by the board, are immune from criminal and civil liability related to their duties in investigating complaints and imposing disciplinary action when acting in good faith and in exercise of reasonable care.

Paragraph (b) provides that members and employees of the board engaged in maintaining records and making reports regarding adverse health care events are

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immune from civil and criminal liability when acting in good faith and in exercise of reasonable care.

Paragraph (c) states that for purposes of this section, a member of the board or a consultant is considered a state employee.

13 **Optometrist cooperation.** Creates § 148.606. Requires an optometrist who is the subject of an investigation to cooperate fully with the investigation.

14 **Disciplinary action.** Creates § 148.607. Lists the types of disciplinary action that can be taken by the board: revocation or suspension of the license, limitations or conditions placed on the license, civil penalties, and censure or reprimand.

15 **Alternate licenses.** Amends § 148E.075.

Subd. 1. Temporary leave license. Paragraph (b) allows a licensee to hold a temporary leave license for no more than four consecutive years.

Paragraph (c) allows a licensee to reactivate their license within the four-year period, but if this is not done within 60 days following the end of the four-year period, the license expires.

Paragraph (d) prohibits a licensee with a temporary leave license from any form of social work practice except as provided in paragraph (e).

Paragraph (e) establishes the procedure for a licensee with a temporary leave license to provide emergency social work services.

Paragraph (f) requires a licensee with a temporary leave license to make this clear in any representation to the public regarding professional status.

Subd. 1a. Emeritus inactive license. Paragraph (a) lists the conditions under which a licensee may qualify for this form of alternate license.

Paragraph (b) allows a licensee with an emeritus inactive license to apply for reactivation within four years of the granting of this license. If not reactivated within that time, the individual may apply for a new license.

Paragraph (c) prohibits a licensee with an emeritus inactive license from any form of social work practice except as provided in paragraph (d).

Paragraph (d) establishes the procedure for a licensee with an emeritus inactive license to provide emergency social work services.

Paragraph (e) requires a licensee with an emeritus inactive license to make this clear in any representation to the public regarding professional status.

Subd. 1b. Emeritus active license. Paragraph (a) lists the conditions under which a licensee may qualify for this form of alternate license.

Paragraph (b) lists the limitations on practice for an individual with an emeritus active license.

Paragraph (c) requires renewal of an emeritus active license.

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Paragraphs (d) and (e) list the continuing education requirements for an individual with an emeritus active license.

Paragraph (f) provides that failure to renew the license will result in an expired license.

Paragraph (g) allows the board to grant a variance to the limitations on practice if the individual provides emergency social work services.

Paragraph (h) requires a licensee with an emeritus active license to make this clear in any representation to the public regarding professional status.

Paragraph (i) allows individuals with an emeritus active license to reactivate the license or apply for a new license.

Subd. 2. Application. Allows licensees to apply for an alternate license when currently licensed or as an alternative to renewing a license.

Subd. 3. Fee. Requires applicants for a temporary leave license or an emeritus inactive license to submit the established fee. Provides that an applicant for an emeritus active license is required to pay one-half of the renewal fee for the applicable license. Requires applicants to submit the fees with the application for the new license.

Subds. 4 to 7 are stricken.

Subd. 8. Disciplinary or other action. Allows the board to resolve pending complaints against a licensee before approving the application for an alternate license. Allows the board to take disciplinary action against a licensee with an alternate license.

16 **Mailing notices to licensees on temporary leave.** Amends § 148E.080, subd. 1. Updates a cross-reference due to the amendments to § 148E.075.

17 **Reactivation from a temporary leave or emeritus status.** Amends § 148E.080, subd. 2. Updates cross-references due to the amendments to § 148E.075.

18 **License fees.** Amends § 148E.180, subd. 2. Establishes an emeritus inactive license fee and an emeritus active license fee.

19 **Late fees.** Amends § 148E.180, subd. 5. Establishes a license late fee.

20 **Annual license fees.** Amends § 150A.091, subd. 4. Allows the Board of Dentistry to increase the annual license fee for a resident dentist or dental provider to no more than $85.

21 **Biennial license or permit fees.** Amends § 150A.091, subd. 5. Establishes an increased cap on fees for dentists, dental therapists, dental hygienists, and licensed dental assistants.

22 **Certificate application fee for anesthesia/sedation.** Amends § 150A.091, subd. 11. Establishes increased cap on fees for anesthesia and sedation applications and biennial renewals.

23 **Advanced dental therapy examination fee.** Amends § 150A.091, by adding subd. 17. Provides that the application fee to sit for the examination cannot exceed $250.

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24 **Corporation or professional firm late fee.** Amends § 150A.091, by adding subd. 18. Allows the Board of Dentistry to assess a late fee of not more than $15 if a corporation or professional firm does not timely submit its annual fee.

25 **Fees.** Amends § 150A.31. Allows the Board of Dentistry to charge dental laboratories a biennial renewal registration fee not to exceed $80.

26 **Pharmacy technician.** Amends § 151.01, subd. 15a. Modifies the definition of pharmacy technician. Provides that a pharmacy technician is a person who has been trained to perform pharmacy tasks that do not require the professional judgment of a licensed pharmacist. Prohibits pharmacy technicians from performing tasks reserved to a licensed pharmacist.

27 **Practice of pharmacy.** Amends § 151.01, subd. 27. Allows pharmacists to administer flu vaccines to individuals age six and older and all other vaccines to patients age 13 and older. (Current law allows administration of flu vaccine to individuals age 10 and older and all other vaccines to patients age 18 and older.)

Requires the pharmacist to check the Minnesota Immunization Information Connection prior to administration of vaccines, except when giving a flu shot to individuals age nine and older. Strikes the requirement to notify the patient's primary physician.

28 **State Board of Pharmacy.** Amends § 151.02. Increases the membership on the board to three public members (currently there are two) and six pharmacists who actively practice (currently there are five).

29 **Application fee.** Amends § 151.056, subd. 1. Increase application fees for licensure and registration assessed by the Board of Pharmacy.

30 **Original license fee.** Amends § 151.065, subd. 2. Increase the pharmacist original license fee.

31 **Annual renewal fees.** Amends § 151.065, subd. 3. Increase annual licensure and registration renewal fees assessed by the Board of Pharmacy.

32 **Miscellaneous fees.** Amends § 151.065, subd. 4. Increases the fees for affidavits, duplicate licenses, and certifications assessed by the Board of Pharmacy.

33 **Pharmacy technician.** Amends § 151.102.

Subd. 1. General. Clarifies that a pharmacy technician can perform tasks that are not reserved to, and do not require the professional judgment of, a licensed pharmacist. Changes the number of pharmacy technicians that can be supervised by a pharmacist from two to three. Allows the board to adopt rules to set ratios of pharmacists to technicians greater than three to one.

Subd. 2. Waivers by board permitted. Allows the board to issue waivers to pharmacists who request permission to supervise more than three pharmacy technicians.

Subd. 3. Registration fee. No change.

34 **Repealer.** Repeals §§ 148.57, subds. 3 (revocation, suspension) and 4 (peddling and canvassing prohibited); 148.571 (use of topical ocular drugs); 148.572 (advice to seek diagnosis and treatment); 148.573, subd. 1 (certificate required for use or possession of

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topical ocular drug); 148.575, subds. 1 (certificate required for use of legend drugs), 3 (display of certificate required), 5 (notice to Board of Pharmacy), and 6 (board certification required); and 148.576 (use of legend drugs; limitations; reports); § 148E.060, subd. 12 (ineligibility for a temporary license); and § 148E.075, subds. 4 (time limits for temporary leaves), 5 (time limits for emeritus license), 6 (prohibition on practice), and 7 (representations of professional status).

Article 11: Health Care

Overview

This article contains provisions related to the Medical Assistance and MinnesotaCare programs. The provisions:

- establish a new payment structure and service modes for nonemergency medical transportation services;
- require new payment methodologies for critical access hospitals and disproportionate share hospital (DSH) payments;
- require periodic data matching to evaluate the eligibility of MA and MinnesotaCare enrollees;
- modify payment rates and procedures for a range of providers and services;
- establish an opioid prescribing improvement program, a pilot program to integrate care for high-risk pregnant women, and behavioral health homes;
- modify requirements for the reporting of administrative costs by managed care and county-based purchasing plans, and require related audits.
- increase MinnesotaCare cost-sharing and premiums
- establish a task force on health care financing; and
- make numerous other changes related to the administration of the MA and MinnesotaCare programs.

1 **Payments on behalf of enrollees in government health programs.** Amends § 62A.045. Paragraph (f) requires a health insurer to process a clean claim from a state agency for covered expenses paid under state medical programs within 90 days. Requires an insurer to pay all other claims within the timeline set forth in federal regulations.

Paragraph (g) permits an insurer to request a refund of a claim paid in error to DHS within two years of the date the payment was made to DHS. Specifies that a request for a refund made after that time period will not be honored.

2 **Resident dentists.** Amends § 150A.06, subd. 1b. Provides that a University of Minnesota School of Dentistry dental resident holding a resident dental license is eligible for enrollment in MA under section 250B.0625, subd. 9b.

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3 **Definition.** Amends § 174.29, subd. 1. Adds certain nonemergency medical transportation services to the definition of special transportation services for purposes of regulation by the commissioner of transportation. Provides a July 1, 2016 effective date.

4 **Other standards; wheelchair securement; protected transport.** Amends § 174.30, subd. 3. Requires the commissioner of transportation to ensure, during inspections, that the safety features of vehicles designated as protected transport are in working order.

Provides a July 1, 2016 effective date.

5 **Vehicle and equipment inspection; rules; decal; complaint contact information; restrictions on name of service.** Amends § 174.30, subd. 4.

A new paragraph (e) requires special transportation service providers to pay an annual fee of $45 to obtain a decal. Appropriates fees collected to the commissioner to pay for administering the special transportation service program.

A new paragraph (g) allows NEMT providers to use the phrase "nonemergency medical transportation" in their names or in advertisements or service descriptions.

Provides a July 1, 2016 effective date.

6 **Variance from standards.** Amends § 174.30, by adding subd. 4b. Allows a NEMT provider not subject to Department of Transportation standards prior to July 1, 2014, to apply for a variance if the provider cannot meet the standards by January 1, 2017. Provides that the commissioner may grant or deny the application, and that variances shall not exceed 60 days. Provides a July 1, 2016 effective date.

7 **Background studies.** Amends § 174.20, by adding subd. 10. Requires providers of special transportation services to initiate background studies on specified employees using the online NETStudy system. Prohibits a provider from allowing an employee to provide services unless the employee passes a background study. Permits a local or contracting agency to initiate background studies of volunteer drivers who provide nonemergency medical transportation services. Provides a January 1, 2016 effective date.

8 **Providers of special transportation service.** Amends § 245C.03, by adding subd. 10. Requires the commissioner to conduct background studies for providers of special transportation services who initiate the studies of their employees, as provided under section 174.30, subdivision 10. Provides a January 1, 2016 effective date.

9 **Providers of special transportation service.** Amends § 245C.10, by adding subd. 11. Requires the commissioner to recover the cost of background studies initiated by special transportation service providers, through a fee of no more than $20 per study. Appropriates the fee to the commissioner to conduct the background studies. Provides a January 1, 2016 effective date.

10 **Cooperation with information requests required.** Amends § 256.015, subd. 7. Requires an employer or third-party payer to provide DHS, within 60 days of a request, the following information as part of the data file: name, date of birth, Social Security number, employer name, policy identification number, group identification number, and plan or coverage type.

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11 **Hospital cost index.** Amends § 256.969, subd. 1. Changes the hospital cost index from the CPI-U to the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. Eliminates the requirement that MMB submit budget change requests for annual adjustments to hospital payment rates.

12 **Hospital payment rates.** Amends § 256.969, subd. 2b. Paragraph (d) extends the 5 percent banding for rate increases and decreases that expires June 30, 2016, until the next rebasing, but only for hospitals paid on a diagnosis-related group (DRG) methodology.

Paragraph (e) extends until the next rebasing the additional adjustments to the rebased hospital payment rates that were set to expire on June 30, 2016.

Paragraph (i) grants DHS the authority to determine a new methodology for determining a cost-based final payment rate for critical access hospitals. No hospital may receive less than 95 percent of its base year payment, except that hospitals with payments greater than 100 percent of costs shall have their rate set at 100 percent of costs. Sets requirements for the new methodology, including criteria for the payment tiers to be incorporated into the new methodology.

13 **Interim payments.** Amends § 256.969, subd. 2d. Extends the authority for the commissioner to implement an interim hospital payment process, until March 1, 2016 (under current law the commissioner has this authority through June 30, 2015). Also allows the commissioner to implement interim payments if electronic systems changes necessary to convert to the ICD-10 coding system are not completed.

14 **Payments.** Amends § 256.969, subd. 3a. Specifies that beginning July 1, 2015, individual hospital payment rate adjustments for fee-for-service to long-term care hospitals and rehabilitation hospitals for inpatient services must be incorporated into the hospital's payment rate and not applied to each claim.

15 **Rateable reduction and readmissions reduction.** Amends § 256.969, subd. 3c. Specifies that beginning July 1, 2015, for long-term care hospitals and rehabilitation hospitals, the ten percent rate reduction and contingent buy-back based on reductions in readmissions must be incorporated into the hospital's payment rate and not applied to each claim.

16 **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Effective July 1, 2015, requires disproportionate share hospital (DSH) payments to be paid according to a new methodology, using 2012 as the base year. Specifies criteria for the new methodology. Requires payments returned to the commissioner because they exceed the hospital-specific DSH limit for a hospital to be redistributed to other DSH-eligible non-children's hospitals with an MA utilization rate at least on standard deviation above the mean, proportionate to the number of discharges. Also strikes language allowing the commissioner to establish a separate DSH rate for critical access hospitals.

17 **Periodic data matching to evaluate continued eligibility.** Adds § 256B.0561.

Subd. 1. Definition. Defines "periodic data matching."

Subd. 2. Periodic data matching. Requires the commissioner, beginning March 1, 2016, to conduct periodic data matching to identify MA and MinnesotaCare

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recipients who, based on available electronic data, do not meet eligibility criteria for the program they are enrolled in. Requires the commissioner to conduct data matching at least once during a recipient's 12-month period of eligibility. Specifies criteria for notifying potentially ineligible recipients, and for terminating recipients.

Subd. 3. Recipient communication requirements. Requires the commissioner to include, in all communications with recipients affected by periodic data matching, contact information for the state or county agency responsible for the recipient's case and consumer assistance partners.

Subd. 4. Report. Requires the commissioner to report specified information related to periodic data matching on an annual basis to the legislative committees with jurisdiction over health and human services finance, beginning September 1, 2017 and each September 1 thereafter.

Subd. 5. Federal compliance. Requires the commissioner to ensure that implementation complies with the ACA, including the state's maintenance of effort requirements. Prohibits the commissioner from terminating eligibility if terminations would not conform with federal requirements, including requirements not yet codified in state law.

18 **Legal referral and assistance grants.** Amends § 256B.06, by adding subd. 6. Requires the commissioner to award grants to nonprofit programs that provide legal services based on indigency, to provide legal services to individuals with emergency medical conditions or chronic health conditions who are not currently eligible for medical assistance or other public health care programs due to their legal status, but may meet eligibility requirements with legal assistance. Requires grantees to provide referral assistance to alternative resources and services.

19 **Dental services provided by faculty members and resident dentists at a dental school.** Amends § 256B.0625, by adding subd. 9b. (a) Allows a dentist who is not enrolled as an MA provider, is on the faculty or an adjunct member at the University of Minnesota or is a resident dentist, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, to be enrolled as an MA provider, if the dentist completes and submits to the commissioner an agreement form. Requires the agreement to specify that the individual:

(1) will not receive payment for services provided to MA or MinnesotaCare enrollees at University of Minnesota dental clinics;

(2) will not be listed in the MA or MinnesotaCare provider directory; and

(3) is not required to serve MA and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.

(b) Provides that an individual enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from MA or MinnesotaCare as a fee-for-service provider.

20 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. The amendment to paragraph (a) modifies eligibility criteria for MA coverage of medication therapy management services, by eliminating the requirement that a recipient be taking three

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or more prescriptions, and making related changes. The amendment to paragraph (c) eliminates a reference to the GAMC program. The amendment to paragraph (d) clarifies the requirement that a pharmacist providing medication therapy management services by interactive video be located within an ambulatory setting. The amendment to paragraph (e) eliminates obsolete language related to a pilot project and authorizes the provision of medication therapy management delivered into a patient's residence by interactive video.

21 **Transportation costs.** Amends § 256B.0625, subd. 17. The amendment to paragraph (i) provides that the local agency shall be the single administrative agency and shall administer and reimburse for service modes, when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment. It also clarifies that the financial obligation of the local agency is limited to the amount of state and federal funds provided.

A new paragraph (l) requires payments for NEMT to be based on the client's assessed mode, and not the type of vehicle used to provide the service. Sets NEMT base payment and mileage rates for the various service modes, as follows:

- 22 cents per mile for client mileage reimbursement
- up to 100 percent of the IRS rate for volunteer transport
- equivalent to the standard fare for unassisted transport when provided by public transit, and $11 base rate and $1.30 per mile when provided by an NEMT provider
- $13 base rate and $1.30 per mile for assisted transport
- $18 base rate and $1.55 per mile for lift-equipped/ramp transport
- $75 base rate and $2.40 per mile for protected transport
- $60 base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant

These rates result in increases in base and mileage rates for most service modes.

A new paragraph (m) extends the higher rural urban commuting area (RUCA) rates to all service modes.

Eliminates a 4.5 percent reduction in payment rates for nonemergency medical transportation, by striking paragraph (o) of current law.

Also makes a large number of conforming and clarifying changes.

Provides a July 1, 2016 effective date.

22 **Payment for ambulance services.** Amends § 256b.0625, subd. 17a. Eliminates a 4.5 percent reduction in payment rates for ambulance services, effective July 1, 2016.

23 **Access to medical services.** Amends § 256B.0625, subd. 18a. Effective July 1, 2016, strikes language setting MA payment rates for direct mileage for recipients. (Payment rates for mileage are now set in section 256B.0625, subd. 17, paragraph (l)).

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24 **Single administrative structure and delivery system.** Amends § 256B.0625, subd. 18e. Requires the commissioner of human services to coordinate implementation of the single administrative structure and delivery system for NEMT with the commissioner of transportation.

25 **Licensed physician assistant services.** Amends § 256B.0625, subd. 28a. Allows licensed physician assistants meeting specified criteria, who have completed 2,000 hours of clinical experience in the evaluation and treatment of mental health, to bill for medication management and evaluation and management services provided to MA enrollees in outpatient settings. (Under current law, billing by physician assistants meeting specified criteria is limited to inpatient hospital settings, and 2,000 hours of clinical experience is not required.)

26 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Strikes language allowing the commissioner to set MA payment rates for specified categories of medical supplies at levels below the Medicare payment rate.

27 **Payment for Part B Medicare crossover claims.** Amends § 256B.0625, subd. 57. Exempts payments to federally qualified health centers and rural health centers from an MA requirement that limits MA payments for cost-sharing associated with Medicare Part B to an amount up to the MA total allowed, when the MA rate exceeds the amount paid by Medicare. Provides a January 1, 2016 effective date.

28 **Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, subd. 58. Prohibits payment under an EPSDT screening for health care services and products that are available at no cost to the provider (the restriction in current law is related to vaccines available at no cost).

29 **Medical assistance co-payments.** Amends § 256B.0631. The amendment to subdivision 1 specifies that the family deductible is $2.75 per month per family and is to be adjusted annually. The amendment also applies the limit on monthly cost-sharing to 5 percent of income to all MA enrollees (current law applies this to enrollees with incomes at or below 100 percent of FPG), and states that this limit does not apply to premiums charged to persons eligible for MA as employed persons with disabilities.

The amendment to subdivision 2 provides that copayments and deductibles do not apply to: (1) American Indians who are eligible to receive, or have received, services from an Indian health care provider or through referral; (2) persons eligible for MA because they need treatment for breast or cervical cancer; and (3) certain preventive services, immunizations, and screenings.

The amendment to subdivision 3 makes a conforming change related to the 5 percent cost-sharing limit.

States that the establishment of the family deductible at $2.75 is effective retroactively from January 1, 2014.

30 **Opioid prescribing improvement program.** Adds § 256B.0638. Establishes the opioid prescribing improvement program.

Subd. 1. Program established. Requires the commissioner of human services, in conjunction with the commissioner of health, to establish a statewide opioid

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prescribing program to reduce opioid dependency and substance use due to the prescribing of opioid analgesics by health care providers.

Subd. 2. Definitions. Defines terms.

Subd. 3. Opioid prescribing work group. Requires the commissioner of human services, in consultation with the commissioner of health, to establish an opioid prescribing work group. Specifies membership.

Subd. 4. Program components. Requires the work group to recommend to the commissioners the components of the statewide opioid prescribing improvement program, including criteria for opioid prescribing protocols; developing sentinel measures; educational resources for opioid prescribers about pain management and the use of opioids to treat pain; opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups; and other program issues as determined by the commissioners. Exempts opioids prescribed to certain patients from the protocols. Requires all prescribers who serve Minnesota health care program enrollees to participate in the program.

Subd. 5. Program implementation. Paragraph (a) requires the commissioner to implement the program and to annually collect and report to opioid prescriber's data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.

Paragraph (b) requires the commissioner to notify the prescriber and all provider groups with which the prescriber is employed or affiliated when the prescriber's prescribing pattern exceeds the opioid quality improvement standards thresholds. If notified by the commissioner, the prescriber is required to submit to the commissioner a quality improvement plan for review and approval.

Paragraph (c) specifies that if after one year the prescriber's prescribing practices are not consistent with community standards, the commissioner may take certain steps.

Paragraph (d) requires the commissioner to disenroll from the Minnesota health care programs all prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Subd. 6. Data practices. Classifies the reports and data identifying an opioid prescriber as private data on individuals until the prescriber is subject to disenrollment as a MA provider. Requires the commissioner to share with all the provider groups with which the prescriber is employed or affiliated a report identifying the prescriber as subject to quality improvement activities. Specifies that data and reports identifying a provider group are nonpublic data until the provider group is subject to disenrollment. At that time the data and reports are public, except that any identifying information of enrollees must be redacted by the commissioner.

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Subd. 7. Annual report to legislature. Requires the commissioner to annually report to the legislature on the status of the implementation of the program, including data on utilization of opioids in the Minnesota health care programs.

31 **Coordinated care through a health home.** Amends § 256B.0757. Expands the certification of health homes to include behavioral health homes.

The amendment to subdivision 1 requires the commissioner to establish behavioral health homes to serve individuals with serious mental illness. Requires the services provided by these behavioral health homes to focus on both behavioral and physical health.

The amendment to subdivision 2 expands who is eligible for health home services to include individuals who have been diagnosed with a mental illness.

The amendment to subdivision 4 specifies that health home services are voluntary and that an eligible individual may choose any designated provider. Defines a designated provider as a clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or another entity that is determined by the commissioner to be qualified to be a health home.

The amendment to subdivision 5 clarifies that the commissioner shall make payments to each designated provider for the provision of health home services.

The amendment to subdivision 6 changes terminology to refer to designated providers.

A new subdivision 8 requires health homes to meet process, outcome, and quality standards developed and specified by the commissioner. Requires the commissioner to collect data from health homes to monitor compliance with certification standards. Permits the commissioner to contract with a private entity to evaluate patient and family experiences, health care utilization, and costs. Requires the commissioners to utilize findings from the utilization of health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

Provides that the section is effective July 1, 2016, or upon federal approval.

32 **Health care delivery pilot program.** Adds § 256B.0758. (a) Allows the commissioner of human services to establish a health care delivery pilot program to test alternative and innovative health care delivery networks. These may include accountable care organizations or a community-based collaborative care networks created by, or including, North Memorial Health Care. Directs the commissioner, if required, to seek federal waiver approval, or amend an existing demonstration pilot project waiver.

(b) Provides that individuals eligible for the pilot program must be eligible for MA. Allows the commissioner to identify individuals for the pilot program based on zip code or whether the individuals would benefit from an integrated health care delivery network.

33 **Managed care contracts.** Amends § 256B.69, subd. 5a. Requires managed care plans and county-based purchasing plans to maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services expensed to state

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public programs. Requires subcontractor agreements determined to be material to be in the form of a written instrument or electronic document and meet specified requirements. Allows the commissioner, upon request, to have access to all subcontractor documentation. Provides that the paragraph does not allow the release of nonpublic information.

34 **Administrative expenses.** Amends § 256B.69, subd. 5i. The amendment to paragraph (a) limits managed care and county-based purchasing plan administrative costs to 6.6 percent of total managed care payments in the aggregate for all state public programs, and specifies related criteria. The provision replaces a provision in current law that limits the growth in administrative costs to 5 percent (measured by the ratio of administrative spending to total revenue).

The amendment to paragraph (b) clarifies existing not allowable administrative expenses, and adds additional not allowable administrative expenses.

A new paragraph (c) provides that payments to a quality improvement organization are an allowable administrative expense for rate-setting, to the extent they are allocated to a state public health care program and approved by the commissioner.

A new paragraph (d) requires expenses for an administrative item to be directly allocated to an individual state public health care program where reasonably possible, and specifies related requirements.

A new paragraph (e) requires the commissioner to reduce administrative expenses paid to managed care and county-based purchasing plans by .50 of a percentage point for contracts beginning January 1, 2017, and ending December 31, 2017. To meet the administrative reduction, allows the commissioner to reduce or eliminate administrative requirements, exclude additional unallowable administrative expenses, and utilize competitive bidding. If the total reduction cannot be achieved through administrative reductions, allows the commissioner to limit rate increases to plans.

35 **Managed care financial reporting.** Amends § 256B.69, subd. 9c. Requires managed care and county-based purchasing plans to reconcile administrative expenses reported to the commissioner with Minnesota Supplemental Report #1A. Requires managed care and county-based purchasing plans to certify to the commissioner, for purposes of state public health care program financial reporting, that costs reported for state public health care programs include only services covered under the state plan and waivers, and related allowable administrative expenses. Also requires plans to certify and report to the commissioner the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, that have been excluded.

36 **Financial and quality assurance audits.** Amends § 256B.69, subd. 9d. A new paragraph (e) requires the commissioner, to the extent of available funding, to conduct ad hoc audits of managed care organization administrative and medical expenses. Specifies expense categories and audit procedures. Requires the commissioner to annually report the number and results of ad hoc audits to legislative committees.

Amendments to various paragraphs strike the requirement in current law that the legislative auditor contract with an audit firm for biennial independent third-party financial audits and

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make related changes. Revised language related to audits by the legislative auditor is added in section 256B.69, subd. 9e.

Also makes technical and clarifying changes.

37 **Financial audits.** Amends § 256B.69, by adding subd. 9e. Requires the legislative auditor to conduct or contract with vendors to conduct independent third-party financial audits of the information provided by managed care and county-based purchasing plans. Provides that the audits shall be conducted as vendor resources permit and specifies other requirements. Requires the audits to include a determination of compliance with the federal Medicaid rate certification process. Provides a definition of "independent third-party" (this definition does not include requirements related to licensure as an accounting firm, and not having provided services to a plan during the audit period, that are in the current law stricken in subdivision 9d).

38 **Hospital outpatient reimbursement.** Amends §256B.75. Effective July 1, 2015, provides that rates for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals for the payment year are the final payment and not settled to actual costs.

39 **Physician reimbursement.** Amends § 256B.76, subd. 1. Effective July 1, 2015, increases payment rates by 90 percent for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase.

40 **Dental reimbursement.** Amend § 256B.76, subd. 2. Effective July 1, 2015, requires the commissioner to increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area, by the maximum percentage possible while remaining within the limits of funding provided for this purpose. Excludes specified providers from the rate increase and requires managed care and county-based purchasing plan payments to be increased to reflect this increase, effective January 1, 2016. Requires the plans to pass on the full amount of the increase in the form of higher payments to dental providers located outside of the seven-county metropolitan area.

41 **Critical access dental providers.** Amends § 256B.76. Eliminates the requirement that a private practicing dentist, in order to be designated as a critical access dental provider, not restrict access or services because of a patient's financial limitations or public assistance status.

42 **Reimbursement for health care services.** Amends § 256B.762. Effective for services provided on or after July 1, 2015, increases payment for managed care and fee-for-service visits for physical therapy, occupational therapy, and speech therapy by 10 percent, when these services are provided as home health services. Requires the commissioner to adjust managed care and county-based purchasing capitation rates to reflect these payment rates.

43 **Reimbursement for basic care services.** Amends § 256B.766. Paragraph (g), effective July 1, 2015, increases payment rates by 90 percent for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract,

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prosthetics and orthotics, and laboratory services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase.

Paragraph (i), effective July 1, 2015, restores payment rates for durable medical equipment, prosthetics, orthotics, or supplies, including individually priced items, to the January 1, 2008 fee schedule rate, updated to include subsequent rate increases. Exempts certain items from this provision. Also requires that a July 1, 2015, 3 percent payment increase in current law be calculated using the 2008 fee schedule rate.

44 **Medicare payment limit.** Amends § 256B.767. Paragraph (d), effective July 1, 2015, exempts durable medical equipment, prosthetics, orthotics, or supplies from the requirement that MA payments not exceed the Medicare payment rate.

Paragraph (e), exempts physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4), from the requirement that MA payment rates not exceed the Medicare payment rate for the applicable service.

45 **Integrated care for high-risk pregnant women.** Adds § 256B.79.

Subd. 1. Definitions. Defines terms.

Subd. 2. Pilot program established. Requires the commissioner to implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are receiving MA, are at a significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations.

Subd. 3. Grant awards. Requires the commissioner to award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Requires the grants to be distributed through a request for proposals (RFP) process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or an entity in the process of meeting the qualifications to become a collaborative.

Subd. 4. Eligibility for grants. Specifies that to be eligible for a grant, an entity must show that the entity meets or is in the process of meeting the qualifications established by the commissioner to be a qualified perinatal care collaborative. Specifies the policies, services, and partnerships that an entity must have in place to meet the qualifications to be a collaborative.

Subd. 5. Gaps in communication, support, and care. Requires a collaborative receiving a grant to develop means to identify and report gaps in communication, administrative support, and direct care that must be remedied for the collaborative to provide integrated care and enhanced services to targeted populations.

Subd. 6. Report. Requires the commissioner to report to the legislature on the status and progress of the pilot program by January 31, 2019.

Subd. 7. Expiration. Specifies that this section expires June 30, 2019.

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46 **Family.** Amends § 256L.01, subd. 3a. Defines "family" for purposes of the MinnesotaCare program, for individuals who do not expect to file a federal tax return and do not expect to be claimed as a dependent, and for married couples. Provides an immediate effective date.

47 **Income.** Amends § 256L.01, subd. 5. Clarifies that the definition of "income" means a household's projected annual income for the applicable tax year. Provides an immediate effective date.

48 **Cost-sharing.** Amends § 256L.03, subd. 5. The amendment to paragraph (a) specifies that the family deductible for MinnesotaCare is $2.75 per month per family and is adjusted annually by the change in the medical component of the CPI-U.

The amendment to paragraph (b) provides that American Indians are not subject to MinnesotaCare cost-sharing.

A new paragraph (f) requires the commissioner to increase MinnesotaCare copayments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 94 percent. Provides that the cost-sharing changes shall not be implemented prior to January 1, 2016, and do not apply to recipients or services exempt from cost-sharing under state law.

A new paragraph (g) provides that the cost-sharing changes under paragraph (f) must satisfy the requirements for cost-sharing under the Basic Health Program.

States that the amendment related to the family deductible is effective retroactively from January 1, 2014, and the cost-sharing exemption for American Indians is effective the day following final enactment.

49 **General requirements.** Amends § 256L.04, subd. 1c. Strikes a reference to being eligible for "coverage" under MinnesotaCare. Provides an immediate effective date.

50 **Annual income limits adjustment.** Amends § 256L.04, subd. 7b. Requires MinnesotaCare program income limits based on the federal poverty guidelines to be adjusted on annually on January 1, as provided in federal regulations. (Under current law, the adjustment is made on July 1.) Provides an immediate effective date.

51 **Eligibility and coverage.** Amends § 256L.05, by adding subd. 2a. States that an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. Also states that for individuals required to pay a premium, coverage is only available for months for which a premium is paid. Provides an immediate effective date.

52 **Effective date of coverage.** Amends § 256L.05, subd. 3. In a provision specifying the effective date of coverage for persons exempt from premiums, strikes a reference to the month in which verification of American Indian status is received.

53 **Redetermination of eligibility.** Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed on an annual basis, rather than every 12 months. Beginning in CY 2015, requires eligibility redeterminations to occur during the open enrollment period for qualified health plans. Makes related changes. Provides an immediate effective date.

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54 **Application processing.** Amends § 256L.05, subd. 4. Increases from 30 to 45 days the time period within which the commissioner must determine an applicant's eligibility for MinnesotaCare. Provides an immediate effective date.

55 **Commissioner's duties and payment.** Amends § 256L.06, subd. 3. Provides that MinnesotaCare disenrollment for nonpayment of premium is effective the month following the month for which the premium was due (under current law, disenrollment is effective the month the premium is due). Allows reenrollment the first day of the month following payment of an amount equal to two months' premiums, and strikes language requiring retroactive enrollment if certain conditions are met. Provides an immediate effective date.

56 **Competitive process.** Amends § 256L.121, subd. 1. Corrects a cross-reference.

57 **Premium determination for MinnesotaCare.** Amends § 256L.15, subd. 1. Paragraph (d) requires the commissioner, after consulting with legislative chairs and ranking minority members, to increase MinnesotaCare premiums effective August 1, 2015, for recipients based on June 2015 program enrollment. Requires the increases to be sufficient to increase projected revenue by at least $27.8 million for the biennium ending June 30, 2017. Requires the commissioner to publish the revised premium scale on the agency web site and in the State Register, by June 15, 2015.

Paragraph (e) requires the commissioner, by July 1, 2015, to provide the chairs and ranking minority members of the legislative committees with jurisdiction over human services with the revised premium scale and statutory language to codify the revised premium scale.

Paragraph (f) provides that the premium changes apply only to enrollees not otherwise excluded from paying premiums. Requires premium changes to satisfy the requirements for a Basic Health Program.

58 **Sliding fee scale; monthly individual or family income.** Amends § 256L.15, subd. 2. Modifies MinnesotaCare premiums to comply with federal regulations for the Basic Health Program. These changes include eliminating premiums for individuals with household incomes below 35 percent of federal poverty guidelines, and reducing premiums for individuals in certain income ranges. Provides an immediate effective date.

59 **Basic health care grants.** Amends Laws 2008, ch. 363, art. 18, § 3, subd. 5. Strikes the administrative cost limit that is in an ongoing rider. (The stricken language is reinstated in modified form in § 256B.69, subd. 5i.)

60 **Application for and terms of variance.** Amends Laws 2014, chapter 312, article 24, section 45, subd. 2. Provides that variances from special transportation service operating standards expire on the earlier of February 1, 2017, or "one year after the date the variance was issued," instead of the earlier of February 1, 2016, or the date the commissioner begins certifying new providers. Prohibits the commissioner from granting variances after June 30, 2016.

Provides a July 1, 2016 effective date.

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61 **Statewide Opioid Prescribing Improvement Program.** Requires the commissioner of human services to report to the legislature by December 1, 2015, any recommendations made by the opioid prescribing work group and steps taken to implement the opioid prescribing improvement program.

62 **Task Force on Health Care Financing.** Requires the Governor to convene a task force on health care financing to advise the governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans. Specifies membership and duties. Requires the commissioner of human services to provide staff and administrative services and specifies related requirements. Requires the commissioner to submit recommendations by January 15, 2016, to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, and commerce policy and finance. Provides that the task force sunsets the day after submittal of the report.

63 **Health Disparities Payment Enhancement.** Requires the commissioner of human services to develop a methodology to pay a higher payment rate for providers and services that takes into account the higher cost, complexity, and resources needed to serve patients and populations who experience the greatest health disparities. The commissioner must submit a report to the legislature by February 1, 2016, that includes options for providing a health disparities payment adjustment.

64 **Capitation payment delay.** Requires the commissioner of human services to delay $135 million in MA capitation payments due in May 2017, and special needs basic care payments due in April 2017, until July 1, 2017. Requires the payment to be made between July 1 and July 31, 2017.

65 **Repealer.** (a) Repeals Minnesota Statutes, sections 256.01, subd. 35 (federal waiver related to operating health coverage program for persons with incomes up to 275 percent of FPG); 256.969, subd. 23 (hospital payment adjustment) and 30 (payment for births); and 256B.69, subd. 32 (initiatives to reduce incidence of low birth weight), effective July 1, 2015.

(b) Repeals Minnesota Statutes, sections 256L.02, subd. 3 (financial management for MinnesotaCare); and 256L.05, subd. 1b (MinnesotaCare enrollment by counties), 1c (open enrollment and streamlined application), 3c (retroactive coverage), and 5 (availability of private insurance), effective the day following final enactment.

(c) Repeals rules requiring providers of special transportation services to conduct driver and criminal record checks, effective January 1, 2016.

Article 12: MNsure

1 **Approval.** Amends § 62A.02, subdivision 2. Requires that plans that offer coverage to being on or after January 1, 2016, and each January 1 thereafter are not grandfathered plans and must receive rate approval from the commissioner no later than 30 days prior to the beginning of the annual open enrollment period for MNsure. Requires that premium rates for all carriers in the applicable market for the next calendar year must be publically available only after all rates for that market are final and approved. Requires release of those rate at a uniform time for all individual and small group health plans that are not grandfathered plans

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to be offered outside MNsure and qualified health plans offered inside MNsure no later than 30 days prior to the beginning of the annual open enrollment period for MNsure.

2 **Application of other law.** Amends § 62V.03, subd. 2. The amendments to paragraph (c) eliminate certain exemptions for MNsure from the open meeting law. The exemptions stricken: (1) allow compensation negotiations to be closed in the same manner as meetings on labor negotiation strategy under § 13D.03; (2) allow meetings on contract negotiation strategy to be closed in the same manner as meetings related to the pricing and appraisal of property to be sold or purchased by a government entity; and (3) allow meetings related to not public individual and employer data and trade secret information to be closed to the public.

The amendments to paragraph (d) eliminate exemptions for MNsure from chapter 14 (administrative procedures), many of the provisions of chapters 16B (Department of Administration) and 16C (state procurement). Under current law, MNsure is exempt from all of the provisions of these chapters, except: sections 16C.08, subd. 2, paragraph (b), clauses (1) to (8) (contract requirements for professional and technical services); 16C.086 (contracts for call centers); 16C.09, paragraphs (a), clauses (1) and (3), (b), and (c) (procedures for general services contracts); and 16C.16 (procurement from small businesses).

The section also strikes all of paragraph (g), which exempts MNsure from specified sections of chapter 16E (Office of MN.IT Services). Under current law, MNsure is exempt from: sections 16E.01, subd. 3, paragraph (b) (chief information officer may require use of shared information and telecommunications technology systems and services); 16E.03, subds. 3 and 4 (evaluation required before implementation of a technology project); 16E.04, subds. 1, 2, paragraphs (c), and 3, (b) (policies and standards for technology systems and services, review of agency requests for technology grant funding, payment for risk assessment and risk mitigation); 16E.0465 (review and approval of state technology projects); 16E.055 (use of single entry site for electronic government services); 16E.145 (appropriations for technology project made to chief information officer); 16E.15 (chief information officer may sell or license computer software products or services); 16E.16 (chief information officer may require a state agency to adjust its operating and management procedures); 16E.17 (chief information officer to supervise and control all state telecommunications facilities and services); 16E.18 (requirements for state information infrastructure); and 16E.22 (statewide electronic licensing system).

3 **Appeals.** Amends § 62V.05, subdivision 6. Allows an appellant aggrieved by an order of MNsure issued in an eligibility appeal to appeal the order to a district court and provides for the requirements of that appeal, including, but not limited to, service requirements, appeals of a district court order, and the handling of eligibility and payments.

4 **Agreements; consultation.** Amends § 62V.05, subdivision 7. Strikes the requirement that MNsure establish and maintain an agreement with the Office of MN.IT Services.

5 **Rulemaking.** Amends § 62V.05, subdivision 8. Strikes obsolete language related to rulemaking that was to be completed by January 1, 2015. Maintains the board's ability to adopt rules using the expedited rulemaking process under section 14.389.

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6 **Prohibition on other product lines.** Amends § 62V.05 by adding subdivision 12. Prohibits MNsure from certifying, selecting, or offering products and policies of coverage that do not meet the definition of health plan or dental plan as provided in section 62V.02.

7 **Expanded access to the small business health care tax credit.** (a) Requires the commissioner of human services, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, to develop a proposal to allow eligible small businesses to obtain the small business tax credit for policies purchases inside or outside of the SHOP marketplace.

(b) Requires the commissioner to seek federal waivers necessary to implement paragraph (a) and submit a draft proposal to the MNsure board and MNsure Legislative Oversight Committee prior to submission to the federal government.

Effective date. This section is effective the day following final enactment.

8 **Expanded access to qualified health plans and subsidies.** Requires the commissioner of commerce, in consultation with the MNsure board and the MNsure legislative oversight committee, to develop a proposal to allow individuals to purchase qualified health plans directly from health plan companies (rather than through MNsure), and receive advanced premium tax credits and cost-sharing subsidies. Requires the commissioner to seek all federal waivers and approvals to implement this proposal. Requires the commissioner to submit a draft proposal to the MNsure board and legislative oversight committee at least 30 days before submitting the final proposal to the federal government, and to notify the board and oversight committee of any federal decision or action related to the proposal.

9 **Repealer.** Repeals section 62V.11, subdivision 3 (reference to review of rulemaking that was removed as obsolete under section 5 of this article).

Article 13: Human Services Forecast Adjustments

See spreadsheet.

Article 14: Health and Human Services Appropriations

See spreadsheet.