HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. 1362 **DATE:** June 1, 2009 (revised)
Version: Conference committee report

Authors: Huntley

Subject: Health and Human Services Omnibus Bill

Analyst: Lynn Aves (articles 1, 3, 7, and 9)
Randy Chun (articles 5 and 8)
Emily Cleveland (article 4, 10, and 11)
Danyell P. LeMire (articles 2, 6, and 8)

Table of Contents

Article 1: Licensing

1 **County fees for background studies and licensing inspections.** Amends § 245A.10, subd. 2. Allows the county agency to charge a licensing inspection fee to corporate license holders for the actual cost of inspections, this fee cannot exceed $500 annually. Deletes language allowing a county agency to recover background study fees.

2 **Application fee for initial license or certification.** Amends § 245A.10, subd. 3. States that an application must be submitted for each county in which residential-based habilitation services under chapter 245B will be provided. Adds that an applicant for a license to provide supported employment or crisis respite services under chapter 245B has to submit a single application to provide services statewide. Permits a license holder to provide home and community-based waiver services for up to three individuals with developmental disabilities in up to each of 10 counties without obtaining a separate license for those counties.

3 **Adult foster care licensed capacity.** Amends § 245A.11, subd. 2a. Permits the commissioner to issue a license to a facility with a five bed capacity if the facility meets the requirements in this subdivision and if the 2009 Legislature imposes a rate reduction on adult foster care providers. Allows the commissioner to issue a license for a fifth bed if this does not increase the overall capacity of licensed adult foster care beds in homes that are not the primary residence of the license holder over the capacity on July 1, 2009. Provides that this authority to issue a license for five bed capacity expires on June 30, 2011.

Provides a July 1, 2009, effective date.

4 **Alternate overnight supervision technology; adult foster care license.** Amends § 245A.11, by adding subdivision 7a. Paragraph (a) permits the commissioner to grant an adult foster care license to a provider who does not have a caregiver in residence during sleeping hours, but has monitoring technology to alert the license holder of an emergency.

Paragraph (b) requires applicants for licensure under this section to submit the application directly to the licensing division of DHS. Requires DHS to notify the host county, lead county contract agency, and host county licensing agency, and to collaborate with the county licensing agency in reviewing the application and licensing the program.

Paragraph (c) requires the license holder to establish and implement specified policies and procedures.

Paragraph (d) lists the policies and procedures that must be implemented.

Paragraph (e) requires the license holder to document what form of emergency response will be used.

Paragraph (f) requires that all placement agreements, individual service agreements, and plans applicable to foster care provide specified information related to the absence of a caregiver during normal sleeping hours. Requires a signed informed consent from each resident that must disclose specified information.

Paragraph (g) permits the applicant or license holder to incorporate the requirements of this

section into the documentation required for other licensing standards.

Paragraph (h) allows the commissioner to grant variances.

Paragraph (i) expands the definition of "license holder" for purposes of paragraphs (b) to (h) to include staff, volunteers, and contractors affiliated with the license holder.

Paragraph (j) defines "assess" and "assessing" as making a remote determination on actions that need to be taken to ensure resident's safety under paragraph (e).

5 **Adult foster care data privacy and security.** Amends § 245A.11, by adding subdivision 8b. Paragraph (a) requires an adult foster care license holder who has any individual's identifying data, whether in electronic or other format, to comply with state and federal data privacy laws.

Paragraph (b) requires monitoring of compliance with data privacy laws and security provisions. Considers the license holder a government entity for data privacy purposes. Requires the license holder to provide written notice to each foster care recipient on the purpose of the data collection and to whom it may be disclosed. Prohibits placement of monitoring cameras in bathrooms and concealing electronic monitoring cameras. Permits storage of the recordings for not more than five days.

Paragraph (c) instructs the commissioner to develop and make available a checklist of data privacy provisions that must be monitored.

6 **Delegation of authority to agencies.** Amends § 245A.16, subd. 1. Removes the authority of county or private agencies to perform background studies on adult foster care and family adult day service providers.

7 **Recommendations to commissioner.** Amends § 245A.16, subd. 3. Removes the authority of county or private agencies to perform background studies on adult foster care providers.

8 **Licensed programs.** Amends § 245C.04, subd. 1. Paragraph (b). Strikes the commissioner's authority to conduct a background study of an individual at reapplication for a license for adult foster care or for family adult day services.

Adds paragraph (f). Provides that from January 1, 2010, to December 31, 2012, the commissioner shall conduct background studies on individuals at the time of reapplication for an adult foster care license. Instructs the license holder to collect the required information and forward the information to the county agency via the commissioner's online system; the county agency will then forward the information to the commissioner via the online system.

Adds paragraph (g). Requires the commissioner to conduct a background study on individuals newly affiliated with an adult foster care license holder. Instructs the license holder to collect the required information and forward it to the county agency via the commissioner's online system, then the county agency will forward the information to the commissioner via the online system.

9 10 **County agency to collect and forward information to the commissioner.** Amends § 245C.05, by adding subd. 2b. For background studies for adult foster care and family adult day services, when the license holder resides in the residence, requires the

county agency to collect specified information on the individual and forward this to the commissioner.

11 **Electronic transmission.** Amends § 245C.05, subd. 4. Requires that the commissioner expand the capacity of the online system to electronically transmit the results of background studies to county agencies for adult foster care.

12 **Background studies conducted by a county agency.** Amends § 245C.08, subd. 2. Removes adult foster care providers from the list of programs for which county agencies conduct background studies.

13 **Adult foster care services.** Amends § 245C.10, by adding subd. 5. Instructs the commissioner to recover the cost of background studies on individuals related to an adult foster care license by assessing a fee of no more than $20 per study. This fee is to be charged to the license holder.

14 **Private agencies.** Amends § 245A.10, by adding subd. 8. Instructs the commissioner to recover the cost of background studies for private adoptions through a fee of no more than $70 per study. This fee is to be charged to the adoption agency. Fees collected are appropriated to the commissioner for conducting background studies.

15 **Notice to county agency.** Amends § 245C.17, by adding subd. 6. Requires the commissioner to provide notice of the background study results to the county agency that initiated the study.

16 **License holder record keeping.** Amends § 245C.20. Provides the process for use of the commissioner's online background study system.

17 **Submission of reconsideration request.** Amends § 245C.21, subd. 1a. Requires reconsideration requests to be submitted to the county agency that initiated the background study. For disqualifications related to child foster care, reconsideration requests are to be submitted to the private agency that initiated the background study.

18 **Commissioner's notice of disqualification that is not set aside.** Amends § 245C.23, subd. 2. Requires the commissioner to provide notice of the background study results to the county agency that initiated the study.

19 **Revised per diem based on legislated rate reduction.** Amends §256B.092, by adding subd. 5b. Provides that if there is a legislated rate reduction, then the commissioner may issue adult foster care licenses that permit a capacity of five adults. Requires the county agency to negotiate a revised per diem rate that results in an overall average per diem reduction for all residents of the home. Requires the provider to maintain, as much as possible, the services provided in the residence.

Provides a July 1, 2009, effective date.

20 **Cost of services and supports.** Amends § 256B.49, subd. 17. Requires a negotiation of the per diem cost when a provider seeks to increase capacity to five persons that reflects any legislated rate reductions. This must also demonstrate a reduction in payment for the persons receiving services affected by the occupancy change.

Provides a July 1, 2009, effective date.

21 **Waiver.** Requires the commissioner to seek federal approval and waiver amendments no later than December 1, 2009, to allow licensed adult foster care homes to provide residential services for up to five individuals.

Provides a July 1, 2009, effective date.

22 **Repealer.** Paragraph (a) repeals § 245C.11, subd. 1 (sharing criminal conviction data among programs) and subd. 2 (background study requirements for jointly licensed programs).

Paragraph (b) repeals §256B.092, subd. 5a (increasing adult capacity to five persons).

Paragraph (c) repeals Minnesota Rules, part 9555.6125, subpart 4, item B (requirement that household members and caregivers be free from communicable disease).

Article 2: MFIP/Child Care/Adult Supports/Fraud Prevention

1 **Date of eligibility for assistance.** Amends § 119B.09, subd. 7. Limits retroactive payment of MFIP child care assistance to a maximum of six months from the date of application.

Makes this section effective October 1, 2009.

2 **Provider payments.** Amends § 119B.13, subd. 6. Specifies that bills must be submitted within 60 days of the last date of service on the bill if a provider has received an authorization of care and been issued a billing form for an eligible family. Specifies that payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form. Makes technical changes. Makes this section effective October 1, 2009.

3 **Child care services grants.** Amends § 119B.21, subd. 5. Requires child care services grants to be increasingly awarded for activities that improve provider quality beginning July 1, 2009.

4 **Family child care technical assistance grants.** Amends § 119B.21, subd. 10. Requires family child care technical assistance grants to be increasingly awarded for activities that improve provider quality beginning July 1, 2009.

5 **Provider eligibility.** Amends § 119B.231, subd. 2. Allows additional providers to participate in the school readiness service agreement (SRSA) program if sufficient funds are available. Gives priority for funds to providers who had agreements prior to June 30, 2009. Modifies the list of requirements providers must meet in order to be eligible to participate. Modifies the list of factors the commissioner must evaluate when determining whether or not to enter into an agreement with a provider.

6 **Family and child eligibility.** Amends § 119B.231, subd. 3. Requires families choosing a provider with an SRSA to maintain eligibility for child care assistance and be in an authorized activity.

7 **Requirements of providers.** Amends § 119B.231, subd. 4. Requires providers who enter

into an SRSA to comply with all SRSA requirements. Requires providers who have been previously selected for an SRSA to begin the process of obtaining a rating using the Parent Aware quality rating system according to the timelines established by the commissioner. Specifies provider and commissioner duties if a provider does not obtain a rating of at least three stars. Requires providers who are selected for a new SRSA on or after July 1, 2009, to have at least a three star rating under the Parent Aware quality rating system at the time their agreement is signed.

8 **Home visitors as MFIP employment and training service providers.** Amends § 145A.17, by adding subd. 4a. Allows home visitors to be used as MFIP employment and training service providers for certain participants. Allows home visitors to be used to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

9 **State agency hearings.** Amends § 256.045, subd. 3. Modifies for whom state agency hearings are available to include any person with an outstanding debt from the receipt of certain programs who is contesting a setoff claim by DHS or a county agency. Specifies the scope of the appeal.

10 **Programs established.** Amends § 256.983, subd. 1. Specifies that the commissioner has the final authority in decisions regarding the creation and realignment of individual county or regional operations under any expansion.

11 **Countable income.** Amends § 256I.03, subd. 7. Removes a $20 reduction from countable income for the GRH program.

12 **Demonstration project.** Amends § 256I.05, subd. 7c. Authorizes the commissioner to expand a food stamp demonstration project. Requires the commissioner to seek federal approval by October 1, 2009.

13 MFIP transitional standard. Amends § 256J.24, subd. 5. Increases the MFIP transitional standard in order to acknowledge the increase in food assistance by the federal government. This section is effective retroactive to April 1, 2009, which is the date the federal changes become effective.

14 **Ill or incapacitated. Amends § 256J.425, subd. 2.** Modifies two MFIP categories of individuals; ill or incapacitated and hard-to-employ, by changing the phrase "a condition that prevents the person from obtaining or retaining employment" to "a condition that severely limits the person's ability to obtain or maintain suitable employment." The new phrase is defined in section 9.

15 **Hard to employ participants. Amends § 256J.425, subd. 3.** Modifies two MFIP categories of individuals; ill or incapacitated and hard-to-employ, by changing the phrase "a condition that prevents the person from obtaining or retaining employment" to "a condition that severely limits the person's ability to obtain or maintain suitable employment." The new phrase is defined in this section.

16 **Scope.** Amends § 256J.49, subd. 1. Corrects a cross-reference to FSS. Technical correction.

17 **Employment and training service provider.** Amends § 256J.49, subd. 4. Modifies the

definition of "employment and training service provider."

18 **Employment plan; contents.** Amends § 256J.521, subd. 2. Strikes language that is no longer necessary due to the implementation of Family Stabilization Services (FSS).

19 **Family violence waiver criteria. Amends § 256J.545.** Strikes obsolete language related to the family violence waiver.

20 **Participation requirements. Amends § 256J.561, subd. 2.** Clarifies MFIP participation requirements.

21 **Child under 12 months of age.** Amends § 256J.561, subd.3. Exempts caregivers with a child under 12 months of age, instead of 12 weeks of age, from MFIP employment requirements.

22 **Good cause for failure to comply. Amends § 256J.57, subd. 1. Expands the list of good cause exceptions for failure to comply with MFIP requirements, to include situations where the documentation needed to determine if a participant is eligible for family stabilization services is not available, but there is information that the participant may qualify and the participant is cooperating with the county to obtain the necessary documentation.**

23 **Eligibility.** Amends § 256J.575, subd. 3. Removes DWP participants from eligibility for Family Stabilization Services

Adds the "60 or older" category to family stabilization services (FSS), and requires the county agency or employment services provider to assist the participant in obtaining documentation to determine eligibility for FSS if the county or provider has information that the participant may meet the eligibility criteria.

Makes this section effective March 1, 2010.

24 **Universal participation.** Amends § 256J.575, subd. 4. Exempts caregivers with a child under 12 months of age, instead of 12 weeks of age, from FSS employment requirements.

Makes this section effective March 1, 2010.

25 **Cooperation with services requirements.** Amends § 256J.575, subd. 6. Makes a technical change.

26 **Sanctions.** Amends § 256J.575, subd. 7. Modifies sanctions related to the MFIP family stabilization services.

27 **Work participation cash benefits.** Amends § 256J.621. Reduces work participation cash benefits from $75 to $50 per month. Specifies that these expenditures are MOE state funds under a separate state program.

28 **Performance base funds.** Amends § 256J.626, subd. 7. Modifies the statute related to performance base funds by adding a definition for "Caseload Reduction Credit (CRC)" and "TANF participation rate target" and incorporates the new terms into this section of law.

29 **Eligibility for DWP.** Amends § 256J.95, subd. 3. Exempts caregivers with a child under 12 months of age, instead of 12 weeks of age, from DWP employment requirements.

Makes this section effective March 1, 2010.

30 **Universal participation required.** Amends § 256J.95, subd. 11. Exempts caregivers with a child under 12 months of age, instead of 12 weeks of age, from universal participation requirements.

Makes this section effective March 1, 2010.

31 **Conversion or referral to MFIP.** Amends § 256J.95, subd. 12. Modifies which participants are considered to be unlikely to benefit from DWP and converted to MFIP. Requires that participants who meet the requirements of Family Stabilization Services be considered to be unlikely to benefit from DWP, provided the necessary documentation is available to support that determination. Makes this section effective March 1, 2010.

32 **Immediate referral to employment services.** Amends § 256J.95, subd. 13. Eliminates the requirement that the DWP written referral include the date, time, and location of the scheduled employment services interview.

33 **Extension; adoption finalized after age 16.** Amends § 259.67, by adding subd. 3b. Makes children who attain the age of 16 prior to the finalization of their adoption eligible for extension of the adoption assistance agreement to the date the child attains age 21 if the child meets certain requirements. Makes this section effective October 1, 2010.

34 **Department of Human Services claims.** Amends § 270A.09, by adding subd. 1b. Requires appeals hearings to be conducted in the same manner as other appeals within DHS for any debtor contesting a setoff claim by DHS or a county agency when claims relate to a debt resulting from receipt of certain program assistance.

35 **American Indian child welfare projects.** Allows the tribes to carry forward unspent funds to the next biennium.

36 **Repealer.** Repeals Minnesota Statutes, section 256I.06, subd. 9 (GRH community living adjustments).

Article 3: State-Operated Services

1 **Cost of care.** Amends § 246.50, subd. 5. Defines "charge for services" as the usual and customary fees charged for services provided to clients. Requires this fee to be established so that all payers can be appropriately billed for services and to include the costs related to operations of any program offered by the state.

2 **State-operated community-based services.** Amends § 246.50, by adding subd. 10. Defines "state-operated community-based services" as any program operated in the community developed and operated by the state and under the commissioner's control.

3 **Health plan company.** Amends § 246.50, by adding subd. 11. Provides that a "health plan company" not only has the meaning given in 62Q.01, subd. 4, but also includes a demonstration provider, a county-based purchasing plan, and a children's mental health collaborative that provides medical assistance for individuals in prepaid medical assistance

and MinnesotaCare.

4 **Clients in state-operated community-based programs; determinations.** Amends § 246.51, by adding subd. 1a. Requires the commissioner to determine what services a client's health plan will cover. If there are uncovered services, co-pays, or deductibles, the commissioner shall determine what part of the costs the client is able to pay. If the client is unable to pay the uncovered costs, then the commissioner is to determine the ability of the client's relatives to pay. The client and the relatives are required to provide the commissioner with documents and proof regarding their ability to pay. If they do not, they may be held responsible for the full cost of care. If they do not have the ability to pay, the commissioner may waive a portion of the cost.

5 **Clients served by regional treatment centers or nursing homes; determination.** Amends § 246.51, by adding subd. 1b. Requires the commissioner to determine what part of the cost of care the client is able to pay. If the client cannot pay the full cost, then the commissioner shall determine whether relatives have the ability to pay. Requires the client and the relatives to provide the commissioner with documents and proof regarding their ability to pay. If they do not, they may be held responsible for the full cost of care.

6 **Relative responsibility.** Amends § 246.511. Provides that for community-based services, a client's relatives shall not be ordered to pay more than the cost of care, and for regional treatment center services, 20 percent of the cost of care. Allows the commissioner to accept voluntary payments.

7 **Payment for care; order; action.** Amends § 246.52. Strikes the requirement that relatives must make monthly payments to the state for their share of the cost of care.

8 **Exceptions.** Amends § 246.54, subd. 2. Provides that the provisions of subdivision 1, (county portion for cost of care) apply to the Minnesota sex offender program.

9 **Client.** Amends § 246B.01, by adding subd. 1a. Defines "client" as a person admitted to MSOP or subject to a court hold for assessment, diagnosis, care, treatment, or other services provided by MSOP.

10 **Client's county.** Amends § 246B.01, by adding subd. 1b. Means the county of legal settlement for poor relief purposes at the time of commitment. If the client has no legal settlement, then county means the county of commitment, unless the client without a county of legal settlement is committed while serving a sentence, then it means the county from which the client was sentenced.

11 **Cost of care.** Amends § 246B.01, by adding subd. 2a. Means the charge for housing and treatment provided to any person admitted to MSOP.

12 **Local social services agency.** Amends § 246B.01, by adding subd. 2b. Means the agency in the client's county and of the county of commitment, and any other local social service agency with information about the financial circumstances of a client.

13 **Payment for care and treatment determination.** Creates § 246B.07.

Subd. 1. Procedures. Requires the commissioner to determine what part of the cost of care a client is able to pay. Requires the client to provide the commissioner with any requested documentation and provides that the client may be held

responsible for the full cost of care until the documentation is provided.

Subd. 2. Rules. Authorizes the commissioner to establish rules.

Subd. 3. Applicability. Permits the commissioner to recover the cost of any care provided by MSOP.

14 **Payment for care; order; action.** Creates § 246B.08. Instructs the commissioner to issue an order to a client or the guardian of the estate that requires payment for the cost of care. The order must specifically state the commissioner's determination, which is considered conclusive unless appealed. If the client fails to pay the amount due, the attorney general may institute a civil action to recover the amount owed.

15 **Claim against the estate of deceased client.** Creates § 246B.09.

Subd. 1. Client's estate. Requires the commissioner to file a claim against the estate of a client for the total cost of care provided, minus the amount actually paid toward the cost of care by the client. States that any recovery shall be divided equally between the state and county.

Subd. 2. Preferred status. Provides that a claim under subdivision 1 is considered an expense of last illness. Permits the commissioner to compromise the claim if the estate is needed for the care and maintenance of a spouse and minor or dependent children.

Subd. 3. Exception from statute of limitations. States that no statutes of limitations apply under this section.

16 **Liability of county; reimbursement.** Creates § 246B.10. Requires the county to pay a portion of the cost of care for a client legally settled in that county.

17 **Minnesota extended treatment options.** Amends § 252.025, subd. 7. Requires the commissioner to develop statewide community based services for individuals with developmental disabilities who exhibit severe behavior problems. Provides that individuals employed to provide these services are state employees supervised by the commissioner. Prohibits layoffs as a result of the restructuring.

18 **Requiring the development of community-based mental health services for patients committed to the Anoka-Metro Regional Treatment Center.** Requires the commissioner, in consultation with stakeholders, to develop an array of community based services for individuals who can be released from the treatment center. Requires a transition plan to be completed by October 1, 2009, and an initial report to the chairs of the health and human services committees by November 30, 2009. Provides that individuals working in the community facilities are state employees supervised by the commissioner. Prohibits layoffs as a result of the restructuring.

19 **Repealer.** Repeals § § 246.51, subd. 1 (procedures for payment of care and treatment), and 246.53, subd. 3 (exception from statute of limitations).

Article 4: Department of Health

1 **Health Information Technology and Infrastructure.** Amends § 62J.495.

Subd. 1. Implementation. Changes the name of the Health Information Technology Advisory Committee to the e-Health Advisory Committee. Requires the uniform standards be updated on an ongoing basis and an annual report to the legislature.

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

Subd. 2. E-Health Advisory Committee. Includes the name change for the advisory committee. Modifies matters which the advisory committee will address.

Subd. 3. Interoperable electronic health record requirements. Requires the electronic health record to be a "qualified electronic health record." Makes changes to conform to federal law.

Subd. 4. Coordination with national HIT activities. Requires that the state update its implementation plan to be consistent with the updated federal HIT strategic plan. Requires the commissioner to coordinate among state, regional, and national efforts to support the effective use of health information technology (HIT). Requires the commissioner to monitor national activity in this area and coordinate state responses and input on related policy. Requires the Departments of Health and Human Services to apply for federal funding to the extent eligible. Requires a report to the legislature as to any recommended policy changes the state should consider.

Subd. 5. Collection of data for assessment and eligibility determination. Authorizes the commissioner to collect certain data from providers, group purchasers, and others to assess the adoption, effective use, and interoperability of e-health records for a variety of listed purposes.

2 **Electronic health record system revolving account and loan program.** Amends §62J.496. Modifies existing loan program to align with the requirements for the federal loan program. Modifies the definition of "eligible borrower" to expand the types of health care providers who are eligible for these loans.

3 **Definitions.** Amends § 62J.497, subd. 1. Adds a definition of "backward compatible" and modifies the definitions of "e-prescribing" and "NCPDP SCRIPT Standard."

4 **Requirements for electronic prescribing.** Amends § 62J.497, subd. 2. Modifies the requirements for e-prescribing.

5 **Development and use of uniform formulary exception form.** Amends § 62J.497, by adding subd. 4.

(a) Requires the commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, to develop by six weeks after enactment of this subdivision, a uniform prior authorization and formulary exception form that allows health care providers to request exceptions from group purchaser drug formularies, including Medicare Part D plans, using a uniform form. Upon development of the form, requires health care providers

to submit requests for formulary exceptions using the uniform form, and requires group purchasers to accept this form from health care providers.

(b) Effective January 1, 2011, requires the form to be accessible by health care providers, and accepted and processed by group purchasers, electronically through the Internet.

6 **Electronic drug prior authorization, standardization, and transmission.** Amends § 62J.497, by adding subd. 5. Requires the commissioner of health, with others, to identify a way to standardize drug prior authorization requests.

Requires that by January 1, 2011, the requests must be accessible and submitted electronically.

7 **Medication therapy management.** Adds § 62Q.676. Requires a pharmacy benefit manager to make medication therapy management services available to certain enrollees with chronic medical conditions. Provides a definition of "medication therapy management."

8 **License, permit, and survey fees.** Amends § 144.122. Increases certain fees for hospitals and outpatient surgical centers.

9 **Vital records surcharge.** Amends § 144.226, subd. 4. Removes a sunset on a temporary surcharge for vital records to keep the surcharge at $4.

10 **Duplicate license fee.** Amends § 148.6445. Imposes a duplicate license fee of $25 for licensed occupational therapists.

Article 5: Health Care Programs

1 **Licensed assuming insurer.** Amends § 60A.092, subd. 2. For purposes of reinsuring against any health risk, defines an insurer as including a health insurer, service plan corporation, and HMO.

2 **Application requirements.** Amends § 62D.03, subd. 4. Makes a conforming change related to reinsurance by HMOs.

3 **Contracts; health services.** Amends § 62D.05, subd. 3. Allows an HMO to contract with other HMOs, as well as insurers and nonprofit health service plan corporations, for reinsurance. Allows an HMO to provide reinsurance or insolvency insurance coverage to health insurers and nonprofit health plan corporations.

4 **Transfers from the commissioner of human services.** Amends § 62J.692, subd. 7. Specifies the distribution of MERC-related payments from money transferred from prepaid MA capitation rates in terms of specific dollar amounts, rather than as a percentage of the amount transferred. This is related to the federal limit on state MERC spending.

5 **Performance payments.** Amends § 256.01, subd. 2b. Eliminates the requirement that the commissioner develop and implement a patient incentive health program for MA, GAMC, and MinnesotaCare enrollees who meet personal health goals for management of a chronic

disease or condition.

6 **Public assistance reporting information system.** Amends § 256.01, by adding subd. 18a. Requires the commissioner, effective October 1, 2009, to comply with federal requirements in implementing the Public Assistance Reporting Information System (PARIS), to determine eligibility for individuals applying for health care benefits under MA, GAMC, and MinnesotaCare, and public benefits under child care programs, GA, group residential housing, and supplemental nutrition assistance. Requires the commissioner to determine eligibility using data matches, including matching with programs operated by other states.

7 **Protection for American Indians.** Amends § 256.01, by adding subd. 18b. Requires the commissioner to comply, effective February 18, 2009, with federal requirements in the American Recovery and Reinvestment Act regarding American Indians.

8 **Outreach grants.** Amends § 256.962, subd. 2. Adds, as an outreach activity eligible for an outreach grant, targeting geographic areas with high rates of eligible but unenrolled children or racial and ethnic minorities and health disparity populations.

9 **School districts and charter schools.** Amends § 256.962, subd. 6. Requires charter schools, as well as school districts, to comply with state health care program outreach requirements. Limits the provision of Web information to school districts and charter schools with a Web site.

10 **Dental care pilot projects.** Adds § 256.964. Requires the commissioner of human services to authorize pilot projects to reduce hospital emergency room costs for preventable and nonemergency dental services. Specifies project criteria. Allows the commissioner to establish special payment rates for urgent dental care services provided as an alternative to emergency room services, and allows the commissioner to change or waive existing payment policies, in order to adequately reimburse providers for alternative services provided in outpatient or urgent care settings. Allows the commissioner to operate the project as part of the existing primary care access initiative.

11 **Operating payment rates.** Amends § 256.969, subd. 2b. Delays inpatient hospital rebasing for an additional three months, until April 1, 2011, and further limits rebasing for the period April 1, 2011, to March 31, 2012, to 39.2 percent of the full value. Requires rates to be rebased at full value effective April 1, 2012.

12 **Payments.** Amends § 256.969, subd. 3a. A new paragraph (h) reduces MA and GAMC fee-for-service payment rates for inpatient hospital admissions occurring on or after July 1, 2009, by 1.0 percent. Excludes facilities operated by the Indian Health Service and Indian tribes from this reduction. Requires payments to managed care plans to be reduced for services provided on or after October 1, 2009, to reflect this reduction.

13 **Nonpayment for hospital-acquired conditions and for certain treatments.** Amends § 256.969, by adding subd. 3b. (a) Prohibits the commissioner from making MA payments to hospitals for the cost of care that results from a condition specified in paragraph (c), if the condition was hospital acquired.

(b) Defines a condition as hospital acquired if it is not identified by the hospital as present on admission. Includes GAMC and MinnesotaCare in the definition of MA for purposes of the subdivision.

(c) Lists conditions governed by the nonpayment policy.

(d) Applies the nonpayment language to any payments that result from a hospital acquired condition listed in paragraph (c), including additional treatment or procedures, readmission to the facility, increased length of stay, change to a higher diagnostic category, or transfer to another hospital. In the event of a transfer to another hospital, the hospital where the condition was acquired is responsible for any costs incurred at the hospital to which the patient is transferred.

(e) Prohibits a hospital from billing a service recipient for any payment disallowed under this subdivision.

14 **Temporary rate increase for qualifying hospitals.** Amends § 256.969, by adding subd. 28. Provides a temporary rate increase for hospitals with an MA utilization rate equal to or greater than 25 percent. The state share of this payment is the amount available under § 256B.199, paragraph (d). Provides an immediate effective date.

15 **Reimbursement for fee increases for the early hearing detection and intervention program.** Amends § 256.969, by adding subd. 29. For services provided on or after July 1, 2010, requires the commissioner to reimburse hospitals for the increase in the fee for the early hearing detection and intervention program described in § 144.125, subdivision 1, paid by the hospital for public program recipients.

16 **Eligible vendors of medical care.** Adds § 256B.032. (a) Requires the commissioner to establish, by January 1, 2011, performance thresholds for providers included in the provider peer grouping system developed by the commissioner of health.

(b) Effective January 1, 2012, prohibits any provider with a combined cost and quality score below the threshold from enrolling as a state health care program vendor. Permits a disenrolled vendor to reenroll effective January 1 of any subsequent year, if the provider's most recent combined cost and quality score exceeds the threshold.

(c) Authorizes the commissioner to create an exception if the commissioner determines this is necessary to ensure access to health care services.

(d) Requires the commissioner to report to the legislature on the impact of this section by January 15, 2013.

17 **Asset limitations for families and children.** Amends § 256B.056, subd. 3c. Provides that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade of business for MA applicants or enrollees who are families and children. Requires specified assets to be disclosed to the local agency at the time of application or reapplication, and verified upon request of the local agency. Provides an effective date of January 1, 2011, or upon federal approval.

18 **Reduction of excess assets.** Amends § 256B.056, subd. 3d. Eliminates the ability of applicants to reduce assets in the three months before the month of application by designating burial funds. Also states that excess assets may only be reduced beginning the month of application by paying bills for health services incurred during the time period in rule for local agencies to act on MA applications (45 days for persons who are not aged, blind, or disabled, 60 days for persons who are aged, blind, or disabled). Applicants who

have excess income as well as excess assets must first spend excess assets to pay health service bills and may meet income spenddown on remaining bills. Provides an effective date of January 1, 2011.

19 **Treatment for colorectal cancer.** Amends § 256B.057, by adding subd. 11. (a) Allows state-only funded MA to be paid for individuals who have been screened by the colorectal cancer prevention demonstration project, need treatment for colorectal cancer, meet income guidelines for the project, are under age 65, and are not otherwise eligible for federally funded MA or covered under creditable coverage.

(b) Limits MA coverage to services provided during the period during which the individual receives treatment for colorectal cancer.

(c) Provides an exemption from MA income and asset standards.

(d) Provides that the subdivision expires December 31, 2010.

20 **Availability of income for institutionalized persons.** Adds § 256B.0575. Clarifies the expenses incurred for necessary medical or remedial care that may be deducted from an institutionalized person's income as reasonable expenses.

21 **Prohibited transfers.** Amends § 256B.0595, subd. 1. Transfers to a pooled trust by a person age 65 or older or the person's spouse, or by any person, court, or administrative body on behalf of the person or person's spouse are prohibited transfers under this section.

22 **Period of ineligibility for long-term care services.** Amends § 256B.0595, subd. 2. Permits the period of ineligibility to be eliminated if the improperly transferred assets, or the cash value of the assets, are returned within 12 months.

This section is effective for periods of ineligibility established on or after January 1, 2011.

23 **Citizenship requirements.** Amends § 256B.06, subd. 4. Allows children and pregnant women who are qualified noncitizens to be eligible, beginning July 1, 2010, for MA with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009. Also allows pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present, who are uninsured and otherwise meet MA eligibility requirements, to receive 60 days post partum coverage beginning July 1, 2009, using CHIP funding. (Under current law, these post partum services are covered by state-only MA.)

24 **Deeming of sponsor income and resources.** Amends § 256B.06, subd. 5. Beginning July 1, 2010, exempts pregnant women and children who are qualified noncitizens from deeming of sponsor's income and resources when determining MA eligibility. Provides a July 1, 2010 effective date.

25 **Physicians' services.** Amends § 256B.0625, subd. 3. Limits rates paid to physicians for the medical direction of a certified registered nurse anesthetist (CRNA) to the rate paid to the CRNA under medical direction.

26 **Health services policy committee.** Amends § 256B.0625, subd. 3c. A new paragraph (b) requires the commissioner to establish a dental subcommittee, to operate under the Health Services Policy Committee. Specifies membership. Requires the subcommittee to advise

the commissioner regarding: (1) the critical access dental provider program, including criteria for designating and terminating providers; (2) any changes to the critical access dental program necessary to comply with expenditure limits; (3) dental coverage policy; (4) dental delivery models; and (5) dental services to be added or eliminated from § 256B.0625, subdivision 9, paragraph (b).

A new paragraph (c) requires the committee to study approaches to making provider reimbursement under the MA, MinnesotaCare, and GAMC programs contingent on patient participation in a patient-centered decision-making process, and to evaluate the impact of these approaches on quality, patient satisfaction, and costs. Requires a report to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

A new paragraph (d) requires the committee to monitor and track physician practice patterns under state health care programs, and requires the commissioner to notify physicians with higher than average utilization or costs.

Paragraph (e) requires the committee to review caesarean section rates for the fee-for-service medical assistance population, and allows the committee to develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for providers and facilities.

27 **Dental services.** Amends § 256B.0625, subd. 9. (a) Eliminates coverage for fixed bridges.

(b) Specifies dental coverage for nonpregnant adults. Limits coverage to:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, once per year;

(3) limited exams;

(4) bitewing x-rays, once per year;

(5) periapical x-rays;

(6) panoramic x-rays, once every five years and only if certain conditions are met. Allows panoramic x-rays to be provided once every two years to certain patients who cannot cooperate for intra-oral film;

(7) prophylaxis, once per year;

(8) application of fluoride varnish, once per year;

(9) posterior fillings at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full mouth debridement, once every five years.

(c) Provides that MA also covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full mouth survey once every five years.

(d) States that MA covers dental services for children that are medically necessary, and that the following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants once every five years per permanent molar; and

(3) application of fluoride varnish is limited to once every six months.

Provides an effective date of January 1, 2010.

28 **Nurse anesthetist services.** Amends § 256B.0625, subd. 11. Provides that rates paid to CRNA who is not directed by a physician shall be the same as the rate paid to a physician directly providing anesthesiology services.

29 **Drugs.** Amends § 256B.0625, subd. 13. Provides MA coverage for prescription drugs prescribed by a physician assistant employed by or under contract with a community health board for communicable disease control.

30 **Payment rates.** Amends § 256B.0625, subd. 13e. Effective July 1, 2009, reduces the MA and GAMC fee-for-service pharmacy reimbursement rate from average wholesale price (AWP) minus 14 percent to AWP minus 15 percent.

31 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. Requires the commissioner to establish a collaborative psychiatric consultation service that would be available to primary care practitioners and include child and adolescent psychiatrists and adult psychiatrists. Also requires prior authorization and a collaborative psychiatric consultation from a provider approved by the commissioner for ADHD, ADD, and psychotropic medications prescribed to children under specified circumstances.

32 **Transportation costs.** Amends § 256B.0625, subd. 17. Clarifies language related to medical transportation services. Also provides a rate increase for special transportation in geographic areas classified as rural or super rural under the rural urban commuting area (RUCA) geographical classification system. The rate increases are as follows:

- for a trip in an area defined as super rural, the base rate is increased by 11.3 percent;
- for a rural or super rural trip equal to 17 miles or less, the mileage rate is 125

percent of the current rate; and

- for a rural or super rural trip between 18 and 50 miles, the mileage rate is 112.5 percent of the current rate.

33 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Requires providers of ambulance services to bill MA according to Medicare criteria (which require the provider to assign a condition code to the patient). Prohibits nonemergency ambulance services from being paid as emergencies.

34 **Broker dispatching prohibition.** Amends § 256B.0625, by adding subd. 18b. Prohibits the commissioner from using a broker for any purpose related to the provision of transportation services in the 11-county metropolitan area using a common carrier or private automobile.

35 **Prior authorization of diagnostic imaging services.** Amends § 256B.0625, by adding subd. 25a. Requires prior authorization or decision support for the following diagnostic imaging services: CT, MRI, MRA, PET, cardiac imaging, and ultrasound diagnostic imaging. Permits the commissioner to contract with a private entity to provide prior authorization.

36 **Special education services.** Amends § 256B.0625, subd. 26. Requires the commissioner to reimburse claims from school districts for health-related services that are part of an individual education plan based on an interim rate, and requires a settle-up at a final rate. Specifies procedures for school district appeals of the final rate.

37 **Data from Social Security.** Amends § 256B.08, by adding subd. 4. Requires the commissioner to accept data from the Social Security Administration related to determination of eligibility for Medicare prescription drug low-income subsidies. Provides an effective date of January 1, 2010.

38 **Policy and applicability.** Amends § 256B.15, subd. 1. Provides that "medical assistance" does not include Medicare cost-sharing benefits for the purposes of this section.

39 **Estates subject to claims.** Amends § 256B.15, subd. 1a. Adds language to this section defining a person's estate that is being stricken from section 256B.15, subd. 1h. New items added to the estate include: brokerage accounts; investment accounts; and assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangement.

Adds that in making recovery from the estate of a surviving spouse, the estate consists of all legal title and interest the recipient spouse had in jointly owned or marital property at the time of the recipient spouse's death. Provides that the recipient spouse who, at death, jointly owned property with the surviving spouse has an interest in the entire property.

40 **Estates of specific persons receiving medical assistance.** Amends § 256B.15, subd. 1h. Strikes paragraph (b) which is moved to subdivision 1a of this section.

41 **Limitations on claims.** Amends § 256B.15, subd. 2. Provides that a claim against the estate of a surviving spouse is payable from the full value of all of the recipient spouse's assets and interest that are part of the surviving spouse's estate. States that the claim is not payable from the assets of an individual married by the surviving spouse after the death of the recipient spouse. Limits claims against marital property to claims against recipients

who died on or after July 1, 2009.

42 **Controlling provisions.** Amends § 256B.15, by adding subd. 2b. Provides that for purposes of medical assistance recovery, at the time of death a recipient spouse has legal title or interest in the undivided whole of all of the property the recipient and surviving spouse owned jointly or as marital property at any time during their marriage. States that marital property includes any and all real or personal property of any kind.

Permits the agency to release specific real and personal property from this section.

43 **Commissioner's intervention.** Amends § 256B.15, by adding subd. 9. Permits the commissioner to intervene as a party in any proceeding involving medical assistance estate recovery.

44 **Intergovernmental transfers; hospital payments.** Adds § 256B.196. Establishes a number of additional MA payments to Hennepin County Medical Center (HCMC) and Regions Hospital, with the state share coming from intergovernmental transfers (IGTs) to the state from Hennepin and Ramsey counties.

Subd. 1. Federal approval required. Makes the section contingent on federal approval and on current payment of the new IGTs.

Subd. 2. Commissioner's duties. Establishes additional payments for outpatient services, affiliated physicians, and the prepaid health plans at the two medical facilities. Also establishes a process for determining the required IGT and requires the additional payments to be made upon receipt of the IGTs.

Subd. 3. Intergovernmental transfers. Requires the two counties to make the IGTs determined under this section. It also requires the IGTs from each county to be used to match federal payments to each county's respective medical facility.

Subd. 4. Adjustments permitted. Authorizes adjustments to the IGTs and the payments under certain circumstances.

Subd. 5. Recession period. Makes the IGTs from October 1, 2008 through December 31, 2010 voluntary, with "voluntary" defined to mean the counties must agree in writing to the IGTs prior to any payments being issued.

45 **Payments reported by governmental entities.** Amends § 256B.199. Requires the commissioner to apply for additional disproportionate share hospital payments available under the American Recovery and Reinvestment Act. These payments shall become the state share of the temporary payments under § 256.969, subd. 28.

46 **Managed care contracts.** Amends § 256B.69, subd. 5a. The amendments to paragraphs (c) and (d) clarify that the withhold of 5 percent of managed care payments applies to county-based purchasing plans and make conforming changes.

New paragraphs (e) through (i) increase the current 3 percent withhold that is returned according to a specified schedule to 4.5 percent in stages over a four-year period. This withhold is reduced to the current 3 percent level for services provided on or after January 1, 2014.

A new (j) reinstates language previously stricken that allows amounts withheld that are

reasonably expected to be returned as admitted assets.

47 **Medical education and research fund.** Amends § 256B.69, subd. 5c. The amendment to paragraph (a) makes a conforming change to hold the amount of a transfer constant.

The amendment to paragraph (b) limits transfers from capitation rates to MERC, effective July 1, 2009, to the total amount transferred for FY 2009. Provides that any excess must first reduce the fixed dollar transfers from general capitation rates, and then proportionally reduce the percentage reductions in capitation rates for different geographic groups of counties.

A new paragraph (d) requires the commissioner, beginning July 1, 2010, to transfer $21,714,000 each fiscal year to the MERC fund from the overall transfer amounts in paragraph (a). Requires the balance of transfers to be transferred no earlier than July 1 of the following fiscal year.

48 **Capitation rates.** Amends § 256B.69, subd. 5f. Beginning July 1, 2009, increases capitation rates each year by the lesser of $21,714,000 or an amount equal to the difference between the estimated value of the county group percentage reductions and the limit set for transfers.

49 **Alternative services; elderly and disabled persons.** Amends § 256B.69, subd. 23. Requires the commissioner, in determining MnDHO payments rates and risk adjustment methods for contract years starting in 2012, to consider methods used to determine county allocations for home and community-based waivers. If rate reductions are necessary, requires the commissioner to achieve the reductions by maintaining the base rate for contract years 2010 and 2011 for services provided under the CADI waiver at the contract year 2009 level. Allows the commissioner to apply other reductions to implement decreases required by law.

50 **Reimbursement rates for births.** Adds § 256B.756.

Subd. 1. Facility rate. For services provided on or after October 1, 2009, requires the commissioner to calculate a single (blended) rate for C-sections without complicating diagnosis, vaginal delivery with complicating diagnosis, and vaginal delivery without complicating diagnosis. Requires the single rate to increase the proportion of vaginal births and reduce the proportion of C-sections, and specifies criteria for the rate.

Subd. 2. Provider rate. For services provided on or after October 1, 2009, requires the payment rate for professional services related to labor, delivery, and antepartum and postpartum care for the diagnosis related groups specified in subdivision 1 to be calculated using the methodology described in that subdivision.

Subd. 3. Health plans. Requires payments to managed care and county-based purchasing plans to be reduced to reflect the adjustments in subdivisions 1 and 2.

Subd. 4. Prior authorization. States that prior authorization shall not be required to receive reimbursement for a C-section delivery.

51 **Physician reimbursement.** Amends § 256B.76, subd. 1. Effective July 1, 2009, reduces MA payment rates for physician and professional services by 5 percent, but exempts from this reduction office, outpatient, and preventive medicine procedure codes when performed

by specified primary care specialties. States that the reduction does not apply to FQHCs, rural health centers, and Indian health services. Requires the commissioner to reduce capitation rates effective October 1, 2009, to reflect this payment reduction.

52 **Reimbursement for basic care services.** Adds § 256B.766. Effective July 1, 2009, reduces MA payments for basic care services by 3.0 percent. Requires payments to managed care and county-based purchasing plans to be reduced for services provided on or after October 1, 2009, to reflect this reduction. Exempts physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, and medical transportation.

53 **General assistance medical care; services.** Amends § 256D.03, subd. 4. A new paragraph (u) reduces GAMC payments for basic care services by 3 percent effective July 1, 2009, in accordance with § 256B.766. Requires payments to managed care and county-based purchasing plans to be reduced to reflect this reduction.

A new paragraph (v) reduces GAMC payment rates for physician and professional services as provided in § 256B.76. Requires the commissioner to reduce capitation rates, effective October 1, 2009, to reflect this payment reduction.

54 **Chiropractic services.** Amends § 256L.03, by adding subd. 3b. States that MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays. Provides a January 1, 2010 effective date.

55 **Families with children.** Amends § 256L.04, subd. 1. Exempts children who were residing in a foster home or juvenile residential correctional facility from the MinnesotaCare eligibility requirements that apply to families with children.

56 **Children with family income greater than 275 percent of federal poverty guidelines.** Amends § 256L.04, by adding subd. 1b. States that children with family incomes greater than 275 percent of FPG are eligible for MinnesotaCare. Provides an effective date of July 1, 2009, or upon federal approval.

57 **Ineligibility.** Amends § 256L.04, subd. 7a. Makes a conforming change related to § 256L.04, subd. 1b. Provides an effective date of July 1, 2009, or upon federal approval.

58 **Sponsor's income and resources deemed available; documentation.** Amends § 256L.04, subd. 10a. Beginning July 1, 2010, exempts pregnant women and children who are qualified noncitizens from deeming of sponsor income and resources when determining MinnesotaCare eligibility. Provides an effective date of July 1, 2010, or upon federal approval.

59 **Application assistance and information availability.** Amends § 256L.05, subd. 1. Requires application assistance to be made available to applicants applying online, requires the commissioner and local agencies to assist enrollees in choosing a managed care organization, and makes related changes.

60 **Open enrollment and streamlined application and enrollment process.** Amends § 256L.05, by adding subd. 1c. Requires the commissioner and local agencies to develop a streamlined and efficient application and enrollment process for MA and MinnesotaCare enrollees that meets the criteria specified in the subdivision. The subdivision also requires the commissioners of human services and education to provide recommendations to the

legislature by January 15, 2010, on the creation of an open enrollment process tied to the public education system. Also requires the submittal on that date of an implementation plan for the open enrollment period and online application process. Requires the open enrollment process to be implemented with the 2010-2011 school year. Provides an effective date of July 1, 2010, or upon federal approval.

61 **Effective date of coverage.** Amends § 256L.05, subd. 3. Provides that the effective date of MinnesotaCare coverage for children eligible under § 256L.07, subd. 8, is the first day of the month following the date of termination from foster care or a juvenile residential correctional facility. Provides an effective date of July 1, 2009, or upon federal approval.

62 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. A new paragraph (e) provides that children in families with income not exceeding 275 percent of FPG, who fail to submit renewal forms and related documentation in a timely manner shall remain eligible for MinnesotaCare. If the commissioner determines through other means that there has been a change in income that affects premiums, requires the commissioner to notify the family of the new premium payment. If the new premium payment is not received, the children will be disenrolled effective the first day of the calendar month following the calendar month for which the premium is due.

A new paragraph (f) states that for children enrolled under § 256L.07, subd. 8, the first period of renewal begins the month the enrollee turns age 21.

Provides an effective date of July 1, 2009, or upon federal approval.

63 **General requirements.** Amends § 256L.07, subd. 1. Permits children in families with incomes greater than 275 percent of FPG to remain on MinnesotaCare. Provides an effective date of July 1, 2009, or upon federal approval.

64 **Must not have access to employer-subsidized coverage.** Amends § 256L.07, subd. 2. Exempts children with family income equal to or less than 200 percent of FPG from the MinnesotaCare ESI insurance barrier. Provides an effective date of July 1, 2009, or upon federal approval.

65 **Other health coverage.** Amends § 256L.07, subd. 3. Exempts children with family income less than 200 percent of FPG from the MinnesotaCare four-months uninsured insurance barrier. Increases, from 150 to 200 percent of FPG, the income limit for the "underinsured" exemption from the no other health coverage requirement. Provides an effective date of July 1, 2009, or upon federal approval.

66 **Automatic eligibility for certain children.** Amends § 256L.07, by adding subd. 8. Provides that any child who was residing in foster care or a juvenile residential correctional facility on their 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release, and is exempt from the ESI and four-month insurance barriers and from premiums. Provides an effective date of July 1, 2009, or upon federal approval.

67 **Medical assistance rate to be used.** Amends § 256L.11, subd. 1. Applies the 3 percent reduction in payments for basic care under § 256B.766 to MinnesotaCare, effective for services provided on or after July 1, 2009. Requires payments to managed care plans to be reduced for services provided on or after October 1, 2009, to reflect this reduction.

68 **Sliding fee scale; monthly gross individual or family income.** Amends § 256L.15, subd. 2. Exempts children with family income equal to or less than 200 percent of FPG from MinnesotaCare premiums. Provides an effective date of July 1, 2009, or upon federal approval.

69 **Exceptions to sliding scale.** Amends § 256L.15, subd. 3. Exempts children with family income equal to or less than 200 percent of FPG from MinnesotaCare premiums. Provides an effective date of July 1, 2009, or upon federal approval.

70 **Documentation.** Amends § 256L.17, subd. 3. Makes a clarifying change related to the form used to determine compliance with the MinnesotaCare asset requirement.

71 **Exemption.** Amends § 256L.17, subd. 5. Clarifies that children are exempt from MinnesotaCare asset limits (this is current law).

72 **Annual filing requirement for supplemental needs trusts.** Amends § 501B.89, by adding subd. 4. Requires the trustee of a supplemental needs trust to submit specified information to the commissioner at the time the beneficiary requests medical assistance.

This section is effective for applications for medical assistance and renewals of medical assistance submitted on or after July 1, 2009.

73 **Liability of husband and wife.** Amends § 519.05. Specifies that necessary medical services includes claims against an estate for provision public assistance payments of medical care.

74 Amends Laws 2003, First Sp. Session, chapter 14, article 13C, section 2, subdivision 1. Amends a rider to make a transfer of $2.157 million per fiscal year from the University of Minnesota to the commissioner of human services for capitation rates ongoing.

75 **Asthma coverage demonstration project.**

Subd. 1. Medical assistance coverage. Requires the commissioner of human services to establish a demonstration project to provide MA coverage for certain durable medical equipment to reduce asthma symptoms, for up to 200 American Indian children in Minneapolis, St. Paul, and Duluth who meet specified criteria.

Subd. 2. Report. Requires the commissioner of health, in collaboration with the department of human services, to report on the number of asthma-related hospital admittances for the children described in subdivision 1, before and after the demonstration project, and on the impact of the project on asthma-related school absenteeism. Requires the commissioner of health to seek nonstate funds to conduct the report, and makes the reporting requirement contingent on availability of nonstate funds.

76 **Claims and utilization data.** Requires the commissioner of human services, in consultation with the Health and Human Services Policy Committee, to develop and provide to the legislature by December 15, 2009, a methodology and draft legislation necessary to allow for release, upon request, of summary data on claims and utilization for Minnesota health care programs at no charge to research institutions, to conduct analyses of health care outcomes and treatment effectiveness.

77 **Administration of publicly funded health care programs.** (a) Requires the commissioner of human services, in cooperation with representatives of county agencies, and with input from advocacy organizations, to develop a plan that would align standards, income and asset methodologies, and procedures for families and children under MA and MinnesotaCare. Specifies other criteria for the plan and requires the commissioner to present recommendations to the legislative committees with jurisdiction over health care by January 15, 2010.

(b) Also requires the commissioner to report in detail to the chairs of the legislative committees with jurisdiction over health care finance, before entering into any contracts involving counties for streamlined electronic enrollment and eligibility determinations for state health care programs, if the contracts require payment from the general fund or health care access fund.

78 **COBRA premium state subsidy.**

Subd. 1. Eligibility. (a) States that an individual and qualified beneficiaries are eligible for a state premium subsidy of 35 percent of COBRA premiums, if the individual and beneficiaries:
(1) are eligible for the 65 percent COBRA premium subsidy under the American Recovery and Reinvestment Act of 2009;
(2) elect COBRA coverage; and
(3) are eligible for MA, GAMC, or MinnesotaCare without application of the four-month uninsured requirement.

Subd. 2. Subsidy. Requires the state subsidy payment to be paid directly to the entity to which the individual is required to make COBRA premium payments. Specifies related requirements.

Subd. 3. Notification. Requires employers and plan administrators who are required to provide notice under the ARRA to include information about the state subsidy. Also requires the commissioner of employment and economic development to inform applicants for unemployment benefits of the availability of a state subsidy.

Subd. 4. Exemption. Provides an exemption from the MinnesotaCare four-month uninsured requirement for persons applying for the program after receiving a state subsidy.

Subd. 5. Expiration. States that this section expires December 31, 2010.

79 **Federal approval.** Requires the commissioner of human services to resubmit for federal approval a request to eliminate the add-back of deprecation to income for self-employed farmers.

80 **Repealer.** Repeals § 256.962, subd. 7 (requirement that renewal notices for Minnesota health care programs be sent at least 60 and 90 days prior to renewal date, and related requirements) and § 256L.17, subd. 6 (reference to federal waiver to apply a MinnesotaCare asset test to children).

Article 6: Technical

Overview

This article contains technical changes related to the redesign and recodification of PCA services. The technical changes update statutory citations related to the PCA recodification in article 9.

1 **License required.** Amends § 144A.46, subd. 1. Updates a statutory citation related to changes in PCA services included in article 1.

2 **Employee.** Amends § 176.011, subd. 9. Updates statutory citations related to changes in PCA services included in article 1.

3 **Personal care provider organizations.** Amends § 245C.03, subd. 2. Updates a statutory citation related to changes in PCA services included in article 1.

4 **Personal care provider organizations.** Amends § 245C.04, subd. 3. Updates statutory citations related to changes in PCA services included in article 1.

5 **Personal care provider organizations.** Amends § 245C.10, subd. 3. Updates a statutory citation related to changes in PCA services included in article 1.

6 **Personal care services.** Amends § 256B.04, subd. 16. Updates a statutory citation related to changes in PCA services included in article 1.

7 **Disabled children.** Amends § 256B.055, subd. 12. Updates statutory citations related to changes in PCA services included in article 1.

8 **Targeted case management; definitions.** Amends § 256B.0621, subd. 2. Updates a statutory citation related to changes in PCA services included in article 1.

9 **Assessment and prior authorization process.** Amends § 256B.0652, subd. 3. Updates statutory citations related to changes in PCA services included in article 1.

10 **Eligibility.** Amends § 256B.0657, subd. 2. Updates a statutory citation related to changes in PCA services included in article 1.

11 **Services covered.** Amends § 256B.0657, subd. 6. Updates a statutory citation related to changes in PCA services included in article 1.

12 **Self-directed budget requirements.** Amends § 256B.0657, subd. 8. Updates a statutory citation related to changes in PCA services included in article 1.

13 **Cost of services and supports.** Amends § 256B.49, subd. 17. Updates a statutory citation related to changes in PCA services included in article 1.

14 **Inclusion of home care costs in waiver rates.** Amends § 256B.501, subd. 4a. Updates a statutory citation related to changes in PCA services included in article 1.

15 **Excluded time.** Amends § 256G.02, subd. 6. Updates a statutory citation related to changes in PCA services included in article 1.

16 **Supplementary service rates.** Amends § 256I.05, subd. 1a. Updates statutory citations related to changes in PCA services included in article 1.

17 **Good cause exemptions for not attending orientation.** Amends § 256J.45, subd. 3. Updates a statutory citation related to changes in PCA services included in article 1.

18 **Application.** Amends § 604A.33, subd. 1. Updates a statutory citation related to changes in PCA services included in article 1.

19 **Vulnerable adult.** Amends § 609.232, subd. 11. Updates a statutory citation related to changes in PCA services included in article 1.

20 **Facility.** Amends § 626.5572, subd. 6. Updates a statutory citation related to changes in PCA services included in article 1.

21 **Vulnerable adult.** Amends § 626.5572, subd. 21. Updates a statutory citation related to changes in PCA services included in article 1.

Article 7: Chemical and Mental Health

1 **Mental health professional.** Amends § 245.462, subd. 18. Adds licensed professional clinical counselor to the definition of mental health professional for purposes of the adult mental health act.

2 **Availability of outpatient services.** Amends § 245.470, subd. 1. Adds licensed professional clinical counselors as mental health professionals who can provide outpatient adult mental health services.

3 **Mental health professional.** Amends § 245.4871, subd. 27. Adds licensed professional clinical counselor to the definition of mental health professional for purposes of the children's mental health act.

4 **Availability of outpatient services.** Amends § 245.488, subd. 1. Adds licensed professional clinical counselors as mental health professionals who can provide outpatient children's mental health services.

5 **Placing authority.** Amends § 254A.02, by adding subd. 8a. Means a county, prepaid health plan, or tribal governing board.

6 **Monitoring.** Amends § 254A.16, by adding subd. 6. Requires measurement of compliance with the Minnesota Rules governing chemical dependency care of public assistance recipients.

7 **Local agency duties.** Amends §254B.03, subd. 1. Removes responsibility from the counties for negotiating provider rates for chemical dependency treatment services. Places this responsibility solely with the commissioner.

Provides a July 1, 2011, effective date.

8 **Local agencies to pay state for county share.** Amends § 254B.03, subd. 3. Provides that counties do not have to pay the state for the county share of services when payment is made according to §254B.09, subd. 8, payments to improve services to American Indians.

9 **Commissioner to select vendors and set rates.** Amends §254B.03, by adding subd. 9. Paragraph (a) gives the commissioner authority, effective July 1, 2011, to enter into agreements with vendors that meet specified standards and to set rates for services.

Paragraph (b) requires the commissioner to consider the acuity and complexity of the problems presented by the client when the commissioner sets rates.

Paragraph (c) provides that rates set for a specific entity to provide chemical dependency treatment pursuant to the American Indian Health Improvement Act supersede rates set under this section.

10 **Licensure required.** Amends §254B.05, subd. 1. Requires eligible vendors to have rules prohibiting residents from bringing chemicals into the facility or using chemicals within the facility.

Provides a July 1, 2011, effective date.

11 **American Indian agreements.** Amends §254B.09, subd. 2. Removes the responsibility from tribes for selecting vendors and negotiating rates for chemical dependency treatment.

Provides a July 1, 2011, effective date.

12 **Maximum rates.** Amends § 254B.11. Requires the commissioner to publish maximum rates for vendors of the consolidated chemical dependency treatment fund. Sets the ceiling for maximum rates.

13 **Rate methodology.** Creates § 245B.12. Requires the commissioner to consult with stakeholders and present a report to the 2011 Legislature proposing a new rate methodology for the consolidated chemical dependency treatment fund. This methodology must replace county-negotiated rates with providers.

14 **Definitions.** Amends § 256B.0622, subd. 2. Adds licensed professional clinical counselors as mental health professionals who can provide intensive inpatient and outpatient rehabilitative mental health services.

15 **Qualifications of provider staff.** Amends § 256B.0623, subd. 5. Adds licensed professional clinical counselors as mental health professionals who can provide adult rehabilitative mental health services.

16 **Mobile crisis intervention staff.** Amends § 256B.0624, subd. 5. Adds licensed professional clinical counselors as mental health professionals who can provide adult mental health crisis intervention services.

17 **Adult crisis stabilization staff qualifications.** Amends § 256B.0624, subd. 8. Adds licensed professional clinical counselors as mental health professionals who can provide adult mental health crisis stabilization services.

18 **Mental health professional.** Amends § 256B.0625, subd. 42. Adds licensed professional

clinical counselor to the definition of mental health professional for purposes of medical assistance.

19 **Definitions.** Amends § 256B.0943, subd. 1. Adds licensed professional clinical counselor to the definition of mental health professional for purposes of providing children's therapeutic services and supports.

20 **Treatment foster care services.** Amends § 256B.0625, subd. 47. Delays the effective date of these services until July 1, 2011.

21 **Excluded services.** Amends § 256B.0943, subd. 12. Prohibits medical assistance payment for treatment by multiple providers within the same agency at the same clock hour under the provisions of children's therapeutic services and supports.

22 **Alternative provider standards.** Amends § 256B.0944, by adding subd. 4a. Allows the commissioner to approve a crisis response provider that is unable to provide mobile crisis intervention services 24 hours a day, 7 days a week.

23 **Scope.** Amends § 256B.0947, subd. 1. Provides an effective date of November 1, 2010, subject to federal approval, for medical assistance coverage of medically necessary, intensive nonresidential rehabilitative mental health services.

24 **Qualified professional.** Amends § 256J.08, subd. 73a. Adds licensed professional clinical counselor to the definition of qualified professional for purposes of providing mental health services under the MFIP chapter.

25 **Autism spectrum disorder joint task force.** Establishes a joint task force on autism spectrum disorder.

Provides an effective date of July 1, 2009, and an expiration date of June 30, 2011.

26 **State-county chemical health care home pilot project.**

Subd. 1. Establishment; purpose. Establishes the pilot project. Provides that the purpose is to redesign the relationship between the state and counties to give counties authority to design and operate a new model for delivery of chemical health services.

Subd. 2. Workgroup. Requires that a workgroup be convened by July 15, 2009, to develop proposals for the pilot project. Requires a report to the legislature no later than January 15, 2010, for approval of one metro and one non-metro county pilot project to be implemented July 10, 2010.

Subd. 3. Report. Requires the commissioner to issue a report to the legislative committees with jurisdiction over chemical health by June 30, 2011, evaluating the effectiveness of the projects. Permits expansion only if the pilots are effective.

Subd. 4. Expiration. Provides an unspecified expiration date for the projects.

Effective date. Provides a June 30, 2012, effective date.

Article 8: Continuing Care

1 **Definitions.** Amends § 144.0724, subd. 2. Defines "activities of daily living" as grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting. Defines "nursing facility level of care determination" as the assessment process that results in a determination of the need for nursing facility level of care, for MA payment of: (1) nursing facility services; (2) elderly waiver services; (3) CADI and TBI waiver services; and (4) for state payment of alternative care services. Makes this section effective January 1, 2011.

2 **Resident assessment schedule.** Amends § 144.0724, subd. 4. Specifies that the assessments used to determine nursing facility level of care also include preadmission screening and a face-to-face long-term care consultation assessment. Makes this section effective January 1, 2011.

3 **Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. If a request for reconsideration of a preadmission screening or face-to-face long-term care consultation assessment is made, provides that the resident continues to be eligible for nursing facility level of care while the request is pending. Makes this section effective January 1, 2011.

4 **Nursing facility level of care.** Amends § 144.0724, by adding subd. 11. (a) For purposes of MA payment of long-term care services, requires a recipient to meet one of the following nursing facility level of care criteria:

(1) the persons needs the assistance of another person or constant supervision to begin and complete at least four activities of daily living;

(2) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning, and the assistance cannot be scheduled;

(3) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(4) the person has a qualifying nursing home stay of at least 90 days; or

(5) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment, according to specified criteria.

(b) Requires the assessment used to establish MA payment for nursing facility services to be the most recent performed, that occurred no more than 90 days before the MA financial eligibility determination.

(c) Requires the assessment used to establish MA payment for waiver services and alternative care service payment to be the most recent performed, that occurred no more than 60 days before eligibility determination for payment of long-term care services.

Makes this section effective January 1, 2011.

5 **Appeal of nursing facility level of care determination.** Amends § 144.0724, by adding subd. 12. Allows a resident or prospective resident to appeal a determination that results in

denial of long-term care services through a state agency hearing.

Makes this section effective January 1, 2011.

6 **Extension of approval of moratorium exception projects.** Amends § 144A.073, by adding subd. 12. Allows the commissioner of health to extend approval of moratorium exception projects by an additional 18 months, for proposals approved between July 1, 2007 and June 30, 2009. (Under current law, approval expires after 18 months unless construction has commenced.)

7 **Interpretation and enforcement of rights.** Amends § 144A.44, subd. 2. Adds unlicensed PCA services to the definition of "home care services" within the Home Care Bill of Rights statute. Requires a copy of these rights be given to an individual at the time home care services, including PCA services, are initiated.

8 **Licensing moratorium.** Amends § 245A.03, by adding subd. 7. Prohibits the commissioner from issuing an initial license for child foster care or adult foster care for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, requires the commissioner to revoke the license of a license holder who moves their primary residence away from the physical location of the foster care license. Lists exceptions to the moratorium. Requires the commissioner to study the effects of the license moratorium and report back to the legislature by January 15, 2011. Makes this section effective the day following final enactment.

9 **Community residential setting license.** Amends § 245A.11, by adding subd. 8. Requires the commissioner to establish standards for residential support services that integrate service standards and the residential setting under one license. Requires the commissioner to propose statutory language and an implementation plan for licensing requirements for residential support services by January 15, 2011. Requires certain child and adult foster care settings to obtain a community residential setting license.

10 **Day training and habilitation rates.** Amends § 252.46, by adding subd. 1a. Requires the commissioner to establish a statewide rate-setting methodology for all day training and habilitation services. Requires the rate-setting methodology to be transparent and equitable across the state, to involve a uniform process of structuring rates for each service, and to promote quality and participant choice.

11 **Community-based programs established.** Amends § 252.50, subd. 1. Allows DHS to consider clients who work within and benefit from these programs employees for tax purposes.

12 **State medical review team.** Amends § 256.01, by adding subd. 29. Requires the commissioner to review all medical evidence submitted by county agencies with a referral and seek additional information from providers, applicants, and enrollees to support the determination of disability where necessary. Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, requires the commissioner to ensure that the missing evidence is necessary and appropriate to determination of a disability and assist applicants and enrollees to obtain the evidence. Requires the commissioner to report to the legislature by February 1, 2010, and annually thereafter with specified information regarding the activities of the SMRT.

13 **Interagency data exchange.** Creates § 256.0281. Allows DHS, MDH, and the Office of the Ombudsman for Mental Health and Developmental Disabilities to establish interagency agreements governing the electronic exchange o data on providers and individuals collected, maintained, or used by each agency when such exchange is outlined by each agency in an interagency agreement to accomplish certain specified purposes including to improve quality management of providers between state agencies and to establish and maintain provider eligibility to participate as providers under Minnesota health care programs. Specifies that each agreement must include provisions to ensure anonymity of individuals, and must outline the specific uses of and access to shared data within each agency. Specifies that other HIPPA provisions related to individual data must also be incorporated.

14 **Reimbursement, allocations, and reporting.** Amends § 256.476, subd. 5. Changes "nonfederal dollars" to "monthly grant levels."

15 **Consumer support grant program after July 1, 2001.** Amends § 256.476, subd. 11. Changes "nonfederal share" to "50 percent." Removes language related to exception grants.

16 **Senior LinkAge line.** Amends § 256.975, subd. 7. Requires the Minnesota Board on Aging statewide information and assistance service to provide long-term care options counseling and describes counselor duties. Current law only requires the service to assist persons in accessing the information. This section also modifies data required to be reported by housing with services establishments and their arranged home care providers.

17 **Aged, blind, or disabled persons.** Amends § 256B.055, subd. 7. Requires certain applicants to be referred to the commissioner's SMRT for a determination of disability.

18 **Home health services.** Amends § 256B.0625, subd.6a. Defines MA home health services to be those specified in law rather than in rule

19 **Private duty nursing.** Amends § 256B.0625, subd. 7. Updates a statutory reference. Changes "foster care provider" to "family foster care provider."

20 **Personal care assistance services.** Amends § 256B.0625, subd. 19a. Adds a requirement that recipients require assistance and be determined dependent in one activity of daily living or in a Level I behavior. Removes statutory references to home health agency covered services. Removes language allowing certain family members to be reimbursed for PCA services if a waiver is granted. Allows unpaid guardians or conservators of adults to be reimbursed for providing PCA services if the guardian or conservator meets all of the statutory criteria for a PCA.

21 **Personal care.** Amends § 256B.0625, subd. 19c. Updates statutory references. Removes language related to physician's statement of need (these statements will no longer be necessary). Removes language requiring county public health nurses to assist recipients or responsible parties in identifying the most appropriate person to provide PCA supervision.

22 **Facility in receivership.** Amends § 256B.0641, subd. 3. Adds cross-references to clarify that a facility licensed as a nursing home that is in receivership may be sold unencumbered. The prior debt incurred will remain the responsibility of the prior owner.

23 **Home care services.** Amends § 256B.0651.

Subd. 1. Definitions. Modifies definitions of "activities of daily living,"

"assessment," "home care services," "home residence," "medically necessary," and "ventilator-dependent."

Subd. 2. Services covered. Updates statutory references. Removes qualified professional of PCA services from the list of covered services.

Subd. 3. Noncovered home care services. Modifies the list of noncovered home care services. Noncovered services include services provided in certain institutional settings, services to other members of the recipient's household, and any home care service included in the daily rate of a community-based residential facility where the recipient is residing.

Subd. 4. Authorization; exceptions. Modifies the list of exceptions to the requirement that home care services be authorized before services begin.

Subd. 5. Retroactive authorization. Repeals this subdivision.

Subd. 6. Authorization. Modifies the way in which home health services and services for people who are ventilator-dependent are authorized by the commissioner.

Subd. 7. Authorization; time limits. Removes references to the flexible use option. Limits the validity of authorizations to no more than 12 months. Changes "prior authorization" to "authorization."

Subd. 8. Authorization requests; temporary services. Makes technical changes. Removes language allowing temporary services to be extended beyond 45 days.

Subd. 9. Authorization for foster care setting. Changes "prior authorization" to "authorization" and changes "department" to "commissioner." Modifies the list of services the commissioner is prohibited from authorizing in foster care settings.

Subd. 10. Limitation on payments. Repeals this subdivision.

Subd. 11. Limits on services without authorization. Limits skilled nurse visits to face-to-face visits.

Subd. 12. Approval of home care services. Updates a statutory reference related to the recodification of PCA statutes.

Subd. 13. Recovery of excessive payments. Adds a statutory reference related to the recodification of PCA statutes.

Subd. 14. Referrals to Medicare providers required. Requires that home care providers that do not participate in or accept Medicare assignment must refer and document the referral of dual-eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services, supplies, and equipment. Requires providers to be terminated from participation in the MA program for failure to make these referrals.

Subd. 15. Quality assurance for program integrity. Requires the commissioner to maintain processes for monitoring ongoing program integrity including provider

standards and training, consumer surveys, and random reviews of documentation.

Subd. 16. Oversight of enrolled providers. Requires the commissioner to establish an ongoing quality assurance process for home care services. Gives the commissioner authority to request proof of documentation of meeting provider standards, quality standards of care, correct billing practices, and other information. Requires failure to provide access to information or to demonstrate compliance with laws, rules, or policies to result in suspension, denial, or termination of the provider agency's enrollment with the department.

24 Authorization and review of home care services. Amends § 256B.0652.

Subd. 1. State coordination. Changes "prior authorization" to "authorization."

Subd. 2. Duties. Modifies who may provide authorization and review services for MA recipients who are receiving home care services. Modifies the list of activities included in authorizations.

Subd. 3. Assessment and authorization process for persons receiving personal care assistance and developmental disabilities services. Removes obsolete language. Changes "prior authorization" to "authorization."

25 Home Health Agency Services. Amends § 256B.0653.

Subd. 1. Scope. Specifies that this section applies to home health agency services, including, home health aide, skilled nursing visits, physical therapy, occupational therapy, respiratory therapy, and speech language pathology therapy.

Subd. 2. Definitions. Defines "assessment," "home care therapies," "home health agency services," "home health aide," "home health agency," "occupational therapy services," "physical therapy services," "respiratory therapy services," "speech-language pathology services," "skilled nurse visit," "store-and-forward technology," "telehomecare," and "telehomecare skilled nurse visit."

Subd. 3. Home health aide visits. Specifies requirements for home health aide visits.

Subd. 4. Skilled nurse visit services. Specifies requirements for skilled nurse visit services. Specifies that skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. Specifies when telehomecare skilled nurse visits are allowed. Specifies that all telehomecare skilled nurse visits require authorization.

Subd. 5. Home care therapies. Lists home care therapies. Specifies requirements for home care therapies. Requires restorative and specialized maintenance therapies to meet certain criteria. Allows physical and occupational therapy assistants to be used under certain circumstances. Prohibits the therapist and the therapist's assistant from both billing for services provided to a recipient on the same day.

Subd. 6. Noncovered home health agency services. Lists noncovered home health agency services, including certain skilled nurse visits and home care therapies

provided in other settings such as a clinic, day program, or as an inpatient or when the recipient can access therapy outside of the recipient's residence.

26 **Private Duty Nursing.** Amends § 256B.065.

Subd. 1. Definitions. Removes the definition of "assessment." Modifies the definition of "complex private duty nursing care." Defines "private duty nursing," private duty nursing agency," "regular private duty nursing," and "shared private duty nursing."

Subd. 2. Authorization; private duty nursing services. Changes "prior authorization" to "authorization." Updates a statutory reference related to the recodification of PCA services.

Subd. 2a. Private duty nursing services. Specifies how private duty nursing services must be used.

Subd. 2b. Noncovered private duty nursing services. Lists noncovered private duty nursing services.

Subd. 3. Shared private duty nursing option. Removes the definition of "private duty nursing agency" (this term is defined elsewhere). Specifies that recipients of shared private duty nursing must be MA-eligible. Specifies that this subdivision is not applicable when a private duty nurse is caring for multiple recipients in more than one setting. Modifies the definition of "setting." Reorganizes the language of this subdivision.

Subd. 4. Hardship criteria; private duty nursing. Limits parents, spouses, or legal guardians to providing no more than 40 hours of services in a seven-day period. For parents and legal guardians, specifies that 40 hours is the total amount allowed regardless of the number of children or adults who receive services. Makes technical changes. Specifies when parents or spouses may not be paid to provide services. Defines "assessment" for purposes of this section.

27 **Assessment.** Amends § 256B.0655, subd. 1b. Changes "a face-to-face assessment" to "an in-person assessment."

28 **Authorization; personal care assistance and qualified professional.** Amends § 256B.0655, subd. 4. Removes language related to the commissioner reviewing the assessment and authorizing services. Requires all PCA services, supervision by a qualified professional, and additional services to be authorized by the commissioner before services begin, with certain exceptions. Requires authorization to be completed within 30 days after receiving a complete request. Specifies how a home care rating is determined. Specifies the methodology for determining the total time for PCA services for each home care rating. Specifies that each home care rating has a base level of hours assigned. Specifies how additional time may be added. Allows up to 96 units of qualified professional supervision to be authorized for each recipient receiving PCA services. Requires requests to exceed this total in a calendar year to be provided to the commissioner on a form approved by the commissioner. Removes language related to complex medical needs (this language is moved to § 256B.0659).

29 **Self-directed budget requirements.** Amends § 256B.0657, subd. 8. Modifies the methodology for establishing the budget for the self-directed service option.

30 **Enrollment and evaluation.** Amends § 256B.0657, subd. 12. Allows PCA recipients to enroll in the self-directed support option. Limits the number of PCA recipients that may enroll in this option.

31 **Personal Care Assistance Program.** Creates § 256B.0659. This section is a recodification of personal care assistance program language from § 256B.0655, which is repealed. This section also includes some reductions related to PCA services, simplifies statute and service delivery requirements, and implements provider standards. This section also includes some of the recommendations made by the Office of the Legislative Auditor in its recent PCA report.

Subd. 1. Definitions. Defines "activities of daily living," "behavior," "complex health-related functions," "critical activities of daily living," "dependency in activities of daily living," "health-related functions," "instrumental activities of daily living," "managing employee," "qualified professional," "personal care assistance provider agency," "personal care assistant," "personal care assistance care plan," "responsible party," "self-administered medication," and "service plan."

Subd. 2. Personal care assistance services; covered services. Lists the PCA services that are eligible for payment.

Subd. 3. Noncovered personal care assistance services. Lists the noncovered PCA services.

Subd. 4. Assessment for personal care assistance services. Requires an assessment to be completed for PCA services. Lists the limitations that apply to the assessment. Specifies that assessment for complex health-related functions must meet certain criteria. Describes how a recipient qualifies as having complex health-related functions. Specifies that an assessment of behaviors must meet certain criteria. Describes how a recipient qualifies as having a need for assistance due to behaviors.

Subd. 5. Service and support planning and referral. Requires the assessor to review the assessment with the recipient or responsible party and determine referrals for other payers, services, and community supports as appropriate. Lists the circumstances under which a recipient must be referred for evaluation, services, or supports that are appropriate to meet the recipient's needs. Specifies the reimbursement rates for public health nurse visits that relate to the provision of PCA services. Specifies that these rates must be adjusted to reflect provider rate increases for PCA services that are approved by the legislature. Reduces the payment rate for an assessment by 25 percent when the assessment is not completed on time and the service agreement documentation is not submitted in time to continue services. Requires the commissioner to reduce the amount of the claim for those assessments that are not submitted on time.

Subd. 6. Service plan. Specifies requirements related to the service plan. Requires the recipient and the provider chosen by the recipient to be given a copy of the completed service plan. Requires the recipient or responsible party to be given

information by the assessor about the options in the PCA program to allow for review and decision making.

Subd. 7. Personal care assistance care plan. Specifies requirements related to the PCA care plan. Lists the components that must be included in the care plan.

Subd. 8. Communication with recipient's physician. Specifies that communication with the recipient's physician about a recipient's assessed needs for services is required by the program. Requires the commissioner to work with the state medical director to develop options for communication with the recipient's physician.

Subd. 9. Responsible party; generally. Defines "responsible party." Lists requirements a responsible party must meet. Specifies when a licensed family foster parent may be the responsible party. Specifies when a responsible party is needed. Allows for two persons to be designated as the responsible party under certain circumstances.

Subd. 10. Responsible party; duties; delegation. Lists the duties the responsible party must perform. Allows certain responsible parties to delegate the responsibility to another adult who is not the PCA during temporary absences. Specifies duties of the responsible party related to the delegation of responsibility.

Subd. 11. Personal care assistant; requirements. Lists the requirements a PCA must meet, including, be employed by a personal care assistance provider agency, be able to effectively communicate with the recipient and PCA provider agency, and not be a consumer of PCA services. Allows a legal guardian to be a PCA if the guardian is not being paid for the guardian services and meets the criteria established for PCAs. Lists persons who do not qualify as PCAs.

Subd. 12. Documentation of personal care assistance services provided. Specifies the documentation of PCA services that is required. Specifies the criteria that must be included in a PCAs time sheet.

Subd. 13. Qualified professional; qualifications. Requires qualified professionals to be employed by PCA provider agencies and meet the statutory definition of "qualified professional." Requires PCA provider agencies to initiate a background study on qualified professionals before they provide PCA services. Specifies the duties of qualified professionals. Specifies additional qualifications qualified professionals must meet, including, completing provider training within six months of being hired by a PCA provider agency.

Subd. 14. Qualified professional; duties. Requires all PCAs to be supervised by a qualified professional. Requires the qualified professional to ensure and document certain information related to the PCA. Lists what information the qualified professional must evaluate at each supervisory visit. Lists the documentation the qualified professional must complete. Lists the qualified professional services not eligible for payment.

Subd. 15. Flexible use. Defines "flexible use." Specifies how authorization of flexible use occurs and describes limitations on the authorization of flexible use.

Requires the recipient, responsible party, and qualified professional to develop a written month-to-month plan of projected use of PCA services that is part of the care plan. Requires the PCA provider agency to monitor the use of services to ensure health and safety needs of the recipient are met. Allows the commissioner to take certain actions in cases of misuse or abuse of the flexible use of PCA services.

Subd. 16. Shared services. Limits MA payments for shared PCA services. Defines "setting." Lists noncovered shared PCA services. Specifies that the option of shared PCA is elected by the recipient or the responsible party with the assistance of the assessor. Specifies other requirements related to shared PCA services. Specifies how shared services are authorized. Lists requirements for PCAs providing shared PCA services.

Subd. 17. Shared services; rates. Requires the commissioner to provide a rate system for shared PCA services. Specifies the methodology for determining shared services rates. Makes these rates applicable only when all of the criteria for the shared PCA service have been met.

Subd. 18. Personal care assistance choice option; generally. Allows the commissioner to allow a recipient of PCA services to use a fiscal intermediary to assist the recipient in paying for medically necessary covered PCA services. Specifies that all other statutory and regulatory provisions relating to PCA services apply to a recipient using the PCA choice option. Describes the PCA choice option.

Subd. 19. Personal care assistance choice option; qualifications; duties. Lists the duties of the recipient or responsible party when using PCA choice. Lists the qualifications and duties that must be met by the PCA choice provider agency.

Subd. 20. Personal care assistance choice option; administration. Requires the PCA choice provider agency, recipient or responsible party, each PCA, and the qualified professional to enter into a written agreement before services commence under the PCA choice option, and annually thereafter. Lists what must be included in the agreement. Specifies how the rates paid to the PCA choice provider agency must be used. Allows the commissioner to deny, revoke, or suspend the authorization to use the PCA choice option under certain circumstances. Allows the recipient or responsible party to appeal the commissioner's decision to deny, revoke, or suspend the authorization to use the PCA choice option.

Subd. 21. Requirements for initial enrollment of PCA provider agencies. Lists the information and documentation that PCA provider agencies must provide to the commissioner at the time of enrollment as a PCA provider agency, including, proof of fidelity bond coverage in the amount of $20,000 and proof of worker's compensation insurance coverage. Requires the commissioner to collect this information from all PCA providers beginning upon enactment of this section. Specifies training requirements for PCA provider agencies.

Subd. 22. Annual review for personal care providers. Requires all PCA provider agencies to resubmit, on an annual basis, the information required in subdivision 21, along with some additional specified information. Requires the commissioner to send annual review notification to PCA provider agencies 30 days prior to renewal. Lists the information that must be included in the notification sent

to providers. Requires PCA provider agencies to submit required documentation to the commissioner within 30 days of notification from the commissioner. Requires the PCA provider agency enrollment number to be terminated or suspended if no documentation is submitted. Deems certain PCA provider agencies in compliance with the requirements for enrollment.

Subd. 23. Enrollment requirements following termination. Prohibits terminated PCA provider agencies from enrolling again for two years following the termination. Establishes enrollment requirements for PCA provider agencies following termination.

Subd. 24. Personal care assistance provider agency; general duties. Lists the duties of PCA provider agencies, including, complying with general MA coverage requirements, complying with background study requirements, and verifying and keeping records of hours worked by the PCA and qualified professional.

Subd. 25. Personal care assistance provider agency; background studies. Requires PCA provider agencies to initiate background studies on owners who have a 5 percent interest or more and all managerial officials, all qualified professionals, and all PCAs.

Subd. 26. Personal care assistance provider agency; communicable disease prevention. Requires provider agencies to establish and implement policies and procedures for prevention, control, and investigation of infections and communicable diseases according to current nationally recognized infection control practices or guidelines established by the CDC, as well as applicable regulations of other federal or state agencies.

Subd. 27. Personal care assistance provider agency; ventilator training. Specifies ventilator training requirements provider agencies must meet when working with recipients who are ventilator dependent.

Subd. 28. Personal care assistance provider agency; required documentation. Requires certain documentation to be completed and kept in the PCA provider agency file or the recipient's home residence. Lists the required documentation, including, employee files, recipient files, and the agency policy manual.

Subd. 29. Transitional assistance. Requires the commissioner, counties, and PCA providers to work together to provide transitional assistance for recipients and families to come into compliance with the requirements of this section, and ensure that services are prohibited from being provided by the housing provider. Requires the commissioner and counties to provide this assistance until July 1, 2010.

Subd. 30. Notice of service changes to recipients. Requires all recipients who will be affected by the changes in home care service to receive a notice of the changes at least 30 days before the effective date of the change. Specifies the information that must be included in the notice. Allows a recipient to request continued services pending appeal within the time period allowed to request an appeal.

Makes subdivisions 4, 22, and 27 effective January 1, 2010.

32 **Purpose and goal.** Amends § 256B.0911, subd. 1. Requires long-term care consultation services to be available to any person regardless of public program eligibility. Requires these services to be coordinated with long-term care options counseling.

33 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services." Defines "long-term care options counseling" and "lead agencies."

Makes this section effective January 1, 2011.

34 **Certified assessors.** Amends § 256B.0911, by adding subd. 2b. Requires each lead agency to have certified assessors who have completed the training and certification process beginning January 1, 2011. Specifies the qualifications of certified assessors.

35 **Assessor training and certification.** Amends § 256B.0911, by adding subd. 2c. Requires the commissioner to develop curriculum and a certification process to begin no later than January 1, 2010. Requires all lead agency staff designated to provide these services to be certified by December 30, 2010. Requires each lead agency to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service by January 1, 2011. Requires certified assessors to be recertified every three years.

36 **Long-term care consultation team.** Amends §256B.0911, subd. 3. Until January 1, 2011, requires the commissioner to allow arrangements and make recommendations that encourage counties to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service.

37 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Expands long-term care consultation services to include applicants for personal care assistant services, private duty nursing services, and home health agency services. It modifies the assessment process.

38 **Transition assistance.** Amends § 256B.0911, subd. 3b. Expands the duties of the long-term consultation team regarding the provision of transition assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility.

39 **Transition to housing with services.** Amends § 256B.0911, subd. 3c. Strengthens the existing transitional long-term care consultation function for prospective residents of housing with services establishments. The establishment must inform prospective residents of the requirement to contact the Senior LinkAge line for long-term care options counseling and transitional consultation. After consultation, the Senior LinkAge line must provide a certificate to the prospective resident and send a copy to the establishment.

40 **Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, subd. 4a. Adds a statutory reference to nursing facility level of care. Makes this section effective January 1, 2011.

41 **Administrative activity.** Amends § 256B.0911, subd. 5. Modifies administrative activities, requiring the commissioner to minimize the number of business processes required to provide services and to implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement,

program planning, evaluation, and policy development.

42 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Requires the commissioner to develop an alternative payment methodology for long-term care consultation services. Requires the commissioner to consider the maximization of federal funding for this activity in developing the new payment methodology.

43 **Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Adds a statutory reference to nursing facility level of care. Makes this section effective January 1, 2011.

44 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Limits Alternative Care (AC) program eligibility to persons determined to require, if AC services are not provided, the level of care provided in a nursing facility according to section 144.0724, subdivision 11, effective January 1, 2011. It also limits AC costs to $600 per month for person with low or no dependencies in activities of daily living.

45 **EW cost limits.** Amends § 256B.0915, subd. 3a. Establishes monthly service cost limits for Elderly Waiver clients with low dependencies in activities of daily living.

46 **Customized living service rate.** Amends § 256B.0915, subd. 3e. Modifies customized living service rates. Specifies that payment rates must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Requires counties and tribes to use tools issued by the commissioner to develop and document customized living service plans and rates. Removes language related to negotiated rates and replaces it with authorized rates. Makes technical changes.

47 **Service rate limits; 24-hour customized living services.** Amends § 256B.0915, subd. 3h. Specifies that payment rates must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Requires counties and tribes to use tools issued by the commissioner to develop and document customized living service plans and rates. Removes language related to negotiated rates and replaces it with authorized rates. Specifies the methodology for setting rates. Allows the commissioner to establish an alternative payment rate system for 24-hour customized living services by applying a single hourly rate for covered component services provided in establishments that meet certain criteria. Makes technical changes.

48 **Assessments and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Requires a determination that the client requires nursing facility level of care at initial and subsequent assessments to initiate and maintain participation in the waiver program. Specifies that only face-to-face assessments that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment. Makes this section effective January 1, 2011.

49 **Waiver payment rates; managed care organizations.** Amends § 256B.0915, by adding subd. 10. Requires the commissioner to adjust the elderly waiver capitation payment rates for managed care organizations to reflect the maximum service rate limits for customized living services and 24-hour customized living services for the contract period beginning October 1, 2010. Prohibits MA rates paid to customized living providers by managed care organizations from exceeding the maximum service rate limits determined by the commissioner.

50 **Distribution of funds; partnerships.** Amends § 256B.0916, subd. 2. Modifies the information counties must provide in their DD waiver plans.

51 **Essential community supports grants.** Amends § 256B.0917, by adding subd. 14. Establishes the purpose of the essential community supports grants program. Specifies to whom funding must be available. Limits funding to $400 per person per month. Requires service coordination to be part of a recipient's community support plan. Requires eligible persons to be reassessed at least annually and to continue to meet the eligibility requirements in order to remain eligible for a grant. Requires the commissioner to allocate grants to counties and tribes under contract with the department based on the historic use of the MA elderly waiver and alternative care grant programs and other criteria as determined by the commissioner. Makes this section effective January 1, 2011.

52 **County concurrence.** Amends § 256B.092, subd. 8a. Modifies the list of reasons why a county of service may refuse to concur with a placement from another county.

53 **Residential support services.** Amends § 256B.092, by adding subd. 11. Establishes a new service called residential support that is available on the CAC, CADI, DD, and TBI waivers, upon federal approval. Requires existing waiver service descriptions to be modified to ensure there is no duplication between other services. Specifies which providers must provide these services. Lists the criteria residential support services must meet. Requires providers of residential support services to be registered using a process determined by the commissioner beginning July 1, 2009.

54 **Waivered services statewide priorities.** Amends § 256B.092, subd. 12. Requires the commissioner to establish statewide priorities for individuals on the waiting list for DD waiver services as of January 1, 2010. Specifies what must be included in the statewide priorities. Requires the commissioner to take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options when allocating resources to lead agencies. Requires the commissioner to evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner.

55 **Foster care rate limits.** Amends § 256B.0948. Requires a 5 percent reduction in rates paid by waiver service programs for adult foster care and supportive living services that are above 95 percent of the statewide rate for the service.

56 **Subrogation.** Amends § 256B.37, subd. 5. Adds alternative care services.

57 **Private benefits to be used first.** Amends § 256B.37, subd. 5. Adds alternative care services.

58 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Suspends the automatic nursing facility rate adjustment on nonproperty-related costs for an additional three years, through the rate year beginning October 1, 2012.

59 **Payment of post-PERA pension benefit costs.** Amends § 256B.434 by adding subd. 21. Provides that nursing facilities that convert from public to private ownership after September 30, 2006, shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Specifies the methodology to be used to determine

the pension costs to be included.

60 **Planned closure rate adjustment.** Amends § 256B.437, subd. 6. Requires the commissioner, for planned closures approved after June 30, 2009, to provide a planned closure rate adjustment of $2,080 per closed bed.

61 **Phase-in of rebased operating payment rates.** Amends § 256B.441, subd. 55. For the rate period October 1, 2009, through September 30, 2013, requires the nursing facilities to be reimbursed at the blended rate of 14 percent rebased rate and 86 percent alternative payment system rate. This provision suspends the phase-in of higher percentages for the rebased rate during that rate period, but retains the same phase-in schedule, so that beginning October 1, 2013, and after, the blended rate is that required under current law.

62 **Implementation delay.** Amends § 256B.441, subd. 58. Specifies when the rebasing of property payment rates, removal of planned closure rate adjustments, and single-bed room incentives go into effect.

63 **Single-bed payments for medical assistance recipients.** Amends § 256B.441, by adding subd. 59. Effective October 1, 2009, sets the amount of the single-bed payment at 111.5 percent of the payment rate for the individual resident (the current percentage is 115 percent).

64 **Waivered services waiting list.** Amends § 256B.49, by adding subd. 11a. Requires the commissioner to establish statewide priorities for individuals on the waiting list for CAC, CADI, and TBI waiver services as of January 1, 2010. Specifies what must be included in the statewide priorities. Requires the commissioner to take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options when allocating resources to lead agencies. Requires the commissioner to evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner.

65 **Informed choice.** Amends § 256B.49, subd. 12. Adds statutory references to nursing facility level of care and long-term care consultation services. Makes this section effective January 1, 2011.

66 **Case management.** Amends § 256B.49, subd. 13. Modifies case management service activities. Makes this section effective January 1, 2011.

67 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Requires a determination that a client needs a hospital level of care or a nursing facility level of care at initial and subsequent assessments to initiate and maintain participation in the waiver program. Requires face-to-face assessments to be used when determining initial and ongoing access to waiver services payment. Makes this section effective January 1, 2011.

68 **Residential support services.** Amends § 256B.49, by adding subd. 22. Specifies that for this section, the provisions of residential support services are controlling.

69 **Home and community-based waivers; providers and payment.** Creates § 256B.4912.

Subd. 1. Provider qualifications. Lists the duties of the commissioner for the home and community-based waivers providing services to seniors and individuals

with disabilities. By July 2010, requires staff that provide direct contact that are employees of waiver services providers to meet certain requirements prior to providing waiver services and as part of ongoing enrollment. Applies this requirement to CDCS upon federal approval.

Subd. 2. Rate-setting methodologies. Requires the commissioner to establish statewide rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. Requires the rate-setting methodologies to abide by the principles of transparency and equitability across the state. Requires the methodologies to involve a uniform process of structuring rates for each service and to promote quality and participant choice.

70 **Contract provisions.** Amends § 256B.5011, subd. 2. Modifies the information that must be included in the service contract with each ICF/MR.

71 **ICF/MR rate decreases effective July 1, 2009.** Amends § 256B.5012, by adding subd. 8. Requires the commissioner to decrease each facility's operating payment adjustments equal to 2.58 percent of the operating payment rates in effect on June 30, 2009. Specifies the method by which the commissioner shall implement the rate reduction for each facility.

72 **Managed care contracts.** Amends § 256B.69, subd. 5a. Requires the managed care plans to use the fee-for-service MA assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies for all PCA services effective for services on or after January 1, 2010.

73 **Special needs.** Amends § 256D.44, subd. 5. Allows payments for special needs of recipients of Minnesota supplemental aid to be used to help recipients relocate to services without 24-hour supervision and receive the equivalent of the recipient's GRH allocation under specified circumstances. This provision is effective to June 30, 2011.

Requires the commissioner to assess the development of publicly owned housing, other housing alternatives, and whether a public equity housing fund may be established. Instructs the commissioner to report findings and recommendations to the legislature no later than January 15, 2012.

74 **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** Amends § 626.556, subd. 3c. Specifies that DHS is the agency responsible for assessing or investigating allegations of maltreatment in unlicensed PCA provider organizations providing services and receiving reimbursements under the MA program. Specifies that MDE is the agency responsible for assessing or investigating allegations of child maltreatment by licensed home care agencies.

75 **Lead agency.** Amends § 626.5572, subd. 13. Clarifies the lead agency for investigating maltreatment reports related to personal care provider organizations.

76 **Development of alternative services.** Requires DHS to develop alternative services to PCA services for persons with mental health and other behavioral challenges who can benefit from other more appropriate services. DHS must report to the legislature by January 15, 2011, with plans to implement the alternatives by July 1, 2011.

77 **Thirty-day notice required.** Requires DHS to give 30-days notice to persons affected by amendments in this article to listed sections.

78 **COLA compensation requirements.** Relieves a variety of community-based providers, and intermediate care facilities for persons with developmental disabilities from the employee compensation requirements included in rate increase legislation approved in 2007 and 2008. This section does not apply to employees covered by a collective bargaining agreement.

79 **Provider rate and grant reductions.** Requires the commissioner of human services to reduce grants, allocations, reimbursement rates, or rate limits, as applicable, by 2.58 percent effective July 1, 2009, for services rendered on or after that date. Specifies the services affected by this reduction.

80 **Recommendations for PCA services changes, consultation with stakeholders, and data reporting.** Requires the commissioner to consult with representatives of interested stakeholders beginning August 2009 to examine and develop recommendations for the PCA services program. Specifies what information must be included in the recommendations. Requires the recommendations to be provided to the legislative committees with jurisdiction over health and human services by January 15, 2010, and January 15, 2011.

81 **Establishing a single set of standards.** Requires the commissioner to consult with specified groups to develop a single set of standards governing services for people with disabilities receiving services under the home and community-based waiver services program to replace all or portions of existing laws and rules related to specified subjects including data practices, background studies, and the psychotropic medication checklist. Specifies what must be included in the standards. Allows the commissioner to consult with existing stakeholder groups convened under the commissioner's authority to meet all or some of the requirements under this section. Requires the commissioner to provide the reports and plans required by the section to the legislative committees and budget divisions with jurisdiction over health and human services policy and finance by January 15, 2012.

82 **Common service menu for home and community-based waiver programs.** Requires the commissioner to confer with specified groups to develop and update a common service menu for home and community-based waiver programs. Allows the commissioner to consult with existing stakeholder groups convened under the commissioner's authority to meet all or some of the requirements of this section.

83 **Intermediate care facilities for persons with developmental disabilities report.** Requires the commissioner to consult with providers and advocates of intermediate care facilities for persons with developmental disabilities to monitor progress made in response to the commissioner's December 15, 2008, report to the legislature regarding intermediate care facilities for persons with developmental disabilities.

84 **Housing options.** Requires the commissioner of human services, in consultation with specified other departments and groups, to explore ways to maximize the availability and affordability of housing choices available to persons with disabilities who need care assistance due to their health challenges. Requires the commissioner to provide a written report on the findings of the evaluation of housing options to the chairs and ranking minority members of the House and Senate standing committees with jurisdiction over

health and human services policy and funding by December 15, 2010. Specifies that this report replaces the November 1, 2010, annual report by the commissioner.

85 **Revisor's Instruction.**

Subd. 1. Renumbering of Minnesota Statutes, section 256B.0652, authorization and review of home care services. Requires the revisor of statutes to renumber certain specified sections. Requires the revisor to make necessary cross-reference changes in statutes and rules consistent with the renumbering. Requires DHS to assist the revisor with any cross-reference changes. Allows the revisor to make changes necessary to correct the punctuation, grammar, or structure of the remaining text to conform with the intent of the renumbering.

Subd. 2. Renumbering personal care assistance services. Requires the revisor to replace old references with new references wherever they appear in statutes or rules. Requires DHS to assist the revisor with any cross-reference changes, and, if necessary, to draft a corrections bill with changes for introduction in the 2010 legislative session. Allows the revisor to make changes necessary to correct the punctuation, grammar, or sentence structure to preserve the integrity of statutes and effectuate the intention of this section.

86 **Repealer.** (a) Repeals Minnesota Statutes, §§ 256B.0655, subd. 1, 1a, 1c, 1d, 1e, 1h, 1i, 3, 5, 6, 7, 8, 9, 10, 11, 12, and 13 (PCA services); and 256B.071, subd. 1, 2, 3, and 4 (MA maximization program).

(b) Repeals Minnesota Statutes, § § 256B.19, subd. 1d (portion of nonfederal share to be paid by certain counties) and 256B.431, subd. 23 (county nursing home payment adjustments), effective May 1, 2009.

(c) Repeals Minnesota Statutes, section 256B.0655, subds. 1f, 1g, and 2, effective January 1, 2010.

Article 9: State-County Results, Accountability, and Service Delivery Reform Act

1 **Citation.** Creates § 402A.01. Provides the name for this act.

2 **Definitions.** Creates § 402A.10. Defines "commissioner," "council," "essential human services programs," "redesign," "service delivery authority," and "steering committee."

Provides an immediate effective date.

3 **Steering Committee on Performance and Outcome Reforms.** Creates § 402A.15.

Subd. 1. Duties. Paragraph (a) requires the steering committee to develop a uniform process for performance and outcome reviews of essential human services programs. In addition, the committee is to develop reporting and accountability measures to determine when a county or human service authority is not achieving performance measures.

Paragraph (b) establishes time lines by which the committee must establish a list of essential services, establish a schedule of program reviews, and develop a process to respond to a county's failure to achieve performance measures.

Paragraph (c) provides that performance measures, reporting systems, and distribution formulas should be consistent across program areas. States that the goal is to reduce the cost of administrative requirements so that these funds can be used for providing services.

Paragraph (d) requires the steering committee to consider input from the redesign council established in section 6. Instructs the steering committee to review the goals established as part of the service delivery authority agreement in section 5 to determine whether they can be used as statewide standards.

Paragraph (e) requires the steering committee to form work groups.

Paragraph (f) requires the steering committee to make an annual report to the legislature. Requires the commissioner to post quarterly updates on the department's website.

Paragraph (g) requires the commissioner to publish bulletins containing the outcome goals and reporting requirements. Instructs the commissioner to submit state plan amendments to implement this act.

Subd. 2. Composition. Paragraph (a) lists the composition of the committee.

Paragraph (b) provides that the committee is to be convened with 60 days of final enactment of this legislation, and the commissioner and a county commissioner are to serve as co-chairs.

Paragraph (c) instructs agency staff to serve as informational resources and to staff the committee. Requires county associations to submit county program data as needed.

Paragraph (d) requires at least one county representative from this committee must also serve as a member of the redesign council.

Provides an immediate effective date.

4 **State-county results, accountability, and service delivery redesign.** Creates § 402A.20. Authorizes the implementation of the service delivery redesign.

5 **Designation of service delivery authority.** Creates § 402A.30.

Subd. 1. Establishment. Permits a county or consortium of counties to establish a service delivery authority to redesign service provision.

Subd. 2. New state-county governance framework. Paragraph (a) permits a county with a population over 55,000, or two or more counties that meet the requirements in subdivision 4, to establish a service delivery authority by resolution of their county boards.

Paragraph (b) lists the elements of the binding agreement that each participating

county must negotiate with the state. Among other things, this agreement must contain the scope of essential services the authority will provide, measurable goals for achieving effective and efficient service delivery, and responsibilities of the state and the service authority for administrative and technological support.

Paragraph (c) requires each county board to determine whether their county will participate in a service delivery authority after January 1, 2010. Permits participating counties to withdraw from participation under specified criteria. Requires repayment of state appropriations under certain circumstances.

Paragraph (d) states that this section does not impair a county's right to contract for services not covered by the redesign, or to establish procedures for local governments to combine.

Subd. 3. Duties. Paragraph (a) lists the duties of a service delivery authority.

Paragraph (b) requires a certified service delivery authority to designate a single administrative structure.

Subd. 4. Certification of service delivery authority. Lists the requirements for a county or consortium of counties to be certified as a service delivery authority. Among the conditions to be certified as a service delivery authority is the requirement that a single county must have a population of at least 55,000, or a group of counties with a combined population of at least 55,000, or four or more counties in reasonable geographic proximity, or a single county that has received on exemption.

Subd. 5. Single county service delivery authority. Permits the board of county commissioners to act as the service delivery authority in counties with a population of 55,000 or more if the county chooses to act as a single service delivery authority. Permits these authorities to enter into shared services arrangements with other authorities or smaller counties.

Subd. 6. Exemptions. Permits exemptions from the minimum population requirements.

Subd. 7. Commissioner remedies. Permits the commissioner to make recommendations to the council on remedies for performance improvement when a service delivery authority does not meet the goals established in the negotiated performance agreement.

6 Council. Creates § 402A.40.

Subd. 1. Council. Paragraph (a) creates the State-County Results, Accountability, and Service Delivery Redesign Council which is responsible for review of the redesign. Exempts the council from the requirements for advisory councils and committees established in section 15.059. States this council does not expire.

Paragraph (b) lists the required composition of the council.

Paragraph (c) permits administrative support to the council to be provided by the Association of Minnesota Counties, and its affiliates.

Paragraph (d) places responsibility for initial and subsequent appointments to the council on the member agencies and associations.

Subd. 2. Council duties. Paragraph (a) lists the responsibilities of the council.

Paragraph (b) requires the commissioner to exercise statutory authority to carry out the provisions of the redesign. This requirement includes seeking necessary federal waivers.

Provides an immediate effective date.

7 **Private sector funding.** Creates § 402A.50. Permits the council to accept private sector funds to help implement the redesign.

8 **Appropriation.** Appropriates $350,000 for the biennium from the general fund to the council to implement the reform. Requires the council to develop a methodology for distribution of the funds to the certified service delivery authorities.

Article 10: Public Health

1 **Permit fee.** Amends § 103I.208, subd. 2. Modifies certain fees related to well management.

2 **Fees for ionizing radiation-producing equipment.** Amends § 144.121, subd. 1a. Increases certain fees related to x-ray equipment at health care facilities.

3 **Penalty fee for late registration.** Amends § 144.121, subd. 1b. Modifies the amount of a late fee for registration applications related to x-ray equipment.

4 **Fees.** Amends § 144.1222, subd. 1a. Increases certain fees related to public pools and spas.

5 **Duty to perform testing.** Amends § 144.125, subd. 1. Increases fee related to the newborn screening program from $101 to $105 per specimen.

Provides a July 1, 2010 effective date for this section.

6 **License required.** Amends § 144.72, subd. 1. Requires youth camps to be licensed under Minnesota Statutes, chapter 157, which governs food, beverage and lodging establishments.

7 **Issuance of license.** Amends § 144.72, subd. 3. Makes conforming changes.

8 **Disclosure pamphlet.** Amends § 144.9501 by adding subd. 8a. Adds a definition of "disclosure pamphlet" to the Lead Poisoning Prevention Act.

9 **Lead sampling technician.** Amends § 144.9501, subd. 22b. Modifies the definition of "lead sampling technician."

10 **Regulated lead work.** Amends § 144.9501, subd. 26a. Modifies the definition of "regulated lead work."

11 **Renovation.** Amends § 144.9501, by adding subd. 26b. Adds a definition of "renovation."

12 **Certified lead firm.** Amends § 144.9505, subd. 1g. Modifies requirements for who must be certified as a lead firm.

13 **Notice of regulated lead work.** Amends § 144.9505, subd. 4. Adds renovation to the list of lead-related projects that do not require notice to the commissioner.

14 **Regulated lead work standards and methods.** Amends § 144.9508, subd. 2. Requires the commissioner to adopt rules consistent with the certain parts of the Toxic Substances Control Act.

15 **Licensure and certification.** Amends § 144.9508, subd. 3. Makes conforming changes.

16 **Lead training course.** Amends § 144.9508, subd. 4. Makes conforming changes.

17 **Grants; administration.** Amends § 144.9512, subd. 2. Removes the named grantee for swab team services. Modifies the services that grantees provide under this program. Requires that projects that provide certain matching funds receive priority for grant funding under this program.

18 **Support services to families.** Amends § 144.966, subd. 3a. Requires the commissioner to contract with a nonprofit for services for families with children who are deaf or have hearing loss. Specifies certain family support services and information that must be provided. Requires the commissioner to give preference to a nonprofit that can provide services statewide.

19 **Accreditation.** Amends § 144.97, subd. 2. Modifies provisions related to environmental laboratories. Replaces the term "certification" with "accreditation" and defines the term.

Provides that this section is effective July 1, 2009.

20 **Commercial laboratory.** Amends § 144.97, subd. 4. Replaces the term "contract laboratory" with "commercial laboratory."

Provides that this section is effective July 1, 2009.

21 **Field of testing.** Amends § 144.97, by adding subd. 5a. Provides a definition of "field of testing."

Provides that this section is effective July 1, 2009.

22 **Laboratory.** Amends § 144.97, subd. 6. Modifies the definition of "laboratory."

Provides that this section is effective July 1, 2009.

23 **Test category.** Amends § 144.97, by adding subd. 8. Provides a definition of "test category."

Provides that this section is effective July 1, 2009.

24 **Authorization.** Amends § 144.98, subd. 1. Modifies certification requirements for environmental laboratories by instead requiring the commissioner to accredit labs according

to certain national standards.

Provides that this section is effective July 1, 2009.

25 **Rules and standards.** Amends § 144.98, subd. 2. Permits the commissioner to adopt rules to conform with the requirements of section 24.

Provides that this section is effective July 1, 2009.

26 **Standards.** Amends § 144.98 by adding subd. 2a. Requires the commissioner to accredit labs according to the most current standards.

Provides that this section is effective July 1, 2009.

27 **Annual fees.** Amends § 144.98, subd. 3. Changes fee schedule from biennial to annual and increases fees for accreditation of environmental labs.

28 **Available programs, categories, and analytes.** Amends § 144.98 by adding subd. 3a. Requires that labs that test samples under certain programs must be accredited by the commissioner.

29 **Additional fees.** Amends § 144.98, by adding subd. 3b. Provides for various fees related to accrediting laboratories including, but not limited to, fees for out of state labs, late fees, and a variance fee.

30 **Refunds and nonpayment.** Amends § 144.98 by adding subd. 3c. Provides that refunds and credits will not be made for applications for accreditation that are not approved and that no accreditation will be awarded until fees are paid.

31 **Application.** Amends § 144.98 by adding subd. 6. Describes the process of application for accreditation and the types of laboratories that the commissioner may accredit.

Provides that this section is effective July 1, 2009.

32 **Implementation and effective date.** Amends § 144.98 by adding subd. 6a. Requires that all labs comply with the standards set out in § 144.98 by July, 1, 2009. Clarifies that accreditations issued on or before June 30, 2009 expire on their current expiration date.

33 **Initial accreditation and annual accreditation renewal.** Amends § 144.98 by adding subd. 7. Directs the commissioner to accredit labs after receipt of a completed application and the required documents. Requires that fees are prorated on a quarterly basis. Provides deadlines for receiving renewal applications and provides that operation of a lab after accreditation has expired is a violation of § 144.98 and is subject to action under the Health Enforcement Consolidation Act.

Provides that this section is effective July 1, 2009.

34 **Remedies available.** Amends § 144.99. Makes conforming changes.

Provides that this section is effective July 1, 2009.

35 **Expenses; fees.** Amends § 153A.17. Requires that fees charged to certified hearing aid dispensers must reflect actual costs of the program and may not be increased to cover costs

associated with investigating uncertified hearing aid dispensers.

36 **Youth camp.** Amends § 157.15 by adding subd. 20. Provides the definition of "youth camp" by cross-referencing the definition in § 144.71, subd. 2.

37 **Licenses required; fees.** Amends § 157.16. Adds youth camps to the food, beverage, and lodging establishments that must be licensed annually by the commissioner of health. Increases certain fees related to food, beverage, and lodging establishments.

38 **Exemptions.** Amends § 157.22. Makes technical changes and states that this chapter, which governs food, beverage, and lodging establishments, does not apply to certain school-sponsored concession stands.

39 **Special event recreational camping area.** Amends § 327.14 by adding subd. 9. Provides a definition of "special event recreational camping area."

40 **License required; renewal; fees.** Amends § 327.15. Provides requirements for a license application for manufactured home parks and recreational camping areas. Provides requirements for license renewals, including certain fees. Provides a fee schedule for manufactured home parks.

41 **Plan review application.** Amends § 327.16. Modifies provisions of current law that govern applications for licensure of manufactured home parks and recreational camping areas by creating a plan review application process.

42 **Rules.** Amends § 327.20, subd. 1. Makes technical changes.

43 **Special event recreational camping areas.** Amends § 327.20 by adding subd. 4. Provides requirements for licensed special event camping areas.

44 **Minnesota colorectal cancer prevention act.**

Subd. 1. Establishment. Requires the commissioner of health to provide grants to HCMC and MeritCare Bemidji to provide colorectal cancer screening to eligible uninsured and underinsured applicants.

Subd. 2. Eligibility. Provides the eligibility requirements for screening under this program. States that applicants must:

- Be at least 50 years of age, or under 50 years of age but at high risk for colon cancer;
- Be uninsured or underinsured (have insurance that does not cover the full cost of colorectal cancer screening);
- Not be eligible for MA, GAMC or MinnesotaCare; and
- Have a gross family income at or below 250 percent of the federal poverty level.

Subd. 3. Services. States that the services provided under this program include colon cancer screening, follow-up services for abnormal tests, and diagnostic services.

Subd. 4. Project evaluation. Requires the commissioner of health, in consultation with the University of Minnesota School of Public Health, to evaluate this program and make recommendations for increasing the number of Minnesotans who are

screened for colon cancer. Requires the commissioner to report its findings to the legislature by January 1, 2011.

45 **Research of exposure pathways for perflurochemicals.** Requires the commissioner of health to conduct a study related to exposure pathways for PFCs.

46 **Feasibility pilot project for cancer surveillance.** Requires the commissioner of health to provide a grant to Hennepin County Medical Center (HCMC) for a one-year pilot project through which HCMC will collect occupational and residential history data from newly diagnosed cancer patients. Lists the purposes of this pilot project, and requires HCMC to report to the legislature by October 1, 2010.

47 **Smoking cessation.** Requires the commissioner of health, in its collaborations with ClearWay, to prioritize smoking cessation activities in certain communities.

48 **Medical Response Unit Reimbursement Pilot Program.** (a) Requires the Department of Public Safety to work with the Minnesota Ambulance Association (MAA) to create a medical response unit reimbursement pilot program.

(b) Specifies that the Department of Public Safety, in consultation with the MAA, Minnesota Fire Chief's Association, Emergency Services Regulatory Board, and the Minnesota Council of Health plans, must:

- identify no more than five medical response units to participate in the program;
- outline criteria for reimbursement;
- determine reimbursement amounts for each unit; and
- collect data for a final report.

(c) Provides certain criteria for the medical response unit reimbursement pilot program including, but not limited to, the following:

- the program expires December 31, 2010, or when the appropriation is expended;
- the Department of Public Safety must report to the legislature by March 1, 2011, as to the effectiveness and value of the program;
- individual entities licensed to provide ambulance services are not eligible for participation in the program;
- if a participating medical response unit withdraws from the program, the Department of Public Safety may select another similarly operating unit to complete the program; and
- the Department of Public Safety and the other organizations involved have no ongoing responsibility to reimburse medical response units beyond this pilot program.

49 **Review of proposed regulations for body art technicians and establishments.** Requires the commissioner of health to review proposed legislation related to regulation of body art technicians and establishments and to make recommendations as to the level of regulation

necessary to protect public health. Requires a report by January 15, 2010.

50 **Hearing aids; enforcement.** Requires MDH to apportion costs of conducting investigations of unlicensed hearing aid dispensers among all licensed or credentialed professions that dispense hearing aids.

Provides that this section is effective July 1, 2011.

51 **Repealer.** (a) Repeals Minnesota Statutes, § 103I.112 (fee exemptions for state and local government); § 144.9501, subd. 17b (definition of "lead interim control worker"); § 327.14, subd. 5 (definition of "primary license"); and § 327.14, subd. 6 (definition of "annual license").

(b) Repeals Minnesota Rules, part 4626.2015, subp. 9 (duplicate certificate provision related to qualified food managers).

Article 11: Health-Related Fees

1 **Application fees.** Amends § 148D.180, subd. 1. Reduces certain fees for licensed social workers.

2 **License fees.** Amends § 148D.180, subd. 2. Reduces certain fees for licensed social workers.

3 **Renewal fees.** Amends § 148D.180, subd. 3. Reduces certain fees for licensed social workers.

4 **Late fees.** Amends § 148D.180, subd. 5. Reduces the renewal late fee for licensed social workers.

5 **Application fees.** Amends § 148E.180, subd. 1. Reduces certain fees for licensed social workers.

6 **License fees.** Amends § 148E.180, subd. 2. Reduces certain fees for licensed social workers.

7 **Renewal fees.** Amends § 148E.180, subd. 3. Reduces certain fees for licensed social workers.

8 **Late fees.** Amends § 148E.180, subd. 5. Reduces the renewal late fee for licensed social workers.

9 **Definitions.** Amends § 152.126, subd. 1. Includes schedule IV drugs in the definition of "controlled substances."

10 **Prescription electronic reporting system.** Amends § 152.126, subd. 2. Provides flexibility to the vendor that the Board of Pharmacy may contract with for the controlled substances prescription electronic reporting system.

11 **Access to reporting system data.** Amends § 152.126, subd. 6. Makes technical changes

and specifies that contracts the board enters are governed under Minnesota Statutes, section 13.05, subd. 6.

12 **Repealer.** Repeals Minnesota Statutes, § 148D.180, subd. 8 (temporary reduction in fees for social workers).

Article 12: Human Service Forecast Adjustments

Overview

This article includes human services forecast adjustments. See article text for details.

Article 13: Appropriations

Overview

This article includes health and human services appropriations. See article text and spreadsheet for details.