HOUSE RESEARCH

Bill Summary

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Article 1: Continuing Care

Overview

This article makes changes to nursing facility provisions, adult foster care licensed capacity provisions, and the common entry point designation centralized database, and repeals obsolete nursing facility statutes.

1 **Exceptions authorizing increase in beds; hardship areas.** Amends § 144A.071, subd. 3. Specifies that the operating payment rates previously in effect shall remain if, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating payment rates will be determined according to interim and settle up operating payment rate rules.

2 **Exceptions for replacement beds.** Amends § 144A.071, subd. 4a. Corrects cross-references.

3 **Licensing moratorium.** Amends § 245A.03, subd. 7. Removes obsolete language. Provides the commissioner the authority to indicate on a license whether the physical location of a foster care setting is the primary residence of the license holder. Requires license holders to notify the commissioner immediately if their primary residence changes. Specifies notification requirements of license holders who also provide services in the foster care home that are covered by a federally approved home and community-based waiver, specifies that these providers are considered registered under the residential support services provision, and requires this registration status to be identified on the license.

4 **Adult foster care license capacity.** Amends § 245A.11, subd. 2a. Prohibits the commissioner from issuing new corporate adult foster care licenses for five beds after June 30, 2014. Allows facilities licensed for five beds before June 30, 2014, to continue with a capacity of five adults if the license holder continues to comply with the requirements of this section.

5 **Community residential setting license.** Amends § 245A.11, subd. 8. Postpones a requirement that the commissioner propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature from January 15, 2011, to January 15, 2012, and

makes it part of the quality outcome standards.

6 **Support grants.** Amends § 252.32, subd. 1a. Makes families who are receiving services under the home and community-based waivers for persons with disabilities, PCA services, or a consumer support grant ineligible to receive a family support grant.

7 **Report by commissioner.** Creates § 252.34. Beginning January 1, 2013, creates one biennial report to the legislature that contains the overarching goals and priorities for individuals with disabilities, including the status of various programs.

8 **Rules.** Amends § 252A.21, subd. 2. Removes a requirement that the guardianship rule address quarterly reports for public wards.

9 **Consumer support grant program after July 1, 2001.** Amends § 256.476, subd. 11. Modifies the methodology used to calculate the maximum allowable monthly consumer support grant.

10 **Nursing home license surcharge.** Amends § 256.9657, subd. 1. Removes an obsolete cross-reference.

11 **Personal care.** Amends § 256B.0625, subd. 19c. Clarifies cross-references.

12 **Definitions.** Amends § 256B.0659, subd. 1. Modifies the definition of "extended PCA service."

13 **Noncovered PCA services.** Amends § 256B.0659, subd. 3. Clarifies language and removes obsolete language.

14 **Responsible party; generally.** Amends § 256B.0659, subd. 9. Modifies the list of persons prohibited from being the responsible party.

15 **PCA; requirements.** Amends § 256B.0659, subd. 11. Removes obsolete language and makes technical changes.

16 **Qualified professional; qualifications.** Amends § 256B.0659, subd. 13. Postpones the effective date, by one year, of certain training requirements for qualified professionals. Makes technical and clarifying changes regarding the requirements of the training. Requires qualified professionals working for a Medicare-certified home health agency to successfully complete the competency test.

Makes this section effective retroactive to July 1, 2011.

17 **Qualified professional; duties.** Amends § 256B.0659, subd. 14. Makes technical changes and modifies the list of activities that are not eligible for MA payment as qualified professional services.

18 **PCA choice option; qualifications; duties.** Amends § 256B.0659, subd. 19. Modifies the list of PCA choice provider agency requirements by removing a reference to qualified professionals.

19 **Requirements for initial enrollment of PCA provider agencies.** Amends § 256B.0659, subd. 21. Modifies requirements related to employee training. Requires Medicare-certified home health agency owners, supervisors, and managers to successfully complete the competency test.

20 **Notice of service changes to recipients.** Amends § 256B.0659, subd. 30. Places a sunset date of January 1, 2012 on a requirement to provide notice of changes in MA PCA services to each affected recipient at least 30 days before the effective date of the change.

Makes this section effective July 1, 2012.

21 **Annual report by commissioner.** Amends § 256B.0916, subd. 7. Sunsets an annual reporting requirement related to the DD waiver on January 1, 2013. This reporting requirement is replaced by

the new report created under section 7.

22 **Residential support services.** Amends § 256B.092, subd. 11. Makes providers licensed to provide child foster care or adult foster care registered under this section.

23 **Biennial report.** Amends § 256B.096, subd. 5. Sunsets a biennial reporting requirement related to the quality management, assurance, and improvement system on January 1, 2013. This reporting requirement is replaced by the new report created under section 7.

24 **External fixed costs.** Amends § 256B.441, subd. 13. Removes an obsolete cross-reference.

25 **Prior system operating cost payment rate.** Amends § 256B.441, subd. 31. Removes an obsolete cross-reference.

26 **Calculation of payment rate for external fixed costs.** Amends § 256B.441, subd. 53. Updates cross-references.

27 **Report.** Amends § 256B.49, subd. 21. Sunsets an annual reporting requirement related to the CAC, CADI, and TBI waivers on January 1, 2013. This reporting requirement is replaced by the new report created under section 7.

28 **Common entry point designation.** Amends § 626.557, subd. 9. Requires the commissioner of human services to maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data.

29 **Establishing a single set of standards.** Amends Laws 2009, ch. 79, art. 8, § 81 as amended by Laws 2010, ch. 352, art. 1, § 24. Creates an exception for customized living services from the quality outcome standards.

30 **Disability home and community-based waiver request.** By December 1, 2012, requires the commissioner to request all federal approvals and waiver amendments to the disability home and community-based waivers to allow properly licensed adult foster care homes to provide residential services for up to five individuals. Makes this section effective July 1, 2012.

31 **Hourly nursing determination matrix.** Requires service providers applying for medical assistance payments for private duty nursing (PDN) services to complete and submit to the commissioner an hourly nursing determination matrix for each recipient of PDN services. Requires the commissioner to collect and analyze data from the hourly nursing determination matrix.

32 **Repealer**. (a) Repeals Minnesota Statutes 2010, sections 256B.431, subds. 2c (operating costs after July 1, 1986), 2g (required consultants), 2i (operating costs after July 1, 1988), 2j (hospital-attached nursing facility status), 2k (operating costs after July 1, 1989), 2l (inflation adjustments after July 1, 1990), 2o (special payment rates for short-stay nursing facilities), 3c (plant and maintenance costs), 11 (special property rate setting procedures for certain nursing facilities), 14 (limitations on sales of certain nursing facilities), 17b (property-related payment rate), 17f (provisions for specific facilities), 19 (refinancing incentive), 20 (special property rate setting), 25 (changes to nursing facility reimbursement beginning July 1, 1995), 27 (changes to nursing facility reimbursement beginning July 1, 1998), and 29 (facility rate increases effective July 1, 2000); 256B.434, subds. 4a (facility rate increases), 4b (facility rate increases effective July 1, 2000), 4c (facility rate increases effective January 1, 2002), 4d (facility rate increases effective July 1, 2001), 4e (rate increases in effect July 1, 2001), 4g (facility rate increase effective October 1, 2007; Otter Tail County), 4h (nursing facility rate increase effective October 1, 2007; Martin County), 7 (case mix assessments), and 8 (optional higher payments for first 100 days); 256B.435 (July 1, 2001, nursing facility reimbursement system); and 256B.436 (voluntary closures; planning).

(b) Repeals Minnesota Statutes 2011 Supplement, section 245B.431, subd. 26 (changes to nursing

facility reimbursement beginning July 1, 1997).

(c) Repeals Minnesota Rules, part 9555.7700 (reports to the state agency).

Article 2: Telephone Equipment Program

Overview

1 **Definitions.** Amends § 237.50. Updates definitions within the TED program. Removes definitions of "communication device," "exchange," "interexchange service," "inter-LATA interexchange service," "local access and transport area," and "local exchange service." Adds definitions of "deafblind," "telecommunications device," "telecommunications," and "telecommunications services."

2 **Telecommunications access Minnesota program administration.** Amends § 237.51. Modernizes terminology and requires devices to be provided to individuals based on assessed need.

3 **Telecommunications access Minnesota fund.** Amends § 237.52. Modernizes terminology and clarifies a reference to the Public Utilities Commission.

4 **Telecommunications device.** Amends § 237.53. Modernizes terminology, removes a requirement for telephone companies to install outside wiring to certain households, and requires the commissioner to establish policies and procedures for the return of equipment when individuals are no longer eligible for the program.

5 **Telecommunications relay services (TRS).** Amends § 237.54. Modernizes terminology and requires TRS providers to comply with all current and subsequent FCC regulations related to TRS and related customer premises equipment for persons with disabilities.

6 **Annual report on telecommunications access.** Amends § 237.55. Clarifies a reference to the Public Utilities Commission and modernizes terminology.

7 **Adequate service enforcement.** Amends § 237.56. Modernizes terminology and clarifies who may participate in the consumer protection process.

Article 3: Comprehensive Assessment and Case Management Reform

Overview

1 **Medical services coordination.** Amends § 256B.0625, subd. 56. Modifies MA in-reach community-based service coordination.

2 **Definitions.** Amends § 256B.0659, subd. 1. Modifies the definition of "self-administered medication."

3 **Personal care assistance services; covered services.** Amends § 256B.0659, subd. 2. Clarifies coverage of PCA services to align with current policy and the comprehensive assessment.

4 **Assessment; defined.** Amends § 256B.0659, subd. 3a. Clarifies who can do PCA assessments and adds a sunset date to the subdivision. Makes timelines for completing assessments consistent with all assessments identified in the long-term care statute. Makes this subdivision expire when notice is given by the commissioner according to the long-term care consultation statute.

5 **Assessment for PCA service eligibility; limitations.** Amends § 256B.0659, subd. 4. Modifies the list of criteria that apply to the PCA assessment for complex health-related needs.

6 **Purpose and goal.** Amends § 256B.0911, subd. 1. Makes technical and clarifying changes to the purpose and goal of long-term care consultation services.

7 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definitions of "long-term care consultation services" and "lead agencies".

8 **Certified assessors.** Amends § 256B.0911, subd. 2b. Removes language requiring assessors to be part of a multidisciplinary team and removes requirements related to assessments for persons with complex health care needs. Modifies who may be a certified assessor.

9 **Assessor training and certification.** Amends §256B.0911, subd. 2c. Requires service providers to be certified within timelines specified by the commissioner. Removes obsolete language.

10 **Long-term care consultation team.** Amends § 256B.0911, subd. 3. Specifies that certified assessors must be part of a multidisciplinary team and specifies the other professionals that must be part of the team. Adds a reference to tribes. Requires tribes and health plans to provide long-term care consultation services as specified in their contracts with the commissioner. Requires the lead agency to provide the commissioner with an administrative contract.

11 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Modifies the effective date of when the assessment and support planning subdivision applies to PCA and private duty nursing services. Specifies who must be consulted for persons with complex health care needs. Adds language specifying the information that must be included in the written community support plan. Modifies the list of information that must be provided to the person receiving the assessment. Makes technical changes.

12 **Transition assistance.** Amends § 256B.0911, subd. 3b. Makes technical and conforming changes. Modifies lead agency duties related to transition assistance.

13 **Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, subd. 4a. Makes technical and conforming changes.

14 **Screening requirements.** Amends § 256B.0911, subd. 4c. Makes technical and conforming changes.

15 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Adds a cross-reference. Removes a cross-reference. Clarifies that until a new payment methodology is implemented, payment for assessments will continue to be billed as it is currently. Modifies a direction to the commissioner regarding development of a new payment methodology.

16 **Case management.** Amends § 256B.0913, subd. 7. Makes technical and conforming changes. Specifies case manager responsibilities.

17 **Requirements for individual coordinated service and support plan.** Amends § 256B.0913, subd. 8. Makes technical and conforming changes. Specifies the requirements the coordinated services and support plan must meet.

18 **Elderly waiver case management services.** Amends § 256B.0915, subd. 1a. Modifies the activities included in case management services. Requires case managers to collaborate with specified persons in the development and review of the coordinated service and support plan. Requires case management services to be provided by either a public or private agency. Defines "private agency." Lists the activities included under case management services.

19 **Provider qualifications and standards.** Amends § 256B.0915, subd. 1b. Makes conforming changes. Requires health plans to arrange or provide for elderly waiver case management services as part of an integrated delivery system.

20 **Service approval and contracting provisions.** Amends § 256B.0915, subd. 3c. Makes a conforming change.

21 **Implementation of coordinated service and support plan.** Amends § 256B.0915, subd. 6. Lists the requirements related to coordinated services and support plan.

22 **Waiver payment rates; managed care organizations.** Amends § 256B.0915, subd. 10. Corrects a cross-reference.

23 **County of financial responsibility; duties.** Amends § 256B.092, subd. 1. Makes technical and conforming changes.

24 **Case management services.** Amends § 256B.092, subd. 1a. Removes language related to the administrative functions of case management. Requires home and community-based waiver recipients to be provided case management services by qualified vendors as described in the federally approved waiver application. Modifies the list of case management service activities. Requires case management services to be provided by either a public or private agency. Defines "private agency." Makes technical and conforming changes.

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

26 **Coordination, evaluation, and monitoring of services.** Amends § 256B.092, subd. 1e. Makes technical and conforming changes.

27 **Conditions not requiring development of coordinated service and support plan.** Amends § 256B.092, subd. 1g. Makes technical and conforming changes.

28 **Medical assistance.** Amends § 256B.092, subd. 2. Makes a conforming change.

29 **Authorization and termination of services.** Amends § 256B.092, subd. 3. Makes technical and conforming changes.

30 **Federal waivers.** Amends § 256B.092, subd. 5. Makes conforming changes to terminology.

31 **Assessments.** Amends § 256B.092, subd. 7. Requires assessments and reassessments to be conducted by certified assessors according to the long-term care consultation statute, and requires assessments and reassessments to incorporate appropriate referrals to determine eligibility for case management. Makes technical and conforming changes. Removes language related to screening teams and case manager responsibilities.

32 **Additional certified assessor duties.** Amends § 256B.092, subd. 8. Modifies the certified assessor's duties for persons with developmental disabilities.

33 **County notification.** Amends § 256B.092, subd. 8a. Modifies the procedure by which a county of financial responsibility places a person in another county for services. Specifies that this section also applies to the CAC, CADI, and TBI waivers.

34 **Reimbursement.** Amends § 256B.092, subd. 9. Makes technical and conforming changes related to changes in terminology.

35 **Residential support services.** Amends § 256B.092, subd. 11. Makes technical and conforming changes related to changes in terminology.

36 **Notice of potential claim.** Amends § 256B.15, subd. 1c. Modifies the information that must be included in the notice.

37 **Agency lien.** Amends § 256B.15, subd. 1f. Modifies the information that must be included in the

application for a statement of the amount of lien.

38 **Case management.** Amends § 256B.49, subd. 13. Modifies the list of case management service activities for the CAC, CADI, and TBI waivers. Prohibits the case manager from delegating certain duties. Requires case management services to be provided by either a public or private agency. Defines "private agency."

39 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Requires assessments and reassessments for CAC, CADI, and TBI services to be conducted by certified assessors according to the long-term care consultation statute.

40 **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Aligns the coordinated service and support plan requirements for recipients of waivers under this section with the requirements for recipients of the DD waiver.

41 **Excluded time.** Amends § 256G.02, subd. 6. Removes a reference to the PCA program from the definition of "excluded time" under the unitary residence and financial responsibility chapter.

42 **Recommendations for further case management redesign and study of county and tribal administrative functions.** Requires the commissioner to develop a legislative report with specific recommendations and language for proposed legislation to be effective July 1, 2013, for further case management redesign. Specifies what must be included in the recommendations and proposed legislation. Directs the commissioner of human services to evaluate county and tribal administrative functions, processes, and reimbursement methodologies for purposes of the administration of home and community-based services and compliance and overnight functions.

Article 4: Chemical and Mental Health

Overview

This article repeals maintenance of effort requirements for Family Services Collaboratives and Children's Mental Health Collaboratives. It allows the commissioner to develop a diagnostic codes list, and also make technical changes.

1 **Diagnostic codes list.** Amends § 245.461, by adding subd. 6. Instructs the commissioner to develop a diagnostic codes list to be used to define the range of child and adult mental illness. Requires the commissioner to establish an advisory panel and to notify providers of changes to the list annually.

2 **Mental illness.** Amends § 245.462, subd. 20. Strikes references to specific clinical manuals that publish diagnostic codes. Inserts a reference to the diagnostic codes list to be developed by the commissioner.

3 **Diagnostic codes list.** Amends § 245.487, by adding subd. 7. Instructs the commissioner to develop a diagnostic codes list to be used to define the range of child and adult mental illness. Requires the commissioner to establish an advisory panel and to notify providers of changes to the list annually.

4 **Emotional disturbance.** Amends § 245.4871, subd. 15. Strikes references to specific clinical manuals that publish diagnostic codes. Inserts a reference to the diagnostic codes list to be developed by the commissioner.

5 **Collaborative responsibilities.** Amends § 245.4932, subd. 1. Strikes the MOE requirement for children's mental health collaborative.

6 **Exception from statute of limitations.** Amends § 246.53, by adding subd. 4. Reinstates a subdivision that was repealed by Laws 2009, chapter 79, article 3, section 19. This provision makes it

clear that the commissioner can file a claim to recover the cost of care against the estate of an individual who received services at a state facility operated by the commissioner.

7 **Eligibility for treatment.** Amends § 254B.04, subd. 2a. Provides clarification that an individual must score at level 4 on either Dimension 5 related to relapse and continued use or Dimension 6 related to recovery environment to be eligible for residential chemical dependency treatment.

8 **Mental health professional.** Amends § 256B.0625, subd. 42. Corrects a cross reference.

9 **Federal revenue enhancement.** Amends § 256F.13, subd. 1. Strikes the MOE requirement for family services collaborative.

Article 5: Health Care

Overview

This article contains policy changes related to the Medical Assistance and MinnesotaCare programs.

1 **District disclosure of information.** Amends § 125A.21, subd. 7. Strikes language that would allow consent given by a parent or legal representative as part of the MA or MinnesotaCare application process to also serve as consent for a school district to disclose information contained in a student's individualized education program to a health plan company.

2 **Competitive bidding.** Amends § 256B.04, subd. 14. Provides that recipient cost-sharing requirements under MA and MinnesotaCare do not affect contract payments under competitive bidding.

3 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Excludes certain assets owned by American Indians from being counted toward the MA asset limit for persons who are aged, blind, or disabled, to conform to requirements in the federal American Recovery and Reinvestment Act of 2009 (ARRA). Provides a retroactive effective date of July 1, 2009.

4 **Asset limitations for families and children.** Amends § 256B.056, subd. 3c. Excludes certain assets owned by American Indians from being counted toward the MA asset limit for families and children, to conform to requirements in the ARRA. Provides a retroactive effective date of July 1, 2009.

5 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Exempts American Indians from paying premiums under the MA employed persons with disabilities program, to conform to requirements in the ARRA. Provides a retroactive effective date of July 1, 2009.

6 **Period of ineligibility for long-term care services.** Amends § 256B.0595, subd. 2. Eliminates the requirement that assets transferred for less than fair market value be returned within 12 months of the start of the period of ineligibility for MA, in order to eliminate the period of ineligibility.

7 **Drugs.** Amends § 256B.0625, subd. 13. Specifies the circumstances under which MA covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions. Also defines active pharmaceutical ingredients and excipients and requires the commissioner to establish a list of these ingredients included in the MA formulary.

Requires over-the-counter drugs to be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; or (2) the number of dosage units required to complete the patient's course of therapy.

8 **Drug formulary.** Amends § 256B.0625, subd. 13d. Adds references to active pharmaceutical ingredients to a section of law specifying the circumstances under which drugs are excluded from the

MA formulary.

9 **Payment rates.** Amends § 256B.0625, subd. 13e. Strikes language requiring over-the-counter medications to be dispensed in the manufacturer's unopened package.

10 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. Allows pharmacists licensed in other states to provide medication therapy management services, by allowing these pharmacists to be licensed in the state in which the service is being performed, rather than being licensed by the Minnesota Board of Pharmacy as under current law.

11 **Diagnostic, screening, and preventive services.** Amends § 256B.0625, subd. 14. Corrects terminology related to consent by a parent or guardian for the application of fluoride varnish to the teeth of a minor.

12 **Cost-sharing.** Amends § 256B.0631, subd. 1. Eliminates the $3 MA copayment for glasses (related to the use of competitive bidding for glasses).

13 **Exceptions.** Amends § 256B.0631, subd. 2. Exempts services subject to volume purchase through competitive bidding from MA cost-sharing. (Note: clarifying amendment needed.)

14 **Additional portion of nonfederal share.** Amends § 256B.19, subd. 1c. Modifies an existing intergovernmental transfer, by replacing a reference to Metropolitan Health Plan with the term demonstration provider, to reflect Metropolitan Health Plan not receiving a contract under competitive bidding to provide managed care services in Hennepin County.

15 **Prospective per capita payment.** Amends § 256B.69, subd. 5. Strikes language that delays payments to plans for elderly waiver services by a month.

16 Managed care contracts. Amends § 256B.69, subd. 5a. The amendment to paragraph (c) sets requirements for clinical or utilization performance targets.

The amendment to paragraph (g) modifies implementation of the performance target related to reducing a health plan's emergency room utilization rate by specifying the initial base year, excluding persons enrolled in programs serving the elderly and persons with disabilities, and requiring evaluation of changes in the health risk of a plan's membership from one year to another. The amendment also corrects a reference to the base year.

The amendment to paragraph (h) modifies implementation of the performance target related to reducing a plan's hospital admission rate, by excluding persons enrolled in programs serving the elderly and persons with disabilities, and requiring evaluation of changes in the health risk of a plan's membership from one year to another.

The amendment to paragraph (i) modifies implementation of the performance target related to reducing a plan's rate of subsequent hospitalization, by excluding persons enrolled in programs serving the elderly and persons with disabilities.

17 **Medicare special needs plans; medical assistance basic health care.** Amends § 256B.69, subd. 28. Allows the commissioner to contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans to provide MA basic health care services to persons with disabilities. Allows the commissioner to contract with demonstration providers and current and former sponsors of qualified Medicare-approved special needs plans to provide basic health care services to persons eligible for both Medicaid and Medicare and to certain Social Security beneficiaries. Also corrects an internal reference.

18 **Effective date of coverage.** Amends § 256L.05, subd. 3. Specifies the effective date of MinnesotaCare coverage for American Indians who are exempted under § 256L.15, subd. 1 from paying MinnesotaCare premiums.

19 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. The amendment to paragraph (b) sets requirements for clinical or utilization performance targets.

The amendment to paragraph (d) modifies implementation of the performance target related to reducing a health plan's emergency room utilization rate by specifying the initial base year, excluding persons enrolled in programs serving the elderly and persons with disabilities, and requiring evaluation of changes in the health risk of a plan's membership from one year to another.

The amendment to paragraph (e) modifies implementation of the performance target related to reducing a plan's hospital admission rate, by excluding persons enrolled in programs serving the elderly and persons with disabilities, and requiring evaluation of changes in the health risk of a plan's membership from one year to another.

The amendment to paragraph (f) modifies implementation of the performance target related to reducing a plan's rate of subsequent hospitalization, by excluding persons enrolled in programs serving the elderly and persons with disabilities.

20 **Premium determination.** Amends § 256L.15, subd. 1. Requires the commissioner to waive MinnesotaCare premiums for enrollees who document their status as American Indians, to conform to the requirements in the ARRA. Provides a retroactive effective date of July 1, 2009.

21 **Contents.** Amends § 514.982, subd. 1. Requires MA lien notices to contain the last four digits of the MA recipient's Social Security number (rather than the entire Social Security number).

22 **Health services advisory council.** Requires the health services advisory council to review the literature on the efficacy of various treatments for autism spectrum disorder and recommend to the commissioner of human services authorization criteria for services, by December 31, 2012. Allows the council to recommend coverage with ongoing collection of outcomes evidence, in circumstances where evidence is not currently available or the strength of evidence is low.

23 **Repealer.** Repeals § 256.01, subd. 18b (general language requiring the commissioner of human services to comply with the requirements in section 5006 of the American Recovery and Reinvestment Act related to American Indians).

Article 6: Technical

1 **Cost estimate of a moratorium exception project.** Amends § 144A.071, subd. 5a. Corrects a cross-reference.

2 **Revisor's instruction.** Instructs the revisor to change terminology from "traumatic brain injury" to "brain injury" in the statutes related to home and community-based service waivers.