HOUSE RESEARCH

Bill Summary

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Authors: Abeler and others

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Analyst: Lynn Aves (651) 296-8079 (Article 5)
Randall Chun (651) 296-8639 (Article 1)
Emily Cleveland (651) 296-5808 (Article 2)
Danyell Punelli (651) 296-5058 (Articles 3 and 4)

Article 1: Health Care

Overview

This article makes various changes related to Medical Assistance and MinnesotaCare.

1 **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** Amends § 62E.14, subd. 4g. Exempts individuals enrolled in the healthy MN contribution program from the MCHA six-month durational residency requirement.

2 **Standards for claim denial.** Amends § 72A.201, subd. 8. Eliminates certain insurer reporting requirements related to the evaluation standards and criteria used by chemical dependency reviewers to deny insurance claims for chemical dependency services. Provides an immediate effective date.

3 **Nonemergency medical transportation advisory committee.** Amends § 256B.0625, by adding subd. 18c. (a) Requires the nonemergency medical transportation advisory committee to advise the commissioner on the administration of nonemergency medical transportation covered under MA. Requires the committee to meet at least quarterly, and to annually elect a chair. Requires the commissioner, or the commissioner's designee, to attend all advisory committee meetings.

(b) Requires the committee to advise and make recommendations to the commissioner on:

(1) the development of, and periodic updates to, a policy manual for nonemergency medical transportation services;

(2) policies and a funding source for reimbursing no-load miles;

(3) policies to prevent waste, fraud, and abuse and to improve efficiency;

(4) other issues identified in the 2011 Office of Legislative Auditor's report on nonemergency medical transportation; and

(5) other aspects of nonemergency medical transportation, as requested by the commissioner.

(c) Requires the committee to coordinate its activities with the Minnesota Council on Transportation Access, and requires the committee chair or a designee to attend meetings of the council.

(d) Provides that the committee sunsets on December 1, 2014.

4 **Advisory committee members.** Amends § 256B.0625, by adding subd. 18d. Specifies membership of the nonemergency medical transportation advisory committee. Provides that members shall not be employed by DHS and receive no compensation.

5 **Single administrative structure and delivery system.** Amends § 256B.0625, by adding subd. 18e. (a) Requires the commissioner to implement a single administrative structure and delivery system for nonemergency medical transportation, beginning July 1, 2013. Specifies criteria for the administrative structure and delivery system.
(b) Requires the commissioner to present to the legislature, by January 15, 2013, any draft legislation necessary to implement the administrative structure and delivery system.

(c) Requires the commissioner to consult with the Nonemergency Medical Transportation Advisory Committee in developing the administrative structure and delivery system and draft legislation.

6 **Enrollee assessment process.** Amends § 256B.0625, by adding subd. 18f. Requires the commissioner, in consultation with the Nonemergency Medical Transportation Advisory Committee, to develop and implement, by July 1, 2013, a comprehensive, statewide, standard assessment process for MA enrollees seeking nonemergency medical transportation services. Specifies criteria for the

assessment process.

7 **Use of standardized measures.** Amends § 256B.0625, by adding subd. 18g. Requires the commissioner, in consultation with the Nonemergency Medical Transportation Advisory Committee, to establish performance measures to assess the cost-effectiveness and quality of nonemergency medical transportation. Specifies criteria for the performance measures and also requires the commissioner to consider the measures identified in the 2012 DHS report to the legislature on nonemergency medical transportation. Requires the commissioner to collect, audit, analyze, and report performance data beginning in CY 2013, and to periodically supplement this information with information from consumer surveys.

8 **Licensed physician assistant services.** Amends § 256B.0625, subd. 28a. Allows licensed physician assistants, supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, to bill for medication management and evaluation and management services provided to MA enrollees in inpatient hospital settings, consistent with their authorized scope of practice. Billing by physician assistants is not allowed for psychotherapy, diagnostic assessments, and providing clinical supervision.

9 **Payments for mental health services.** Amends § 256B.0625, subd. 38. Sets MA payments for mental health services provided by physician assistants at 80.4 percent of the base rate paid to psychiatrists.

10 **Cost-sharing.** Amends § 256B.0631, subd. 1. Provides that the commissioner may allow managed care and county-based purchasing plans to waive the MA family deductible. Also allows the commissioner to waive the collection of the family deductible from individuals, and allow long-term care and waivered service providers to assume responsibility for payment.

11 **Pediatric care coordination.** Amends § 256B.0751, by adding subd. 9. Requires the commissioner to implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, and who receive MA services. Requires care coordination to be targeted to children not already receiving the service. Requires care coordination services to be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but may be part of a community care team shared by providers or practices. Requires the commissioner, to the extent possible, to use the existing health care home certification and payment structure.

12 **Managed care contracts.** Amends § 256B.69, subd. 5a. Specifies criteria for clinical or utilization performance targets that apply to managed care and county-based purchasing plans. Modifies procedures for implementing the various performance targets, by specifying the base year for 2012 and subsequent years, requiring performance measurement to take into account differences in a plan's membership in the baseline year compared to the measurement year, allowing payment of a portion of the withhold to a plan, and making other changes.

13 **Reporting.** Amends § 256B.69, subd. 9. Requires managed care and county-based purchasing plans to report to the commissioner on the extent to which providers employed or under contract use patient centered decision-making tools or procedures, and the steps taken by the plan to encourage their use.

14 **Financial audit.** Amends § 256B.69, by adding subd. 9d. (a) Requires the legislative auditor to contract for a biennial independent third-party financial audit of information required to be provided by managed care and county-based purchasing plans. Requires the audit to be conducted according to generally accepted government auditing standards. Requires the contract with the audit firm to be designed to obtain any available federal subsidy, include a determination of compliance with the Medicaid rate certification process, and determine if administrative expenses and investment income are in compliance with state and federal law.

(b) Defines "independent third-party" and prohibits an audit firm under contract from having provided services to a plan during the period for which the audit is conducted.

(c) Requires each managed care and county-based purchasing plan to submit to and fully cooperate with the independent third-party financial audit, and provide the commissioner and the audit firm with access to all data required to complete the audit. Provides the audit firm with specified investigative powers of the legislative auditor.

(d) Requires each plan to provide the commissioner with biweekly encounter data and claims data for state programs, and participate in a data quality assurance program. Requires the commissioner to develop written protocols for the data quality assurance program and make these protocols available to the public. Requires the commissioner to contract for an independent third-party audit to evaluate the quality assurance protocols and the commissioner's implementation of the protocols.

(e) Requires the legislative auditor to provide copies of the audit report required under paragraph (a) to the commissioner, state auditor, attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature. Requires the commissioner to provide copies of the evaluation required by paragraph (d) to the chairs and ranking minority members of the health and human services finance committees of the legislature.

(f) Requires actuaries under contract with the commissioner to meet the independence requirements of the professional code for fellows in the Society of Actuaries and not to have provided actuarial services to a plan under contract with the commissioner during the period in which actuarial services are being provided. Requires an actuary or actuarial firm to certify and attest to the rates paid to managed care and county-based purchasing plans, and requires this certification and attestation to be auditable.

(g) States that this subdivision does not allow the release of nonpublic data.

States that this section is effective the day following final enactment and applies to plan contracts effective January 1, 2014, and biennially thereafter.

15 **Initiatives to reduce incidence of low birth weight.** Amends § 256B.69, by adding subd. 32. Directs the commissioner to require managed care and county-based purchasing plans to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence. Requires the strategies to coordinate health care with social services and the local public health system. Requires each plan to develop and report to the commissioner outcome measures, and requires the commissioner to consider these outcomes when considering plan participation in competitive bidding.

16 **Competitive bidding.** Amends § 256B.69, by adding subd. 33. (a) Allows the commissioner, for managed care contracts effective on or after January 1, 2014, to utilize a competitive price bidding program for nonelderly, nondisabled adults and children in MA and MinnesotaCare in the seven-county metropolitan area. Requires the program to allow a minimum of two managed care plans to serve the area.

(b) Requires the commissioner to consider, and incorporate, where appropriate, procedures and criteria used in the current competitive bidding pilot project. Exempts a Hennepin County pilot program from competitive bidding.

(c) Directs the commissioner to use past performance data as a factor in selecting vendors, and to consider this and other information, in determining whether to contract with a plan under the competitive bidding program. Provides criteria for collecting and evaluating data on past performance. Requires the data submitted by plans to include health outcome measures on reducing the incidence of low birth weight.

17 **Critical access dental providers.** Amends § 256B.76, subd. 4. Provides a critical access dental clinic with the critical access dental reimbursement rate for dental services provided off-site at a private dental office, if the following requirements are met:

(1) the clinic is located in a health professional shortage area and outside the seven-county metropolitan area;

(2) the clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service would be reimbursed at the critical access reimbursement rate if the service was provided at the critical access dental clinic;

(4) the dental professionals providing services off-site are licensed and in good standing;

(5) the dentist providing the services is enrolled as an MA provider;

(6) the critical access dental clinic submits the claim and receives the payment for the services provided off-site; and

(7) the critical access dental clinic maintains dental records for each claim submitted.

Provides an effective date of July 1, 2012, or upon federal approval, whichever is later.

18 **Cost-sharing.** Amends § 256L.03, subd. 5. Provides that the commissioner may allow managed care and county-based purchasing plans to waive the MinnesotaCare family deductible.

19 **Use of defined contribution; health plan requirements.** Amends § 256L.031, subd. 2. Increases from three to four months the period of time an enrollee has to select a health plan. Allows the commissioner to determine criteria under which an enrollee would have more than four months to select a plan. Also clarifies that the defined contribution can be used to pay premiums for coverage under MCHA and that this MCHA coverage must meet the requirements of the healthy MN contribution program.

20 **Determination of defined contribution amount.** Amends § 256L.031, subd. 3. Makes a conforming change related to enrollee eligibility for MCHA.

21 **Minnesota Comprehensive Health Association (MCHA).** Amends § 256L.031, subd. 6. Allows MinnesotaCare enrollees who are eligible for MCHA coverage for any reason (not just because they have been denied coverage in the individual market) to receive MCHA coverage under the healthy MN defined contribution program.

22 **Other health coverage.** Amends § 256L.07, subd. 3. Exempts coverage purchased under the healthy MN contribution program from being considered health coverage for purposes of the MinnesotaCare four-month uninsured requirement. Also removes obsolete references to the General Assistance Medical Care program.

23 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. Specifies criteria for clinical or utilization performance targets that apply to managed care and county-based purchasing plans under MinnesotaCare. Modifies procedures for implementing the various performance targets, by specifying the base year for 2012 and subsequent years, requiring performance measurement to take into account differences in a plan's membership in the baseline year compared to the measurement year, allowing payment of a portion of the withhold to a plan, and making other changes.

24 **Nonemergency medical transportation services request for information.** Requires the commissioner of human services to issue a request for information from vendors about potential solutions for the management of nonemergency medical transportation services. Specifies criteria for the RFI. Requires the commissioner to provide information obtained from the RFI to the chairs and

ranking members of legislative committees with jurisdiction over health and human services policy and financing, by November 15, 2012.

25 **Physician assistants and outpatient mental health.** Requires the commissioner of human services to convene a group of stakeholders to assist the commissioner in developing recommendations to improve access to, and the quality of, outpatient mental health services for MA enrollees through the use of physician assistants. Requires the commissioner to report recommendations to specified legislative chairs and ranking minority members, by January 15, 2013.

26 **Health Services Advisory Council.** Directs the Health Services Advisory Council to review literature on the efficacy of various treatments of autism spectrum disorder, and recommend to the commissioner of human services authorization criteria for services based on existing evidence, by December 31, 2012. Allows the council to recommend coverage with ongoing collection of outcomes evidence, in circumstances where evidence is currently unavailable or the strength of evidence is low.

27 **Reporting requirements.**

Subd. 1. Evidence-based childbirth program. Allows the commissioner of human services to discontinue the evidence-based childbirth program, and requires the commissioner to discontinue affiliated reporting requirements once certain goals for the program have been achieved.

Subd. 2. Provider networks. Requires the commissioners of health, commerce, and human services to merge certain HMO and county-based purchasing plan reporting requirements related to network adequacy and provider lists.

Provides an immediate effective date.

28 **Emergency medical assistance study.** Requires the commissioner of human services to develop a plan to provide coordinated and cost-effective health care and coverage for individuals who meet eligibility standards for EMA and who are ineligible for other state public programs. Requires the commissioner to consult with relevant stakeholders and to consider specified plan elements. Directs the commissioner to submit the plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing, by January 15, 2013.

29 **Emergency medical condition coverage exceptions.** Provides that the following services are covered as emergency medical conditions for purposes of EMA: (1) dialysis services provided in a hospital or free-standing dialysis facility; and (2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer, if the recipient has a cancer diagnosis that is not in remission. States that this coverage is effective May 1, 2012, through June 30, 2013.

30 **Cost-sharing requirements study.** Requires the commissioner of human services, in consultation with stakeholders, to develop recommendations to implement a revised cost-sharing structure for state public health care programs that ensures application of meaningful cost-sharing requirements, within the limits of federal law. Requires the commissioner to report to the chairs and ranking minority members of the legislative committees with jurisdiction over these issues by January 15, 2013, with draft legislation to implement the recommendations effective January 1, 2014.

31 **Study of managed care.** (a) Requires the commissioner of human services to contract with an independent vendor to evaluate the value of managed care and county-based purchasing for MA and MinnesotaCare. Specifies criteria for the evaluation.

(b) Requires the evaluation to also consider the need to continue the requirement for health maintenance organizations to participate in the MA and MinnesotaCare programs as a condition of

licensure.

(c) Requires a preliminary report to be submitted to the chairs and ranking minority members of the health and human services legislative committees by February 15, 2013, and a final report by July 1, 2013.

32 **Repealer.**

Subd. 1. Summary of complaints and grievances. Repeals Minnesota Rules, part 4685.2000 (report providing an annual summary of HMO and county-based purchasing plan complaints and grievances), the day following final enactment.

Subd. 2. Medical necessity denials and appeals. Repeals § 62M.09, subd. 9 (report on number and rate of medical necessity denials and appeals by utilization review organizations), the day following final enactment.

Subd. 3. Salary reports. Repeals § 62Q.64 (report on high-five salaries for HMOs and county-based purchasing plans), the day following final enactment.

Article 2: Department of Health

1 **Community-based health care coverage program.** Amends § 62Q.80. Modifies requirements for certain community-based health care coverage programs. Removes obsolete language that established and funded demonstration projects, which permits established programs to continue under the regulation of the commissioner of health, but remove references to receipt of grant funding that is no longer available. Modifies reporting requirements from quarterly to annually. Removes the August 2014 expiration date.

2 **Exemptions.** Amends § 144.1222, by adding subd. 6. Provides an exemption from certain public swimming pool regulations for a natural swimming pond called Webber Lake in the city of Minneapolis. Defines "naturally treated swimming pool."

Provides an immediate effective date.

3 **Advanced diagnostic imaging services.** Adds § 144.1225.

Subd. 1. Definition. Defines "advanced diagnostic imaging services" the same as in federal law.

Subd. 2. Accreditation required. (a) Provides that advanced diagnostic imaging services can only be reimbursed if the facility that conducts and processes the service is accredited by the American College of Radiology, by the Intersocietal Accreditation Commission, or the Joint Commission.

(b) Requires that any facility that provides advanced diagnostic imaging services and is eligible to receive reimbursement from any source, must obtain accreditation by August 1, 2013.

Subd. 3. Reporting. (a) Requires advanced diagnostic imaging facilities and providers to annually report to the commissioner of health to demonstrate it is accredited as required in this section.

(b) Permits the commissioner of health to promulgate rules necessary to administer this reporting requirement.

4 **Cost.** Amends § 144.292, subd. 6. Modifies a provision related to the cost of providing a patient with copies of a health record. Permits providers to charge a $10 retrieval fee, but not the per page copying

fee for copies if requested by a patient for purposes of appealing a denial of certain Social Security benefits. Provides that no fee can be charged to persons who are on public assistance, or are represented by legal services or a volunteer attorney.

5 **Liability of provider or other person.** Amends § 144.298, subd. 2. Establishes liability for an intentional, unauthorized access of records within a record locator service.

6 **Radiation therapy facility construction.** Amends § 144.5509. (a) No change.

(b) Provides an exception to the existing moratorium on construction of radiation therapy facilities in the metropolitan area by stating the moratorium does not apply, as of January 1, 2013, to relocation of a machine from Maplewood to Woodbury.

(c) Establishes new criteria for construction of radiation therapy facilities in the 14-county metro area that will be effective upon expiration of the existing restriction and moratorium, August 1, 2014. Provides that an entity constructing the radiation therapy facility must be controlled by or under common control of a hospital and must be located at least seven miles from an existing radiation therapy facility.

(d) Requires referring physicians in the 14-county metro area to provide patients with a list of all radiation therapy facilities located in the 14-county metropolitan area. Requires physicians with a financial interest in a radiation therapy facility to disclose that to patients.

(e) Provides a definition of the phrases "controlled by" and "under common control with."

(f) Provides a definition of the phrase "financial interest in any radiation therapy facility."

(g) Provides that the limitations and conditions established under this section do not apply to relocation or reconstruction of existing radiation therapy facilities if ownership of the facility remains unchanged; the relocation or reconstruction is within one mile of an existing facility; and the time period between closing the existing facility and opening the relocated or reconstructed facility is 12 months or less.

7 **Maternal and child health advisory task force.** Adds § 145.8811. Reestablishes a task force that expired in June 2011. Extends the expiration date to June 30, 2015.

8 **Postpartum depression education and information.** Amends § 145.906. Requires the commissioner to work with the women, infants, and children (WIC) program in developing and making available information on postpartum depression.

9 **Evaluation of health and human services regulatory responsibilities.** Requires the commissioners of health and human services to update information on websites related to certain licensed facilities and services to provide consistent clear information to providers. Requires the commissioner of management and budget to evaluate and make recommendations as to whether to reorganize certain regulatory functions within the Departments of Health and Human Services.

10 **Health record access study.** Requires the commissioner of health, with its Minnesota e-Health Advisory Committee, to study issues related to audit procedures for representation of consent and unauthorized access to patient records, and the feasibility of informing patients of unauthorized access or an audit log of who accessed records. Requires a report to the legislature by February 2013.

11 **Reporting prevalence of sexual violence.** Requires the commissioner, to the extent federal funding is available, to publicly report data on the prevalence and incidence of sexual violence in Minnesota using data provided by Centers for Disease Control and Prevention.

Provides an immediate effective date for this section.

12 **Licensed home care providers.** Requires the commissioner of health to make recommendations to the legislature by February 1, 2013, as to development of a plan for regulation of licensed home care providers.

13 **Evaluation of health and commerce regulatory responsibilities.** Requires the commissioner of health, with the commissioner of commerce, to report by February 15, 2013 on recommendations to maximize administrative efficiencies in regulating health maintenance organizations.

14 **Study of radiation therapy facilities capacity.** Requires the commissioner of health, within available appropriations, to study issues related to treatment capacity and current and projected need for services related to radiation therapy facilities. Permits the commissioner to contract for the study, and requires that it be completed and submitted to the legislature by March 15, 2013.

15 **MERC distribution.** (a) Requires the commissioner of health to first distribute $300,000 of MERC money in 2013 to Gillette Children's Specialty Healthcare before following the distribution formula provided in Minnesota Statutes, 62J.692, subdivision 4, paragraph (a).

(b) Provides that this section is effective upon federal approval.

Article 3: Children and Family Services

1 **Absent days.** Amends § 119B.13, subd. 7. Modifies the child care assistance ten absent days policy for reimbursement to allow more absent days for children in families where at least one parent is (1) under the age of 21; (2) does not have a high school diploma or GED; and (3) is a student in a school district or similar program that provides or arranges child care, and other supportive services.

2 **Drug convictions.** Amends § 256.01, by adding subd. 18c. Requires the court administrator to send an electronic report to the commissioner of human services every six months with certain information regarding persons who have a felony drug conviction. Requires the commissioner to determine whether the individuals who are the subject of the data are receiving general assistance or MFIP benefits. If an individual is receiving benefits, then the commissioner must instruct the county to issue vendor payment of benefits and initiate random drug screening for the individual. Prohibits the commissioner from retaining any data that does not relate to an individual receiving general assistance or MFIP benefits. Requires the court administrator to provide a onetime report on individuals with a felony drug conviction dated from July 1, 1997, until the date of the transfer. Provides a July 1, 2013 effective date.

3 **Data sharing with the Department of Human Services; multiple identification cards.** Amends § 256.01, by adding subd. 18d. Requires the commissioner of public safety to periodically provide the commissioner of human services with certain information regarding all applicants and holders whose drivers' licenses or state identification cards have been canceled by the commissioner of public safety. Requires the commissioner of human services to compare the information provided with the commissioner's data regarding recipients of all public assistance programs managed by the Department of Human Services to determine whether any person with multiple identification cards has illegally or improperly enrolled in any DHS public assistance program. Requires the commissioner to provide all due process protections to an individual before terminating the individual from the applicable program according to the applicable statute and notifying the county attorney. Provides a July 1, 2013 effective date.

4 **Data sharing with the Department of Human Services; legal presence date.** Amends § 256.01, by adding subd. 18e. Requires the commissioner of public safety to periodically provide the commissioner of human services with certain information regarding all applicants and holders of drivers' licenses or state identification cards whose temporary legal date has expired and whose driver's license or state identification card has been canceled by the commissioner of public safety. Requires the commissioner of human services to use the information provided to determine whether

the eligibility of any person receiving DHS public assistance has changed as a result of the status change in the Department of Public Safety data. Requires the commissioner to provide all due process protections to an individual before terminating the individual from the applicable program according to the applicable statute and notifying the county attorney.
Provides a July 1, 2013 effective date.

5 **Financial transaction cards.** Amends § 256.9831, subd. 2. Adds to the list of locations at which no person may obtain cash benefits through the use of an EBT card.

6 **Electronic Benefit Transfer (EBT) card.** Amends § 256.987, subd. 1. Makes a technical correction.

7 **Prohibited purchases.** Amends § 256.987, subd. 2. Modifies the prohibition on using the EBT card to purchase tobacco products and alcoholic beverages.

8 **EBT use restricted to certain states.** Amends § 256.987, by adding a subdivision. Limits use of the cash portion of EBT cards to Minnesota and surrounding states.

Makes this section effective March 1, 2013.

9 **Disqualification.** Amends § 256.987, by adding a subdivision. Disqualifies anyone found to be guilty of using an EBT card to purchase prohibited items for one year for the first offense, two years for the second offense, and permanently for the third offense. Specifies the needs of the disqualified individual shall not be taken into consideration in determining the grant fund level for that assistance unit. Makes this section effective June 1, 2012.

10 **Earned income savings account.** Amends § 256D.06, subd. 1b. Increases the GA earned income savings disregard from $150 to $500 per month for certain specified persons. Increases the amount in the savings account that must be disregarded from asset limits from $1,000 to $2,000.

Makes this section effective October 1, 2012.

11 **Household eligibility; participation.** Amends § 256E.35, subd. 5. Reinstates state and federal TANF matching funds for the family assets for independence program.

12 **Withdrawal; matching; permissible uses.** Amends § 256E.35, subd. 6. Specifies how state and federal TANF matching funds are provided.

13 **Grant authority.** Amends § 256E.37, subd. 1. Directs 80 percent of grant funds to construct or rehabilitate facilities for early childhood programs, crisis nurseries, or parenting time centers to facilities located in counties outside of the seven-county metro area.

14 **Supplementary service rates.** Amends § 256I.05, subd. 1a. Prohibits counties from negotiating supplementary service rates with GRH providers that do not make referrals to available community services for volunteer and employment opportunities for residents.

15 **Supplementary rate for certain facilities.** Amends § 256I.05, subd. 1e. Requires a county agency to negotiate a supplementary rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a certain GRH provider, not to exceed an additional 115 beds.

16 **Person convicted of drug offenses.** Amends § 256J.26, subd. 1. Modifies the MFIP eligibility criteria for individuals convicted of a drug offense. Requires individuals who have been convicted of a felony drug offense within the past ten years to have benefits vendor paid and to submit to random drug testing. Currently, individuals who have had a drug conviction anytime since July 1, 1997, must have benefits vendor paid and submit to random drug testing. Modifies the definition of "drug offense" to include the felony offense for manufacturing or attempting to manufacture methamphetamine in the presence of a child or vulnerable adult. Makes this section effective October 1, 2012, for all new MFIP applicants who apply on or after that date and for all recertifications

occurring on or after that date.

17 **Vendor payment; uninhabitable units.** Amends § 256J.26, by adding subd. 5. Requires counties to cease MFIP vendor payments for rent to a landlord when a MFIP assistance unit's housing unit has been deemed uninhabitable. Prohibits a landlord who is required to return vendor paid rent or who is prohibited from receiving future rent under this subdivision from taking an eviction action against anyone in the MFIP assistance unit.

18 **Purpose.** Amends §256J.575, subd. 1. Clarifies that family stabilization services are designed for families who don't make significant progress in the regular employment and training services provided in the MFIP program.

19 **Definitions.** Amends §256J.575, subd. 2. Strikes definitions of "case manager" and "case management." Modifies the definition of "family stabilization services" to include services provided by or through a county agency or employment services agency.

20 **Family stabilization plans; services.** Amends §256J.575, subd. 5. Requires the agency to attempt to meet with a new participant within 30 days of eligibility determination in order to develop a family stabilization plan. Requires that family stabilization participants be given access to employment and training services that are available to other MFIP recipients.

21 **Cooperation with service requirements.** Amends §256J.575, subd. 6. Requires the participant to engage in family stabilization services based on the needs of the participant and family.

22 **Funding.** Amends §256J.575, subd. 8. Modifies which assistance units meet the criteria for family stabilization service eligibility.

23 **Reporting potential welfare fraud.** Creates § 626.5533. Requires a peace officer to report to the head of the officer's department every arrest where a person possesses multiple electronic benefit transfer (EBT) cards. The report must include: the offender's name, license or ID number, and home address; name and number on each EBT card; date and location of offense; crime committed; and any other information deemed necessary. The law enforcement agency must forward the report to the commissioner of human services within 30 days to be used by the commissioner in assessing the person's continued eligibility for benefits. Finally, it directs the commissioner of human services, in consultation with the Bureau of Criminal Apprehension, to adopt reporting forms.

24 **Required referral to early intervention services.** Amends § 626.556, subdivision 10n. Modifies the Maltreatment of Minors Act, requiring that a child under age three who is involved in a substantiated case of maltreatment be referred for screening under the Individuals with Disabilities Act, Part C. Parents must be informed that the evaluation and acceptance of services are voluntary. Within available appropriations, the commissioner must monitor referral rates by the county and annually report to the Legislature, beginning March 15, 2014.

25 **Asset development and financial literacy task force.** Amends Laws 2010, ch. 374, § 1. Modifies the membership of the task force, modifies the duties of the task force, extends the expiration date of the task force to June 1, 2014, and makes this section effective the day following final enactment.

26 **Total appropriation.** Amends Laws 2011, First Special Session ch. 9, art. 10, § 3, subd. 1. Modifies TANF transfers to the federal CCDF fund and the working family credit amount claimed for TANF MOE.

27 **Minnesota visible child work group.**

Subd. 1. Purpose. Establishes the Minnesota visible child work group to identify and recommend issues that should be addressed in a statewide, comprehensive plan to improve the

well-being of children who are homeless or have experienced homelessness.

Subd. 2. Membership. Lists the members of the work group.

Subd. 3. Duties. Lists the duties of the work group.

Subd. 4. Work group convening and facilitation. Specifies the organizations that will staff the work group.

Subd. 5. Report. Requires the work group to make recommendations related to the duties under subdivision 3 to the legislative committees with jurisdiction over education, housing, health, and human services policy and finance by December 15, 2012. Requires the recommendations to also be submitted to the Children's Cabinet to provide the foundation for a statewide visible child plan.

Subd. 6. Expiration. Specifies the work group expires on June 30, 2013.

28 **Uniform asset limit requirements.** Requires the commissioner of human services, in consultation with others, to analyze the various asset limits within programs administered by the commissioner and to establish a consistent asset limit across human services programs to minimize the administrative burdens on counties in implementing asset tests. Requires the commissioner to report the findings and conclusions to the legislature by January 15, 2013, and include draft legislation establishing a uniform asset limit for human services assistance programs.

29 **Directions to the commissioner.** Instructs the commissioner of human services, in consultation with the commissioner of public safety, to issue a report to the legislature regarding implementation of section 256.01, subdivisions 18c, 18d, and 18e. Requires the report to be submitted no later than December 1, 2013.
Makes this section effective July 1, 2013.

30 **Revisor's instruction.** Instructs the Revisor to change certain specified terms in statute. Allows the Revisor to make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Article 4: Continuing Care

1 **Eligibility.** Amends § 62J.496, subd. 2. Adds nursing facilities certified to participate in the MA program and certain elderly waiver providers to the list of providers receiving priority for the electronic health record system revolving loan program.

2 **Moratorium exception funding.** Amends § 144A.073. Adds a new subdivision that allows the MDH to approve an exception to the nursing facility moratorium if the full annualized share of Medical Assistance costs does not exceed $1 million.

3 **Balancing long-term care services and supports: report required.** Amends § 144A.351. Modifies an annual report on long-term care services to include consultation with stakeholders and information on the status of long-term care supports for persons with disabilities and mental illnesses.

4 **Contents of contract.** Amends § 144D.04, subd. 2. Modifies what must be included in a housing with services contract.

5 **Adult foster care homes serving people with mental illness; certification.** Amends § 245A.03, by creating subd. 6a. Instructs the commissioner to develop a certification for corporate adult foster care homes that serve individuals with mental illness. Lists the requirements that must be met in order for the home to receive certification.

6 **Licensing moratorium.** Amends § 245A.03, subd. 7. Allows DHS to de-license up to 128 adult foster care beds by June 30, 2013, under certain circumstances using, a needs determination process. Requires DHS to work with stakeholders in collecting data on long-term care services and supports capacity, and provide information by February 1 of each year. Exempts adult foster care homes certified for people with mental illness, along with other residential settings, from the requirement that once service recipients move out, license capacity is decreased by the same amount.

7 **Adult foster care license capacity.** Amends § 245A.11, subd. 2a. Exempts adult foster care homes from the four-bed license maximum, allowing a fifth bed for respite services, with certain staffing, time-restriction, and notification requirements.

8 **Adult foster care; variance for alternate overnight supervision.** Amends § 245A.11, subd. 7. Provides that if a license holder has had a conditional license issued or other licensing sanction during the prior 24 months, then the provider cannot receive a variance for alternate overnight supervision. Current law prohibits the variance if a license holder has had a licensing action.

9 **Alternative overnight supervision technology; adult foster care license.** Amends § 245A.11, subd. 7a. Clarifies certain requirements in order to receive an adult foster care home license where a caregiver is not present during normal sleeping hours. It outlines license application review timelines and processes, and approval or denial timelines and processes.

10 **Consumer data file.** Amends § 245B.07, subd. 1. Prohibits license holders from being sanctioned or penalized financially for not having a current individual service plan in the consumer's data file if the case manager fails to provide the plan after receiving a written request from the license holder.

11 **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** Amends § 245C.04, subd. 6. Adds paragraph (c). Provides that an annual background study does not need to be completed on an individual who works for a provider with DHS licensed programs and unlicensed services if the provider complies with certain requirements and the individual provides at least 40 hours of direct contact services in the provider's licensed program.

12 **Probation officer and corrections agent.** Amends § 245C.05, subd. 7. Requires probation officers and corrections agents to notify the commissioner of an individual's conviction if the individual has been affiliated with a licensed program within the preceding year and has been convicted of a disqualifying crime.

13 **Contribution amount.** Amends § 252.27, subd. 2a. Extends the temporary changes to the contribution amounts that were implemented in fiscal year 2011 for two years.

14 **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** Amends § 256.975, subd. 7. Requires the Senior LinkAge Line to develop processes to assist health care homes and hospitals to identify at-risk older adults, and determine when long-term care counseling is appropriate.

15 **Income and assets generally.** Amends § 256B.056, subd. 1a. Adds a cross-reference. Makes this section effective April 1, 2012.

16 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Modifies the list of items that are disregarded in the value of assets that are considered in determining MA eligibility for persons who are aged, blind, or disabled to include the income and assets of spouses of certain persons enrolled in MA-EPD and the assets of the person enrolled in MA-EPD up to the asset amounts specified under the MA-EPD program. Makes this section effective April 1, 2012.

17 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Modifies the MA-EPD program by removing age limits. Makes this section effective April 1, 2012.

18 **Personal care assistant; requirements.** Amends § 256B.0659, subd. 11. Modifies the PCA provider rate reduction for relatives by making the reduction effective July 1, 2013.

19 **Commissioner's access.** Amends § 256B.0659, by adding a subd. Requires PCA providers to give the commissioner access to documentation and records when the commissioner is investigating a possible overpayment of MA funds.

20 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Allows an elderly waiver client's provider of customized living or 24-hour customized living services to submit a copy of the provider's written report outlining the recommendations regarding the client's care needs. Requires the person conducting the assessment to notify the provider of the date by which the information must be submitted. Requires the information to be submitted to the person conducting the assessment prior to the assessment.

21 **Consultation for housing with services.** Amends § 256B.0911, subd. 3c. Requires housing with services establishments to inform a prospective resident or their legal representative of the long-term care options counseling requirement. Modifies the list of circumstances when consultation services are required within five working days.

22 **Exemptions.** Amends § 256.0911, by adding subd. 3d. Adds a new subdivision exempting long-term care consultation requirements under certain circumstances.

23 **Consultation at hospital discharge.** Amends § 256B.0911, by adding a subd. Requires hospitals to refer certain individuals prior to discharge to the Senior LinkAge Line for long-term care options counseling.

24 **Customized living service rate.** Amends § 256B.0915, subd. 3e. Allows the provider of customized living services to provide input into ensuring there is a documented need for all customized living services authorized.

25 **Service rate limits; 24-hour customized living services.** Amends § 256B.0915, subd. 3h. Allows the provider of 24-hour customized living services to provide input into ensuring there is a documented need for all customized living services authorized. Specifies the types of providers authorized to deliver 24-hour customized living services.

26 **Individual service plan.** Amends § 256B.092, subd. 1b. Requires approved, written, and signed changes to a consumer's services to be an addendum to the consumer's individual service plan.

27 **Screening teams.** Amends § 256B.092, subd. 7. Allows a person's current provider of services to submit a written report outlining recommendations for the person's care needs. Requires the screening team to notify the provider of the date by which the information must be submitted. Requires the information to be submitted to the screening team and the person or person's legal representative and to be considered prior to the finalization of the screening.

28 **State quality council.** Amends § 256B.097, subd. 3. Modifies the duties of the state quality council by adding two new duties.

29 **Replacement-costs-new per bed limit effective October 1, 2007.** Amends § 256B.431, subd. 17e. Requires the replacement-costs-new amounts to be increased annually beginning October 1, 2012.

30 **Rate adjustments for some moratorium exception projects.** Amends § 256B.431, by adding subd. 45. Requires money available for moratorium exception projects to be used to fund the incremental rate increases for any nursing facility with an approved moratorium exception project completed after August 30, 2010, where the replacement-costs-new limits were higher at any time after project approval than at the time of project completion. Requires the commissioner to calculate the property rate increase for these facilities using the highest set of limits. Prohibits any rate increases from being

effective until on or after the effective date of this section, contingent upon federal approval. Makes this section effective upon federal approval.

31 **Exemptions.** Amends § 256B.434, subd. 10. Removes a reference to a subdivision being repealed from the list of exemptions for nursing facilities participating in the Alternative Payment Demonstration Project.

32 **Critical access nursing facilities.** Amends § 256B.441, subd. 63. Adds a new subdivision creating a critical access designation for nursing facilities. DHS will work with the MDH and stakeholders in establishing the designation proposal process, and grant the designation on a competitive basis. The funding will be limited to a $1 million appropriation in fiscal year 2013, which will be ongoing and added to the base.

DHS will request designation proposals every two years. Facilities currently designated may apply for continued designation; if the continued designation is not granted, the benefits listed below will no longer apply.

33 **Referrals to Medicare providers required.** Amends § 256B.48, subd. 6a. Adds a new subdivision requiring nonMedicare participating nursing facilities to refer dual-eligible (Medicare and Medicaid) recipients qualifying for Medicare-covered stay to Medicare providers.

34 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Allows a recipient's current provider of services to submit a written report outlining recommendations for the person's care needs. Requires the person conducting the assessment or reassessment to notify the provider of the date by which the information must be submitted. Requires the information to be submitted to the person conducting the assessment and the person or the person's legal representative and to be considered prior to the finalization of the assessment or reassessment.

35 **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Allows licensed adult foster care capacity to not be reduced if savings realized through the licensed bed closure reductions for foster care settings are met. This reassessment process is extended by one year.

36 **Community-living settings.** Amends § 256B.49, subd. 23. Modifies the definition of "community-living settings" by adding a requirement that a service provider transfer a lease to an individual within two years of signing the initial lease. Allows the commissioner to approve an exception within sufficient time to ensure the continued occupancy by the individual if the landlord denies the transfer.

37 **Home and community-based settings.** Creates § 256B.492. Defines home and community-based settings for purposes of the home and community-based waiver programs.

38 **Adult foster care planned closure.** Amends § 256B.493. Adds a new section establishing an adult foster care planned closure program, requiring DHS to seek proposals for the conversion of services for persons with disabilities to other community settings. The section outlines the process for planned closure of adult foster care homes.

39 **ICF/DD rate decrease effective July 1, 2013.** Amends § 256B.5012, subd. 13. Modifies the ICF/DD contingent rate reduction.

40 **Special needs.** Amends § 256D.44, subd. 5. Requires service providers for those deemed shelter needy and who meet certain requirements to transfer the lease to the service recipient within two years, and allows an exemption to this requirement if the landlord is not willing to transfer the lease. Also sets the maximum number of units in a building utilized by general assistance recipients to be four units, or 25 percent, whichever is greater.

41 **Implement nursing home level of care criteria.** Amends Laws 2011, First Special Session ch. 9, art. 7, § 52. Modifies a direction to the commissioner related to implementing nursing home level of

care criteria.

42 **Contingency provider rate and grant reductions.** Amends Laws 2011, First Special Session ch. 9, art. 7, § 54. Modifies continuing care provider contingent rate reductions.

43 **Forecasted programs.** Amends Laws 2011, First Special Session ch. 9, art. 10, § 3, subd. 3. Modifies the rider related to the reduction of rates for congregate living for individuals with lower needs.

44 **Grant programs.** Amends Laws 2011, First Special Session ch. 9, art. 10, § 3, subd. 4. Modifies the rider for local planning grants for creating alternatives to congregate living for individuals with lower needs.

45 **Independent living services billing.** Requires the commissioner to allow for daily rate and 15-minute increment billing for independent living services under the BI and CADI waivers. Requires the commissioner to submit a waiver amendment to the state plan no later than December 31, 2012, if necessary to comply with this requirement.

46 **Home and community-based services waivers amendment for exception.** By September 1, 2012, requires the commissioner of human services to submit amendments to the home and community-based waiver plans consistent with the definition of home and community-based settings, including a request to allow certain exceptions.

47 **Commissioner to seek amendment for exception to consumer-directed community supports budget methodology.** By July 1, 2012, requires the commissioner of human services to request an amendment to the home and community-based services waiver for persons with disabilities to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for certain participants. Makes the exception process effective upon federal approval for persons eligible during 2013 and 2014.

Makes this section effective the day following final enactment.

48 **Direction to Ombudsman for Long-Term Care.** Directs the ombudsman for long-term care to (1) research the existence of differential treatment based on source of payment in assisted living settings, (2) convene stakeholders to provide technical assistance and expertise in studying and addressing these issues, and (3) submit a report of findings to the legislature by January 31, 2013, with recommendations for the development of policies and procedures to prevent and remedy instances of discrimination based on participation in or potential eligibility for MA.

49 **Licensing personal care attendant services.** Directs the commissioner of human services to study the feasibility of licensing PCA services and issue a report to the legislature by January 15, 2013.

50 **Autism housing with supports study.** Directs the commissioner of human services, in consultation with others, to complete a study to determine one or more models of housing with supports for children with an autism diagnosis. Specifies the information that must be included in the study. Requires the study to be submitted to the legislative committees with jurisdiction over health and human services by January 15, 2013.

51 **Repealer.** Repeals Minnesota Statutes, sections 144A.073, subd. 9 (budget request) and 256B.48, subd. 6 (Medicare certification). Repeals Minnesota Rules, part 4640.0800, subp. 4 (orders for treatment).

Article 5: Miscellaneous

1 **Children's health supervision services and prenatal care services.** Amends § 62A.047. Clarifies that a health plan company may use a network of providers and impose cost-sharing requirements for

out-of-network providers for child health supervision services and prenatal care services. Provides that this provision is effective August 1, 2012, and expires June 30, 2013.

2 **Creation.** Amends § 245.697, subd. 1. Adds representatives of marriage and family therapy and professional clinical counseling to the State Advisory Council on Mental Health.

3 **Civil commitments.** Amends § 254A.19, by adding subd. 4. Provides that a Rule 25 assessment does not need to be completed for individuals who are civilly committed in order for a county to access consolidated chemical dependency treatment funds.

4 **Service delivery criteria.** Amends § 256B.0943, subd. 9. Requires that children's day treatment be provided by a state-certified provider.

5 **Change in child care.** Amends § 518A.40, subd. 4. Allows the public authority to stop collecting child care support if either party informs the public authority no child care costs are being incurred and the obligee verifies the information or the obligee fails to respond to a written request for information about child care costs.

6 **Base adjustment.** Amends Laws 2011, First Special Session ch. 9, art. 10, § 8, subd. 8. Corrects a subtracting error from last session to the base adjustment for the administrative services unit.

7 **Foster care for individuals with autism.** Instructs the commissioner of human services to work with counties that agree to develop licensed foster homes for people with autism.

8 **Chemical health integrated model of care development.** Instructs the commissioner to work with stakeholders and counties to develop a plan to more efficiently and effectively provide chemical dependency services. Requires a report to the legislature no later than March 15, 2013.

9 **Biennial budget request; University of Minnesota.** Requires the university, as part of its biennial budget request, to include a request for funding for rural primary care training for family practice residents.