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Article 1: ACA Implementation; Better Health Care for More Minnesotans

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 Strikes a cross-reference to a section repealed later in the bill (§ 256B.057, subd. 2).

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

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

(2) Medicaid; and

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

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

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

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

(e) Requires the commissioner to report progress to the relevant legislative committees by December 1, 2014.

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

3 **Affordable Care Act or ACA.** Amends § 256B.02, by adding subd. 17. Defines the "Affordable Care Act." Provides a January 1, 2014 effective date.

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

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

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

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

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

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

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

11 **Children ages 19 and 20.** Amends § 256B.055, by adding subd. 16. Establishes a separate statutory eligibility group for children ages 19 and 20 years of age (these individuals are eligible for MA under current law). Provides a January 1, 2014 effective date.

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

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

14 **Income and assets generally.** Amends § 256B.056, subd. 1a. Provides that modified adjusted gross income (MAGI), as defined in the ACA, shall be the income methodology used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers;

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(ii) children ages 19 and 20;
(iii) pregnant women;
(iv) infants; and
(v) adults without children.

Requires the commissioner to provide a standard 5 percent income disregard for individuals whose income eligibility is determined using MAGI. Provides a January 1, 2014 effective date.

15 **Families with children income methodology.** Amends § 256B.056, subd. 1c. Strikes a cross-reference to a section repealed in the bill, related to MA income eligibility for children.

16 **Asset limitations for certain individuals.** Amends § 256B.056, subd. 3. Strikes language that states that no asset limit applies to persons eligible for MA as adults without children. Provides a January 1, 2014 effective date.

17 **Asset limitations for families and children.** Amends § 256B.056, subd. 3c. Effective January 1, 2014, exempts parents and relative caretakers from the current MA asset limit, unless these individuals qualify for MA through a spend-down.

18 **Income.** Amends § 256B.056, subd. 4. Effective January 1, 2014, increases the MA income limit for parents and relative caretakers from 100 to 133 percent of FPG, the MA income limit for adults without children from 75 to 133 percent of FPG, and the MA income limit for children ages 19 and 20 from 100 to 133 percent of FPG.

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

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

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

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

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

Provides a January 1, 2014 effective date.

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

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

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

24 **Certain persons needing treatment for breast or cervical cancer.** Amends § 256B.057, subd. 10. Removes a cross-reference to a section repealed in this bill.

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

26 **Definitions.** Amends § 256B.059, subd. 1. Expands the definition of "institutionalized spouse" to include persons receiving services under a range of home and community-based waivers for persons with disabilities. Also makes related changes in terminology. Provides a January 1, 2014 effective date.

27 **Citizenship requirements.** Amends § 256B.06, subd. 4. Clarifies that MA coverage, funded through the federal Children's Health Insurance Program, is for pregnancy related services for pregnant women funded who are ineligible for federally funded MA (current law refers to person who are undocumented, nonimmigrants, or lawfully present under CRS title 8, section 103.12). Adds a new paragraph (k) providing MA coverage without a federal match for all services to this group of noncitizens who are lawfully present. Provides a January 1, 2014 effective date.

28 **Affordable Care Act.** Amends § 256L.01, by adding subd. 1b. Provides a definition of the Affordable Care Act. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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

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

31 **Commissioner's duties.** Amends § 256L.02, subd. 2. Requires a web site to be used to provide information about medical programs and to promote access to services. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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

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

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

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

36 **Families with children.** Amends § 256L.04, subd. 1. Modifies MinnesotaCare income eligibility criteria, to cover families with children with incomes above 133 percent of FPG and not exceeding 200 percent of FPG and makes related changes. (Under current law, MinnesotaCare covers families with children with incomes not exceeding 275 percent of FPG, with a fixed income limit for parents of $57,500.) Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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

38 **Applicants potentially eligible for medical assistance.** Amends § 256L.04, subd. 8. Strikes language that allows potentially eligible persons to enroll in either MinnesotaCare or MA. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

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39 **Citizenship requirements.** Amends § 256L.04, subd. 10. Expands MinnesotaCare coverage to include individuals who are lawfully present and ineligible for MA due to immigration statues, with family incomes not exceeding 200 percent of FPG (current law provides coverage to immigrants). Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

40 **Persons in detention.** Amends § 256L.04, subd. 12. Strikes language that allows MinnesotaCare coverage for persons in a correctional or detention facility until their renewal date. Provides a January 1, 2014 effective date.

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

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

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

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

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

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

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

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

47 **Residency requirement.** Amends § 256L.09, subd. 2. Strikes a reference to pregnant women. Provides an effective date of January 1, 2104, or upon federal approval, whichever is later.

48 **Reimbursement of inpatient hospital services.** Amends § 256L.11, subd. 6. Strikes language related to the annual inpatient hospital benefit limit and makes related changes. Provides an effective date of January 1, 2014 or upon federal approval, whichever is later.

49 **Premium determination.** Amends § 256L.15, subd. 1. Strikes references to nonpayment of premiums for pregnant women and children. Also strikes a premium exemption for members of the military. Provides an effective date of January 1, 2014 or upon federal approval, whichever is later.

50 **Sliding fee scale; monthly gross individual or family income.** Amends § 256L.15, subd. 2. Adjusts the MinnesotaCare premium scale to reflect the reduction in the program income limit to 200 percent of FPG. Makes conforming changes. Provides an effective date of January 1, 2014, or upon federal approval, whichever is later.

51 **Repealer.**

Subd. 1. Repeal; certain health care provisions. Repeals § 256B.055, subds. 3 (MA coverage until March 31, 1998, for AFDC-related dependent children), 5 (MA coverage for certain AFDC-related pregnant women), and 10b (MA for children under age two; sections remains in effect until the reform waiver expires);

§ 256B.056, subd. 5b (requiring certain recipients not residing in a long-term care facility to verify their income every six months)

§ 256B.057, subd. 1c (no asset test for pregnant women) and 2 (children eligible at 150 percent FPG; use of six-month budget periods)

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

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

Overview

This article modifies the Disability LinkAge Line, the Senior LinkAge Line, long-term care consultations, SAIL projects, the common entry point for reporting maltreatment of a vulnerable adult, and creates community first services and supports.

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

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

Subd. 1. Report requirements. No changes.

Subd. 2. Critical access study. Requires the commissioner to conduct a onetime study to assess local capacity and availability of home and community-based services for older adults and people with disabilities and people with mental illnesses. Requires the study to assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. Requires the report to be submitted to the legislature no later than August 15, 2015.

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

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

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

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

7 **Preadmission screening activities related to nursing facility admissions.** Amends § 256.975, by adding subd. 7a. Requires all individuals seeking admission to Medicaid certified nursing facilities to be screened prior to admission. States the purpose of the screening is to determine the need for nursing facility level of care and to complete federally required activities related to mental illness and developmental disabilities. Lists the criteria that apply to the preadmission screening. Allows the local county mental health authority or

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the state developmental disability authority to prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services. Lists the screener's duties in assessing a person's needs. Makes this section effective October 1, 2013.

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

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

10 **Payment for preadmission screening.** Amends § 256.975, by adding subd. 7d. Specifies funding sources for preadmission screening. Requires the Minnesota Board on Aging to employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding for the service. Makes this section is effective October 1, 2013.

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

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

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

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

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15	**Work, empower, and encourage independence.** Amends § 256B.021, by adding subd. 6. Upon federal approval, requires the commissioner to establish a demonstration project to provide navigation, employment supports, and benefits planning services to a targeted group of Medicaid recipients beginning July 1, 2014. Requires the project to promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants.
16	**Housing stabilization.** Amends § 256B.021, by adding subd. 7. Upon federal approval, requires the commissioner to establish a demonstration project to provide service coordination, outreach, in-reach, tenancy support, and community living assistance to a targeted group of Medicaid recipients beginning January 1, 2014. Requires this project to promote housing stability, reduce costly medical interventions, and increase opportunities for independent community living.
17	**Purpose and goal.** Amends § 256B.0911, subd. 1. Updates cross-references.
18	**Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definitions of "long-term care consultation services" and "long-term care options counseling" by updating cross-references and making conforming changes.
19	**Assessment and support planning.** Amends § 256B.0911, subd. 3a. Updates cross-references and modifies the information that must be provided to the person receiving assessment or support planning, or the person's legal representative.
20	**Preadmission screening of individuals under 60 years of age.** Amends § 256B.0911, subd. 4d. Modifies the age at which preadmission screening is required, updates cross-references, makes conforming changes, specifies the funding source for preadmission screenings provided by the Disability LinkAge Line, and requires the Disability LinkAge Line to employ sufficient personnel to provide preadmission screening and level of care determination services and to maximize federal funding. Makes this section is effective October 1, 2013.
21	**Determination of institutional level of care.** Amends § 256B.0911, by adding subd. 4e. Requires the determination of the need for nursing facility, hospital, and ICF/DD levels of care to be made according to criteria developed by the commissioner. Specifies the criteria to be used in determining the need for nursing facility level of care.
22	**Reimbursement for certified nursing facilities.** Amends § 256B.0911, subd. 7. Updates cross-references.
23	**Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.0913, subd. 4. Updates a cross-reference.
24	**Essential community supports grants.** Amends § 256B.0913, by adding subd. 17. Specifies the purpose of the essential community supports grant program. Lists grant eligibility criteria. Requires a person receiving any of the essential community supports to also receive service coordination as part of their community support plan. Requires essential community supports grant recipients to be reassessed annually. Authorizes the commissioner to use federal matching funds for essential community supports. Makes essential community

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supports available, upon federal approval, to individuals who meet specified criteria related to loss of eligibility for MA payment of nursing facility services. Lists services available through essential community supports.

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

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

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

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

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

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

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

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

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

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

35 **Development and implementation of quality profiles.** Amends § 256B.439, subd. 1. Requires the commissioner to develop quality profiles for providers of long-term care services by July 1, 2014. Requires the quality profiles to be developed using existing data sets and to be incorporated with information on quality maintained by specified organizations and the long-term care database.

36 **Quality measurement tools.** Amends § 256B.439, subd. 2. Removes unnecessary language.

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

38 **Home and community-based services report card in cooperation with the commissioner of health.** Amends § 256B.439, by adding subd. 3a. Requires the profiles developed for home and community-based services providers to be incorporated into a report card and maintained by the Minnesota Board on Aging. Specifies the categories that must be used to organize the consumer information in the profiles. Requires the commissioner to develop and disseminate the quality profiles for a limited number of provider types initially, and to develop quality profiles for additional provider types as measurement tools are developed and data becomes available. Specifies this includes providers of services to older adults and people with disabilities, regardless of payor source.

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

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

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

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

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43 **Community first services and supports.** Creates § 256B.85.

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

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

Subd. 3. Eligibility. Lists eligibility requirements in order to receive CFSS services. Specifies under what circumstances the commissioner must disenroll or exclude participants from the flexible spending model and transfer them to the agency-provider model. Specifies appeal rights.

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

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

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

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

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Subd. 8. Determination of CFSS service methodology. Requires all CFSS services to be authorized by the commissioner before services begin except for certain assessments. Requires authorizations to be completed within 30 days after receiving a complete request. Requires the amount of CFSS authorized to be based on the recipient's home care rating. Specifies how the home care rating is determined. Specifies the methodology for determining the number of minutes of CFSS to authorize.

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

Subd. 10. Provider qualifications and general requirements. Lists requirements for agency-providers delivering services under the agency-provider model and financial management service contractors. Requires the commissioner to develop policies and procedures designed to ensure program integrity and fiscal accountability for goods and services provided under CFSS.

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

Subd. 12. Requirements for initial enrollment of CFSS provider agencies. Lists the information and documentation CFSS provider agencies must provide to the commissioner at the time of enrollment as a CFSS provider agency. Specifies mandatory training requirements for certain CFSS provider agency employees and owners.

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

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

Subd. 15. Documentation of support services provided. Requires support services provided to a participant by a support worker to be documented daily by each

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support worker on a form approved by the commissioner. Allows documentation to be Web-based, electronic, or paper documentation. Requires completed forms to be submitted on a monthly basis. Requires the activity documentation to correspond to the written service delivery plan. Lists the criteria that must be included in the time sheet.

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

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

Subd. 18. Service unit and budget allocation requirements. Specifies how services are authorized for the agency-provider model and the flexible spending model. Specifies how maximum CFSS budget allocations are determined.

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

Subd. 20. Service-related rights. Requires participants to be provided with adequate information, counseling, training, and assistance to ensure that the participant is able to choose and manage services, models, and budgets. Lists information that must be provided. Requires the commissioner to ensure that the participant has a copy of the most recent service delivery plan.

Subd. 21. Development and implementation council. Requires the commissioner to establish a Development and Implementation Council. Requires the commissioner to consult and collaborate with this council when developing and implementing CFSS.

Subd. 22. Quality assurance and risk management system. Requires the commissioner to establish quality assurance and risk management measures for use in developing and implementing CFSS. Requires the commissioner to provide ongoing technical assistance and resource and educational materials for CFSS participants. Requires performance assessment measures and ongoing monitoring of health and well-being to be identified in consultation with the Development and Implementation Council.

Subd. 23. Commissioner's access. Requires the commissioner to be given immediate access without prior notice to documentation and records related to services provided and submission of claims for services provided when the commissioner is

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investigating a possible overpayment of MA funds. States that denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment or the financial management services contract.

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

Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when this occurs.

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

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

46 **Common entry point designation.** Amends § 626.557, subd. 9. Removes language requiring each county board to designate a common entry point for reports of suspected maltreatment of vulnerable adults. Requires the commissioner to establish a common entry point effective July 1, 2014. Requires the common entry point to have access to the centralized database and to log reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation. Specifies requirements for the operation of the common entry point. Requires the commissioners of human services and health to collaborate on the creation of a system for referring reports to the lead investigative agencies.

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

48 **Repealer.** (a) Repeals Minnesota Statutes, sections 245A.655 (federal grants to establish and maintain a single common entry point for reporting maltreatment of a vulnerable adult); and 256B.0917, subds. 1 (SAIL purpose, mission, goals and objectives), 2 (design of SAIL projects), 3 (local long-term care strategy), 4 (information, screening, and assessment function), 5 (service development and delivery), 7 (contract), 8 (living-at-home/block nurse program grant), 9 (state technical assistance center), 10 (implementation plan), 11 (SAIL evaluation and expansion), 12 (public awareness campaign), and 14 (essential community supports grants).

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

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49 **Effective date; contingent systems modernization appropriation.**

Subd. 1. Definitions. Defines "commissioner," "contingent systems modernization appropriation," "department," "plan," and "reform 2020."

Subd. 2. Intent; effective dates generally. Specifies the purpose of this section is to outline how this article and the contingent systems modernization appropriation are implemented if Reform 2020 is fully, partially, or incrementally approved or denied. Specifies the changes contained in this article generate savings that are contingent upon federal approval of Reform 2020. Requires the commissioner to follow the provisions of subdivisions 3 and 4 in order for sections 1 to 48 to be effective.

Subd. 3. Federal approval. Specifies the implementation of this article is contingent upon federal approval. Requires the commissioner to develop a plan for implementing the provisions in this article that receive federal approval as well as any that do not require federal approval. Lists the information that must be included in the plan. Allows the department to implement the plan upon approval of the commissioner of management and budget. Requires the commissioner to notify the legislature of the plan and to make the plan available online.

Subd. 4. Disbursement; implementation. Requires the commissioner of management and budget to disburse certain appropriations to the commissioner of human services to allow for implementation of the approved plan and make necessary adjustments in the accounting system to reflect any modified funding levels. Requires the commissioner of management and budget to reflect the modified funding levels in the first fund balance following the approval of the plan.

Article 3: Safe and Healthy Development of Children

Overview

This article modifies child care assistance programs; child care licensing provisions; MFIP; and child welfare provisions, including creating the Northstar Care for Children Act.

1 **Student parent.** Amends § 119B.011, by adding subd. 19b. Defines the term "student parent" in the child care assistance program statutes. Makes this section effective November 11, 2013.

2 **Child care market rate survey.** Amends § 119B.02, by adding subd. 7. Instructs the commissioner to biennially survey prices charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in county price clusters. Makes this section effective September 16, 2013.

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3 **Factors which must be verified.** Amends § 119B.025, subd. 1. Specifies a family is considered to have met the eligibility redetermination requirement if a complete redetermination form and all required verifications are received within 30 days after the date the form was due. Makes assistance payable retroactively from the redetermination due date. Makes this section effective August 4, 2014.

4 **Funding priority.** Amends § 119B.03, subd. 4. Modifies the first priority for basic sliding fee child care assistance funding by including "student parents." Makes this section effective November 11, 2013.

5 **Eligible participants.** Amends § 119B.05, subd. 1. Modifies the list of families eligible for MFIP child care assistance by adding "student parents." Makes this section effective November 11, 2013.

6 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Beginning September 16, 2013, modifies the maximum rate paid for child care assistance programs. Allows the commissioner to assign a county with no reported provider prices to a similar price cluster and to consider county level access when determining final price clusters. Specifies maximum registration fees in effect on January 1, 2013, remain in effect.

7 **Legal nonlicensed family child care provider rates.** Amends § 119B.13, subd. 1a. Makes conforming changes related to the modifications of the maximum rates. Makes this section effective September 16, 2013.

8 **Provider rate differential for Parent Aware.** Amends § 119B.13, by adding subd. 3b. Provides for a 15 or 20 percent provider rate differential above the maximum rate established, up to the actual provider rate, for child care providers who hold a three- or four-star Parent Aware quality rating. Makes this section effective March 3, 2014.

9 **Weekly rate paid for children attending high-quality care.** Amends § 119B.13, by adding subd. 3c. Allows child care providers to be paid up to the applicable weekly maximum rate, not to exceed the provider's actual charge, if certain conditions are met. Makes this section effective August 4, 2014.

10 **Provider payments.** Amends § 119B.13, subd. 6. Allows counties to withhold the provider's authorization or payment for up to three months beyond the time a county has corrected certain specified conditions. Makes this section effective February 3, 2014.

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

12 **Reduction of risk of sudden unexpected infant death in licensed programs.** Amends § 245A.1435. Changes "sudden infant death syndrome" to "sudden unexpected infant death." Requires a license holder to have written documentation from the infant's physician directing an alternative sleep position for the infant. Current law requires written permission from a parent. Provides that an infant who independently rolls over may be allowed to remain sleeping on its stomach. Prohibits loose bedding, such as blankets and

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sheets, from being placed in the crib with the infant.

Adds paragraph (c). Requires the license holder to place an infant who has fallen asleep before being placed in the crib to place the infant in a crib as soon as practicable.

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

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

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

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

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

16 **Child care license holder insurance.** Amends § 245A.152.

Subd. 1. Insurance coverage required for child care licensure. Paragraph (a) requires licensed family child care providers and child care centers to have liability insurance with coverage limits of at least $100,000 per person and $250,000 per occurrence.

Paragraph (b) provides that no license shall take effect until insurance coverage becomes effective. If coverage lapses or is terminated and no replacement coverage is in effect, the commissioner shall suspend or revoke the license.

Paragraph (c) requires the license holder to immediately notify the commissioner if insurance coverage has lapsed or been terminated and no replacement coverage has taken effect.

Subd. 2. Evidence of insurance. Requires a license holder to post the certificate of coverage in a prominent location in the facility and, upon request, provide a copy of the current certificate of coverage to the commissioner or a parent whose child is receiving services from the program.

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

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

Subd. 1. Initial training. No changes.

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

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

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

Subd. 5. Sudden unexpected infant death and abusive head trauma training. Updates terminology. Strikes the option of video training. Requires training to occur annually; currently training is required every five years.

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

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

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

Subd. 9. Supervising for safety; training requirements. Adds that effective July 1, 2014, all family child care license holders and adult caregivers must have at least six hours of training on supervising for safety prior to licensure and before caring for children. At least two hours of this training must be repeated annually.

19 **Background studies conducted by the Department of Human Services.** Amends § 245C.08, subd. 1. Requires a background study to be completed when permanent legal and physical custody of a child is transferred to a relative.

20 **Background studies conducted by the commissioner.** Amends § 245C.22, subd. 1. Requires the commissioner, when transferring permanent legal and physical custody of a child to a relative, to complete a background study on each person over age 13 living in the home.

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21 **Contracts for child foster care services.** Amends § 256.0112, by adding subd. 10. Requires local agencies to follow the provisions of chapter 256N when negotiating contracts for child foster care services.

22 **Foster care maintenance payments.** Amends § 256.82, subd. 2. Strikes obsolete language.

23 **Setting foster care standard rates.** Amends §2 56.82, subd. 3. Establishes child foster care payments during the transition to Northstar Care for Children under chapter 256N.

24 **Disqualification from program.** Amends § 256.98, subd. 8. Modifies the time period a family is disqualified from receiving child care assistance when a family member is found to be guilty of wrongfully obtaining child care assistance in order to be consistent with other income assistance programs. Makes this section effective February 3, 2014.

25 **Disregard.** Amends § 256J.08, subd. 24. Modifies the definition of "disregard" under the MFIP program. Makes this section effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

26 **Income exclusions.** Amends § 256J.21, subd. 2. Modifies MFIP income exclusions to include certain foster care, guardianship, and adoption assistance payments. Makes this section effective January 1, 2015.

27 **Initial income test.** Amends § 256J.21, subd. 3. Modifies terminology. Makes this section effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

28 **Individuals who must be excluded from an assistance unit.** Amends § 256J.24, subd. 3. Modifies the list of individuals who must be excluded from an MFIP assistance unit to include children receiving certain guardianship and adoption assistance payments. Makes this section effective January 1, 2015.

29 **Family wage level.** Amends § 256J.24, subd. 7. Modifies the family wage level. Makes this section effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

30 **Work participation cash benefits.** Amends § 256J.621.

Subd. 1. Program characteristics. No changes.

Subd. 2. Program suspension. Suspends the work participation cash benefit program effective December 1, 2013. Allows the commissioner to reinstate the program if Minnesota does not meet the federal work participation rate and receives a notice of penalty to reduce the federal TANF block grant. Requires the commissioner to notify the legislature of the potential penalty and the commissioner's plans to reinstate the work participation cash benefit program within 30 days of the date the commissioner receives notification that the state failed to meet the federal work participation rate.

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31 **Performance base funds.** Amends § 256J.626, subd. 7. Modifies MFIP performance base funds allocated to counties and tribes beginning in calendar year 2016.

32 **TANF demonstration projects or waiver from federal rules and regulations.** Creates § 256J.78.

Subd. 1. Duties of the commissioner. Allows the commissioner to pursue TANF demonstration projects or waivers of federal TANF requirements as needed to allow the state to build a more results-oriented MFIP program to better meet the needs of Minnesota families.

Subd. 2. Purpose. Specifies the purpose of the TANF demonstration projects or waivers.

Subd. 3. Report to legislature. Requires the commissioner to report to the legislature by March 1, 2014, regarding the progress of this waive or demonstration project.

Makes this section effective the day following final enactment.

33 **Citation.** Creates § 256N.001. Cites §§ 256N.001 to 256N.28 as the "Northstar Care for Children Act." The act provides certain benefits for children who are in foster care, the permanent care of a relative, or in the care of adoptive parents.

34 **Public policy.** Creates § 256N.01. Paragraph (a) provides that it is the state's policy to keep children safe from harm, and if they do suffer harm, to make appropriate services immediately available to them.

Paragraph (b) states that children do best in permanent homes, and if that home cannot be with their parents, then an alternative permanent home must quickly be made available.

Paragraph (c) provides that in achieving permanency for a child, stable benefits must be available for caregivers without consideration of the placement setting.

35 **Definitions.** Creates § 256N.02. Defines the terms "adoption assistance," "assessment," "at-risk child," "basic rate," "caregiver," "commissioner," "county board," "disability," "financially responsible agency," "guardianship assistance," "human services board," "initial assessment," "legally responsible agency," "maintenance payments," "permanent legal and physical custody," "reassessment," "relative," "relative custodian," "special assessment," and "supplemental difficulty of care rate."

36 **Northstar Care for children; generally.** Creates § 256N.20

Subd. 1. Eligibility. Provides that a child is eligible for Northstar Care if the child is eligible for foster care, guardianship assistance, or adoption assistance.

Subd. 2. Assessments. Requires each eligible child receive an assessment.

Subd. 3. Agreements. For children eligible for guardianship assistance or adoption assistance, requires negotiations and the development of a written, binding

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agreement with the caregivers of the child.

Subd. 4. Benefits and payments. Benefits are based primarily on assessments, and, if appropriate, negotiations and agreements. Although the benefits are paid to the caregiver, the benefits are considered the benefits of the child.

Subd. 5. Federal, state, and local shares. Requires Northstar costs to be shared by the federal government, state, counties of financial responsibility, and tribes.

Subd. 6. Administration and appeals. Provides that administration and appeals are governed by section 256N.28.

Subd. 7. Transition. Provides that children in foster care or receiving relative custody assistance or adoption assistance prior to January 1, 2015, who remain with the same caregivers will generally continue to receive benefits under programs preceding Northstar. Specifies the sections of this act dealing with the transition to Northstar Care for foster children, children in relative custody, and children in adoptive placements.

37 **Eligibility for foster care benefits.** Creates § 256N.21.

Subd. 1. General eligibility requirements. Establishes criteria for a child's eligibility for foster care benefits.

Subd. 2. Placement in foster care. Requires that a child to be placed away from the child's parent or guardian and that the following criteria are met:

- the legally responsible agency has placement authority and care responsibility for the child; and
- the child is placed in an emergency relative placement, a licensed foster placement, or , for a child 18 or older and under age 21, a supervised independent living setting.

Subd. 3. Minor parent. Clarifies that when a minor parent is in foster care with the child and both are in the same placement, the foster care benefit is limited to the minor parent, unless the agency has separate legal responsibility for the minor parent's child.

Subd. 4. Foster children ages 18 up to 21 placed in an unlicensed supervised independent living setting. Provides that a child between the ages of 18 and 21 who has maintained eligibility for foster care is entitled to benefits.

Subd. 5. Excluded activities. States that foster care benefits represent costs for activities similar to those expected of parents. Provides that the agency may pay an additional fee for specific services provided by the foster parent.

Subd. 5. Transition from pre-Northstar Care for Children program. Provides that children in family foster care on December 31, 2014, will continue to receive benefits under pre-Northstar Care criteria. Establishes the bases for transition from pre-Northstar Care to Northstar Care.

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38 **Guardianship assistance eligibility.** Creates § 256N.22.

Subd. 1. General eligibility requirements. Establishes the eligibility criteria for payment of guardianship assistance to a relative who has accepted permanent legal and physical custody of a child.

Subd. 2. Agency determinations regarding permanency. Lists determinations that must be made by the legally responsible agency prior to the transfer of permanent legal and physical custody.

Subd. 3. Citizenship and immigration status. Requires the child to be a citizen or otherwise eligible for federal public benefits in order to be eligible for guardianship assistance.

Subd. 4. Background study. Requires completion of a background study on each prospective relative custodian and any other adult residing in the household. Provides that if the background study reveals a conviction of specified felony offense, then the relative custodian is prohibited from receiving guardianship assistance.

Subd. 5. Responsibility for determining guardianship assistance eligibility. Requires the commissioner to determine a child's eligibility for guardianship assistance.

Subd. 6. Exclusions. Paragraph (a) makes a child with a guardianship assistance agreement ineligible for the MFIP child-only grant.

Paragraph (b) prohibits the commissioner from entering into a guardianship assistance agreement with a child's biological parent, an individual who has assumed legal and physical custody of a child under tribal code without child welfare system involvement, or for a child who was placed in Minnesota by another state or tribe outside Minnesota.

Subd. 7. Guardianship assistance eligibility determination. Requires the financially responsible agency to determine whether a child is eligible for guardianship assistance and submit this determination to the commissioner for final approval.

Subd. 8. Termination agreement. Lists the conditions under which a guardianship assistance agreement must be terminated.

Subd. 9. Death of relative custodian or dissolution of custody. Requires termination of the agreement upon the death or dissolution of custody of both relative custodians when custody has been assigned to two individuals, or the sole relative custodian in the assignment of custody to one individual.

Subd. 10. Assigning a child's guardianship assistance to a court-appointed guardian or custodian. Allows the commissioner to consent to the continuation of guardianship assistance to an individual who is a guardian or custodian appointed by a court upon the death of the relative custodian. The temporary assignment may be

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approved for a maximum of six months.

Subd. 11. Extension of guardianship assistance after age 18. Allows the commissioner to extend guardianship assistance beyond the date the child turns 18, up to the date the child turns 21, when specified conditions and criteria are met.

Subd. 12. Beginning guardianship assistance component of Northstar Care for Children. Effective November 27, 2014, allows a child who meets eligibility criteria for guardianship assistance to have the agreement negotiated under the Northstar Care criteria.

Subd. 13. Transition to guardianship assistance under Northstar Care for Children. Lays out the procedure for executing guardianship assistance agreements for a child who has a relative custody assistance agreement in effect on or before November 26, 2014.

39 **Adoption assistance eligibility.** Creates § 256N.23.

Subd. 1. General eligibility requirements. Lists the criteria for adoption assistance eligibility.

Subd. 2. Special needs determination. Lists the requirements for a child to be considered a child with special needs.

Subd. 3. Citizenship and immigration status. Requires the child to be a citizen or otherwise eligible for federal public benefits to be eligible for IV-E adoption assistance. To be eligible for non IV-E adoption assistance, a child must be a citizen or meet the qualified alien requirements.

Subd. 4. Background study. Requires completion of a background study on each prospective adoptive parent. Provides that if the background study reveals a conviction of specified felony offense, then the adoptive parent is prohibited from receiving adoption assistance.

Subd. 5. Responsibility for determining adoption assistance eligibility. Requires the commissioner to determine the child's eligibility for adoption assistance.

Subd. 6. Exclusions. Lists the individuals the commissioner must exclude from receiving adoption assistance on behalf of a child.

Subd. 7. Adoption assistance eligibility determination. Requires the financially responsible agency to determine whether a child is eligible for adoption assistance and submit this determination and supporting documentation to the commissioner for final approval.

Subd. 8. Termination of agreement. Lists the conditions under which an adoption assistance agreement must be terminated.

Subd. 9. Death of adoptive parent or adoption dissolution. State that the adoption assistance agreement ends upon the death or termination of parental rights of

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the adoptive parent, if sole adoptive parent, or parents, in the case of a two-parent adoption.

Subd. 10. Continuing a child's title IV-E adoption assistance in a subsequent adoption. Lists the conditions under which adoption assistance continues in a subsequent adoption and the conditions in which it will not continue.

Subd. 11. Assigning a child's adoption assistance to a court-appointed guardian or custodian. Allows the commissioner to consent to the continuation of adoption assistance to an individual who is a guardian or custodian appointed by a court upon the death of the adoptive parent or parents. The temporary assignment may be approved for a maximum of six months.

Subd. 12. Extension of adoption assistance agreement. Allows continuation of an adoption assistance agreement beyond the date the child turns 18 up until the child turns 21 under certain limited circumstances.

Subd. 13. Beginning adoption assistance under Northstar Care for Children. Effective November 27, 2014, allows a child who meets eligibility criteria for adoption assistance to have the agreement negotiated under the Northstar Care criteria.

Subd. 14. Transition to adoption assistance under Northstar Care for Children. Lays out the procedure for executing adoption assistance agreements under this chapter to a child with an adoption assistance agreement under chapter 259A.

40 **Assessments.** Creates § 256N.24.

Subd. 1. Assessment. Requires an assessment of each child eligible for foster care, guardianship, or adoption assistance to determine the level of benefits the child may receive.

Subd. 2. Establishment of assessment tool, process, and requirements. Requires the commissioner to develop an assessment tool and process to be used for performing assessments required in subdivision 1.

Subd. 3. Child care allowance portion of assessment. Establishes the criteria and considerations for providing a child care allowance to caregivers.

Subd. 4. Timing of initial assessment. For children entering Northstar Care, requires completion of the initial assessment within 30 days after the child is placed in foster care.

Subd. 5. Completion of initial assessment. Establishes agency responsibilities for completion of the assessment.

Subd. 6. Timing of special assessment. Establishes criteria for performing a special assessment as part of a negotiation for guardianship assistance, adoption

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assistance, or when a child transitions from pre-Northstar Care to Northstar Care.

Subd. 7. Completing the special assessment. Requires the special assessment to be completed in consultation with the child's caregivers. If the caregivers refuse to participate, then establishes the level of care that will be assigned to the child.

Subd. 8. Time of and requests for reassessments. Lists the events that trigger the requirement for a reassessment. Requires the reassessment to be conducted within 30 days of the event.

Subd. 9. Caregiver requests for reassessments. Allows a caregiver to submit a written request for reassessment if at least six months have passed since a previously requested review. Allows a request in less than six months if there has been a significant change in the child's needs.

Subd. 10. Completion of reassessment. Requires the reassessment to be completed in consultation with the child's caregivers. If the caregivers refuse to participate, then establishes the level of care that will be assigned to the child.

Subd. 11. Approval of initial assessments, special assessments, and reassessments. Identifies agency personnel who must approve assessments completed by others in the agency. Establishes when the commissioner must approve the assessments.

Subd. 12. Notice for caregiver. Requires the agency to provide written notice to the caregiver of the results of the assessment or reassessment. Lists the information that must be provided to the caregiver.

Subd. 13. Assessment tool determines rate of benefits. Provides that the assessment tool determines the monthly benefit level for children in foster care. For guardianship assistance or adoption assistance, the monthly payment may be negotiated up to the monthly benefit level under foster care.

41 **Agreements.** Creates § 256N.25.

Subd. 1. Agreement; guardianship assistance; adoption assistance. Establishes the requirements for the written, binding agreement between the caregivers and the agency.

Subd. 2. Negotiation of agreement. Requires the agency and caregivers to negotiate the assistance agreement and submit the finalized agreement to the commissioner for approval. Provides that the benefit rate must be negotiated and included in the agreement.

Subd. 3. Renegotiation of agreement. Allows a relative caregiver or adoptive parent to request renegotiation of the agreement when there is a change in the needs of the child or the family's circumstances. Provides that the agreement must be renegotiated if the child receives retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, or black lung benefits.

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42 **Benefits and payments.** Creates § 256N.26.

Subd. 1. Benefits. Identifies three potential benefits: medical assistance, basic payment, and supplemental difficulty of care payment.

Subd. 2. Medical assistance. States that eligibility is determined according to section 256B.055.

Subd. 3. Basic monthly rate. Lists the monthly rates based on age ranges for the period from January 1, 2015, to June 30, 2016. Rates range from $565 to $790 per month.

Subd. 4. Difficulty of care supplemental monthly rate. Lists the supplemental rates for the period from January 1, 2015, to June 30, 2016. Rates range from $60 to $600 per month.

Subd. 5. Alternate rates for preschool entry and certain transitioned children. Establishes that a child subject to a guardianship or adoption assistance agreement before the age of six shall receive 50 percent of the basic rate and supplemental rate.

Subd. 6. Emergency foster care rate for initial placement. Establishes the formula for determining the emergency foster care rate when a child is placed in an emergency foster care placement. Sets out the conditions that must exist for application of this payment rate.

Subd. 7. Special at-risk monthly payment for at-risk children in guardianship assistance and adoption assistance. Establishes a payment rate for children who are considered at-risk of developing a disability.

Subd. 8. Daily rates. Instructs the commissioner to establish prorated rates to be used when a partial month is involved in foster care, guardianship assistance, and adoption assistance.

Subd. 9. Revision. Requires the commissioner to make biennial adjustments to the rates in subdivisions 3 through 7 based on the USDA Estimates of the Cost of Raising a Child. Limits the adjustment to no more than three percent per annum.

Subd. 10. Home and vehicle modification. Allows reimbursement for vehicle and home modifications to accommodate the needs of a child eligible for adoption assistance. Requires the reimbursement to be negotiated as part of the adoption assistance agreement.

Subd. 11. Child income or income attributable to the child. Provides that the monthly guardianship or adoption assistance payments made on behalf of the child are considered income and resources available to the child. In some cases, the receipt of other income on behalf of the child may impact the amount of the monthly assistance payments received by the adoptive parent or relative custodian.

Subd. 12. Treatment of Supplemental Security Income. Permits the county of

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financial responsibility to apply to be the payee for a foster child for the duration of the child's foster care placement. Sets out the requirements for adoptive parents and relative caregivers to receive SSI payments on behalf of the child.

Subd. 13. Treatment of retirement survivor's disability insurance, veteran's benefits, railroad retirement benefits, and black lung benefits. Permits the county of financial responsibility to apply to be the payee for a foster child for the duration of the child's foster care placement. Sets out the requirements for adoptive parents and relative caregivers if a child becomes eligible for one of these benefits after placement.

Subd. 14. Treatment of child support and Minnesota family investment program. Provides that child support may be redirected to the county of financial responsibility when a child is in foster care. For child eligible for adoption or guardianship assistance, court-ordered child support cannot have any impact on the Northstar Care monthly payment. A child eligible for Northstar Care payments is excluded from an MFIP assistance unit.

Subd. 15. Payments. Requires monthly payments to caregivers. Establishes which agency must make the monthly payment.

Subd. 16. Effect of benefit on other aid. Northstar Care payments are not considered income for child care assistance or any other financial benefit. Children receiving a payment under Northstar Care are excluded from an MFIP assistance unit.

Subd. 17. Home and community-based services waiver for persons with disabilities. Allows foster child to qualify for HCBS waiver services. Clarifies that HCBS waiver services cannot substitute for foster care.

Subd. 18. Overpayments. Authorizes the commissioner to collect any amount of foster care, adoption assistance, or guardianship assistance paid in excess of payment due. Requires the commissioner to provide written notification to the caregiver.

Subd. 19. Payee. Requires adoption and guardianship assistance payments to be made to the caregiver specified in the agreement. When there is more than one adoptive parent or relative caregiver, both must be listed on the agreement. Sets out the procedure if there is a divorce, separation, or death.

Subd. 20. Notification of change. Requires caregivers to notify the commissioner of specified changes in status or circumstances.

Subd. 21. Correct and true information. Requires the commissioner to initiate a fraud investigation against the caregiver under specified circumstances.

Subd. 22. Termination notice for caregiver. Requires the agency that makes the maintenance payment to provide 15 days notice to the caregiver when benefits will be terminated. Lists information that must be included in the notice.

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43 **Federal, state, and local shares.** Creates § 256N.27.

Subd. 1. Federal share. Requires the county of financial responsibility to determine IV-E eligibility for children in foster care and for children who qualify for guardianship assistance or adoption assistance.

Subd. 2. State share. Establishes the formula for the commissioner to pay the state share of the maintenance payments.

Subd. 3. Local share. Requires the county of financial responsibility to pay the local share of maintenance payments. In cases of federally required adoption assistance where there is no financially responsible agency, the commissioner must pay the local share. For an Indian child who is IV-E eligible, the agency or entity assuming responsibility for the child is responsible for the nonfederal share.

Subd. 4. Nonfederal share. Sets out the calculations for establishing state and local shares.

Subd. 5. Adjustments for proportionate shares among financially responsible agencies. Requires the commissioner to adjust the nonfederal share expenditures so that the relative share for each agency is proportional to its foster care expenditures before Northstar Care.

44 **Administration and appeals.** Creates § 256N.28.

Subd. 1. Responsibilities. Describes the responsibilities of the financially responsible agency and the commissioner

Subd. 2. Procedures, requirements, and deadlines. Requires the commissioner to specify procedures, requirements, and deadlines for administration of Northstar Care, including the transition.

Subd. 3. Administration of title IV-E programs. Requires the IV-E programs to comply with federal law and regulations.

Subd. 4. Reporting. Instructs the commissioner to identify required fiscal and statistical reports that must be completed.

Subd. 5. Promotion of programs. Requires the commissioner to actively promote the guardianship and adoption assistance programs. Instructs the commissioner to inform families of the adoption tax credit when they adopt a child under the commissioner's guardianship.

Subd. 6. Appeals and fair hearings. Sets out a caregiver's appeal rights.

Subd. 7. Transitions from pre-Northstar Care for Children programs. Establishes the transition processes, priorities, and considerations.

Subd. 8. Purchase of child-specific adoption services. Allows the commissioner to reimburse a placing agency for adoption services.

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45 **Services.** Amends § 257.85, subd. 2. Limits applicability of relative custody assistance to district court or tribal court ordered placements made on or before November 26, 2014.

46 **Relative custody assistance agreement.** Amends § 257.85, subd. 5. Limits applicability of relative custody assistance to those placements in which the agreement is signed on or before November 26, 2014.

47 **Eligibility criteria.** Amends § 257.85, subd. 6. Prohibits execution of new relative custody assistance agreements after November 26, 2014. Requires renegotiation of agreements signed before this date if the transfer of custody did not occur before this date.

48 **No new execution of adoption assistance agreements.** Creates § 259A.12. Prohibits execution of new adoption assistance agreements after November 26, 2014. Requires renegotiation of agreements signed before this date if the adoption was not finalized before this date.

49 **Pre-Northstar Care for Children foster care program.** Creates § 260C.4411.

Subd. 1. Pre-Northstar Care for Children foster care program. Establishes county of financial responsibility and tribal agency duties for children placed in family foster care on or before December 31, 2014.

Subd. 2. Consideration of other programs. Provides that if a child is eligible for funds through RSDI, SSI, or IV-E, those funds must be used to meet the needs of the child. Provides that if a child is eligible for HCBS waiver programs, these programs are not a substitute for foster care.

50 **Payment for residential placements.** Creates § 260C.4412. Provides that when a foster child is placed in a group residential setting, foster care maintenance payments must be made on behalf of the child. Provides an effective date of January 1, 2015.

51 **Initial clothing allowance.** Creates § 260C.4413. Requires an initial clothing allowance for children placed in foster care under pre-Northstar and Northstar Care. Provides an effective date of January 1, 2015.

52 **Distribution of funds recovered for assistance furnished.** Amends § 260C.446. Strikes the cross-reference to a statutory section that is being repealed in this article. Provides an effective date of January 1, 2015.

53 **Repealer.** (a) Repeals Minnesota Statutes §§ 256.82, subd. 4 (foster care payments) and 260C.441 (county payments to commissioner) effective January 1, 2015.

(b) Repeals Minnesota Statutes, section 256J.24, subd. 10 (MFIP exit level), effective October 1, 2013, or upon approval from the United States Department of Agriculture, whichever is later.

(c) Repeals Minnesota Rules, parts 9560.0650, subps. 1 (foster care maintenance payments), 3 (agency contract care), and 6 (reassessments); 9560.0651 (difficulty of care payments); and 9560.0655 (difficulty of care rates), effective January 1, 2015.

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(d) Repeals Minnesota Rules, part 9502.0355, subp. 4 (day care insurance coverage).

Article 4: Strengthening Chemical and Mental Health Services

Overview

This article amends various chemical and mental health statutes. It allows the commissioner authority to spend funds from the state-operated services account for transition services for individuals leaving institutional settings. It allows medical assistance reimbursement for family psychoeducation services, mental health clinical coordination, and intensive treatment in foster care.

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

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

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

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

5 **Transfers.** Amends §2 46.18, by adding subd. 9. Allows the commissioner to transfer state mental health grant funds to the state-operated services account for noncovered costs of a state-operated services IRTS provider.

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

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

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

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

Subd. 1a. Definitions. Defines the terms "clinical care consultation," "clinical supervision," "clinical supervisor," "clinical trainee," "crisis assistance," " culturally appropriate," "culture," "diagnostic assessment," " family," "foster care," "foster family setting," "individual treatment plan," "mental health practitioner," "mental health professional," "mental illness," "parent," "psychoeducation services," "psychotherapy," and "team consultation and treatment planning."

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

Subd. 3. Eligible mental health services providers. Requires providers to be certified by the state, have a service provision contract with a county board or reservation tribal council, and demonstrate the ability to provide services.

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

Subd. 5. Service authorization. No changes.

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

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

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

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

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Article 5: Department of Human Services Program Integrity

Overview

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

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

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

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

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

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

Subd. 1. Definitions. Defines the terms "applicant," "child care assistance program," "commissioner," "controlling individual," "county," "department," "financial misconduct" or "misconduct," "identify," "license holder," "mail," "provider," "recipient," and "terminate."

Subd. 2. Investigating provider or recipient financial misconduct. Authorizes the department to investigate alleged or suspected financial misconduct and payment errors.

Subd. 3. Scope of investigations. Allows the department to contact and interview any person, organization, agency, or other entity that is necessary to an investigation. Allows the department to examine any document or evidence that may be relevant.

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Subd. 4. Determination of investigation. Requires the department to classify the results of its findings.

Subd. 5. Actions or administrative sanctions. Provides a list of the actions and sanctions that may be initiated or imposed by the department.

Subd. 6. Duty to provide access. Requires a provider, license holder, controlling individual, employee, staff person, or recipient to provide access upon request to specified records or to the program facility. Details the actions the department can take if access is denied.

Subd. 7. Honest and truthful statements. Makes it unlawful for a provider, license holder, controlling individual, or recipient to make false representations, conceal or cover up facts, or produce false documents to a fraud investigator or law enforcement officer conducting an investigation into financial misconduct.

Subd. 8. Record retention. Provides a list of the records that must be maintained, controlled, and immediately accessible.

Subd. 9. Factors regarding imposition of administrative sanctions. Lists the factors the department must consider in determining whether to impose administrative sanctions.

Subd. 10. Written notice of department sanction. Requires the department to send written notice when an administrative sanction is to be imposed. Lists what must be contained in the notice, including the right to appeal.

Subd. 11. Appeal of department sanction under this section. Provides that if the department does not pursue criminal charges for financial misconduct, but imposes administrative sanctions, an individual or entity may appeal the sanctions.

Subd. 12. Consolidated hearings with licensing sanction. Permits a consolidated contested case hearing if a financial misconduct sanction and licensing sanction involve the same set of facts.

Subd. 13. Grounds for and methods of monetary recovery. Allows the department to obtain monetary recovery for improper payments. Lists the means by which the department can recover the funds.

Subd. 14. Reporting of suspected fraudulent activity. Provides that a person who makes a good faith report and who in no way was involved in the financial misconduct is immunity from liability. Provides that if a person has been involved in the financial misconduct and reports the misconduct, that report may be considered as a mitigating factor in the department's pursuit of remedies.

Subd. 15. Data privacy. Provides that data obtained in relation to fraud investigations is classified as licensing data under section 13.46.

Subd. 16. Monetary recovery; random sample extrapolation. Authorizes the

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department to calculate the amount of monetary recover based on an extrapolation from a statistical random sample of claims submitted by the provider and paid by the child care assistance program.

Subd. 17. Effect of department's monetary penalty determination. Provides that absent a timely appeal of the monetary penalty, the sanction shall be considered a final agency determination.

Subd. 18. Office of Inspector General recoveries. Excludes recoveries from child care provider fraud investigations initiated by the OIG investigation staff from the county recovery provision in section 119B.11, subdivision 3.

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

Provides an immediate effective date.

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

Provides an immediate effective date.

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

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

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

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

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10 **Requirements for initial enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. Increase surety bond coverage amount for PCA provider agencies. Requires annual renewal of the bond.

Provides an immediate effective date.

Article 6: 2013 Managed Care Organizations Rate Conformity

1 **Payments.** Amends § 256.969, subd. 3a. Increases MA payment rates for inpatient hospital admissions occurring on or after January 1, 2014, by two percent. States that payments to managed care plans shall not be adjusted to reflect these payments.

2 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective January 1, 2014, increases MA payment rates for ambulance services by three percent over the rates in effect on December 31, 2013. States that payments to managed care plans shall not be adjusted to reflect these payments.

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

4 **Payment reduction.** Amends § 256B.69, subd. 31. For the CY 2013, adjusts the maximum annual trend changes for rates paid to managed care and county-based purchasing plans, as follows:

(1) from 7.5 to 5.4 percent for MA elderly basic care (and includes in this trend limit Medicare cost-sharing, nursing facility services, and personal care assistance services);

(2) from 5.0 to 0.0 percent for MA special needs basic care;

(3) from 2.0 to 0.0 percent for MA families and children;

(4) from 3.0 to -5.1 percent for MA adults without children;

(5) from 3.0 to 2.7 percent for MinnesotaCare families and children; and

(6) from 3.0 to 11.4 percent for MinnesotaCare adults without children.

5 **Physician reimbursement.** Amends § 256B.76, subd. 1. Effective January 1, 2014, increases payment rates for physician and professional services (including physical therapy, occupational therapy, speech pathology, and mental health services) by five percent. Provides that the increase does not apply to federally qualified health centers, rural health centers, and Indian health services. States that payments to managed care plans shall not be adjusted to reflect these payments.

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

7 **Reimbursement for mental health services.** Amends § 256B.761. Effective January 1, 2014, increases payments rates for outpatient mental health services by five percent over the rates in effect on December 31, 2013. States that payments to managed care plans shall not be adjusted to reflect these payments.

8 **Reimbursement for basic care services.** Amends § 256B.766. Effective January 1, 2014, increases payments by three percent for the following services: ambulatory surgical center facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract. Effective January 1, 2014, increases payments for outpatient hospital facility fees by five percent. States that payments to managed care plans shall not be adjusted to reflect these payments.

The amendment to paragraph (d) removes hospice services from the list of services subject to a payment reduction; hospice services were never made subject to the reduction, given federal law requiring these services to be paid at the Medicare rate.

Article 7: Health Care

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

2 **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) requires the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program to be estimated at wholesale acquisition cost minus 44 percent, for purposes of MA payment.

The amendment to paragraph (d) allows payment for drugs administered in an outpatient setting to be at the lower of the specialty pharmacy rate or the maximum allowable cost (in addition to the lower of the usual and customary cost or 106 percent of the average sales price, as under current law). Requires the commissioner to discount the payment rate for drugs obtained through the federal 340B Drug Discount Program by 33 percent. Requires payment for drugs administered in an outpatient setting to be made to the administering facility or the practitioner. Provides that a retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

Provides an effective date of January 1, 2014.

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

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

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

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

7 **Payment for certain primary care services and immunization administration.** Amends § 256B.76, by adding subd. 7. Requires payment for certain primary care services and immunization administration services provided January 1, 2013 through December 331, 2014, to be made in accordance with § 1902(a)(13) of the Social Security Act (this provision requires primary care services to be paid at a rate not less than Medicare rates for 2013 and 2014).

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

Article 8: Continuing Care

Overview

This article makes changes to continuing care programs including the corporate foster care moratorium, long-term care consultation services, home and community-based services waivers, and nursing facilities. This article also includes provisions to create a new autism early intensive intervention benefit, and directs the commissioner to submit certain requests and waiver amendments to the federal government.

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

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required to provide. Modifies exemptions from decreased licensed capacity for certain residential settings.

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

3 **Preadmission screening of individuals under 65 years of age.** Amends § 256B.0911, subd. 4d. Specifies payments for individuals under age 65 shall be made until September 30, 2013.

4 **Payment for long-term care consultation services.** Amends § 256B.0911, subd. 6. Specifies payment for long-term care consultation face-to-face assessments shall be made until September 30, 2013. Specifies the alternative payment methodology for long-term care consultation services is effective October 1, 2013. Requires the alternative payment methodology to include the use of appropriate time studies and the state financing of nonfederal share as part of the state's MA program.

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

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

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

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

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

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

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approval, but not earlier than March 1, 2014.

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

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

Subd. 4. Treatment plan. Specifies requirements related to a child's treatment plan.

Subd. 5. Ongoing eligibility. Requires a child receiving this benefit to receive an independent progress evaluation by a licensed mental health professional every six months, or more frequently as determined by the commissioner, to determine if progress is being made toward goals contained in the treatment plan. Specifies the information to be included in the progress evaluation, allows the observation component of the progress evaluation to be performed by a child's special education teacher, and requires progress evaluations to be submitted to the commissioner in a manner determined by the commissioner. Makes children who continue to achieve treatment plan goals eligible to continue receiving this benefit.

Subd. 6. Refining the benefit with stakeholders. Requires the commissioner to develop the implementation details of the benefit in consultation with stakeholders and to consider recommendations of specified councils and task forces. Requires the commissioner to release the implementation details for a 30-day public comment period prior to submission to the federal government for approval. Lists items that must be included in the implementation details.

Subd. 7. Revision of treatment options. Allows the commissioner to revise covered treatment options as needed to ensure consistency with evolving evidence.

Subd. 8. Coordination between agencies. Requires the commissioners of human services and education to coordinate diagnostic and educational assessment, service delivery, and progress evaluations across health and education sectors.

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

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

12 **Home and community-based services quality profiles.** Creates § 256B.4391.

Subd. 1. Development and implementation of quality profiles. Requires the commissioner of human services, in consultation with the commissioner of health, to develop and implement quality profiles for home and community-based services

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(HCBS) providers, except when quality profiles would duplicate certain statutory requirements. Defines HCBS providers. Specifies how the quality profiles must be developed and designed.

Subd. 2. Quality measurement tools. Requires the commissioners to identify and apply quality measurement tools and specifies the information the tools must include.

Subd. 3. Consumer surveys. Requires the commissioner to conduct surveys of HCBS consumers to develop quality profiles of providers. Specifies how and when the surveys must be conducted.

Subd. 4. Home and community-based services report card. Requires the profiles developed to be incorporated into a report card and maintained by the Minnesota Board on Aging as data becomes available. Requires the commissioner to use specified categories to organize the consumer information in the profiles. Requires the commissioner to develop and disseminate quality profiles for a limited number of provider types initially, and to develop quality profiles for additional provider types as measurement tools are developed and data becomes available.

Subd. 5. Dissemination of quality profiles. Requires the commissioner to implement a public awareness effort to disseminate the quality profiles by July 1, 2014. Specifies how the profiles may be disseminated.

Subd. 6. Implementation of home and community-based services performance-based incentive payment program. By July 1, 2014, requires the commissioner to develop incentive-based grants for HCBS providers for achieving outcomes specified in a contract. Requires the commissioner to solicit proposals and to implement those which best meet the state's policy objectives. Requires the commissioner to determine the types of HCBS providers that will participate in the program. Allows the participating provider types to be revised annually by the commissioner. Specifies the policy objectives the commissioner must consider in establishing outcomes and related criteria.

Subd. 7. Calculation of HCBS quality score. Requires the commissioner to determine a quality score for each participating HCBS provider. Specifies how scores will be determined for each quality measure. Gives the commissioner the authority to annually revise the quality measures and methods of calculating scores.

Subd. 8. Calculation of HCBS quality add-on. Effective January 1, 2016, requires the commissioner to determine the quality add-on payment for participating HCBS providers. Specifies the quality add-on will be a variable amount based on each provider's quality score. Requires the commissioner to limit the types of HCBS providers that may receive the quality add-on and the amount of the quality add-on payments to operate the quality add-on within funds appropriated for this purpose and based on the availability of the quality measures.

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

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14 **Calculation of operating rate increase and quality add-on for the October 1, 2013, rate year.** Amends § 256B.441, by adding subd. 46b. Effective October 1, 2013, requires the commissioner to (1) implement an operating payment rate increase of 1.09 percent and (2) determine quality add-ons to the operating payment rate for each facility .

15 **Calculation of operating rate increase and quality add-on for the October 1, 2014, rate year.** Amends § 256B.441, by adding subd. 46c. Effective October 1, 2014, requires the commissioner to (1) implement an operating payment rate increase of 1.09 percent and (2) determine quality add-ons to the operating payment rate for each facility .

16 **Calculation of quality add-on for the October 1, 2015, rate year.** Amends § 256B.441, by adding subd. 46d. Requires the commissioner to determine add-ons to the operating payment rates for each facility. Specifies how the quality add-ons shall be computed and requires the commissioner to implement the quality add-ons effective October 1, 2015. Specifies how the quality add-on must be computed for publicly owned nursing facilities.

17 **Calculation of quality add-on for the October 1, 2016, rate year.** Amends § 256B.441, by adding subd. 46e. Requires the commissioner to determine add-ons to the operating payment rates for each facility. Specifies how the quality add-ons shall be computed and requires the commissioner to implement the quality add-ons effective October 1, 2016. Specifies how the quality add-on must be computed for publicly owned nursing facilities.

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

19 **Waivered services statewide priorities.** Amends § 256B.49, subd. 11a. Modifies statewide priorities for funding individuals on the waiting list for the CAC, CADI, and BI waivers. Allows the commissioner to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe. Removes obsolete language.

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

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

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

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

24 **Safety net for home and community-based services waivers.** Requires the commissioner to submit a request by December 31, 2013, to the federal government to amend the CAC, CADI, and BI home and community-based services waivers to modify the financial management of the HCBS waivers to provide a state-administered safety net when costs for an individual increase above an identified threshold. Allows implementation of a statewide safety net to result in a decreased allocation for individual counties, or collaborative or counties or tribes, but prohibits a decrease in the net statewide allocation.

25 **Shared living model.** Requires the commissioner of human services to develop and promote a shared living model option for individuals receiving services through the CAC, CADI, DD, and BI home and community-based services waivers for individuals who require 24-hour assistance. Requires the option to be a companion model with a limit of one or two individuals receiving support in the home, planned respite for the caregiver, and the availability of intensive training and support on the needs of the individual or individuals. Requires any necessary amendments to implement the model to be submitted to the federal government by December 31, 2013.

26 **Money follows the person grant.** Requires the commissioner to submit to the federal government all necessary waiver amendments to implement the Money Follows the Person federal grant by December 31, 2013.

27 **Repealer.** Repeals Minnesota Statutes, section 256B.5012, subd. 13 (ICF/DD rate decrease effective July 1, 2013) and Laws 2011, First Special Session, ch. 9, art. 7, section 54, as amended by Laws 2012, ch. 247, art. 4, section 42, and Laws 2012, ch. 298, section 3 (contingency provider rate and grant reductions).

Article 9: Waiver Provider Standards

Overview

This article modifies human services licensing provisions and home and community-based services standards.

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

2 **Health care facility; notice of status.** Amends §243.166. Strikes the word "developmental."

Section

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

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

Subd. 2. Data collection. Requires the commissioner to consult with stakeholders and collect data on the use of aversive and controlled procedures from providers who will be licensed under chapter 245D.

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

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

6 **Licensing moratorium.** Amends §245A.03, subd. 7. Adds community residential setting licenses to the list of licenses subject to the moratorium. Adds references to community residential settings.

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

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

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

10 **Fees.** Amends §245A.10.

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

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

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

Subd. 4. License or certification fee for certain programs. Strikes obsolete

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language and fees. Establishes new license fees fro programs licensed under chapter 245D.

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

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

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

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

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

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

16 **Delegation of authority to agencies.** Amends §245A.16, subd. 1. Prohibits county agencies from granting variances for community residential setting licenses.

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

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

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

Subd. 2. Relationship to other standards governing home and community-based services. Modifies standards related to foster care services. Exempts license

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holders providing (1) services in supervised living facilities, (2) residential services to person in an ICF/DD, and (3) homemaker services from certain standards. Specifies nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 or older, provided all relevant standards are met.

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

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

Subd. 4. Program certification. Allows an applicant or license holder to apply for program certification.

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

20 **Health services.** Amends § 245D.05.

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

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

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

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

Subd. 3. Medication assistance. Repeals this subdivision.

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

Subd. 5. Injectable medications. No changes.

Makes this section effective January 1, 2014.

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21 **Psychotropic medication use and monitoring.** Creates § 245D.051.

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

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

Makes this section effective January 1, 2014.

22 **Protection standards.** Amends § 245D.06.

Subd. 1. Incident response and reporting. Makes technical and conforming changes. Specifies when incident reviews must be conducted and what must be included in the review. Requires license holders to report the emergency use of manual restraint of a person to DHS within 24 hours of the occurrence. Specifies reporting requirements when a death or serious injury occurs at an ICF/DD.

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

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

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

Subd. 5. Prohibitions. Prohibits license holders from using chemical restraints, mechanical restraint practices, manual restraints, time out, or seclusion as a substitute for adequate staffing, a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience. Defines "chemical restraint" and "mechanical restraint practice." Makes this section effective January 1, 2014.

23 **Emergency use of manual restraints.** Creates § 245D.061.

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

Subd. 2. Definitions. Defines "manual restraint" and "mechanical restraint."

Subd. 3. Conditions for emergency use of manual restraint. Lists the conditions that must be met for emergency use of manual restraint.

Subd. 4. Permitted instructional techniques and therapeutic conduct. Requires physical contact or instructional techniques to use the least restrictive alternative possible to meet the needs of the person and allows them to be used under specified

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conditions. Specifies when restraint may be use as therapeutic conduct. Requires a plan to be developed for using restraint as therapeutic conduct.

Subd. 5. Restrictions when implementing emergency use of manual restraint. Lists prohibitions regarding emergency use of manual restraint procedures.

Subd. 6. Monitoring emergency use of manual restraint. Requires the license holder to monitor a person's health and safety during an emergency use of manual restraint. Requires the license holder to complete a monitoring form for each incident involving the emergency use of manual restraint.

Subd. 7. Reporting emergency use of manual restraint incident. Requires the staff person who implemented the emergency use of a manual restraint to report each incident involving the emergency use of manual restraint. Specifies the information that must be included in the incident report. Requires each single incident of emergency use of manual restraint to be reported separately.

Subd. 8. Internal review of emergency use of manual restraint. Requires license holders to complete an internal review of each report of emergency use of manual restraint, lists the information that must be evaluated as part of the review, and requires a corrective action plan to be developed and implemented if any lapses in performance are found.

Subd. 9. Expanded support team review. Requires license holders to consult with the expanded support team following the emergency use of manual restraint.

Subd. 10. Emergency use of manual restraints policy and procedures. Requires license holders to develop, document, and implement a policy and procedures for the emergency use of manual restraints. Specifies the information that must be included in the policy and procedures.

Makes this section effective January 1, 2014.

24 **Service planning and delivery.** Amends § 245D.07.

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

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

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

Subd. 3. Reports. No changes.

Makes this section effective January 1, 2014.

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

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

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

27 **Staffing standards.** Amends § 245D.09.

Subd. 1. Staffing requirements. Modifies staffing requirements.

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

Subd. 3. Staff qualifications. Makes conforming changes by modifying

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terminology and modifies staff qualifications.

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

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

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

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

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

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

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

Makes this section effective January 1, 2014.

28 **Intervention services.** Creates § 245D.091.

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

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

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

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

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

Makes this section effective January 1, 2014.

Section

29 **Record requirements.** Creates § 245D.095.

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

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

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

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

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

Makes this section effective January 1, 2014.

30 **Policies and procedures.** Amends § 245D.10.

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

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

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

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

Makes this section effective January 1, 2014.

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

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

Subd. 2. Health and safety. Requires license holders to establish policies and procedures that promote health and safety. Lists health and safety requirements.

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

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

Makes this section effective January 1, 2014.

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

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

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

Makes this section effective January 1, 2014.

33 **Facility sanitation and health.** Creates § 245D.22.

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

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

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

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

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

Subd. 6. Emergency equipment. Requires each facility to have a flashlight and a portable radio or TV that do not require electricity and can be used if a power failure

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occurs.

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

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

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

Makes this section effective January 1, 2014.

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

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

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

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

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

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

Subd. 6. Person requiring staff ratio of one to six. Requires a person who does not have any of the characteristics described in subdivisions 4 and 5 to be assigned a staff ratio of one to six.

Subd. 7. Determining number of direct support service staff required. Specifies the steps for determining the number of direct support service staff required

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to meet the combined staff ratio requirements of the persons present at any one time.

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

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

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

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

Makes this section effective January 1, 2014.

42 **Alternative licensing inspections.** Creates § 245D.32.

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

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

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

Subd. 4. Programs approved for alternative licensing inspection; deemed compliance licensing requirements. Requires license holders approved for alternative licensing inspection to maintain compliance with all licensing standards, prohibits the commissioner from performing routine licensing inspections, and requires the commissioner to investigate complaints and take action as provided for in human services licensing statutes.

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

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maltreatment of a minor or a vulnerable adult.

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

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

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

Makes this section effective January 1, 2014.

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

44 **Residential support services.** Amends § 256B.092, subd. 11. Modifies the types of settings than can provide residential support services and the criteria residential support services must meet.

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

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

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

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

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

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

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

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

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

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

Article 10: Waiver Provider Standards Technical Changes

Overview

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

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

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

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

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

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5	**Scope.** Amends § 245A.02, subd. 1. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
6	**License holder.** Amends § 245A.02, subd. 9. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
7	**Permitted services by an individual who is related.** Amends § 245A.03, subd. 9. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
8	**Funds and property; other requirements.** Amends § 245A.04, subd. 13. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
9	**License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
10	**Personal care.** Amends § 256B.0625, subd. 19c. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
11	**Contract provisions.** Amends § 256B.5011, subd. 2. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
12	**Agreement.** Amends § 471.59, subd. 1. Makes technical and conforming changes to cross-references and terminology related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
13	**Definitions.** Amends § 626.556, subd. 2. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
14	**Persons mandated to report.** Amends § 626.556, subd. 3. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
15	**Notification of neglect or abuse in facility.** Amends § 626.556, subd. 10d. Makes technical and conforming changes to cross-references related to the establishment of waiver provider standards in chapter 245D. Makes this section effective January 1, 2014.
16	**Repealer.** Repeals Minnesota Statutes, section 256B.49, subd. 16a (MA reimbursement), effective January 1, 2014.

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Article 11: Miscellaneous

Overview

This article changes the county share for placement costs for county residents at regional treatment centers, state nursing homes, and forensic transition services at the security hospital. Modifications are made to chapter 402A related to essential community services and service delivery authorities. A change is also made to the commissioner's authority to subsidize retailers for EBT transactions for SNAP transactions.

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

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

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

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

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

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

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

Subd. 2. Duties. Requires the council to meet at least quarterly, to review performance data submitted by counties or service delivery authorities, consider appeals from counties or service delivery authorities, provide advice and recommendations to the commissioner, and submit an annual report to the legislature and the commissioner.

Subd. 3. Membership. Lists the stakeholder groups that must be represented on the council in equal balance. Requires council members to be appointed for a minimum of two years.

Subd. 4. Commissioner's duties. Lists the duties of the commissioner.

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Subd. 5. County or service delivery authority duties. Requires the counties or service delivery authorities to report performance data and provide training to personnel.

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

Subd. 1. Underperforming county; specific services. Makes technical changes.

Subd. 2. Underperforming county; more than one-half of services. Makes technical changes.

Subd. 2a. Financial responsibility of underperforming county. Makes technical changes.

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

Paragraph (b) requires the commissioner to notify a county or service delivery authority that has not met minimum performance standards for a given measure that fiscal penalties may result unless performance improves. Instructs the commissioner to provide technical assistance. Allows the county to show extenuating circumstances exist for failure to meet minimum standards.

Paragraph (c) states the requirements for a performance improvement plan.

Paragraph (d) requires the commissioner to monitor the performance improvement plan for two years.

Paragraph (e) provides that if minimum performance standards are not met after two years, the next phase of the remedies process shall be implemented.

Paragraphs (f) through (h) provide for ongoing remedies and monitoring of counties or service delivery authorities that do not meet performance standards.

6 **EBT transaction costs.** Amends Laws 1998, chapter 407, article 6, section 116. Prohibits the commissioner from subsidizing retailers for EBT SNAP transactions.

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

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Article 12: Home Care Providers

Overview

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

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

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

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

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

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

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

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

7 **Regulation of home care services.** Amends § 144A.45. Makes technical changes and updates terminology. Modifies listed purposes of the commissioner's regulation of home care providers. Makes conforming changes related to repeal of Minnesota Rules, chapter 4668. Requires the commissioner to inspect temporary licensees within one year of issuance

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of a temporary license and requires inspection of licenses at an interval that will promote the health and safety of clients. Removes provision related to Medicaid reimbursement for Class F providers. Removes provision related to licensed home care providers who provide Alzheimer's disease services.

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

9 **Home care provider license; application and renewal.** Adds § 144A.472. Specifies information that must be provided to the commissioner by applicants for a home care provider license. Requires applicants for a comprehensive home care license to provide verification of certain policies and procedures. Includes license renewal provisions and requires licensees with multiple units that cannot share supervision and administration to obtain separate licenses for each unit. Prohibits transfer of any home care license. Sets fee schedule for initial licensure and license renewal fees.

10 **Issuance of temporary license and license renewal.** Adds § 144A.473. Provides a process for temporary licensure, which is effective for one year, and requires inspection during that first year.

11 **Surveys and investigations.** Adds § 144A.474. Requires the commissioner to conduct inspections of each home care provider and requires that surveys and investigations be conducted without advance notice. Requires home care providers to provide accurate and truthful information and specifies certain information that must be provided upon request. Requires the commissioner to investigate complaints against home care providers. Provides a process for correction orders, reconsideration and assessing fines.

12 **Enforcement.** Adds § 144A.475. Sets out enforcement provisions. Provides reasons for which the commissioner may refuse to grant or renew or may suspend or revoke a license. Requires that providers must request an appeal no later than 15 days after receipt of notice of an action. Restricts eligibility for certain licenses for certain providers after a license is revoked or not renewed for noncompliance.

13 **Background studies.** Adds § 144A.476. Requires background studies for owners and managers of home care provider services and for employees, contractors and volunteers.

14 **Compliance.** Adds § 144A.477. Provides that the commissioner shall survey licensees under this chapter at the same time as for certification under Medicare, to the extent feasible. Provides that certain state regulations are equivalent to federal requirements for providers that are certified for participation in Medicare as a home health agency.

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15	**Innovation variance.** Adds § 144A.478. Defines "innovation variance" for purposes of this section. Establishes a process by which a provider may apply for and the commissioner may grant an innovation variance from requirements of this chapter.
16	**Home care provider responsibilities; business operation.** Adds § 144A.479. Requires certain actions of home care providers with regard to business operations. Restricts non-governmental licensees from accepting powers-of-attorney from clients and from serving as a client's representative. Requires home care providers to report maltreatment of minors or vulnerable adults and must report suspected maltreatment. Requires each licensee to have an individual abuse prevention plan for vulnerable minors and adults for whom they provide services. Requires certain information to be kept as part of employee records.
17	**Home care provider responsibilities with respect to clients.** Adds § 144A.4791. Requires providers to give clients notice of their rights under the home care bill of rights. Provides special requirements for home care providers that serve clients with dementia. Sets out requirements for licensees related to only accepting clients for which the provider is qualified to provide services; making referrals when the provider reasonably believes medical services from another health care provider are required; assessment and monitoring of services provided under a basic- or comprehensive-level of licensure; actions required in response to a request to discontinue life-sustaining treatment; termination of services plans; emergency preparedness; and client complaint processes.
18	**Medication management.** Adds § 144A.4792. Prohibits medication management under a basic home care license. Provides requirements for medication management under a comprehensive home care license.
19	**Treatment and therapy management services.** Adds § 144A.4793. Prohibits treatment and therapy management under a basic home care license. Provides requirements for treatment and therapy management under a comprehensive home care license.
20	**Client record requirements.** Adds §144A.4793. Regulates licensee maintenance of client records, including disclosure and access requirements; content requirements; and the duration of retention of records after client discharge or termination.
21	**Home care provider responsibilities; staff.** Adds § 144A.4795. Provides requirements for the training and competency of staff providing home care services, including licensed health professionals and unlicensed personnel. Lists requirements for staff instructors and competency evaluators.
22	**Orientation and annual training requirements.** Adds § 144A.4796. Requires staff who provide or supervise direct home care services to complete certain orientation requirements. Requires special training for providers who provide services for clients with Alzheimer's disease. Requires certain annual training for all staff who provide direct home care services.
23	**Provision of services.** Adds § 144A.4797. Requires licensees to make available a contact person for staff consultations, and under a comprehensive license, that person must be a registered nurse. Provides supervision requirements for staff who perform basic home care services and for staff who perform delegated nursing or therapy tasks.

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24 **Employee health status.** Adds §144A.4798. Requires licensees to have in place a TB prevention and control program and requires providers to follow guidelines for prevention and control of other communicable diseases.

25 **Department of health licensed home care provider advisory council.** Adds § 144A.4799. Requires the commissioner of health establish a home care provider advisory council to advise the commissioner on home care provider regulation including, but not limited to, regulation of community standards, enforcement f licensing standards and training standards.

26 **Home care licensing implementation for new licensees and transition period for current licensees.** Adds §144A.481. Requires initial license applications to begin October 1, 2013. provides that home care providers licensed under the current structure must apply for either a basic or comprehensive home care license beginning October 1, 2013. Requires that all home care providers be have either a basic or comprehensive home care license by September 30 , 2014.

27 **Application of home care licensure during transition period.** Adds § 144A.4811. Describes application of licensure requirements during the transition period.

28 **Registration of home management providers.** Adds § 144A.482. Sets out requirements and regulation provisions for home management providers. Requires entities that operate home management services, such as housekeeping or meal preparation, to be registered with the commissioner of health. Provides an annual fee for this required registration.

29 **Integrated licensing system for home care and home and community-based services.** Requires the Department of Health's compliance and monitoring division and the Department of Human Services' licensing division to develop an integrated licensing system for providers who provide both home care services subject to licensure under Minnesota Statutes, chapter 144A and home and community-based services subject to licensure under Minnesota Statutes, chapter 245D.

30 **Repealer.** (a) Repeals Minnesota Statutes §§ 144A.46 and 144A.461 (licensure and registration of home care services).

(b) Repeals Minnesota Rules, chapter 4668 (home care licensure and class F home care providers). Repeals Minnesota Rules, chapter 4669 (home care licensure fees).

31 **Effective Date.** Provides an immediate effective date for this article.

Article 13: Health Department

1 **Bored geothermal heat exchanger.** Amends § 103I.005, by adding subd. 1a. Adds a definition of "bored geothermal heat exchanger."

2 **Fees.** Amends § 103I.521. Directs fees collected by the commissioner under Minnesota Statutes, chapter 103I (wells, borings, and underground uses), to be credited to the state government special revenue fund.

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3 **Who must pay.** Amends § 144.123, subd. 1. Modifies the provision for collecting a fee for diagnostic laboratory services by permitted the commissioner to contract for the costs of analysis rather than charge a flat handling fee. Specifies that funds collected under contracts pursuant to this section must be deposited into a special account and appropriated to the commissioner. (Minn. Stat. § 144.123, subd. 2 is repealed in this article.)

4 **Duty to perform testing.** Amends § 144.125, subd. 1. Increases the fee for the newborn screening programs, including early hearing detection, by $34. Specifies that $5 of the total fee amount must be deposited into the general fund for the support services required under the early hearing detection and intervention program and the remaining fee amount , $135, must credited to the state government special revenue fund.

5 **Health facilities construction plan submittal and fees.** Adds § 144.554. Requires the commissioner to collect a fee for review of the construction plan submitted for approval from hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities. Provides a fee schedule based on total estimated cost of the project.

6 **Newborn Hearing Screening Advisory Committee.** Amends § 144.966, subd. 2. Extends expiration of the committee by six years.

7 **Annual fees.** Amends § 144.98, subd. 3. Reduces fees for environmental lab accreditation.

Provides an immediate effective date.

8 **State government special revenue fund.** Amends § 144.98, subd. 5. Specifies that the fees collected under this program must be credited to the state government special revenue fund.

Provides an immediate effective date.

9 **Establishing a selection committee.** Amends § 144.98 by adding subd. 10. Requires the commissioner to establish a selection committee to recommend approval of qualified lab assessors and assessment bodies. Provides required membership and structure of the committee.

10 **Activities of the selection committee.** Amends § 144.98 by adding subd. 11. Sets out duties of the selection committee established under subd. 10, including that the committee will determine assessor and assessment body application requirements and consider submitted applications.

11 **Commissioner approval of assessors and scheduling of assessments.** Amends § 144.98 by adding 12. Provides criteria for assessors to meet in order to be approved by the commissioner.

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12 **Laboratory requirements for assessor selection and scheduling assessments.** Amends § 144.98 by adding subd. 13. Requires accredited labs or those seeking accreditation that need an assessment by the commissioner to select from a list of approved assessors. Limits the number of times a lab can select the same assessor to not more than twice in succession. Provides other requirements for labs relative to selecting an assessor. Specifies that the fees collected under this section are deposited in a special account and appropriated to the commissioner for assessment activities.

13 **Administrative penalty orders.** Amends § 144.99, subd. 4. Provides the commissioner authority to issue certain specified administrative penalty orders for violations of the Lead Poisoning Prevention Act, Minnesota Statutes, sections 144.9501 to 144.9512. Specifies that revenue collected from these penalties must be credited to the state government special revenue fund.

14 **Statewide health improvement program.** Amends § 145.986.

Subd. 1. Purpose. Adds a purpose statement for the statewide health improvement program (SHIP).

Subd. 1a. Grants to local communities. Requires grantees to address health disparities and inequities in their community. Removes obsolete language. Permits the commissioner to award funding for strategies targeted at reducing other risk factors for chronic disease, aside from tobacco use, poor diet, and lack of physical activity. Requires the commissioner to develop criteria and procedures to allocate funding under this section.

Subd. 2. Outcomes. Makes no changes.

Subd. 3. Technical assistance and oversight. Requires the commissioner to award contracts to entities to assist in training and providing technical assistance to grantees. Permits contracts awarded under this section to be used for assistance in the following areas: community engagement and capacity building; tribal support; community asset building and risk behavior reduction; legal; communications; site-specific strategies; and health equity.

Subd. 4. Evaluation. Removes a requirement that the commissioner conduct an evaluation biennially and requires grantees to collect, monitor, and submit annual data. Requires the commissioner to award contracts to assist in designing and implementing evaluation systems and specifies uses of those contracts.

Subd. 5. Report. Removes obsolete language.

Subd. 6. Supplantation of existing funds. Makes no changes.

15 to 65 **Alkaline hydrolysis.** Amends §§ 149A.02 to 149A.96. Modifies mortuary science provisions. Includes alkaline hydrolysis as a means of final disposition of dead human bodies and requires the commissioner of health to enforce all laws and adopt rules related to licensing and operation of alkaline hydrolysis facilities. Defines “branch funeral establishment” and provides these establishments are not required to have a preparation or

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embalming room. Provides that fees collected by the commissioner shall be credited to the state government special revenue fund.

66 **Revisor's instruction.** Instructs the revisor to replace the term "vertical heat exchanger" with "bored geothermal heat exchanger."

67 **Repealer.** (a) Repeals Minnesota Statutes, § 103I.005, subd. 20. (Definition of "vertical heat exchanger.)

Repeals Minnesota Statutes, §§ 149A.025 (alkaline hydrolysis regulation); 149A.20, subd. 8 (mortuary science fee); 149A.30, subd. 2 (mortuary science fee); 149A.40, subd. 8 (mortuary science fee); 149A.45, subd. 6 (mortuary science fee); 149A.50, subd. 6 (mortuary science fee); 149A.51, subd. 7 (mortuary science fee); 149A.52, subd. 5a (mortuary science fee); and 149A.53, subd. 9 (mortuary science fee)

Repeals Minnesota Statutes, § 485.14 (Receipt of vital statistics records by district court for preservation of records).

(b) Effective July 1, 2014, repeals Minnesota Statutes, § 144.123, subd. 2 (fees for diagnostic lab services).

Article 14: Health and Human Service Appropriations

See spreadsheet.