HOUSE RESEARCH

Bill Summary

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Article 1: Health Care

Overview

This article contains provisions related to Medical Assistance.

1 **Payments on behalf of enrollees in government health programs.** Amends § 62A.045. A new paragraph (f) requires health insurers to process third-party liability claims from the state within 90 business days of claim submission. If the health insurer needs more information to process the claim, allows the insurer an additional 30 business days to process the claim, if the insurer submits the request for additional information within 30 business days of receiving the claim.

A new paragraph (g) allows health insurers to request refunds from DHS for claims paid in error within two years of the date of payment to DHS. Provides that a request for a refund will not be honored once this time period has lapsed.

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

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

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

5 **Prescription drug price comparison.** Amends § 256.01, by adding subd. 40. Requires the commissioner to establish on the agency's web site an interactive application that allows consumers to compare local pharmacy prices for the most commonly filled prescription drugs. Specifies criteria for the application.

6 **Hospital payment rates.** Amends § 256.969, subd. 2b. Requires payment rates for critical access hospitals located in Minnesota or the local trade area to be determined using a new cost-based methodology, effective for discharges on or after July 1, 2015. Requires the commissioner to include in the methodology tiers of payment to promote efficiency and cost-effectiveness. Specifies other requirements for the methodology and lists factors to be used to develop the new methodology.

7 **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Requires disproportionate share hospital (DSH) payments to be paid according to a new methodology, effective July 1, 2015. Requires annual DSH payments under the new methodology to equal the total amount of DSH payments made for 2012. Lists factors that the methodology must take into account. Requires payments returned to the commissioner

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because they exceed the hospital-specific DSH limit for a hospital to be redistributed to other DSH-eligible hospitals in a manner established by the commissioner.

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

9 **Asset availability.** Amends § 256B.059, subd. 5. Strikes language that, for purposes of determining MA eligibility of a spouse for long-term care, would count assets converted into an income stream as assets available to the institutionalized spouse. (This provision is intended to bring the state into compliance with a federal court decision.)

10 **Dental services provided by faculty members and resident dentists at a dental school.** Amends § 256B.0625, by adding subd. 9b. (a) Allows a dentist who is not enrolled as an MA provider, is on the faculty or an adjunct member at the University of Minnesota or is a resident dentist, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, to be enrolled as an MA provider, if the dentist completes and submits to the commissioner an agreement form. Requires the agreement to specify that the individual:

(1) will not receive payment for services provided to MA or MinnesotaCare enrollees at University of Minnesota dental clinics;

(2) will not be listed in the MA or MinnesotaCare provider directory; and

(3) is not required to serve MA and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.

(b) Provides that an individual enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from MA or MinnesotaCare as a fee-for-service provider.

11 **Drugs.** Amends § 256B.0625, subd. 13. Modifies the procedure used to calculate the number of dosage units of an over-the-counter medication that can be dispensed under MA. Current law requires this quantity to be the lowest of the number of dosage units in the manufacturer's original package or the number dosage units required to complete the patient's course of therapy. This section adds to this list the number of dosage units dispensed from a system using retrospective billing. Provides an effective date of January 1, 2016, or upon federal approval, whichever is later.

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

A new paragraph (b) allows pharmacies dispensing prescriptions to residents of long-term care facilities, that use an automated drug distribution system, or a packaging system that meets the standards in rule that allow drugs to be returned, to use retrospective billing. Requires claims to be submitted only for the quantity of medication used during a defined

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billing period, and requires a retrospectively billing pharmacy to use a billing period not less than one calendar month or 30 days.

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

Provides an effective date of January 1, 2016, or upon federal approval, whichever is later.

13 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. The amendment to paragraph (a) modifies eligibility criteria for MA coverage of medication therapy management services, by eliminating the requirement that a recipient be taking three or more prescriptions, and making related changes. The amendment to paragraph (c) eliminates a reference to the GAMC program. The amendment to paragraph (d) clarifies the requirement that a pharmacist providing medication therapy management services by interactive video be located within an ambulatory setting. The amendment to paragraph (e) eliminates obsolete language related to a pilot project and authorizes the provision of medication therapy management delivered into a patient's residence by interactive video.

14 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Strikes language allowing the commissioner to set MA payment rates for specified categories of medical supplies at levels below the Medicare payment rate.

15 **Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, subd. 58. Prohibits payment under an EPSDT screening for health care services and products that are available at no cost to the provider (the restriction in current law is related to vaccines available at no cost).

16 **Medical assistance co-payments.** Amends § 256B.0631. The amendment to subdivision 1 specifies that the family deductible is $2.75 per month per family and is to be adjusted annually. The amendment also applies the limit on monthly cost-sharing to 5 percent of income to all MA enrollees (current law applies this to enrollees with incomes at or below 100 percent of FPG), and states that this limit does not apply to premiums charged to persons eligible for MA as employed persons with disabilities.

The amendment to subdivision 2 provides that copayments and deductibles do not apply to: (1) American Indians who are eligible to receive, or have received, services from an Indian health care provider or through referral; (2) persons eligible for MA because they need treatment for breast or cervical cancer; and (3) certain preventive services, immunizations, and screenings.

The amendment to subdivision 3 makes a conforming change related to the 5 percent cost-sharing limit.

States that the establishment of the family deductible at $2.75 is effective retroactively from January 1, 2014.

17 **Managed care contracts.** Amends § 256B.69, subd. 5a. Requires managed care plans and county-based purchasing plans to maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services expensed to state

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public programs. Requires subcontractor agreements of over $200,000 in annual payments to be in the form of a written instrument or electronic document and meet specified requirements. Allows the commissioner, upon request, to have access to all subcontractor documentation. Provides that the paragraph does not allow the release of nonpublic information.

18 **Administrative expenses.** Amends § 256B.69, subd. 5i. The amendment to paragraph (a) limits managed care and county-based purchasing plan administrative costs to 6.6 percent of total managed care payments in the aggregate for all state public programs, and specifies related criteria. The provision replaces a provision in current law that limits the growth in administrative costs to 5 percent (measured by the ratio of administrative spending to total revenue).

The amendment to paragraph (b) clarifies existing not allowable administrative expenses, and adds additional not allowable administrative expenses.

A new paragraph (c) requires plans to report administrative expenses using the formats designated by the commissioner as part of the rate-setting process, and specifies categories and other requirements. Also requires plans to identify and record expense items for public program administrative expenses in a manner that allows independent verification of unallowable expenses for purposes of determining state public health care program payment rates.

A new paragraph (d) applies the administrative expenses requirements of the subdivision to demonstration providers under section 256B.0755.

19 **Managed care financial reporting.** Amends § 256B.69, subd. 9c. Requires managed care and county-based purchasing plans to certify to the commissioner, for purposes of state public health care program financial reporting, that costs reported for state public health care programs include only services covered under the state plan and waivers, and related allowable administrative expenses. Also requires plans to certify and report to the commissioner the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, for purposes of managed care financial reporting. Applies the requirements of this subdivision to demonstration providers under section 256B.0755.

20 **Financial and quality assurance audits.** Amends § 256B.69, subd. 9d. A new paragraph (e) requires the commissioner to conduct ad hoc audits of managed care organization administrative and medical expenses. Specifies expense categories and audit procedures.

Amendments to various paragraphs strike the requirement in current law that the legislative auditor contract with an audit firm for biennial independent third-party financial audits and make related changes. Revised language related to audits by the legislative auditor is added in section 256B.69, subd. 9e.

A new paragraph (g) applies the audit requirements of this subdivision to demonstration providers under section 256B.0755.

Also makes technical and clarifying changes.

21 **Financial audits.** Amends § 256B.69, by adding subd. 9e. Requires the legislative auditor to contract with vendors to conduct independent third-party financial audits of DHS's use of

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the information provided by managed care and county-based purchasing plans. Provides that the audits shall be conducted as vendor resources permit and specifies other requirements. Requires the audits to include a determination of DHS's compliance with the federal Medicaid rate certification process. Provides a definition of "independent third-party" (this definition does not include requirements related to licensure as an accounting firm, and not having provided services to a plan during the audit period, that are in the current law stricken in subdivision 9d).

22 **Hospital outpatient reimbursement.** Amends §256B.75. Effective July 1, 2015, provides that rates for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals for the payment year are the final payment and not settled to actual costs.

23 **Physician reimbursement.** Amends § 256B.76, subd. 1. Effective July 1, 2015, increases payment rates by 90 percent for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase.

24 **Dental reimbursement.** Amend § 256B.76, subd. 2. Effective July 1, 2015, increases payments rates for dental services by 5 percent. Excludes specified providers from the rate increase and requires managed care and county-based purchasing plan payments to be increased to reflect this increase, effective January 1, 2016.

25 **Reimbursement for basic care services.** Amends § 256B.766. Paragraph (g), effective July 1, 2015, increases payment rates by 90 percent for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, and laboratory services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase.

Paragraph (i), effective July 1, 2015, restores payment rates for durable medical equipment, prosthetics, orthotics, or supplies, including individually priced items, to the January 1, 2008 fee schedule rate, updated to include subsequent rate increases. Exempts certain items from this provision. Also requires that a July 1, 2015 3 percent payment increase in current law be calculated using the 2008 fee schedule rate.

26 **Medicare payment limit.** Amends § 256B.767. Paragraph (d), effective July 1, 2015, exempts durable medical equipment, prosthetics, orthotics, or supplies from the requirement that MA payments not exceed the Medicare payment rate.

Paragraph (e), exempts physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4), from the requirement that MA payment rates not exceed the Medicare payment rate for the applicable service.

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27 **Basic health care grants.** Amends Laws 2008, ch. 363, art. 18, § 3, subd. 5. Strikes the administrative cost limit that is in an ongoing rider. (The stricken language is reinstated in modified form in § 256B.69, subd. 5i.)

28 **Reduction in administrative costs.** Requires the commissioner of human services to negotiate reductions in managed care and county-based purchasing administrative costs, sufficient to achieve state MA savings of $100,000,000 for the biennium ending June 30, 2017.

29 **Advisory group on administrative expenses.** Directs the commissioner of health to reconvene the Advisory Group on Administrative Expenses, to develop standards and procedures for examining state public program administrative expenses. Specifies related duties and membership.

30 **Capitation payment delay.** (a) Requires the commissioner of human services to delay $135 million in MA capitation payments due in May 2017, and special needs basic care payments due in April 2017, until July 1, 2017. Requires the payment to be made between July 1 and July 31, 2017.

(b) Requires the commissioner of human services to delay $135 million in MA capitation payments due in the second quarter of CY 2019 and the April 2019 payment for special needs basic care, until July 1, 2019. Requires the payment to be made between July 1 and July 31, 2019.

31 **Health and economic assistance program eligibility verification audit services.**

Subd. 1. Request for proposals. Requires the commissioner of human services, by October 1, 2015, to issue a request for proposals for a contract to provide eligibility verification audit services for health and economic assistance program benefits. Provides that the RFP must require the vendor to:

(1) conduct an eligibility verification audit of all health and economic assistance program recipients that includes, but is not limited to, data matching against relevant state and federal data bases;

(2) identify any ineligible recipients in these programs and report these findings to the commissioner; and

(3) identify a process for ongoing eligibility verification of health and economic assistance program applicants and recipients.

Subd. 2. Additional vendor criteria. Provides that the RFP must require the following minimum vendor capabilities and experience: a rules-based process for making eligibility determinations, eligibility advocates to assist recipients through the verification process, a formal claims and appeals process, and experience in performing eligibility verification audits.

Subd. 3. Contract required. Requires the commissioner to enter into a contract with a vendor by January 1, 2016. Requires the contract to: (1) incorporate performance-based vendor financing that compensates the vendor based on the amount of savings generated; (2) require the vendor to reimburse the commissioner and county agencies for reasonable costs incurred in implementing this section; (3)

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require the vendor to comply with enrollee data privacy requirements and use encryption; and (4) provide penalties for vendor noncompliance. States that the contract may be renewed for three additional one-year periods, and allows the commissioner to require additional audits if specified conditions are met.

Subd. 4. Health and economic assistance program. Defines health and economic assistance program as the MA program, MFIP and diversionary work programs, child care assistance programs, general assistance, alternative care, and chemical dependency programs.

32 **Request for proposals.** Requires the commissioner of human services to issue a request for proposals to use technologically advanced software and services to improve the identification and rejection of improper Medicaid payments. Specifies criteria for the RFP. Requires the commissioner, based upon responses, to enter into a contract by October 1, 2015. Requires the contract to incorporate a performance-based vendor financing option. Provides an immediate effective date.

Article 2: MinnesotaCare

Overview

This article requires the Commissioner of Revenue to provide state income tax credits to qualified individuals who purchase qualified health plans through MNsure, the state's insurance exchange. The article also repeals the MinnesotaCare program, effective January 1, 2016, and modifies the MinnesotaCare program for the period through December 31, 2015, to reflect federal requirements.

1 **Health carrier and health plan requirements; participation.** Amends § 62V.05, subd. 5. Requires health carriers offering coverage through MNsure to provide premium advances to qualified individuals eligible for a state tax credit under § 290.0661, equal to the amount of the tax credit. Requires qualified individuals receiving a premium advance to repay the full amount of the advance, by April 15 of the year following the coverage year for which the premium advance was provided. Requires the MNsure eligibility system to automatically notify health carriers if an enrollee is eligible for a state tax credit, and the amount of the tax credit. Provides that the section is effective for taxable years beginning after December 31, 2015.

2 **Wrongfully obtaining assistance.** Amends § 256.98, subd. 1. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date.

3 **Projects.** Amends § 256b.021, subd. 4. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date.

4 **Family.** Amends § 256L.01, subd. 3a. Defines "family" for purposes of the MinnesotaCare program, for individuals who do not expect to file a federal tax return and do not expect to be claimed as a dependent, and for married couples. Provides an immediate effective date.

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5 **Income.** Amends § 256L.01, subd. 5. Clarifies that the definition of "income" means a household's projected annual income for the applicable tax year. Provides an immediate effective date.

6 **Cost-sharing.** Amends § 256L.03, subd. 5. The amendment to paragraph (a) specifies that the family deductible for MinnesotaCare is $2.75 per month per family and is adjusted annually by the change in the medical component of the CPI-U.

The amendment to paragraph (b) provides that American Indians are not subject to MinnesotaCare cost-sharing.

States that the amendment related to the family deductible is effective retroactively from January 1, 2014, and the cost-sharing exemption for American Indians is effective the day following final enactment.

7 **General requirements.** Amends § 256L.04, subd. 1c. Strikes a reference to being eligible for "coverage" under MinnesotaCare. Provides an immediate effective date.

8 **Annual income limits adjustment.** Amends § 256L.04, subd. 7b. Requires MinnesotaCare program income limits based on the federal poverty guidelines to be adjusted on annually on January 1, as provided in federal regulations. (Under current law, the adjustment is made on July 1.) Provides an immediate effective date.

9 **Citizenship requirements.** Amends § 256L.04, subd. 10. Changes the federal citation for a reference to noncitizens who are "lawfully present."

10 **Eligibility and coverage.** Amends § 256L.05, by adding subd. 2a. States that an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. Also states that for individuals required to pay a premium, coverage is only available for months for which a premium is paid. Provides an immediate effective date.

11 **Effective date of coverage.** Amends § 256L.05, subd. 3. In a provision specifying the effective date of coverage for persons exempt from premiums, strikes a reference to the month in which verification of American Indian status is received.

12 **Redetermination of eligibility.** Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed on an annual basis, rather than every 12 months. Beginning in CY 2015, requires eligibility redeterminations to occur during the open enrollment period for qualified health plans. Makes related changes. Provides an immediate effective date.

13 **Application processing.** Amends § 256L.05, subd. 4. Increases from 30 to 45 days the time period within which the commissioner must determine an applicant's eligibility for MinnesotaCare. Provides an immediate effective date.

14 **Commissioner's duties and payment.** Amends § 256L.06, subd. 3. Provides that MinnesotaCare disenrollment for nonpayment of premium is effective the month following the month for which the premium was due (under current law, disenrollment is effective the month the premium is due). Allows reenrollment the first day of the month following payment of an amount equal to two months' premiums, and strikes language requiring retroactive enrollment if certain conditions are met. Provides an immediate effective date.

15 **Competitive process.** Amends § 256L.121, subd. 1. Corrects a cross-reference.

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16 **Debt.** Amends § 270A.03, subd. 5. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date.

17 **Disclosure to commissioner of human services.** Amends § 270B.14, subd. 1. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date.

18 **State tax credit for MNsure premium payments.** Adds § 290.0661.

Subd. 1. Definitions. Defines terms. Defines "qualified individual" as a resident individual applying for, or enrolled in, qualified health plan coverage through MNsure with: (1) an income greater than 133 percent but not exceeding 200 percent of FPG; or (2) an income equal to or less than 133 percent of the FPG, if the person would have been eligible for MinnesotaCare under the eligibility criteria specified in Minnesota Statutes 2014, chapter 256L.

Subd. 2. Credit allowed; payment to health carrier. (a) Provides qualified individuals with a credit against the state income tax equal to the amount determined under subdivision 3.

(b) Specifies the method of allocating the credit for part-year residents.

(c) Requires qualified individuals receiving a premium advance under § 62V.05, subdivision 5, paragraph (j), to repay the premium advance by April 15 of the year following the coverage year for which the premium advance was provided.

Subd. 3. Calculation of credit amount. Requires the commissioner of revenue, in consultation with the commissioner of human services and the MNsure board, to provide qualified individuals with tax credits to reduce the cost of MNsure premiums by specified dollar amounts. Requires the dollar amount of the credit to equal the base premium reduction amount, adjusted for household size. Requires the commissioner to establish separate base premium reduction amounts, on a sliding scale, for: (1) households with incomes not exceeding 150 percent of FPG; and (2) households with incomes greater than 150 percent but not exceeding 200 percent of FPG. Requires the commissioner, in developing the tax credit methodology and base premium reduction amounts, to ensure that aggregate tax credits do not exceed an unspecified dollar amount per taxable year.

Subd. 4. Credit refundable; appropriation. (a) Provides that the credit is refundable, if the credit allowed exceeds the individual's tax liability.

(b) Appropriates to the commissioner from the general fund an amount sufficient to pay the credits required by this section.

Subd. 5. Payment in advance. Requires the commissioner of human services to seek all federal approvals and waivers necessary to pay the tax credit on a monthly basis, in advance, to the health carrier providing coverage to the qualified individual, without affecting the amount of the individual's federal advanced premium tax credit. If the necessary approvals and waivers are obtained, requires the commissioner of human services to submit to the legislature any legislative changes necessary to implement advanced payment of tax credits, and directs the MNsure board to require health carriers to reduce premiums charged to qualified individuals by the amount of

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the tax credit. Provides that this section is effective for taxable years beginning after December 31, 2015.

19 **MinnesotaCare provider taxes.** Amends Laws 2011, First Special Session, ch. 9, article 6, section 97, subd. 6. Repeals the MinnesotaCare provider taxes for gross revenues received after December 31, 2018. (This advances the repeal date by one year.)

20 **Revisor instruction.** Directs the revisor to strike references to MinnesotaCare and make grammatical and conforming changes, in Minnesota Statutes and Minnesota Rules.

21 **Repealer.**

Subd. 1. MinnesotaCare program. Repeals sections of Minnesota Statutes, chapter 256L (the MinnesotaCare program).

Subd. 2. Conforming repealers. Repeals sections 13.461, subd. 26 and 62A.046, subd. 5, to conform to the repeal of the MinnesotaCare program.

Provides a January 1, 2016, effective date.

Article 3: MNsure

Overview

This article, among other things, requires MNsure to, if existing resources allow, develop a proposal to allow individuals to obtain advanced premium tax credits and cost-sharing reductions when purchasing health insurance outside of the exchange. The article also makes multiple changes to existing MNsure statutes. The article repeals MNsure if the United States Supreme Court holds that persons can obtain advanced premium tax credits on the federal exchange. Should MNsure be repealed, the article requires the commissioner of commerce to establish a federally facilitated exchange. The article also puts requirements on federal grant funds received for MNsure and state funds used to match federal grants.

1 **Expanded access to qualified health plans and subsidies.** Requires the commissioner of commerce, if existing resources allow, and in consultation with the MNsure board and the MNsure legislative oversight committee, to develop a proposal to allow individuals to purchase qualified health plans directly from health plan companies (rather than through MNsure), and receive advanced premium tax credits and cost-sharing subsidies. Requires the commissioner to seek all federal waivers and approvals to implement this proposal. Requires the commissioner to submit a draft proposal to the MNsure board and legislative oversight committee at least 30 days before submitting the final proposal to the federal government, and to notify the board and oversight committee of any federal decision or action related to the proposal.

2 **Group II salary limits.** Amends § 15A.0815, subdivision 3. Adds the executive director of MNsure to positions that may not receive a salary exceeding 120 percent of the salary of the governor.

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3 **Approval.** Amends § 62A.02, subdivision 2. Requires that, beginning January 1, 2016, and each January 1 thereafter, individual and small group market health plans that are offered inside and outside of MNsure receive rate approval from the commissioner of commerce no later than 30 days prior to the beginning of open enrollment for MNsure. Requires that premium rates for all carriers in the applicable market be made available at a uniform time and only after all rates for that market are final and approved. Requires the premium rates for the next calendar year to be made publicly available no later than 30 days prior to the beginning of the open enrollment period for MNsure.

4 **Consumer assistance partner.** Amends § 62V.02, by adding subdivision 2a. Defines "consumer assistance partner" as individuals and entities certified by MNsure to serve as a navigator, in-person assister, or certified application counselor.

5 **Application of other law.** Amends § 62V.03, subd. 2. The amendments to paragraph (c) eliminate certain exemptions for MNsure from the open meeting law. The exemptions stricken: (1) allow compensation negotiations to be closed in the same manner as meetings on labor negotiation strategy under § 13D.03; (2) allow meetings on contract negotiation strategy to be closed in the same manner as meetings related to the pricing and appraisal of property to be sold or purchased by a government entity; and (3) allow meetings related to not public individual and employer data and trade secret information to be closed to the public.

The amendments to paragraph (d) eliminate exemptions for MNsure from many of the provisions of chapters 16B (Department of Administration) and 16C (state procurement). Under current law, MNsure is exempt from all of the provisions of these chapters, except: sections 16C.08, subd. 2, paragraph (b), clauses (1) to (8) (contract requirements for professional and technical services); 16C.086 (contracts for call centers); 16C.09, paragraphs (a), clauses (1) and (3), (b), and (c) (procedures for general services contracts); and 16C.16 (procurement from small businesses).

The section also strikes all of paragraph (g), which exempts MNsure from specified sections of chapter 16E (Office of MN.IT Services). Under current law, MNsure is exempt from: sections 16E.01, subd. 3, paragraph (b) (chief information officer may require use of shared information and telecommunications technology systems and services); 16E.03, subds. 3 and 4 (evaluation required before implementation of a technology project); 16E.04, subds. 1, 2 (c), and 3 (b) (policies and standards for technology systems and services, review of agency requests for technology grant funding, payment for risk assessment and risk mitigation); 16E.0465 (review and approval of state technology projects); 16E.055 (use of single entry site for electronic government services); 16E.145 (appropriations for technology project made to chief information officer); 16E.15 (chief information officer may sell or license computer software products or services); 16E.16 (chief information officer may require a state agency to adjust its operating and management procedures); 16E.17 (chief information officer to supervise and control all state telecommunications facilities and services); 16E.18 (requirements for state information infrastructure); and 16E.22 (statewide electronic licensing system).

6 **Board.** Amends § 62V.04, subd. 1. Increases the size of the MNsure board, from seven to eleven members.

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7 **Appointment.** Amends § 62V.04, subd. 2. Adds the following individuals to the MNsure board: one member who is an insurance producer, two members who are county employees involved in the administration of public health care programs, and the chief information officer of MN.IT, or a designee. Makes related changes. Provides board members are subject to confirmation by the Senate. Strikes language providing that members serve unless both the House of Representatives and the Senate vote not to confirm.

8 **Conflicts of interest.** Amends § 62V.04, subd. 4. Provides that a MNsure board member who is an insurance producer or a county employee must meet the conflict of interest standards in state law that apply to public and local officials. Makes a conforming change.

9 **Executive director.** Adds § 62V.045. Provides that the governor appoints the executive director of MNsure, and that the executive director serves in the unclassified service.

10 **General.** Amends § 62V.05, subd. 1. Strikes language under which the salaries of the director and managerial staff of MNsure are governed by a compensation plan prepared by the board, submitted to the commissioner of management and budget, and approved by the Legislative Coordinating Commission and the legislature. Also provides that the director shall not receive a salary increase on or after July 1, 2015, unless the increase is approved under the procedures specified in current law for setting salaries for positions whose salaries are set in relation to the governor's.

11 **Health carrier and health plan requirements; MNsure participation.** Amends § 62V.05, subd. 5. Strikes language that allows the MNsure board to establish policies and procedures for the selection of health plans to be offered as qualified health plans, beginning January 1, 2015. Requires the board to permit all health plans that meet the applicable certification requirements to be offered through MNsure. Makes conforming changes.

Effective date. States the effective date of this section is July 1, 2015.

12 **Appeals.** Amends § 62V.05, subdivision 6. Removes conforming language to the board's ability to select specific qualified health plans (removed in section 10 of this bill).

13 **Health carrier notification.** Amends § 62V.05 by adding subdivision 11. Requires MNsure to provide enrollee information to a health carrier within 48 hours of MNsure having determined the enrollee's eligibility in the qualified health plan.

14 **Purchase of individual health coverage.** Amends § 62V.05 by adding subdivision 12. Requires MNsure to provide the options of members of the same household to purchase individual health plans and apportion any advanced premium tax credit between the separate health plans.

15 **Prohibition on other product lines.** Amends § 62V.05 by adding subdivision 13. Prohibits MNsure from certifying, selecting, or offering products and policies of coverage that are not health or dental plans.

16 **Membership; meetings; compensation.** Amends § 62V.11, subd. 2. Requires the legislative oversight committee to meet at least quarterly.

17 **Reports to the committee.** Amends § 62V.11, by adding subd. 5. Directs the board to submit enrollment reports to the legislative oversight committee on a monthly basis and

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specifies report requirements. Also requires the board to report specified information to the committee at quarterly meetings.

18 **MNsure consumer assistance partners.** Amends § 245C.03, by adding subd. 11. Requires the commissioner of human services to conduct background studies on individuals as required under section 256.962, subdivision 9, effective January 1, 2016.

19 **MNsure consumer assistance partners.** Amends § 245C.10, by adding subd. 12. Requires the commissioner of human services to collect a fee of no more than $20 per background study and appropriates that money to the commissioner for purposes of conducting background studies.

20 **Background studies for consumer assistance partners.** Amends § 256.962, by adding subd. 9. Requires consumer assistance partners, as defined in § 62V.02, subdivision 2a (section 4 of this article), to undergo a background study effective January 1, 2016.

21 **Transition.** Requires the commissioner of management and budget to assign the positions of MNsure managerial employees (other than the director) to salary ranges and salaries in the managerial plan, effective the first payroll period beginning on or after July 1, 2015. Specifies staggered terms for the new board members, and requires these members to be appointed by the governor within 30 days of enactment.

22 **Expanded access to the small business health care tax credit.** (a) Requires the commissioner of commerce, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, to develop a proposal to allow eligible small businesses to obtain the small business tax credit for policies purchases inside or outside of the SHOP marketplace.

(b) Requires the commissioner to seek federal waivers necessary to implement paragraph (a) and submit a draft proposal to the MNsure board and MNsure Legislative Oversight Committee prior to submission to the federal government.

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

23 **Confirmation deadline.** Provides that MNsure board members on the effective date of this section and new members appointed under section 7 are subject to Senate confirmation. Provides that if any of these members is not confirmed before adjournment of the 2016 regular session, the appointment of that member terminates.

24 **Establishment of federally facilitated marketplace.**

Subd. 1. Establishment. Requires the commissioner of commerce, in cooperation with the secretary of health and human services, to establish a federally facilitated marketplace for Minnesota, for coverage beginning January 1, 2017. States that the federally facilitated marketplace shall take the place of MNsure. Requires the commissioner of commerce, in developing the marketplace, to: (1) incorporate, where appropriate and cost-effective, elements of the MNsure eligibility determination system; (2) regularly consult with stakeholders; and (3) seek all available federal grants and funds.

Subd. 2. Implementation plan; draft legislation. Requires the commissioner of commerce, in consultation with the commissioner of human services, MN.IT, and the MNsure board, to develop and present to the 2016 legislature an implementation plan

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for conversion to a federally facilitated marketplace. Requires the plan to include draft legislation.

Subd. 3. Vendor contract. Requires the commissioner of commerce, in consultation with the commissioner of human services, MN.IT, and the MNsure board, to contract with a vendor to provide technical assistance in developing and implementing the plan to convert to a federally facilitated marketplace.

Subd. 4. Contingent implementation. Prohibits the commissioner from implementing this section if the U.S. Supreme court rules that federal advanced premium tax credits are not available to persons receiving coverage through a federally facilitated marketplace.

25 **Requirements for state match for federal grants.** (a) Prohibits any state funds from being used as a state match to obtain federal grant funding for MNsure unless the following conditions are met:

(1) 20 percent of the state match and 20 percent of the federal grant are deposited into a premium reimbursement account for uses described in paragraph (b);

(2) the commissioner of human services and the legislative auditor have verified that persons enrolled in medical assistance or MinnesotaCare as of September 20, 2013 have had their eligibility re-determined at least once since enrollment;

(3) the administrative costs of MNsure are less than 5 percent of MNsure's total operating budget in each year; and

(4) verification from the Office of the Legislative Auditor that (i) all life events or changes in circumstances are being processed in a timely manner by MNsure and the Department of Human Services; and (ii) MNsure is transmitting electronic enrollment files in a format that conforms with standards under the federal Health Insurance Portability Act of 1996.

(b) Requires funds deposited according to paragraph (a) to be used only for reimbursement of the first month's premium for any individual who submitted a complete application for coverage through MNsure, but did not receive a policy card or other appropriate documentation within 20 days of submitted of a complete application. Requires the MNsure board to provide reimbursement on a first-come, first-served basis, subject to the limits of available funding.

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

26 **Repealer.** Repeals sections 62V.01, 62V.02, 62V.03, 62V.04, 62V.05, 62V.06, 62V.07, 62V.08, 62V.09, 62V.10, and 62V.11 (MNsure), effective January 1, 2017. States this repealer will not take effect if the U.S. Supreme Court rules in the same way stated in section 23, subdivision 4, of this bill.

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Article 4: Continuing Care

Overview

This article contains provisions related to home and community-based service standards, TEFRA parental fees, local and regional dementia grants, MA-EPD, the State Quality Council, reimbursement rates for various home and community-based providers, home and community-based settings, and ABLE accounts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section

23 **Duties.** Amends § 256.975, subd. 2. Adds duties to the Minnesota Board on Aging related to (1) administering the regional and local dementia grants, and (2) providing progress reports to the legislature related to the grants.

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

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

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

Paragraph (d) lists the information that must be included in grant applications and establishes the timeline for submitting proposals.

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

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

Paragraph (g) requires the board to award any available grants by October 1, 2015, and each October 1 thereafter.

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

Makes this section effective July 1, 2015.

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

26 **State Quality Council.** Amends § 256B.097, subd. 3. Corrects cross-references.

27 **Regional quality councils.** Amends § 256B.097, subd. 4. By July 1, 2015, requires the commissioner to continue the operation of three regional quality councils. By July 1, 2016, requires the commissioner to establish three additional regional quality councils. Lists duties of the commissioner in establishing the regional councils.

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

29 **Disability Waiver Reimbursement Rate Adjustments.** Creates § 256B.4915.

Subd. 1. Historical rate. Requires the commissioner to adjust the historical disability waiver rates in effect during the banding period for each reimbursement rate increase effective on or after July 1, 2015.

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Subd. 2. Residential support services. Requires the commissioner to adjust the residential support services rates for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 3. Day programs. Requires the commissioner to adjust the day program rates for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 4. Unit-based services with programming. Requires the commissioner to adjust the unit-based services with programming rates for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 5. Unit-based services without programming. Requires the commissioner to adjust the unit-based services without programming rates for each reimbursement rate increase effective on or after July 1, 2015.

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

31 **ICF/DD rate increase effective July 1, 2016.** Amends § 256B.5012, by adding subd. 17. Paragraph (a) requires the commissioner, for the rate period from July 1, 2016, to June 30, 2017, to increase operating payment rates for each ICF/DD reimbursed under this section in the rate year equal to 5 percent of the operating payment rates in effect on June 30, 2016.

Paragraph (b) specifies how the commissioner must apply the rate increase to each facility.

Paragraph (c) requires facilities that receive a rate increase to use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the facility on or after the effective dates of the rate adjustments in paragraph (a), except for certain listed employees.

Paragraph (d) lists compensation-related costs.

Paragraph (e) specifies how the wage and benefit increases apply to public employees under a collective bargaining agreement.

Paragraph (f) specifies requirements for facilities that have employees that are represented by an exclusive bargaining representative.

Paragraph (g) requires the commissioner to amend state grant contracts that include direct personnel-related grant expenditures to include the allocation for the portion of the contract related to employee compensation. Specifies the timelines for the contracts to be amended and the effective date of the increase.

Paragraph (h) requires facilities that receive a rate adjustment to prepare, and upon request, submit to the commissioner a distribution plan that specifies the amount of money the facility expects to receive that is subject to the employee compensation encumbrance in paragraphs (c) and (d), including how the money will be distributed to increase compensation for employees.

Paragraph (i) requires facilities to post the distribution plan in an area of the facility's operation to which all eligible employees have access and to provide instructions for employees who do not believe they have received the wage and other compensation-related

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increases specified in the plan. Lists the information that must be included in the instructions.

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

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

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

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

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

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

Subd. 4. Account. Defines "account."

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

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

Subd. 7. Application. Defines "application."

Subd. 8. Board. Defines "board."

Subd. 9. Commissioner. Defines "commissioner."

Subd. 10. Contribution. Defines "contribution."

Subd. 11. Department. Defines "department."

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

Subd. 13. Earnings. Defines "earnings."

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

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

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

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

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

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

Subd. 20. Person. Defines "person."

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

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

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

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

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

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

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

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

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

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

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

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

36 ABLE Plan Administration. Creates § 256Q.05.

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

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

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

40 **Commissioner to seek amendment exception to consumer-directed community supports budget methodology.** Amends Laws 2012, ch. 247, art. 4, section 47. Modifies an exception to the CDCS budget methodology to allow more people to be eligible for the exception.

Section

41 **Provider rate and grant increases effective July 1, 2016.** Paragraph (a) requires the commissioner to increase rates, grants, allocations, individual limits, and rate limits, as applicable, by 5 percent for the rate period from July 1, 2016, to June 30, 2017, for services rendered on or after those dates. Requires county or tribal contracts for services specified in this section to be amended to pass through these rate increases within 60 days of the effective date of the increase.

Paragraph (b) lists the services for which the rate increase must be provided.

Paragraph (c) requires managed care plans or county-based purchasing plans receiving state payments for the services listed in paragraph (b) to include these increases in their payments to providers. Specifies the manner in which the commissioner must implement the rate increases for managed care plans and county-based purchasing plans.

Paragraph (d) requires counties to increase the budget for each recipient of consumer-directed community supports by 5 percent for the rate year beginning July 1, 2016.

Paragraph (e) requires providers that receive a rate increase to use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after the effective dates of the rate adjustments in paragraph (a), except for certain listed employees.

Paragraph (f) lists compensation-related costs.

Paragraph (g) specifies how the wage and benefit increases apply to public employees under a collective bargaining agreement.

Paragraph (h) specifies requirements for providers that have employees that are represented by an exclusive bargaining representative.

Paragraph (i) requires the commissioner to amend state grant contracts that include direct personnel-related grant expenditures to include the allocation for the portion of the contract related to employee compensation. Specifies the timelines for the contracts to be amended and the effective date of the increase.

Paragraph (j) requires the Board on Aging and its area agencies on aging to amend their grants that include direct personnel-related grant expenditures to include the allocation for the portion of the contract related to employee compensation. Specifies the timelines for the contracts to be amended and the effective date of the increase.

Paragraph (k) requires providers that receive a rate adjustment to prepare, and upon request, submit to the commissioner a distribution plan that specifies the amount of money the provider expects to receive that is subject to the employee compensation encumbrance in paragraph (e), including how the money will be distributed to increase compensation for employees.

Paragraph (l) requires providers to post the distribution plan in an area of the provider's operation to which all eligible employees have access and to provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the plan. Lists the information that must be included in the instructions.

Section

42 **Direction to commissioner; pediatric home care study.** Directs the commissioner of human services to review the status of delayed discharges of pediatric patients and determine if an increase in the MA payment rate for intensive pediatric home care would decrease the number of delayed discharges of pediatric patients. Requires the commissioner to report to the legislature on the results of the review by January 15, 2016.

Article 5: Nursing Facility Payment Reform and Workforce Development

Overview

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

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

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

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

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

8 **Employee scholarship costs and training in English as a second language.** Amends § 256B.431, subd. 36. Allows nursing facilities with no employee scholarship cost per diem to request a scholarship cost per diem between October 1, 2015, and September 30, 2017. Reduces the average number of hours worked per week necessary to qualify, expands eligible professions, and includes additional eligible costs. Specifies that this rate increase is an optional rate add-on that a facility must request from the commissioner and that the rate increase must be used for scholarships.

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

Section

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

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

Paragraph (b) specifies that money available from canceled moratorium exception projects shall be used to reduce the fiscal impact of the increases allowed under paragraph (a).

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

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

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

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

25 **Performance-based incentive payments.** Amends § 256B.441, by adding subd. 46d. Moves the performance-based incentive payment language from § 256B.434, subdivision 4, paragraph (d) to this new subdivision.

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

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

Article 6: Public Health

Overview

This article creates the Minnesota Telemedicine Act, a primary care residency expansion grant program, requirements for hospitals to provide discharge notices and planning, and a certification for community medical response emergency medical technicians. The article also allows certain entities to obtain and administer epinephrine auto-injectors, amends the definition of residential hospice facilities, creates the Born Alive Infants Protection Act, and requires certain health care practitioners to provide notices on trisomy diagnoses. The article establishes the smile health Minnesota 2016 grant program and amends the definition of lodging establishments.

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

Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

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

Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

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

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

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

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

Subd. 3. Reimbursement for telemedicine services. (a) Requires a health carrier to reimburse a distant site provider for covered services delivered via telemedicine on the same basis as if the services were delivered in person.

(b) States that it is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, so long as it is not in addition to and does not exceed any payment that would applicable for in-person contact.

Subd. 4. Originating site facility fee payment. Requires a health care to make a facility fee payment to the originating site provider if a critical access hospital provides the facility used as the originating site for the delivery of telemedicine.

Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

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

Subd. 1. Defines terms.

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

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

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

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

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

5 Requirements for certain notices and discharge planning.

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

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

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

6 Life-saving allergy medication. Adds § 144.999.

Subd. 1. Definitions. Defines terms, including "authorized entity." Authorized entity includes entities that fall in the categories of recreation camps, colleges and universities, preschools and daycares, and any other entity or organization approved by the commissioner of health.

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

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

Subd. 4. Use of epinephrine auto-injectors. (a) Allows an employee or agent of an authorized entity who has received the required training under subdivision 5 to use epinephrine auto-injectors to: (1) provide an auto-injector to an individual or parent, guardian, or caregiver of an individual, if the employee or agent believes, in good faith, the individual is experiencing anaphylaxis; or (2) administer an auto-injector to an individual the employee or agent believes, in good faith, is experiencing anaphylaxis. An employee or agent can provide or administer the auto-injector under this section regardless of if the person has a prescription or has a previous diagnosis of an allergy.

(b) States that this section does not require any authorized entity to maintain a stock of epinephrine auto-injectors.

Subd. 5. Training. (a) Requires an employee or agent of an authorized entity to complete a training program every two years that is either nationally recognized or

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has been approved by the commissioner. The training must include how to recognize signs and symptoms of allergic reactions, standards and procedures for storage and administration of auto-injectors, and emergency follow-up procedures.

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

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

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

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

(2) houses no more than 21 hospice patients;

(3) meets federal hospice certification regulations; and

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

8 **Community medical response emergency medical technician.** Amends § 144E.001 by adding subdivision 5h. Defines "community medical response emergency medical technician" or "CEMT."

9 **Definition.** Amends § 144E.275, subdivision 1. Allows a medical response unit to provide, under certain conditions, episodic population health support, episodic individual patient education, and prevention education programs.

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

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

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

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 **Prenatal Trisomy Diagnosis Awareness Act.** Adds § 145.471.

Subd. 1. Short title. State this section shall be known as the "Prenatal Trisomy Diagnosis Awareness Act."

Subd. 2. Definitions. Defines terms.

Subd. 3. Health care practitioner duty. Requires a health care practitioner who orders tests for a pregnant woman to screen for trisomy 13, 18, or 21, to provide information as required in subdivision 4 if the test reveals a positive result for any of the conditions.

Subd. 4. Commissioner duties. Requires the commissioner of health to make certain information available to health care practitioners, including up-to-date and evidence-based information about the trisomy conditions, which includes, but is not limited to, expected outcomes and treatment options. Requires the commissioner to post the information on the department website and ensure, through the department's existing procedures, the information is culturally and linguistically appropriate. Allows local or national organizations that provide education or services related to trisomy conditions to request the commissioner include the organization's information on the website.

Effective date. States this section is effective August 1, 2015.

14 **Smile Healthy Minnesota 2016 Grant Program.** Adds § 145.9299. Requires the commissioner of health to establish the Smile Healthy Minnesota 2016 grant program to provide access to dental care for at-risk children, adolescents, adults, and seniors in rural areas of Minnesota. States that the grants are available to nonprofit agencies that provide mobile dental care through portable dental equipment. Lists eligibility for the grant,

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requires grantees to report outcomes to the commissioner by December 31, 2018, and prohibits billing for preventative screenings until the comprehensive oral health services are completed.

15 **Lodging establishment.** Amends § 157.15, subdivision 8. Adds a second definition to be included as a lodging establishment. The definition includes a building, structure, or enclosure located within ten miles distance or 15 minutes travel time from a hospital or medical center and is used or held out to be a place where exclusively patients, their families, and caregivers can sleep while the patient is receiving treatment for periods of one week or more. Specifically excludes places providing health or home care services.

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

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

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

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

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

(e) Cross-references other sections for definitions.

(f) States that the criteria in paragraph (b) does not apply to managed care organizations and county-based purchasing plans, which may establish criteria for coverage of telemedicine services.

Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

17 **Community medical response emergency medical technician services covered under the medical assistance program.**

(a) Requires the commissioner of human services, in consultation with other specified persons, to determine services and payment rates for CEMTs to be covered by medical assistance.

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

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

Section

18 **Evaluation of Community Advanced Emergency Medical Technician Services.** Requires the commissioner of human services, if medical assistance coverage legislation is enacted, to evaluate the effect on medical assistance and MinnesotaCare and reporting findings to certain members of the legislature by December 1, 2017.

Article 7: Children and Family Services

Overview

This article amends various statutes related to child support, out-of-home placements, youth at risk of sex trafficking, and interstate enforcement of child support in order to comply with changes in federal laws (P.L. 113-183 and the Affordable Care Act). Additionally, Northstar Care is changed to a forecasted program.

1 **Definitions.** Amends § 256.741, subd. 1. Clarifies, for purposes of child support, that MinnesotaCare and health plans supplemented by tax credits are not considered public assistance.

2 **Assignment of support and maintenance rights.** Amends § 256.741, subd. 2. Strikes references to MinnesotaCare in this subdivision on child support and maintenance.

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

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

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

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

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

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

Paragraph (e) allows kinship assistance benefits to be approved for a maximum of six months following the death or incapacity of the relative custodian. Provides that if the

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court has not appointed a permanent legal guardian for the child in that time, the kinship assistance benefits end.

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 **Collection services.** Amends § 518A.53. Strikes a cross-reference to the application fee for IV-D services.

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

Strikes the requirement that a family assessment shall be the preferred response for all reports except those alleging substantial child endangerment, instead providing that a family assessment shall be conducted when there is no alleged substantial child endangerment.

Clarifies that all reports alleging sexual abuse and substantial child endangerment must be handled as investigations and not accepted as family assessment.

Makes technical changes to the structure of this subdivision.

36 **Definitions.** Amends § 626.556, subd. 2. Amends paragraph (g), the definition of physical abuse. Clarifies that certain actions are not considered reasonable and moderate physical discipline. (Current law provides that these actions are not reasonable or moderate physical discipline when done in anger or without regard to the safety of the child. This is the language that was stricken.)

37 **Persons mandated to report.** Amends § 626.556, subd. 3. Clarifies that all reports received by the local welfare agency must be referred to law enforcement. This includes reports that are not accepted for investigation or assessment.

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

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39 **Report; information provided to parent.** Amends § 626.556, subd. 7. Clarifies that the local welfare agency shall refer all reports to law enforcement, including those not accepted for investigation or assessment.

In paragraph (f), strikes language prohibiting the use of information contained in screened out reports. Requires the local welfare agency to consider prior reports, including screened-out reports, when making screening decisions.

Requires screened-out reports to be maintained according to the record retention schedule in subdivision 11c.

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

Paragraph (b) allows a county social service agency to consult with the county attorney in order to accept reports that are not required to be screened in.

41 **Duties of local welfare agency and local law enforcement agency upon receipt of report.** Amends § 626.556, subd. 10. Adds that the local welfare agency must notify law enforcement when the agency receives a report, including reports not accepted for investigation or assessment.

Adds that an investigation shall be conducted on reports involving sexual abuse.

Adds that prior screened out reports are relevant information in investigations and family assessments.

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

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

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

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

44 **Commissioner's duty to provide oversight; quality assurance reviews; annual summary of reviews.** Amends § 626.556, by adding subd. 16. Paragraph (a) instructs the commissioner to develop a plan for quality assurance reviews of local agency screening practices. Requires the commissioner to oversee and provide guidance to counties so that

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screening decisions are consistent throughout the state. Requires the reviews to begin no later than September 30, 2015.

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

45 to 62 **Uniform Interstate Family Support Act.** These sections make technical amendments to various sections the Uniform Interstate Family Support Act, chapter 518C, to conform to changes in federal law.

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

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

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

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

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

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

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

Paragraph (b) instructs the commissioner to publish and distribute the updated guidelines no later than September 30, 2015.

Paragraph (c) requires county staff to implement the guidelines on October 1, 2015.

Article 8: Chemical and Mental Health

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

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

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

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

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

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

Subd. 3. Rules. Requires the commissioner to adopt rules to establish certification for certification of behavioral health clinics and a prospective payment system.

Subd. 4. Reform projects. Allows the commissioner to establish standards for certification of behavioral health clinics. Lists the required standards. Requires the commissioner to establish standards and methodologies for a payment system.

Subd. 5. Public participation. Requires the commissioner to consult with stakeholders, recipients of mental health services, and mental health professionals.

Subd. 6. Information systems support. Requires the commissioner and the state chief information officer to provide information systems support to the projects.

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

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

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

Provides that this section is effective July 1, 2016, or upon federal approval which is later.

Section

6 **Chemical dependency provider rate increase.** Adds § 256B.7631. Effective July 1, 2015, increases MA payment rates for chemical dependency services by 10 percent over the rates in effect on January 1, 2014.

7 **Report to legislature; performance measures for chemical dependency treatment services.** Requires the commissioner, in consultation with specified parties, to develop performance measures to assess the outcomes of chemical dependency treatment services. Requires the commissioner to report these measures to members of the health and human services policy and finance committees in the House and Senate, on or before January 15, 2016.

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

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

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

11 **Special projects; intensive treatment and supports.** Paragraph (a) requires the commissioner of human services to fund special projects to individuals age 26 and younger who experience their first psychotic or manic episode; conduct outreach and training to mental health professionals on early psychosis symptoms, screening, and best practices.

Paragraph (b) lists the services that make up intensive treatment and supports.

12 **Instructions to the commissioner.** Instructs the commissioner of human services to consult with stakeholders in order to develop funding recommendations for children's mental health crisis residential services that will allow timely access without requiring county authorization or child welfare placement.

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

14 **Comprehensive mental health center.** Paragraph (a) instructs the commissioner to establish a grant for Beltrami County to develop a comprehensive mental health center for individuals who are under arrest or are subject to arrest who are experiencing a mental health crisis, or under a transport hold.

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Paragraph (b) requires the program to maintain certain data for the purpose of measuring program effectiveness. Requires the commissioner to issue a report to the legislature every two years, beginning February 1, 2017.

Paragraph (c) requires the commissioner to encourage the commissioners of health, corrections, and the Minnesota Housing Finance Agency to work with the program to support its mission and function.

15 **Report on intensive community rehabilitation services.** Requires the commissioner, in consultation with stakeholders, to issue a report to the legislature that analyzes how intensive community rehabilitation services programs provide mental health services and supports that are not covered services under medical assistance and how other states provide these services and the mechanisms those states use to cover the costs. Requires the report to include recommendations for sustainable funding.

16 **Commissioner's duties related to peer specialist training and outreach.** Instructs the commissioner to collaborate with MnSCU to identify courses to fulfill peer specialist training requirements. Requires the commissioner to provide information to community mental health centers to increase their awareness of services provided by peer specialists.

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

Article 9: Direct Care and Treatment

Overview

This article extends insurance coverage for employees who, as a result of an assault by a patient at a DHS institution, are totally and permanently disabled. It requires the special review board at least once every three years to review the status of individuals who are committed as mentally ill and dangerous. This article also prohibits the commissioner from closing the CARE facility in Fergus Falls prior to July 1, 2019.

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

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

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

Section

2 **Special review board.** Amends § 253B.18, subd. 4c. Makes structural changes to create new paragraph (b) which requires the special review board to review each petition for a reduction in custody from a person who has been committed as mentally ill and dangerous to determine if barriers and obstacles prevent a patient from progressing in treatment. Requires the board to report to the commissioner the trends in barriers and obstacles noted in cases before the board in the previous year.

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

4 **Closure of facility prohibited.** Prohibits the commissioner from closing, or otherwise terminating services at, the CARE program in Fergus Falls earlier than July 1, 2019.

5 **Closure of facility prohibited.** Prohibits the commissioner from closing the CABHS facility in Willmar without legislative approval.

Article 10: Withdrawal Management Programs

Overview

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

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

2 **Definitions.** Creates § 245F.02. Defines the following terms as used in this chapter: "administration of medications," "alcohol and drug counselor," "applicant," "care coordination," "chemical," "clinically managed program," "commissioner," "department," "direct patient contact," "discharge plan," "licensed practitioner," "medical director," "medically monitored program," "nurse," "patient," "peer recovery support services," "program director," "protective procedure," "recovery peer," "responsible staff person," "substance," "substance use disorder," "technician," and "withdrawal management program."

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

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

7 Stabilization planning. Creates § 245F.07.

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

Section

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

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

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

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

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

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

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

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

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

Subd. 1. Use of protective procedures. Specifies the situations in which protective procedures may be used, the situations in which these procedures prohibited, and the observation requirements when a client is subject to protective procedures.

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

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

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

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

Section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

15 Staff qualifications. Creates § 245F.15.

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

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

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

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

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

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

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

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

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

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

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

Section

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

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

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

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

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

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

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

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

Article 11: Health-Related Licensing Boards

Overview

This article amends the optometry, pharmacy, body art, and social work practice acts. It modifies licensing fees for dental professionals, optometrists, pharmacy professionals, and social workers. In addition, it clarifies the process by which a board can temporarily suspend a regulated person's credential to practice. It prohibits a board from taking disciplinary action for failure to repay a student loan.

1 **Supervision.** Amends § 146B.01, subd. 28. Clarifies that there are two types of supervision, direct and indirect, and defines both types.

2 **Licensure requirements.** Amends § 146B.03, subd. 4. Changes the structure of the subdivision to include two paragraphs. Existing language is designated as paragraph (a) and applies to all applicants for new licenses issued before January 1, 2016.

Paragraph (b) requires an applicant for a license to submit a signed affidavit from each licensed technician who provided supervision for the experiences required for licensure. Requires the applicant to complete a minimum of five hours of coursework in bloodborne pathogens and various infection control techniques. This paragraph is effective for applicants for new licenses issued on or after January 1, 2016.

Section

3 **Licensure term; renewal.** Amends § 146B.03, subd. 6. Adds a requirement for the commissioner to notify a licensee of pending license expiration at least 90 days prior to the expiration of the license.

4 **Required supervised experience.** Amends § 146B.03, by adding subd. 12. Creates a separate subdivision for supervised experience requirements for applicants for tattoo and body piercing technicians. Establishes different supervised experience requirements for tattoo artists who wish to perform advanced and complex body piercing.

5 **Proof of age.** Amends § 146B.07, subd. 1. Requires body art technicians to require proof of age from clients who state they are 18 years of age or older.

6 **Parent or legal guardian consent; prohibitions.** Amends § 146B.07, subd. 2. Adds requirements for both the parent and the child to provide proof of identification that includes a photograph. Requires the parent or legal guardian to provide documentation to establish that the individual is the parent or legal guardian of the child. Clarifies the types of piercings that cannot be performed on a child.

7 **Grounds listed.** Amends § 147.091, subd. 1. Strikes failure to repay a student loan as one of the grounds for disciplinary action in the Medical Practice Act.

8 **Exceptions.** Amends § 148.271. Allows nurses licensed in other states, but not in Minnesota, to provide continuing education, serve as a guest lecturer, present at conferences, and provide distance learning in Minnesota without having a Minnesota license.

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

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

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

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

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

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

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

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

Section

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

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

19 **Reporting obligations.** Creates § 148.604.

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

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

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

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

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

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

20 **Immunity.** Creates § 148.605.

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

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

Paragraph (b) provides that members and employees of the board engaged in maintaining records and making reports regarding adverse health care events are immune from civil and criminal liability when acting in good faith and in exercise of reasonable care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subds. 4 to 7 are stricken.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41 **Pharmacy technician.** Amends § 151.102.

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

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

Subd. 3. Registration fee. No change.

42 **Temporary license suspension; imminent risk of serious harm.** Amends § 214.077. Paragraph (a) requires a health-related licensing board to temporarily suspend a person's authority to practice if the person presents an imminent risk of serious harm. Requires the board to issue a temporary suspension order which takes effect upon personal service, or upon the third calendar day after the order is served by first class mail.

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Paragraph (b) clarifies that the temporary suspension remains in effect until the investigation is completed, a contested case hearing is conducted, and a final order is issued.

Paragraph (c) requires the health-related licensing board to schedule a contested case hearing at the time the temporary suspension order is issued. Requires the board to provide the regulated person with at least ten days' notice of the hearing. Provides that the hearing must be scheduled to begin no later than 30 days after service of the order on the regulated person.

Paragraph (d) requires the administrative law judge (ALJ) to issue a report and recommendation no later than 30 days after the hearing, and requires the board to issue a final order no later than 30 day after receipt of the ALJ's report and recommendations. Provides that except as provided in paragraph (e), if the board does not issue its final order within 30 days, the temporary suspension shall be lifted.

Paragraph (e) allows the regulated person to request a delay in the proceedings for any reason.

Paragraph (f) provides that for the purposes of this section, "health-related licensing board" does not include the Office of Unlicensed Complementary and Alternative Health Practices.

43 **Investigation and hearing.** Amends § 214.10, subd. 2. Makes technical changes by striking the word "disciplinary" and inserting "contested case" to more accurately name the type of hearing that is conducted in response to complaints against a regulated person.

44 **Proceedings.** Amends § 214.10, subd. 2a. Strikes the conviction for receiving stolen property (Minn. Stat. § 609.52), from the list of offenses that require a board to initiate proceedings to suspend or revoke a license or refuse to renew a license of a regulated person.

45 **Duties of a participating board.** Amends § 214.32, subd. 6. Makes changes to conform to the amendments to section 214.077 in section 42.

46 **Repealer.** Repeals §§ 148.57, subds. 3 (revocation, suspension) and 4 (peddling and canvassing prohibited); 148.571 (use of topical ocular drugs); 148.572 (advice to seek diagnosis and treatment); 148.573, subd. 1 (certificate required for use or possession of topical ocular drug); 148.575, subds. 1 (certificate required for use of legend drugs), 3 (display of certificate required), 5 (notice to Board of Pharmacy), and 6 (board certification required); and 148.576, subds. 1 (authority to prescribe or administer legend drugs) and 2 (adverse reaction reports); § 148E.060, subd. 12 (ineligibility for a temporary license); § 148E.075, subds. 4 (time limits for temporary leaves), 5 (time limits for emeritus license), 6 (prohibition on practice), and 7 (representations of professional status); and § 214.105 (repealing the authority granted to the health boards to take disciplinary action against a person regulated by a board if the person fails to repay student loans).

Section

Article 12: Public Assistance Simplification

Overview

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

In 2014, a new chapter of statutes, chapter 256P, was created which contained uniform procedures for determining and verifying eligibility for several human services programs including general assistance (GA), Minnesota Supplemental Aid (MSA), group residential housing (GRH), and the Minnesota Family Investment Program (MFIP).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 **Exempted programs.** Amends § 256P.03, subd. 1. Exempts CCAP participants from the earned income disregard under the Economic Assistance Program Eligibility and Verification chapter.

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

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

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

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

Subd. 1. Reporting of income. Requires the county agency to evaluate income received by members of the assistance unit, or by others whose income is considered available to the assistance unit, and to only count income that is available to the assistance unit to determine eligibility.

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

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

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

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

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

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

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reporting are handled. Lists the changes an assistance unit must report within ten days.

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

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

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

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

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

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

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

Subd. 3. Notice of overpayment. Requires county agencies to notify participants or former participants of overpayments in writing. Lists the information that must be included in the notice. Specifies no limit applies to the period in which the county agency is required to recoup or recover an overpayment.

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

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

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

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

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

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

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

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

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

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

35 **Effective date.** Makes sections 1 to 34 effective August 1, 2016.

Article 13: Forecast Adjustments

See spreadsheet.

Article 14: Health and Human Services Appropriations

See spreadsheet.