HOUSE RESEARCH

Bill Summary

File Number: S.F. 800 **Date:** April 5, 2017
Version: First unofficial engrossment

Authors: Dean

Subject: Omnibus health and human services bill

Analyst: Randall Chun (articles 1 and 7)
Elisabeth Klarqvist (articles 3, 8, 10, and 11)
Danyell Punelli (articles 2, 4, and 9)
Sarah Sunderman (articles 4, 5, and 6)

This publication can be made available in alternative formats upon request. Please call 651-296-6753 (voice); or the Minnesota State Relay Service at 1-800-627-3529 (TTY) for assistance. Summaries are also available on our website at: www.house.mn/hrd/.

Section

Article 1: Health Care

Overview

This article contains provisions related to the Medical Assistance (MA) and MinnesotaCare programs. The article modifies or adds provisions related to hospital and prescription drug payment rates, nonemergency medical transportation, health care delivery systems, residential treatment facilities, claims against estates, competitive bidding, provider payment, MinnesotaCare premiums, and audits and the monitoring of outcomes, and makes other changes related to state health care programs.

1 **Audits of the Department of Human Services (DHS).** (a) Directs the legislative auditor to give high priority to auditing the programs, services, and benefits administered by DHS, in order to ensure continuous legislative oversight and accountability. Requires the audits to determine whether DHS offered programs and provided services and benefits only to eligible persons and organizations, and complied with applicable legal requirements.

(b) Requires the legislative auditor, no less than three times each year, to test a representative sample of MA and MinnesotaCare enrollees, to determine whether they are eligible to receive benefits under those programs. Requires the legislative auditor to report the results to the commissioner of human services and recommend corrective actions, which the commissioner must implement within 20 business days. Requires the legislative auditor to monitor implementation of corrective actions and periodically report to the legislative audit commission and the legislative committees with jurisdiction over health and human services policy and finance. Requires these reports to include recommendations for any legislative actions needed to ensure that MA and MinnesotaCare benefits are provided only to eligible persons.

2 **Establishment and authority.** Amends § 245.4889, subd. 1. Allows the commissioner to make grants for start-up funding to support providers in meeting program requirements and beginning operations, when establishing a new children's mental health program. Provides an immediate effective date.

3 **Rate year.** Amends § 256.9686, subd. 8. Defines "rate year" as the state fiscal year, effective with the 2012 base year. Provides an immediate effective date.

4 **Hospital cost index.** Amends § 256.969, subd. 1. Allows automatic inflation adjustments for hospital payment rates, if authorized by this section of law. Provides a July 1, 2017, effective date.

5 **Hospital payment rates.** Amends § 256.969, subd. 2b. The amendment to (e) extends the period by which the commissioner may make additional adjustments to rebased rates, to include the next two rebasing periods (current law allows this until the next rebasing).

The amendment to (f) provides that for determining rates for discharges in subsequent base years, the per discharge rates shall be based on Medicare cost-finding methods and allowable costs.

Section

The amendment to (h) requires changes in costs between base years to be measured using the lower of the change in the CMS Inpatient Hospital Market Basket or the change in the case mix adjusted cost per claim.

The amendment to (i) clarifies that it is "inpatient" rates for critical access hospitals that are to be determine using the new cost-based methodology.

Provides a July 1, 2017, effective date.

6 **Alternate inpatient payment rate.** Amends § 256.969, by adding subd. 2e. (a) Establishes a contingent, alternate inpatient payment rate for children's hospitals that would be implemented retroactively to January 1, 2015, if these hospitals are required to include the days, costs, and revenues of patients eligible for MA who also have private health insurance in the calculation of the DSH rate. Requires the commissioner to reimburse a hospital at the higher of the alternate payment rate or the DSH rate.

(b) Provides that:

(1) the alternative payment rate target an aggregate reimbursement amount that is two percent less than each hospital's cost coverage percentage under fee-for-service MA;

(2) costs be determined using the MA cost report, with costs determined using Medicare methods, and that the Medicare Cost Report is to be used if the MA cost report is not available;

(3) DSH payments shall not be made in any rate year in which a hospital is paid under the alternate payment rate; and

(4) if the alternative payment amount increases at a rate higher than the inflation factor used in rebasing, the commissioner shall consider this when setting rates at the next rebasing.

7 **Payments.** Amends § 256.969, subd. 3a. Effective for discharges on or after July 1, 2017, requires rate adjustments for long-term hospitals to be incorporated into the rates and not applied to each claim. Provides a July 1, 2017, effective date.

8 **Medical assistance cost reports for services.** Amends § 256.969, subd. 4b. Requires children's hospitals to file medical assistance cost reports with the commissioner. Under current law, these hospitals file MA cost reports due to their receiving DSH payments. Provides a retroactive effective date of January 1, 2015.

9 **Unusual length of stay experience.** Amends § 256.969, subd. 8. Requires the commissioner to establish outlier payment rates for admissions that result in long length of stays (current law refers only to transfers). Provides a July 1, 2017, effective date.

10 **Hospital residents.** Amends § 256.969, subd. 8c. Effective for discharges on or after July 1, 2017, requires payment for long stays to equal the payments established under the DRG system for unusual length of stay. Provides a July 1, 2017, effective date.

11 **Disproportionate numbers of low-income patients served.** Amends § 256.969, subd. 9. Makes a technical change in the terminology used to refer to nonchildren's hospitals. Provides a July 1, 2017, effective date.

Section

12 **Rehabilitation hospitals and distinct parts.** Amends § 256.969, subd. 12. Effective for discharges on or after July 1, 2017, requires payment to rehabilitation hospitals to be established using the DRG methodology. Provides a July 1, 2017, effective date.

13 **Limitation on service.** Amends § 256B.04, subd. 12. Strikes language requiring DHS to adopt rules that would reimburse nonemergency medical transportation providers at a lower rate for additional passengers.

14 **Telemedicine services.** Amends § 256B.0625, subd. 3b. Allows mental health practitioners, working under the general supervision of a mental health professional, to provide telemedicine services under MA.

15 **Drugs.** Amends § 256B.0625, subd. 13. Strikes the quantity limit for dispensing of over-the-counter medications.

16 **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) sets the basis for determining drug payment, effective April 1, 2017, or upon federal approval, at the lower of the ingredient cost, plus a fixed dispensing fee; or the usual and customary price charged to the public. Sets the professional dispensing fee at $11.35 for drugs that meet the federal definition of "covered outpatient drug." (The current MA dispensing fee is $3.65.) Sets the dispensing fee for certain intravenous solutions at $11.35 per bag (this varies under current law based on the product). Also sets the dispensing fee at $11.35 for over-the-counter drugs that meet the covered outpatient drug definition at $11.35, subject to pro-ration for smaller quantities. Sets the dispensing fee for over-the-counter drugs that do not meet the covered outpatient drug definition at $3.65, with pro-ration for small quantities. Requires the National Average Drug Acquisition Cost (NADAC) to be used to determine the ingredient cost of a drug. Sets the ingredient cost at wholesale acquisition cost minus two percent for drugs for which a NADAC is not reported. Sets the ingredient cost of drugs acquired through the 340B program at that program's maximum allowable cost. Requires the maximum allowable cost of a multisource drug to be comparable to the actual acquisition cost, and no higher than the NADAC of the generic product.

The amendment to paragraph (c) strikes language related to payment under a unit dose blister card system.

The amendment to paragraph (d) includes the NADAC of the generic product as one of the pricing factors for the ingredient cost of multisource drugs.

The amendment to paragraph (f) allows the commissioner to establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas and sets criteria for providers of these products. Also makes conforming changes.

A new paragraph (h) requires the commissioner, for prescriptions filled on or after April 1, 2017, or upon federal approval, to increase ingredient cost reimbursement by two percent for drugs subject to the wholesale drug distributor tax under section 295.52.

States that the section is effective retroactively from April 1, 2017, or from the effective date of federal approval.

Section

17 **Transportation costs.** Amends § 256B.0625, subd. 17.

The amendment to paragraph (b) makes a change in terminology and clarifies that taxicabs must meet the MA requirements for nonemergency medical transportation (NEMT).

The amendment to paragraph (g) includes the securement of car seats in the list of driver-assisted services.

The amendment to paragraph (i) strikes language that prohibits implementation of the covered modes of transportation, without a new rate structure.

A new paragraph (q) requires the commissioner, when determining NEMT reimbursement rates, to exempt the covered modes of transportation from an MA rule that sets payment rates and requires pro-rating for transporting two or more persons.

18 **Documentation required.** Amends § 256B.0625, subd. 17b. Makes a conforming change related to implementation of all modes of NEMT.

19 **Nursing facility transports.** Amends § 256B.0625, by adding subd. 17c. Exempts from level of need determinations Minnesota health care program enrollees who are residing in, or being discharged from, a nursing facility. States that these individuals are eligible for NEMT services until they no longer reside in a nursing facility.

20 **Managed care.** Amends § 256B.0626, subd. 18h. Lists the MA provisions related to NEMT services that managed care and county-based purchasing plans must comply with (current law specifies the provisions from which these plans are exempt). A new paragraph (b) requires NEMT providers to comply with special transportation services standards, but exempts publicly operated transit systems, volunteers, and not-for-hire vehicles from this requirement. Provides an immediate effective date.

21 **Other clinic services.** Amends § 256B.0625, subd. 30. The amendment to paragraph (f) places a December 31, 2018, sunset on a provision that allows FQHCs and rural health clinics to be paid under a prospective payment system or an alternative payment methodology.

A new paragraph (g) allows FQHCs and rural health clinics to elect to be paid, for services provided on or after January 1, 2019, under a prospective payment system or the alternative payment methodology established in existing law (as provided in paragraph (f)), or a new alternative payment methodology established in paragraph (l).

The amendment to paragraph (i) requires FQHCs and rural health clinics to submit claims for services provided on or after July 1, 2017, directly to the commissioner for payment. Requires the commissioner to provide claims information to managed care and county-based purchasing plans.

A new paragraph (l) establishes a new alternative payment methodology for FQHCs and rural health clinics. This paragraph:

(1) requires each FQHC and rural health clinic to receive a single medical and a single dental organization rate;

(2) requires the commissioner to reimburse FQHCs and rural health clinics for allowable costs, and specifies these costs;

Section

(3) sets criteria for base year payment rates;

(4) requires the commissioner to annually inflate payment rates and specifies the method to be used;

(5) requires payment rates to be rebased every two years, and adjusted biannually;

(6) requires the commissioner to seek approval from the Centers for Medicare and Medicaid Services to modify payments to FQHCs and rural health clinics according to subdivision 63 (allowing payment for mental health or dental services provided on the same day as other covered services);

(7) requires the commissioner to reimburse FQHCs and rural health clinics for an additional two percent of their medical and dental rates, only if the MinnesotaCare provider tax is required to be paid;

(8) specifies criteria for FQHCs and rural health clinics seeking a change in scope of services; and

(9) specifies criteria for establishing rates for new FQHCs and rural health clinics.

This section also replaces the term "federally qualified health center" with the acronym FQHC throughout, and makes conforming changes.

22 **Psychiatric residential treatment facility services for persons under 21 years of age.** Amends § 256B.0625, subd. 45a. Clarifies that MA coverage of psychiatric residential treatment facility services must be provided according to section 256B.0941, and makes conforming and technical changes.

23 **Community medical response emergency medical technician services.** Amends § 256B.0625, subd. 60a. Expands CEMT covered services under MA to include post-discharge visits following discharge from a skilled nursing facility. (Under current law, only hospital post-discharge visits are covered.) Changes terminology to refer to a CEMT as a community medical response emergency medical technician. Also makes conforming changes.

24 **Investigational drugs, biological products, and devices.** Amends § 256B.0625, subd. 64. Allows the EPSDT program to cover stiripentol only:

(1) when determined to be medically necessary;

(2) for enrollees with Dravet syndrome or certain children with Malignant Migrating Epilepsy in Infancy;

(3) if all other covered prescription medications have been tried without successful outcomes; and

(4) if the U.S. Food and Drug Administration has approved the treating physician's individual patient new drug application for the use of stiripentol for treatment.

Provides that the MinnesotaCare program does not cover stiripentol.

Section

25 **Reimbursement under other state health care programs.** Amends § 256B.0644. Exempts dental providers providing dental services outside of the seven-county metropolitan area from the requirement that they participate as a provider in MA and MinnesotaCare, in order to participate as a provider in insurance plans and programs for state employees, the public employees insurance program, insurance plans for local government and school district employees, the workers' compensation system, and MCHA. Provides that the section is effective upon any necessary federal waiver or approval.

26 **Integrated health partnership demonstration project.** Amends § 256B.0755. The amendments to subdivision 1 and throughout the section change the name of the health care delivery systems demonstration project to integrated health partnership demonstration project, and make related and conforming changes.

The amendment to subdivision 1, paragraph (b) requires the commissioner, in developing the request for proposals for integrated health partnerships, to allow these entities to be customized for the special needs and barriers of patients experiencing health disparities due to social, economic, racial, or ethnic factors.

The amendment to subdivision 3 requires accountability standards to be appropriate to the particular population served.

The amendment to subdivision 4 requires the payment system for integrated health partnerships to include a population-based payment that supports care coordination services, and is risk-adjusted to reflect variations in the intensiveness of care coordination for enrollees with chronic conditions, limited English skills, cultural differences, and other barriers to health care. Requires this payment to be a per member per month payment that is paid at least quarterly. Requires integrated health partnerships to continue to meet cost and quality metrics for the program, in order to maintain eligibility for the population-based payment. Provides that an integrated health partnership is eligible to receive a payment under this paragraph even if it is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served. States that an integrated health partnership certified as a health care home, that agrees to a payment method that includes population-based payments for care coordination, is not eligible to receive health care home payments, care coordination fees, or payments for in-reach community-based service coordination, for MA or MinnesotaCare recipients enrolled in, or attributed to, the integrated health partnership.

27 **Health care delivery systems demonstration project.** Adds § 256B.0759.

Subd. 1. Implementation. (a) Requires the commissioner to develop and implement a demonstration project to test delivery system payment and care models that provide services to MA and MinnesotaCare enrollees based on prospective per capita or total cost of care payments. Requires the project to be implemented in coordination with, and as an expansion of, the integrated health partnership demonstration project.

(b) Specifies criteria for the commissioner to follow in developing the project.

Subd. 2. Requirements for health care delivery systems. (a) Requires health care delivery systems to provide required services and care coordination, establish a

Section

process to monitor enrollment and ensure quality of care, coordinate service delivery with social services programs, provide a system for advocacy and consumer protection, and adopt innovative and cost-effective methods of care delivery and coordination.

(b) Specifies the types of health care providers that may establish a health care delivery system.

(c) Requires a health care delivery system to contract with a third-party administrator, specifies related criteria, and allows the commissioner to waive this requirement.

Subd. 3. Enrollment. (a) States that individuals eligible for MA or MinnesotaCare are eligible to enroll in a health care delivery system. Allows individuals to opt-out of prepaid MA or prepaid MinnesotaCare, and receive care through a health care delivery system.

(b) Allows individuals to enroll in a health care delivery system that serves the county in which they reside, and to have a choice between delivery systems if more than one delivery system serves the county. States that enrollment in a specific health care delivery system is for 12 months, except that persons who do not maintain eligibility shall be disenrolled and persons experiencing a qualifying life event may change delivery systems or opt out of the demonstration project.

(c) Specifies criteria governing assignment of individuals to a delivery system.

Subd. 4. Accountability. (a) States that health care delivery systems are responsible for quality of care, and enrollee cost of care and utilization. Requires the commissioner to adjust accountability standards to take into account various barriers to care experienced by a delivery system's patient population.

(b) Requires a delivery system to contract with community health clinics, federally qualified health centers, and other specified entities, to the extent practicable.

(c) Specifies requirements for coordination of services with other providers, county agencies, and other local entities.

Subd. 5. Payment system. Requires the commissioner to develop a payment system for the project that includes prospective per capita payments, total cost of care benchmarks, and risk/gain sharing payment options. Also requires the payment system to include incentive payments related to quality and performance targets.

Subd. 6. Federal waiver or approval. Directs the commissioner to seek all federal waivers or approval necessary to implement the demonstration project, and to report to legislative committees on any federal action related to the request.

States that the section is effective January 1, 2018, or upon receipt of federal waivers or approval, whichever is later.

28 **Psychiatric residential treatment facility for persons under 21 years of age.** Adds § 256B.0941.

Section

Subd. 1. Eligibility. (a) States that individuals eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, the services are determined to be medically necessary by the state's medical review agent;

(2) be younger than age 21 at the time of admission, with services continuing until the individual meets discharge criteria or reaches age 22, whichever occurs first;

(3) has a mental health diagnosis, and clinical evidence of severe aggression or a finding that the individual is a risk to self or others;

(4) has a functional impairment and a history of difficulty in functioning safely and successfully, an inability to adequately care for one's physical needs, or caregiver, guardians, and family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that these services cannot provide the needed level of care; and

(7) was referred to residential treatment by a qualified mental health professional.

(b) Requires the mental health professional making a referral to submit specified documentation to the state's medical review agent, within 180 days of the individual's admission.

Subd. 2. Services. Requires psychiatric residential treatment facility services providers to offer and have the capacity to provide the following:

(1) development of the individual plan of care, review of the plan every 30 days, and discharge planning;

(2) any services provided by a psychiatrist or physician for purposes of the services required in clause (1);

(3) active treatment seven days per week;

(4) individual therapy, at least twice per week;

(5) family engagement activities, at least once per week;

(6) consultation with other professionals;

(7) coordination of educational services between local and resident school districts and the facility;

(8) 24-hour nursing; and

(9) direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Subd. 3. Per diem rate. (a) Requires the commissioner to establish a statewide per diem rate for facility services for individuals 21 years of age or younger. Specifies criteria for the rate and the reporting of costs.

Section

(b) Specifies rate components.

(c) Allows a facility to submit a claim for payment outside of the per diem for professional services, and specifies related criteria.

(d) Requires Medicaid to reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge. Defines concurrent services and specifies related criteria.

(e) Excludes the costs of the following services from payment rates: educational services, acute medical care or specialty services for other conditions, dental services, and pharmacy drug costs.

(f) Provides a definition of "actual cost."

Subd. 4. Leave days. Provides medical assistance coverage for therapeutic and hospital leave days, and specifies requirements for payment and payment levels.

Provides an immediate effective date.

29 **Exception to excluded services.** Amends § 256B.0943, subd. 13. Adds a psychiatric residential treatment facility to the list of facilities for which payment can be made under MA for children's therapeutic services and supports. Strikes obsolete language.

30 **Covered services.** Amends § 256B.0945, subd. 2. Provides that MA covers mental health services provided to children with severe emotional disturbance in a residential facility determined by CMS to be an institution for mental diseases, except for room and board, using state-only MA funding.

31 **Payment rates.** Amends § 256B.0945, subd. 4. Provides that payments to counties, for services provided to children with severe emotional disturbance by a residential facility that is determined to be an institution for mental diseases, shall be equivalent to the federal share of the payment that would have been made were the facility not an institution for mental diseases. Requires the portion of payment representing what would be the nonfederal share to be paid by the county. Specifies other payment criteria and makes conforming changes.

32 **Policy and applicability.** Amends § 256B.15, subd. 1, paragraph (c). Removes the beginning date from a MA definition.

Makes this section effective the day following final enactment, and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016.

33 **Estates subject to claims.** Amends § 256B.15, subd. 1a. Strikes language allowing recovery from the estate of a person over 55 years of age for general MA services rendered before January 1, 2014. Limits estate recovery claims to the amount of MA paid on behalf of a person who resided in a medical institution, who received general assistance medical care (formerly under chapter 256D), or who received MA long-term services and supports at or after 55 years of age.

Makes section effective the day following final enactment and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016.

Section

34 **Limitations on claims.** Amends § 256B.15, subd. 2. Removes language allowing estate recovery for general MA services rendered before January 1, 2014. Specifies that an estate claim must only include: (1) the amount of medical assistance rendered to persons 55 or older for long-term services and supports; (2) the total amount of medical assistance rendered during a period of institutionalization; and (3) the total amount of general assistance medical care (formerly under chapter 256D). Clarifies that "home and community-based services" includes alternative care services, even when those services receive only state funding.

Makes section effective the day following final enactment and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016.

35 **Commissioner's duties.** Amends § 256B.192, subd. 2. The amendment to paragraph (d) allows ambulance services owned and operated by a governmental organization to participate in an existing intergovernmental transfer (IGT) arrangement for ambulance services that currently applies to ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. Requires the commissioner to determine an upper payment limit for these ambulance services, inform participating governmental entities of the IGTs necessary to match federal Medicaid payments available, and upon receipt of these transfers, to make supplementary payments to these entities equal to the difference between the MA payment rate and the upper payment limit. Provides that tribal governments that operate an ambulance service are not eligible to participate in the IGT arrangement for ambulance services.

A new paragraph (e) directs the commissioner to determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. Requires the commissioner to inform the University of Minnesota Medical School and School of Dentistry of the periodic intergovernmental transfers needed to match federal Medicaid payments available, in order to make supplemental payments to physicians, dentists, and other billing professionals equal to the difference between the established MA payment rate and the upper payment limit. Upon receipt of these transfers, requires the commissioner to make these supplemental payments.

A new paragraph (f) allows the University of Minnesota Medical School and School of Dentistry, beginning January 1, 2018, to make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $20 million per year from the medical school and $6 million per year from the school of dentistry. Directs the commissioner to increase MA capitation payments to any health plan under contract with MA that agrees to make enhanced payments to the University of Minnesota and the University of Minnesota Physicians, and specifies related requirements. Requires any health plan that receives increased capitation payments to increase its MA payments to the University of Minnesota and the University of Minnesota Physicians by the same amounts as the increased capitation payment received.

A new paragraph (i) states that all data and funding transactions are between the commissioner and the governmental entities.

States that paragraph (a) is effective July 1, 2017, or upon federal approval, whichever is later.

Section

36 **Intergovernmental transfers.** Amends § 256B.196, subd. 3. Requires all intergovernmental transfer payments made by the University of Minnesota Medical School and School of Dentistry to be used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraphs (e) and (f).

37 **Adjustments permitted.** Amends § 256B.196, subd. 4. Adds the average commercial rates for physician and other professional services to the list of factors for which the commissioner may adjust intergovernmental transfers and payments. Adds university schools to the list of entities that the commissioner must consult with prior to making adjustments.

38 **Managed care contracts.** Amends § 256B.69, subd. 5a. For services provided on or after January 1, 2018, through December 31, 2018, requires the commissioner to withhold two percent of capitation payments for each MA enrollee. Requires the commissioner to return the withhold, between July 1 and July 31 of the following year, for capitation payments for enrollees for whom the managed care or county-based purchasing plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. Specifies requirements for the form. Requires a plan to request all enrollees to complete the form, and requires the plan to submit all completed forms to the commissioner by February 28, 2018. If a completed form for an enrollee is not received by the commissioner by that date, requires the commissioner to not return funds withheld for that enrollee, cease making capitation payments for the enrollee, and disenroll the enrollee from MA, subject to enrollee appeal.

39 **Competitive bidding and procurement.** Amends § 256B.69, by adding subd. 36.

(a) For managed care organization contracts effective on or after January 1, 2019, requires the commissioner to utilize a competitive price bidding program on a regional basis for nonelderly adults and children who are not eligible based on a disability and are enrolled in MA and MinnesotaCare. Requires the commissioner to establish geographic regions, and to not implement competitive bidding for more than 40 percent of the regions during each procurement. Requires the commissioner to ensure there is an adequate choice of managed care organizations, in a manner consistent with section 256B.694 (which allows sole-source contracting with county-based purchasing plans). Requires the commissioner to operate competitive bidding by region, but to award contracts by county and allow partial bids within a region based on counties served. Defines managed care organization.

(b) Requires the commissioner to provide the scoring weight of selection criteria in the request for proposals. Requires substantial weight to be given to county board resolutions and priority areas identified by counties.

(c) Requires that each responding managed care organization be given the opportunity to submit a best and final offer, if a best and final offer is requested.

(d) Requires the commissioner to consider network adequacy for dental and other services when evaluating proposals.

(e) Requires the commissioner to provide each managed care organization with its scoring sheet and other information and specifies related criteria.

Section

(f) Allows a managed care organization to appeal the commissioner's selection decision using a three-person mediation panel, but states that the panel recommendation is binding on the commissioner.

(g) Requires the commissioner to contract for an independent evaluation of the competitive bidding process. Requires the contractor to solicit recommendations for improving the competitive bidding process. Requires the commissioner to make evaluation results available on the department's Web site.

40 **Hospital outpatient reimbursement.** Amends § 256B.75. Specifies the method for determining outpatient payment rates for critical access hospitals. Requires Medicare cost report information to be used until DHS finalizes the MA cost reporting process for critical access hospitals. Specifies components of the outpatient rate. Provides a July 1, 2017, effective date.

41 **Reimbursement for evidence-based public health nurse home visits.** Adds § 256B.7635. For services provided on or after January 1, 2018, sets MA payment rates for prenatal and post-partum follow-up home visits provided by a public health nurse, or a registered nurse supervised by a public health nurse, using evidence-based models, at a minimum of $140 per visit. Requires follow-up home visits to be administered by home visiting programs that meet specified criteria. Requires home visits to target mothers and their children beginning with prenatal visits through age three for the child.

42 **Reimbursement for basic health care services.** Amends § 256B.766. Effective for items provided on or after January 1, 2016, sets the MA payment rate for non-pressure support ventilators at the lower of the submitted charge or the Medicare fee schedule rate, and sets the MA payment rate for pressure support ventilators at the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. Provides a retroactive effective date of January 1, 2016.

43 **Definitions.** Adds § 256B.90. Defines terms.

44 **Medical assistance outcomes-based payment program.** Adds § 256B.91.

Subd. 1. Generally. Requires the commissioner to establish a hospital outcomes program to provide hospitals with information and incentives to reduce potentially avoidable events.

Subd. 2. Potentially avoidable event methodology. Requires the commissioner to select a methodology for identifying potentially avoidable events and associated costs, and for measuring hospital performance with respect to these events. Requires the commissioner to develop definitions for each potentially avoidable event. Requires the methodology, to the extent possible, to be one that has been used by other Medicaid programs or by commercial payers, and specifies other criteria.

Subd. 3. Medical assistance system waste. Requires the commissioner to analyze state databases to identify waste in the MA system. Requires the analysis to identify potentially avoidable events in MA and associated costs. Specifies related requirements.

Section

45 **Hospital outcomes program.** Adds § 256B.92.

Subd. 1. Generally. Requires the hospital outcomes program to: (1) target reduction of potentially avoidable readmissions and complications; (2) apply to all state acute care hospitals participating in MA; and (3) be implemented in two phases—performance reporting and outcomes-based financial incentives.

Subd. 2. Phase 1; performance reporting. Requires the commissioner to develop and maintain a reporting system to provide each hospital with reports on its performance for potentially avoidable readmissions and potentially avoidable complications. Specifies duties for the commissioner. Allows a hospital to share information in the outcome performance reports with health care providers to foster coordination and cooperation in the hospital's outcome improvement and waste reduction initiatives.

Subd. 3. Phase 2; outcomes-based financial incentives. Requires the commissioner, 12 months after implementation of performance reporting, to establish financial incentives for a hospital to reduce potentially avoidable readmissions and potentially avoidable complications.

Subd. 4. Rate adjustment methodology. Requires the commissioner to adjust hospital reimbursement based on the hospital's performance on outcome results. Specifies criteria for the rate methodology.

Subd. 5. Amendment of contracts. Requires the commissioner to amend hospital contracts as necessary to incorporate the financial incentives.

Subd. 6. Budget neutrality. Requires the program to be implemented in a budget-neutral manner for aggregate Medicaid hospital expenditures.

46 **Sliding fee scale; monthly individual or family income.** Amends § 256L.15, subd. 2. Effective October 1, 2017, increases premiums for MinnesotaCare enrollees. Under current law, premiums range between $4 and $50 depending upon income. Under the new premium scale, premiums will range between $5 and $85.

47 **Capitation payment delay.** (a) Requires the commissioner of human services to delay $135 million of MA and MinnesotaCare capitation payments to managed care and county-based purchasing plans due in May 2019 and the special needs basic care payment due in April 2019, until July 1, 2019. Requires payment to be made between July 1, 2019, and July 31, 2019.

(b) Requires the commissioner of human services to delay $135 million of MA and MinnesotaCare capitation payments to managed care and county-based purchasing plans due in the second quarter of calendar year 2021 and the special needs basic care payment due in April 2021, until July 1, 2021. Requires payment to be made between July 1, 2021, and July 31, 2021.

48 **Children's mental health report and recommendations.** Requires the commissioner of human services to conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children

Section

served in residential treatment. Lists criteria for the analysis. Requires the analysis to be supported and informed by extensive stakeholder engagement. Requires the commissioner to present the report with specific recommendations and implementation timelines to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.

49 **Encounter reporting of 340B eligible drugs.** (a) By January 1, 2018, requires the Commissioner of Human Services, in consultation with specified entities, to develop a process to identify and report at point of sale 340B drugs dispensed to enrollees of managed care organizations who are patients of an FQHC, in order to exclude these claims from the Medicaid drug rebate program. Requires the commissioner to ensure that FQHCs are allowed to utilize 340B drug discounts if a FQHC utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program, and to also ensure that duplicate discounts for drugs do not occur.

(b) Requires the commissioner, by January 1, 2018, to notify the chairs and ranking minority members of the legislative committees with jurisdiction over MA when the process required by paragraph (a) was developed, or to report why the process was not developed.

50 **Rate-setting analysis report.** Requires the commissioner of human services to analyze and report on the current rate-setting methodology for outpatient, professional, and physician services that do not have a cost-based, federally mandated, or contracted rate. Requires the report to include recommendations for changes to the existing Resource-Based Relative Value System fee schedule, and alternative payment methodologies for services that do not have relative values, to simplify the rate structure and improve consistency and transparency. Requires the commissioner to consult with outside experts in Medicaid financing when developing the report. Requires the commissioner to report the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by November 1, 2019.

51 **Study of payment rates for durable medical equipment and supplies.** Requires the commissioner of human services to study the impact of basing MA payment for durable medical equipment and supplies on Medicare payments, as limited by the federal 21st Century Cures Act, on access by MA enrollees to these items. Requires the study to include recommendations for ensuring and improving access by MA enrollees to durable medical equipment and supplies. Requires the commissioner to report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by February 1, 2018.

52 **Federal approval.** Requires the commissioner of human services to request any federal waivers and approvals necessary to allow the state to retain federal funds accruing in the state's basic health program trust fund, and expend those funds for purposes other than those specified in federal law. (In general, federal law requires the trust funds to be used only to reduce premiums and cost-sharing or provide additional benefits to eligible individuals.) Requires the commissioner to report any federal action regarding the request to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. Provides an immediate effective date.

Section

53 **Federal waiver or approval.** Requires the commissioner to seek any federal waiver or approval necessary to implement section 256B.0644.

Article 2: Continuing Care

Overview

This article makes changes to hospital swing beds, TEFRA parental fees, home health services, ICF/DD payments, the Disability Waiver Rate System (DWRS), the consumer-directed community supports (CDCS) budget methodology, and the nursing facility payment system; extends the Alzheimer's disease working group; modernizes the Deaf and Hard-of-Hearing Services Act; and creates caregiver support grants and an electronic service delivery documentation system.

1 **Penalties for late or nonsubmission.** Amends § 144.0724, subd. 6. Expands the commissioner of human services' authority to reduce penalties incurred by a nursing facility for failure to complete or submit a case mix assessment. Makes this section effective the day following final enactment.

2 **Eligibility for license condition.** Amends § 144.562, subd. 2. Modifies the commissioner's authority to approve swing bed use above the cap by requiring patients to agree to referral to skilled nursing facilities under certain circumstances.

3 **Maximum charges.** Amends § 144A.74. Amends a section setting maximum charges a supplemental nursing services agency is permitted to bill or receive payments from a nursing home, to specify that a nursing home that pays for actual travel and housing costs for supplemental nursing services agency staff working at the facility is not violating the limitation on charges in this section.

4 **Applicability.** Amends § 245D.03, subd. 1. Modifies the list of services that are governed by the home and community-based services standards chapter of statutes by adding three new employment services. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

5 **Contribution amount.** Amends § 252.27, subd. 2a. Reduces TEFRA parental fees by 25 percent.

6 **Day training and habilitation (DT&H) services for adults with developmental disabilities.** Amends § 252.41, subd. 3. Modifies the list of DT&H services by removing supported employment and clarifying work-related activities are center-based. Specifies that DT&H services do not include three new employment services that are proposed to be provided under the HCBS disability waivers. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

Section

7 **Caregiver support programs.** Creates § 256.9755.

Subd. 1. Program goals. States the goal of all area agencies on aging and caregiver support programs is to support family caregivers of persons with Alzheimer's disease or other related dementias who are living in the community by promoting caregiver support programs and providing caregiver support services.

Subd. 2. Authority. Requires the Minnesota Board on Aging to allocate to the area agencies on aging the caregiver support program state and federal funds in a manner consistent with federal requirements.

Subd. 3. Caregiver support services. Requires funds allocated to an area agency on aging for caregiver support services to be used in a manner consistent with the National Family Caregiver Support Program to reach family caregivers of persons with Alzheimer's disease or related dementias. Requires funds to be used to provide social, nonmedical, community-based services and activities that provide respite for caregivers and social interaction for participants.

8 **Home health services.** Amends § 256B.0625, subd. 6a. Allows medical assistance (MA) to cover home health services provided in the community where normal life activities take the recipient.

9 **Definitions.** Amends § 256B.0653, subd. 2. Modifies the definition of "home health agency services."

10 **Home health aide visits.** Amends § 256B.0653, subd. 3. Allows home health aide visits to be provided in the community where normal life activities take the recipient.

11 **Skilled nurse visit services.** Amends § 256B.0653, subd. 4. Allows skilled nurse visits to be provided in the community where normal life activities take the recipient.

12 **Home care therapies.** Amends § 256B.0653, subd. 5. Allows home care therapies to be provided in the community where normal life activities take the recipient. Home care therapies include physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

13 **Noncovered home health agency services.** Amends § 256B.0653, subd. 6. Modifies the list of noncovered home health agency services by removing from the list home care therapies provided at a day program and adding to the list home health agency services without documentation of a face-to-face encounter.

14 **Face-to-face encounter.** Amends § 256B.0653, subd. 7. Requires a face-to-face encounter to be completed for all home health services, except when providing a one-time perinatal visit by skilled nursing. Allows the face-to-face encounter to occur through telemedicine. Specifies when the encounter must occur and who may conduct the encounter. Lists duties of the physician responsible for ordering the services. For home health services requiring authorization, specifies that home health agencies must retain documentation of the face-to-face encounter and submit the qualifying documentation to the commissioner upon request.

15 **Bed layaway and delicensure.** Amends § 256B.431, subd. 30. Modifies the timing of property payment rate increases due to a bed layaway or delicensure. Updates a cross-reference.

Section

16 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Limits an inflationary adjustment to the property payment rate for rate years beginning on and after January 1, 2018, and removes obsolete language. Makes this section effective the day following final enactment.

17 **Rate stabilization adjustment.** Amends § 256B.4913, subd. 4a. Modifies the historical rate for certain day service recipients. Makes this section effective the day following final enactment.

18 **New services.** Amends § 256B.4913, by adding subd. 7. Specifies that a service added after January 1, 2014, is not subject to the rate stabilization adjustment. Specifies that employment support services authorized after January 1, 2018, under the new employment services definition according to the HCBS waivers for persons with disabilities are not subject to the rate stabilization adjustment. Makes this section effective the day following final enactment.

19 **Definitions.** Amends § 256B.4914, subd. 2. Modifies the definition of "unit of service" for certain unit-based services without programming. Makes this section effective upon federal approval. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

20 **Applicable services.** Amends § 256B.4914, subd. 3. Adds independent living skills specialist services and three employment services to the list of services that are governed by the Disability Waiver Rate System (DWRS). Makes this section effective upon federal approval, except independent living skills specialist services are effective January 1, 2020. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

21 **Base wage index and standard component values.** Amends § 256B.4914, subd. 5. Modifies various base wage calculations and adds calculations for independent living skills specialist staff, employment exploration services staff, and employment development services staff. Modifies certain component values for day services, unit-based services with programming, and unit-based services without programming. Removes language requiring the commissioner to make certain inflationary adjustments every five years and requires the adjustments to be made every two years beginning on January 1, 2022. Requires the commissioner to publish updated values and load them into the rate management system.

Paragraph (j) requires the commissioner to recommend to the legislature codes or items to update and replace missing component values if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future.

Paragraph (k) requires the commissioner to ensure that wage values and component values reflect the cost to provide the service. Requires providers enrolled to provide services with rates determined under the DWRS to submit business cost data to the commissioner to support research on the cost of providing services that have rates determined by the DWRS. Lists the cost data that must be submitted.

Paragraph (l) requires providers to submit the cost data at least once in any five-year period, on a schedule determined by the commissioner. Requires the commissioner to temporarily suspend payments to a provider if cost component data is not received 90 days after the

Section

required submission date. Requires withheld payments to be made once data is received by the commissioner.

Paragraph (m) requires the commissioner to conduct a random audit of data submitted by providers to ensure accuracy.

Paragraph (n) requires the commissioner to analyze cost documentation and to submit recommendations on component values and inflationary factor adjustments to the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. Requires the commissioner to release business cost data in an aggregate form.

Paragraph (o) requires the commissioner to develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation.

Makes the amendments to paragraphs (a) to (g) effective January 1, 2018, except the change in the absence and utilization factor for day services is effective January 1, 2019. Makes the amendments to paragraphs (h) to (o) effective the day following final enactment.

22 **Payments for residential support services.** Amends § 256B.4914, subd. 6. Makes a conforming change to a cross-reference.

23 **Payments for day programs.** Amends § 256B.4914, subd. 7. Makes a conforming change to a cross-reference.

24 **Payments for unit-based services with programming.** Amends § 256B.4914, subd. 8. Adds independent living skills specialist services and the three new employment services to unit-based services with programming. Makes a conforming change to a cross-reference. Increases the number of service recipients who may share certain employment services. Makes this section effective the day following final enactment.

25 **Payments for unit-based services without programming.** Amends § 256B.4914, subd. 9. Makes a conforming change to a cross-reference.

26 **Updating payment values and additional information.** Amends § 256B.4914, subd. 10. Modifies certain analyses and evaluations the commissioner must conduct. Modifies the date of the next report to the legislature regarding the DWRS. Removes obsolete language. Beginning July 1, 2017, requires the commissioner to renew analysis and implement changes to the regional adjustment factors when certain adjustments occur. Requires the commissioner to study the underlying cost of absence and utilization for day services. Requires the commissioner to make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component values for day services. Beginning July 1, 2017, requires the commissioner to collect transportation and trip information for all day services through the DWRS. Makes this section effective the day following final enactment.

27 **Filing an appeal.** Amends § 256B.50, subd. 1b. Modifies the date by which an appeal must be received by the commissioner.

28 **Therapeutic leave days.** Amends § 256B.5012, by adding subd. 3a. Counts a vacant bed in an intermediate care facility for persons with developmental disabilities as a reserved bed when determining occupancy rates and eligibility for payment of a therapeutic leave day.

Section

29 **ICF/DD rate increase effective July 1, 2017; Murray County.** Amends § 256B.5012, by adding subd. 17. Effective July 1, 2017, specifies the daily rate for a specific ICF/DD located in Murray County is $400. Adds this increase to any other increase that is effective on July 1, 2017.

30 **Culturally affirmative.** Amends § 256C.23, by adding subd. 1a. Defines "culturally affirmative" in the chapter of statute governing deaf and hard-of-hearing services.

31 **Deaf.** Amends § 256C.23, subd. 2. Updates the definition of "deaf."

32 **Interpreting services.** Amends § 256C.23, by adding subd. 2c. Defines "interpreting services."

33 **Real-time captioning.** Amends § 256C.23, by adding subd. 6. Defines "real-time captioning."

34 **Deaf and Hard-of-Hearing Services Division.** Amends § 256C.233, subd. 1. Updates the list of activities the division must address. Removes language referring to an "interagency management team" and replaces it with "interagency advisors." Updates language to be person-centered.

35 **Responsibilities.** Amends § 256C.233, subd. 2. Updates the list of duties the division must perform. Updates language to be person-centered.

36 **Location.** Amends § 256C.24, subd. 1. Sets a minimum number of regional service centers the division must establish. Updates language to be person-centered.

37 **Responsibilities.** Amends § 256C.24, subd. 2. Updates the list of duties the regional service centers must perform. Updates language to be person-centered. Allows people who have to travel more than 50 miles round-trip from home or work to receive services at a regional service center to be reimbursed for mileage at the reimbursement rate established by the IRS.

38 **Services for persons who are deafblind.** Amends § 256C.261. Removes obsolete language and updates language to be person-centered. Requires consumer-directed services to be provided in whole by grant-funded providers. Prohibits the regional services centers from providing grant-funded consumer-directed services.

39 **Administrative costs.** Amends § 256R.02, subd. 4. Modifies the definition of "administrative costs" in the chapter of statutes governing nursing facility payment rates by clarifying insurance costs and including costs incurred for travel and housing for people employed by a supplemental nursing services agency. This includes these costs in the facility's other operating payment rate.

40 **Direct care costs.** Amends § 256R.02, subd. 17. Modifies the definition of "direct care costs" by adding costs for nurse consultants, pharmacy consultants, and medical directors. Requires that salaries and payroll taxes for nurse consultants who work out of a central office be allocated proportionately to the nursing facilities served by those consultants.

41 **Employer health insurance costs.** Amends § 256R.02, subd. 18. Clarifies the definition of "employer health insurance costs."

Section

42 **External fixed costs.** Amends § 256R.02, subd. 19. Modifies the definition of "external fixed costs" by adding rate adjustments for compensation-related costs for minimum wage changes and by clarifying the PERA costs that are included.

43 **Fringe benefit costs.** Amends § 256R.02, subd. 22. Clarifies the definition of "fringe benefit costs."

44 **Raw food costs.** Amends § 256R.02, subd. 42. Includes the allocation of dietary credits in the definition of "raw food costs."

45 **Real estate taxes.** Amends § 256R.02, by adding subd. 42a. Defines "real estate taxes."

46 **Special assessments.** Amends § 256R.02, subd. 48a. Defines "special assessments."

47 **Therapy costs.** Amends § 256R.02, subd. 52. Clarifies the definition of "therapy costs."

48 **Notice to residents.** Amends § 256R.06, subd. 5. Modifies requirements related to notifying private pay residents of nursing facility rate increases.

49 **Criteria.** Amends § 256R.07, subd. 1. Corrects cross-references.

50 **Electronic signature.** Amends § 256R.07, by adding subd. 6. Allows the use of an electronic signature for documentation requiring a signature under the nursing facility payment system.

51 **Extended record retention requirements.** Amends § 256R.13, subd. 4. Corrects changes to cross-references.

52 **Biennial report.** Creates § 256R.18. Requires the commissioner to provide to the legislature a biennial report including:

- the impact of the quality adjusted care limits;
- the ability of nursing facilities to retain employees, including whether rate increases are passed through to employees;
- the efficacy of the critical access nursing facility program; and
- the impact of payment rate limit reduction.

Makes this section effective January 1, 2019.

53 **Scholarships.** Amends § 256R.37. Removes the requirement that registered nurses and licensed practical nurses be newly hired and newly graduated in order to be eligible for a scholarship under the nursing facility payment system.

54 **Definitions.** Amends § 256R.40, subd. 1. Modifies the definition of "completion of closure" for the purposes of the planned closure rate adjustment.

55 **Planned closure rate adjustment.** Amends § 256R.40, subd. 5. Modifies the timing of the planned closure rate adjustment due to the closure of a facility. Adds language specifying the timing of a rate adjustment for a nursing facility that is closing operations.

Section

56 **Single-bed room incentive.** Amends § 256R.41. Modifies the timing of the single-bed room incentive due to the delicensure of beds.

57 **Rate adjustment for critical access nursing facilities.** Amends § 256R.47. Extends the suspension of this program through December 31, 2019. The current suspension expires on December 31, 2017.

58 **Rate adjustments for compensation-related costs for minimum wage changes.** Amends § 256R.49. Makes rate increases provided under this section expire after two years. Removes language requiring the rate adjustment to be used to pay compensation costs for employees paid less than $14 per hour. Allows rate adjustments to be made for minimum wage changes implemented in statute or by local ordinance. Modifies the formula for determining the rate adjustment.

59 **Nursing facilities in border cities.** Amends § 256R.53, subd. 2. Adds nonprofit nursing facilities in Moorhead to the nursing facility payment rate exemption that already exists for Breckenridge. Requires the commissioner to make a comparison of rates by November 1 of each year and apply it to the rates to be effective on the following January 1. Exempts facilities under this subdivision from rate limits if the adjustments under this subdivision result in a rate that exceeds the limits. Makes this section effective for rate increases for facilities in Moorhead for rate years beginning January 1, 2020, and annually thereafter.

60 **Expansion of CDCS budget methodology exception.** Amends Laws 2015, ch. 71, art. 7, § 54. Expands the 2015 CDCS budget methodology exception. Limits the exception for persons who are currently using licensed providers for employment supports or services during the day or residential services to persons who can demonstrate that the total cost of CDCS services, including the exception, will be less than the cost of current waiver services. Makes the exception effective October 1, 2017, or upon federal approval, whichever is later. Requires the commissioner of human services to notify the revisor of statutes when federal approval is obtained.

61 **Alzheimer's Disease Working Group.** Creates § 256.999.

Subd. 1. Members. Requires the Minnesota Board on Aging to appoint an Alzheimer's disease working group consisting of 16 members. Lists the organizations that must be represented on the working group. Requires the appointing authorities to complete their appointments no later than December 15, 2017. Requires the membership of the working group to reflect the diversity in Minnesota.

Subd. 2. Duties; recommendations. Requires the working group to review and revise the 2011 report titled "Preparing Minnesota for Alzheimer's: the Budgetary, Social and Personal Impacts." Requires the working group to consider and make recommendations and findings on several issues, including:

- trends and disparities in the state's Alzheimer's population;
- risk reduction, including health education and health promotion on risk factors, safety, and potentially avoidable hospitalizations; and
- health disparities and access to high quality dementia care.

Section

Subd. 3. Meetings. Requires the Board on Aging to convene the first meeting of the working group no later than January 15, 2018. Requires meetings of the working group to be open to the public, and to the extent practicable, technological means, such as Web casts, must be used to reach the greatest number of people throughout the state. Requires the Board of Aging to designate one member to serve as chair. Limits the working group to no more than five meetings.

Subd. 4. Compensation. Provides that working group members serve without compensation, except for allowed expense reimbursement.

Subd. 5. Administrative support. Requires the Board of Aging to provide administrative support.

Subd. 6. Report. Requires the Board on Aging to submit a report providing the findings and recommendations of the working group to the governor and the legislature no later than January 15, 2019.

Subd. 7. Expiration. Provides an expiration date for the working group.

62 **CDCS revised budget methodology report.** Requires the commissioner of human services, in consultation with others, to develop a revised CDCS budget methodology. Specifies criteria upon which the new methodology must be based. By December 15, 2018, requires the commissioner to report a revised CDCS budget methodology, including proposed legislation and funding necessary to implement the new methodology, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. Makes this section effective the day following final enactment.

63 **Direction to commissioner; telecommunication equipment program.** Requires the commissioner of human services to work in consultation with the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by January 15, 2018, to the legislative committees with jurisdiction over human services to modernize the telecommunications equipment program. Lists the items the recommendations must address.

64 **Direction to commissioner; billing for mental health services.** By January 1, 2018, requires the commissioner of human services to report to the legislative committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

65 **Electronic service delivery documentation system.**

Subd. 1. Documentation; establishment. Requires the commissioner of human services to establish implementation requirements and standards for an electronic service delivery documentation system to comply with the 21st Century Cures Act.

Subd. 2. Definitions. Defines the terms “electronic service delivery documentation,” “electronic service delivery documentation system,” and “service.”

Subd. 3. Requirements. Requires the commissioner to consider electronic visit verification systems and other electronic service delivery documentation methods in developing implementation requirements for an electronic service delivery

Section

documentation system. Requires the commissioner to convene impacted stakeholders to ensure that the requirements meet certain criteria, including:

- being minimally administratively and financially burdensome to a provider;
- considering existing best practices and use of electronic service delivery documentation; and
- being effective methods for preventing fraud.

Requires the commissioner to: (1) make training available to providers on the electronic service delivery documentation system requirements; (2) establish baseline measurements related to preventing fraud; and (3) establish measures to determine the effect of electronic service delivery documentation requirements on program integrity.

Subd. 4. Legislative report. Requires the commissioner to submit a report by January 15, 2018, to the legislative committees with jurisdiction over human services with recommendations to establish electronic service delivery documentation system requirements and standards. Lists items the report must include. Makes this section effective the day following final enactment.

66 **Transportation study.** Requires the commissioner of human services to conduct a study to increase access to transportation services for an individual who receives HCBS. Requires the commissioner to submit a report to the legislative committees with jurisdiction over human services by January 15, 2019. Lists the information that must be included in the report. Makes this section effective the day following final enactment.

67 **Direction to commissioner; ICF/DD Payment Rate Study.** Directs the commissioner, within available appropriations, to study the ICF/DD payment rates and make recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 1, 2018.

68 **Federal waiver amendments.** Requires the commissioner of human services to submit necessary waiver amendments to CMS to add employment exploration services, employment development services, and employment support services to the HCBS disability waivers. Also requires the commissioner to submit necessary waiver amendments to remove community-based employment services from DT&H and prevocational services. Requires the commissioner to submit all necessary waiver amendments by October 1, 2017. Makes this section effective the day following final enactment.

69 **Exception to the budget methodology for persons leaving institutions and crisis residential settings.** By September 30, 2017, requires the commissioner to establish an institutional and crisis bed CDCS budget exception process. Lists to whom the exception process will apply. For purposes of this exception, lists the settings that are considered to be institutional. Limits the budget exception to no more than the amount of appropriate less-restrictive available services determined by the lead agency managing the individual's home and community-based services (HCBS) waiver. Requires lead agencies to notify DHS of the budget exception. Makes this section effective the day following final enactment.

Section

70 **Repealer.** Paragraph (a) repeals Minnesota Statutes, sections 256C.23, subd. 3 (definitions; regional service center); 256C.233, subd. 4 (duties of state agencies; state commissioners); and 256C.25, subds. 1 (interpreter services; establishment) and 2 (interpreter services; duties).

Paragraph (b) repeals Minnesota Statutes, section 256B.4914, subd. 16 (budget neutrality adjustments), effective January 1, 2018.

Article 3: Health Department and Public Health

Overview

This article creates or modifies programs operated by the Minnesota Department of Health. This article:

- establishes the Palliative Care Advisory Council;
- authorizes the use of handheld dental x-ray equipment;
- modifies the health professional education loan forgiveness and physician residency expansion grant programs, and establishes senior care workforce innovation and primary care and mental health professions clinical training grant programs;
- authorizes a statewide tobacco quitline service administered by the Department of Health;
- authorizes adding beds to an existing psychiatric hospital in Hennepin County;
- establishes a biomedicine and bioethics innovation grant program;
- authorizes licensure of prescribed pediatric extended care centers;
- modifies abortion reporting requirements;
- authorizes pilot programs and studies regarding brain health, a comprehensive plan to end HIV/AIDS, early dental disease prevention, safety and quality improvement practices for long-term care services, and the home care nursing workforce shortage; and
- repeals the Minnesota Radon Licensing Act.

1 **Palliative Care Advisory Council.** Adds § 144.059. Establishes a 22-member Palliative Care Advisory Council to advise the commissioner of health on improving the quality and delivery of patient-centered, family-focused palliative care. Specifies the council's membership, and requires at least six members to reside outside counties in and surrounding the Twin Cities metro area. Establishes requirements for meetings and terms, and provides that public members of the council shall not receive compensation except for expenses. Directs the council to consult with and advise the commissioner on palliative care initiatives in the state, and requires the council to submit an annual report on the availability of palliative care, barriers, and recommendations for legislative action. Requires the report to

Section

also be published on MDH's Web site. Makes the section effective the day following final enactment.

2 **Authorization to use certain handheld dental x-ray equipment.** Adds § 144.1215. Allows the use of handheld dental x-ray equipment that meet the requirements of this section.

Subd. 1. Definition; handheld dental x-ray equipment. Defines handheld dental x-ray equipment.

Subd. 2. Use authorized. Allows a facility to use handheld dental x-ray equipment if the equipment has been approved for human use by the FDA and is being used consistent with that approval and uses a backscatter shield that meets the listed requirements. Prohibits use of the equipment if its backscatter shield is broken or not permanently affixed to the system. Prohibits limiting the use of handheld equipment to situations when it is impractical to transfer a patient to a stationary system. Allows the system's tube housing and position-indicating device to be handheld during exposure. Requires the equipment to be securely stored when not in use and establishes calibration requirements.

Subd. 3. Exemptions from certain shielding requirements. Exempts handheld equipment from the following requirements in Minnesota Rules: shielding requirements and requirements for the location of the x-ray console or use of a protective barrier.

Subd. 4. Compliance with rules. Requires handheld dental x-ray equipment to otherwise comply with Minnesota Rules, chapter 4732, which governs sources of ionizing radiation.

3 **Creation of account.** Amends § 144.1501, subd. 2. Expands the category of nurses eligible for loan forgiveness through the health professional education loan forgiveness program to include nurses who agree to practice in a housing with services establishment or practice with a home care provider.

4 **Senior care workforce innovation grant program.** Adds § 144.1504. Establishes a senior care workforce innovation grant program.

Subd. 1. Establishment. Establishes a grant program to fund new pilot programs or expand existing programs that increase the pool of caregivers providing senior care services.

Subd. 2. Competitive grants. Directs the commissioner to make competitive grants, to expand the senior care services workforce.

Subd. 3. Eligibility. Specifies that applicants eligible for a grant under this section must (1) recruit and train individuals to work primarily with people 65 years of age and older and (2) provide services in a home and community-based setting, in an adult day care setting, through home care, or in a nursing home.

Subd. 4. Application. Requires applicants to apply for grants on forms and according to timelines established by the commissioner. Requires applicants to propose a project to expand the number of workers in the senior care services field, and specifies what proposals must include.

Section

Subd. 5. Commissioner's duties; requests for proposals; grantee selections. Requires the commissioner to annually publish a request for proposals (RFP) for the grant program. Requires the commissioner to give priority to proposals that target employment of individuals who have multiple employment barriers, have been unemployed long-term, or are veterans. Directs the commissioner to determine maximum grant awards and to make grant selections.

Subd. 6. Grant funding. Specifies that grant awards do not lapse until the grant agreement expires.

Subd. 7. Reporting requirements. Establishes reporting requirements for grant recipients and the commissioner of health. Authorizes the commissioner to collect information from grant recipients as necessary to evaluate the grant program.

5 **Primary care and mental health professions clinical training expansion grant program.** Adds § 144.1505. Establishes a program administered by the commissioner of health to provide grants to physician assistant (PA), advanced practice registered nurse (APRN), pharmacy, dental therapy, and mental health professional training programs, to expand clinical training for these professions.

Subd. 1. Definitions. Defines terms: eligible advanced practice registered nurse program; eligible dental therapy program; eligible mental health professional program; eligible physician assistant program; eligible pharmacy program; mental health professional; and project.

Subd. 2. Program. Directs the commissioner of health to award grants to eligible programs training advanced practice registered nurses, physician assistants, pharmacists, dental therapists, advanced dental therapists, or mental health professionals, to plan and implement expanded clinical training for these professions. Establishes limits for planning and training grants and lists purposes for which grant funds may be used.

Subd. 3. Applications. Directs eligible PA, APRN, pharmacy, dental therapy, and mental health professional programs seeking a grant to apply to the commissioner and lists required content for applications.

Subd. 4. Consideration of applications. Directs the commissioner to review and score applications and specifies factors the commissioner must use to score applications.

Subd. 5. Program oversight. Directs the commissioner to determine grant amounts for eligible programs based on their application scores. Specifies that appropriations do not cancel and are available until expended and allows the commissioner to collect from programs information necessary for evaluation.

6 **Physician residency expansion grant program.** Amends § 144.1506. Renames the primary care residency expansion grant program as the physician residency expansion grant program. Expands the types of residency training programs eligible to receive grants under this section, to include obstetrics and gynecology programs and programs that train medical residents in other physician specialties if the program incorporates rural training components.

Section

7 **Statewide tobacco quitline services.** Adds § 144.397. Directs the commissioner of health to administer or contract for administration of a statewide tobacco quitline service to help Minnesotans quit using tobacco products. Also requires statewide awareness activities to notify the public about the service. Lists services to be provided, and requires services to be evidence-based best practices and to be coordinated with other tobacco prevention and cessation services.

8 **Restricted construction or modification.** Amends § 144.551, subd. 1. Current law prohibits the construction of a new hospital and any hospital construction that increases hospital bed capacity or increases or redistributes hospital beds in the state. This section establishes an exception, to allow PrairieCare's inpatient psychiatric hospital for children and adolescents in Brooklyn Park to add 21 new beds to that facility. This section is effective the day following final enactment.

9 **Minnesota biomedicine and bioethics innovation grants.** Adds § 144.88. Establishes a Minnesota biomedicine and bioethics innovation grant program to be used to fund biomedical and bioethical research and related clinical translation and commercialization activities in the state. Lists criteria for the commissioner of health, in consultation with interested parties, to consider in awarding grants. Specifies parties with whom the commissioner must consult when awarding grants.

10 **Remedies available.** Amends § 144.99, subd. 1. Allows the Minnesota Department of Health to enforce section 144.1215 (authorizing the use of handheld dental x-ray equipment) using the tools of the Health Enforcement Consolidation Act (HECA; sections 144.99 to 144.993; these sections include provisions on correction orders, administrative penalty orders, injunctive relief, cease and desist orders, actions related to licenses, contested case hearings, and penalty amounts).

11 **Fines.** Amends § 144A.474, subd. 11. Requires the revenue from fines collected from home care providers to be used by the commissioner of health for special projects to improve home care in Minnesota, as recommended by the home care provider advisory council. (Current law permits, but does not require, the revenue to be used for these special projects.)

12 **Duties.** Amends § 144A.4799, subd. 3. Directs the home care provider advisory council to annually review the balance in the account that holds fines collected from home care providers, and to make recommendations to the legislature regarding uses of those funds for special projects to improve home care.

13 **Nurse.** Adds subd. 4a to § 144A.70. Defines "nurse" for purposes of statutes regulating supplemental nursing services agencies, to mean an LPN or an RN.

14 **Supplemental nursing services agency.** Amends § 144A.70, subd. 6. Amends the definition of supplemental nursing services agency, by removing "other licensed health professionals" from the list of health professionals an agency may provide for temporary employment in a health care facility. With this language removed, a supplemental nursing services agency that is regulated by the commissioner of health is an agency that provides nurses, nursing assistants, nurse aides, and orderlies for temporary employment in health care facilities.

Section

15 **Definitions.** Adds § 144H.01. Defines terms for a new chapter licensing prescribed pediatric extended care centers: basic services, commissioner, licensee, medically complex or technologically dependent child, owner, prescribed pediatric extended care center, and supportive services or contracted services.

16 **Licensure required.** Adds § 144H.02. Prohibits a person from owning or operating a prescribed pediatric extended care center, or PPEC center, unless the center is licensed by the commissioner of health under this chapter.

17 **Exemptions.** Adds § 144H.03. Exempts facilities operated by a federal agency and facilities licensed under chapters 144 (hospitals and supervised living facilities) and 144A (nursing homes, boarding care homes, and hospices) from the licensing requirements of this chapter.

18 **License application and renewal.** Adds § 144H.04. Establishes a procedure and requirements for seeking licensure and for license renewal. Specifies that PPEC center licenses are not transferrable.

19 **Fees.** Adds § 144H.05. Specifies fees for initial license applications, license renewal, late submission of a renewal application, and change of ownership. Provides that fees are not refundable.

20 **Application of rules for hospice services and residential hospice facilities.** Adds § 144H.06. Provides that rules for hospice services and residential hospice facilities, administered by the commissioner of health, also apply to PPEC centers, except that the rules listed in clauses (1) to (11) do not apply.

21 **Services; limitations.** Adds § 144H.07. Requires PPEC centers to provide basic services to medically complex and technologically dependent children, based on a protocol of care established for each child. Allows a PPEC center to provide care up to 24 hours a day and up to seven days a week. Prohibits a child from attending a PPEC center more than 14 hours in a 24-hour period. Prohibits a PPEC center from providing other services besides services to medically complex or technologically dependent children. Specifies that the maximum capacity for a PPEC center is 45 children.

22 **Administration and management.** Adds § 144H.08. Provides that the owner of a PPEC center has the full legal authority and responsibility for operation of the center, and requires the owner to designate an administrator who is responsible for overall management of the center. Lists duties for center administrators.

23 **Admission, transfer, and discharge policies; consent form.** Adds § 144H.09. Requires a PPEC center to have written policies for admitting, transferring, and discharging children, and requires a parent or guardian to sign a consent form before admitting a child to a PPEC center. Also requires notice of discharge to a parent or guardian at least ten days before a child's discharge.

24 **Medical director.** Adds § 144H.10. Requires a PPEC center to have a medical director who is a physician licensed in Minnesota and certified by the American Board of Pediatrics.

Section

25 **Nursing services.** Adds § 144H.11. Requires a PPEC center to have a nursing director who is a registered nurse licensed in Minnesota and who has specified expertise. Also establishes requirements that registered nurses, licensed practical nurses, and other direct care personnel (including nursing assistants and individuals trained in the fields of education, social services, or child care) must meet in order to be employed by a PPEC center.

26 **Total staffing for nursing services and direct care personnel.** Adds § 144H.12. Requires a minimum of one staff person providing direct care for every three children at a PPEC center.

27 **Medical record; protocol of care.** Adds § 144H.13. Requires a medical record and individualized nursing protocol of care to be developed, maintained, and appropriately signed for each child admitted to a PPEC center.

28 **Quality assurance program.** Adds § 144H.14. Requires PPEC centers to have a quality assurance program.

29 **Inspections.** Adds § 144H.15. Allows the commissioner of health to inspect PPEC centers and center records at reasonable times to ensure compliance with this chapter and rules that apply to PPEC centers, and before issuing or renewing a license.

30 **Compliance with other laws.** Adds § 144H.16. Requires PPEC centers to:

- develop procedures for reporting suspected child maltreatment; and
- comply with crib safety requirements in section 245A.146, to the extent they are applicable.

31 **Denial, suspension, revocation, refusal to renew a license.** Adds § 144H.17. Specifies grounds for denying, suspending, revoking, and refusing to renew a PPEC center license, and provides for a contested case hearing before suspending, revoking, or refusing to renew a license.

32 **Fines; corrective action plans.** Adds § 144H.18.

Subd. 1. Corrective action plans. Authorizes the commissioner to require a PPEC center to submit a corrective action plan to remedy violations found by the commissioner.

Subd. 2. Fines. Authorizes the commissioner to issue a fine to a PPEC center, employee, or contractor, and lists factors for the commissioner to consider in determining fine amounts.

Subd. 3. Fines for violations of other statutes. Directs the commissioner to impose a fine of $250 for violating the Maltreatment of Minors Act or crib safety requirements.

33 **Closing a PPEC center.** Adds § 144H.19. If a PPEC center voluntarily closes, requires a PPEC center to provide notice to the parents and guardians of children attending the center at least 30 days before the center closes.

Section

34 **Physical environment.** Adds § 144H.20. Requires PPEC centers to conform with the physical environment requirements in this section, and otherwise with requirements that apply to day care facilities in Minnesota Rules, chapter 9502. Establishes specific requirements for center entrances, treatment rooms, isolation procedures, outdoor and indoor spaces, and application of the building code.

35 **Forms.** Amends § 145.4131, subd. 1. Requires a physician or facility performing an abortion to include in abortion data reports submitted to the commissioner of health, the facility code for the patient and the facility code for the physician, if the abortion was performed via telemedicine. This section is effective January 1, 2018.

36 **Duties of director.** Amends § 145.4716, subd. 2. Authorizes the commissioner of health to manage funds that were used or intended to be used to commit a crime related to prostitution or sex trafficking, were subject to forfeiture under state law, and were deposited in the safe harbor for youth account. The commissioner may use these funds for distribution to crime victims services organizations that serve sexually exploited youth.

37 **Prescribed pediatric extended care centers.** Adds § 256B.7651. Directs the commissioner of human services to set payment rates for PPEC centers at 85 percent of the rate for one hour of complex home care nursing services.

38 **Disposition of money; prostitution.** Amends § 609.5315, subd. 5c. Transfers authority to distribute the forfeited funds used or intended to be used to commit a prostitution or sex trafficking crime, from the commissioner of public safety to the commissioner of health.

39 to 41 Amends § 626.556, subds. 2, 3, 3c, 10d. Adds references to PPEC centers in section 626.556, the Maltreatment of Minors Act, to make PPEC centers subject to the reporting requirements and standards in that section.

42 **Brain health pilot programs.** Directs the commissioner to award grants to up to five pilot programs to improve brain health in youth sports, using a request for proposal process. Requires working group members to be included in scoring proposals unless the member has a financial interest in the proposal. Requires at least one program to be funded in each area of the state. Requires programs to be funded for one year, and requires the commissioner to report to the health care policy and finance committees in the legislature on the progress and outcomes of the programs.

43 **Comprehensive plan to end HIV/AIDS.** Directs the commissioner of health to work with the commissioner of human services and stakeholders to develop a statewide, comprehensive plan of priorities and actions to address HIV/AIDS in Minnesota. Allows the commissioner to develop the plan as part of existing department activities. Requires the plan to:

- determine the levels of testing, care, and services necessary to eliminate HIV, and specifies initial outcomes that must be met;
- provide recommendations for how to use existing funds to make the greatest impact and ensure a coordinated statewide effort;
- provide recommendations for new and enhanced interventions, and additional resources needed for these interventions; and

Section

- be developed using existing resources

Directs the commissioner to submit the comprehensive plan and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over HHS policy and finance, by February 1, 2018.

44 **Direction to commissioner of human services; federal waiver amendments.** Directs the commissioner of human services to seek necessary waiver amendments to add services at PPEC centers to home and community-based waivers.

45 **Early dental disease prevention pilot program.** Paragraph (a) directs the commissioner of health to develop and implement a pilot program to increase awareness and encourage early preventive dental disease interventions for infants and toddlers. Under this program, the commissioner shall award grants to five communities of color or recent immigrant communities to participate in the program.

Paragraph (b) requires the commissioner to distribute educational materials to expectant and new parents in designated communities of color and recent immigrant communities on the importance of early dental care.

Paragraph (c) requires the commissioner to work with and assist communities of color and recent immigrant communities in performing certain work under this program.

Paragraph (d) directs the commissioner to develop measurable outcomes for the program and evaluate the program's performance within each community.

Paragraph (e) requires the commissioner to provide a report on the program, by March 15, 2019, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care.

46 **Recommendations for safety and quality improvement practice for long-term care services and supports.** Directs the commissioner of health to consult with interested stakeholders to explore and make recommendations on how to apply safety and quality improvement practices to long-term care services and supports. Lists interested stakeholders who must be consulted and what the recommendations must include. Requires the recommendations and any necessary implementing legislation to be submitted to the legislature by July 15, 2018.

47 **Safe harbor for all; statewide sex trafficking victims strategic plan.** Directs the commissioner of health to consult with the commissioners of public safety and human services and develop a statewide strategic plan, by October 1, 2018, to address the needs of sex trafficking victims. Directs the commissioner of health to seek recommendations and input from a range of organizations and individuals. Requires the strategic plan to include recommendations regarding the expansion of the safe harbor law to adult victims. Requires the commissioner to report, by January 15, 2019, to the chairs and ranking minority members of the relevant legislative committees on the plan and recommendations for legislation and funding.

Section

48 **Study and report on home care nursing workforce shortage.** Requires house and senate chairs and ranking minority members of the listed health and human services committees to convene a working group to study and report on the shortage of RNs and LPNs available to provide low-complexity regular home care services to clients. Specifies working group membership, who will convene the first meeting, and who will provide support, meeting space, technical assistance, and recommendations to the working group. Lists working group duties, and requires the working group to submit a report and draft legislation by January 15, 2018.

49 **Youth sports concussion working group.** Directs the commissioner of health to establish a working group to assess the causes and incidence of brain injuries in youth sports and best practices for preventing, evaluating, identifying, and treating brain injuries in youth sports.

Subd. 1. Working group established; duties and membership. Directs the commissioner of health to establish a youth sports concussion working group of up to 30 members. Directs the group to be formed through nominations of individuals with specified experience, and specifies what the working group must study and evaluate. Requires the working group to be geographically and professionally diverse, and provides that working group members shall not be compensated.

Subd. 2. Working group goals defined. Lists specific tasks for the working group, including gathering data on topics related to youth sports-related concussions; reviewing youth sports rules and concussion education policies; identifying pilot projects related to concussions in youth sports; and identifying barriers to obtaining better brain health outcomes.

Subd. 3. Voluntary participation; no new reporting requirements created. Specifies that participation in the working group is voluntary and the study shall create no new reporting requirements.

Subd. 4. Report. Requires the working group to submit an interim report and a final report to the legislative committees with jurisdiction over health and education, proposing a Minnesota model for reducing brain injury in youth sports. Specifies recommendations the report must include.

Subd. 5. Sunset. Sunsets the working group the day after submitting the final report required in subdivision 4, or January 15, 2020, whichever is earlier.

50 **Repealer.** Repeals § 144.4961, the Minnesota Radon Licensing Act, effective the day following final enactment.

Section

Article 4: Children and Families

Overview

This article makes changes to the child care assistance programs, child care program integrity, child care licensing provisions, group residential housing (GRH), MFIP, and foster care. The article also establishes mobile food shelf grants and the Minnesota pathways to prosperity Dakota and Olmsted counties' pilot project.

1 **Enforcement authority.** Amends § 119B.011, by adding subd. 12a. Defines "enforcement authority." Makes this section effective July 1, 2017.

2 **Stop payment.** Amends § 119B.011, by adding subd. 19c. Defines "stop payment." Makes this section effective July 1, 2017.

3 **Program integrity.** Amends § 119B.02, subd. 5. Adds a cross-reference to the chapter of statutes governing child care assistance program fraud investigations. Makes this section effective July 1, 2017.

4 **Funding priority.** Amends § 119B.03, subd. 4. Modifies the funding priorities for the BSF program. Makes this section effective July 1, 2017.

5 **Allocation formula.** Amends § 119B.03, subd. 6. Modifies the formula for allocating BSF funds to counties. Makes this section effective January 1, 2018.

6 **Child care centers; assistance.** Amends § 119B.09, subd. 9a. Modifies the provision limiting the number of children in a child care center who are dependents of center employees and who may receive child care assistance. Allows a center to receive authorizations for 25 or fewer children who are dependents of the center's employees. Makes this section effective April 23, 2018.

7 **Authorization with a secondary provider.** Creates § 119B.097. Requires a parent to choose one primary provider and one secondary provider per child that can be paid by child care assistance if a child uses certain combinations of providers paid by child care assistance. Limits the amount of child care authorized with the secondary provider and the total amount of child care authorized with both providers. Makes this section effective April 23, 2018.

8 **Unsafe care.** Amends § 119B.125, subd. 4. Makes a technical change. Makes this section effective April 23, 2018.

9 **Record-keeping requirement.** Amends § 119B.125, subd. 6. Requires providers to keep accurate and legible daily attendance records as a condition of payment under the child care assistance programs. Allows the county or commissioner to revoke a provider's authorization to receive child care assistance, pursue a fraud disqualification, take action against the provider according to the fraud investigation statutes, or establish an attendance record overpayment when a provider has not complied with the record-keeping requirement. Establishes the calculation for attendance record overpayments. Requires the commissioner

Section

to develop criteria for counties regarding the establishment of overpayments. Makes this section effective April 23, 2018.

10 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Modifies child care assistance program maximum rates by setting the maximum rate for child care providers who are located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns at the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. Limits maximum payments if a child uses two providers. Makes technical and conforming changes. Makes this section effective April 23, 2018.

Makes paragraph (a) effective July 1, 2018. Makes paragraphs (d) to (i) effective April 23, 2018.

11 **Provider payments.** Amends § 119B.13, subd. 6. Paragraph (a) requires providers to bill only for services documented in attendance records. Requires payments under the child care fund to be made within 21 days of receiving a complete bill from the provider. Under current law, payments must be made within 30 days if bills are submitted within 10 days of the end of the service period.

Paragraphs (d) to (i) expand the list of provider activities that may result in the county or commissioner refusing to issue an authorization, revoking an existing authorization, stopping payment, or refusing to pay a submitted bill. Specifies when a county or the commissioner must deny or revoke a provider's authorization and either pursue a fraud disqualification or refer the case to an enforcement authority. Specifies the length of time the denial or revocation lasts. Makes technical and conforming changes.

Makes paragraph (a) effective September 25, 2017. Makes paragraphs (d) to (i) effective April 23, 2018.

12 **Fair hearing allowed for applicants and recipients.** Amends § 119B.16, subd. 1. Paragraph (a) allows an applicant or recipient adversely affected by an action of a county agency or the commissioner to request and receive a fair hearing.

Paragraph (b) requires a county agency to offer an informal conference to an applicant or recipient who is entitled to a fair hearing, and to advise an adversely affected applicant or recipient that a request for a conference is optional and does not delay or replace the right to a fair hearing.

Paragraph (c) specifies that an applicant or recipient does not have a right to a fair hearing if a county agency or the commissioner takes action against a provider.

Paragraph (d) requires a county agency or the commissioner to mail notice to a child care assistance program recipient receiving care from the provider if a provider's authorization is suspended, denied, or revoked.

Makes this section effective April 23, 2018.

13 **Fair hearing allowed for providers.** Amends § 119B.16, subd. 1a. Modifies fair hearings for providers by removing language limiting fair hearings only to providers who have been assigned responsibility for overpayments. Allows a provider to request a fair hearing if a county agency or the commissioner:

Section

- denies or revokes a provider's authorization;
- assigns responsibility for an overpayment to a provider;
- establishes an overpayment for failure to comply with attendance record requirements;
- seeks monetary recovery or recoupment;
- initiates an administrative fraud disqualification hearing; or
- issues a payment and the provider disagrees with the amount of the payment.

Specifies the process for a provider to request a fair hearing and the information that must be included in the appeal request.

Makes this section effective April 23, 2018.

14 **Joint fair hearings.** Amends § 119B.16, subd. 1b. Removes language requiring the family in whose case an overpayment was created to be made a party to a fair hearing requested by the provider, and also removes language requiring the provider to be made a party to a fair hearing requested by a family when the family claims that an overpayment assigned to the family should have been assigned to the provider. Makes this section effective April 23, 2018.

15 **Notice to providers.** Amends § 119B.16, by adding subd. 1c. Requires a county agency or the commissioner to mail written notice to the provider against whom an adverse action is being taken. Lists the information that must be included in the notice. Makes this section effective April 23, 2018.

16 **Consolidated contested case hearing.** Amends § 119B.16, by adding subd. 3. Limits a provider to appealing the denial or revocation of an authorization based on a licensing action to the same contested case proceeding in which the provider appeals the licensing action. Makes this section effective April 23, 2018.

17 **Final department action.** Amends § 119B.16, by adding subd. 4. A county agency's or the commissioner's action is considered a final department action unless the commissioner receives a timely and proper request for an appeal. Makes this section effective April 23. 2018.

18 **Administrative review.** Creates § 119B.161.

Subd. 1. Temporary denial or revocation of authorization. Specifies the circumstances under which a provider has rights under this section. A county agency's or the commissioner's action is considered a final department action unless the commissioner receives a timely and proper request for an appeal. Allows the commissioner to temporarily suspend a provider's authorization without prior notice and opportunity for hearing if the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the child care assistance program or the suspension is necessary for public safety and the best interests of the child care assistance program. Specifies when the commissioner may determine that an allegation is credible.

Section

Subd. 2. Notice. Requires the county or the commissioner to mail a provider notice within five days of suspending, revoking, or denying a provider's authorization. Lists the information that must be included in the notice. Requires the county or commissioner to send notice of termination to an affected family under certain circumstances. Makes the termination sent to an affected family effective on the date the notice is created.

Subd. 3. Duration. Specifies the duration of a provider's denial, revocation, suspension, and payment suspension.

Subd. 4. Good cause exception. Allows the county or the commissioner to find that good cause exists not to deny, revoke, or suspend a provider's authorization under certain circumstances.

Makes this section effective April 23, 2018.

19 **Application of coverage.** Amends § 245.814, subd. 2. Removes liability insurance restriction, allowing for insurance to cover property owned by an individual foster home provider and damage caused intentionally by a person over 12 years old.

20 **Compensation provisions.** Amends § 245.814, subd. 3. Raises the amount the state is required to compensate for property damage cause or sustained by foster children or adults to from $250 to $1,000 for each occurrence.

21 **Annual or annually.** Amends § 245A.02, subd. 2b. Adds an exception.

22 **Annual or annually; family child care training requirements.** Adds subd. 2c to § 245A.02. Specifies that "annual" or "annually" for the purposes of section 245A.50 (family child care training requirements) means the 12 month period beginning on the license anniversary and ending the day prior to the anniversary.

23 **Inspections; waiver.** Amends § 245A.04, subd. 4. Requires a licensing agency to offer a child care license holder an exit interview to discuss violations observed during inspection and offer technical assistance to help the license holder comply, before completing a licensing inspection. Allows commissioner to issue a correction order or negative action for violations not discussed in an exit interview, or if the license holder does not participate in an exit interview. Makes section effective October 1, 2017.

24 **Requirement to post correction order.** Amends § 245A.06, subd. 8. Requires the commissioner to issue an amended correction order and requires the license holder to post the amended order, if the commissioner reverses or rescinds a violation in a correction order upon reconsideration. Requires the license holder to remove the original posted correction order if the correction order is rescinded or reversed in full upon reconsideration.

25 **Child care correction order quotas prohibited.** Adds subd. 9 to § 245A.06. Prohibits the commissioner and county licensing agencies from mandating or suggesting quotas for issuing correction orders to any person responsible for licensing or inspecting child care centers or family child care providers.

26 **Child care fix-it ticket.** Proposes coding for § 245A.065. (a) Requires the commissioner to issue a "fix-it ticket" to a child care license holder if:

Section

(1) the license holder failed to comply with statute or rule that is eligible for a fix-it ticket;

(2) the violation does not imminently endanger the health, safety, or welfare of anyone the program serves;

(3) the license holder did not receive a fix-it ticket or correction order for the same violation at the previous inspection;

(4) the violation can be corrected at the time of inspection or within 48 hours; and

(5) the license holder in fact corrects the violation at the time of inspection, or agrees to correct the violation within 48 hours.

(b) Specifies that the fix-it ticket must state:

(1) the conditions that led to violation;

(2) the specific law or rule violated; and

(3) that the violation was corrected, or will be corrected within 48 hours.

(c) States that a fix-it ticket will not be available on a public Web site.

(d) Requires the child care license holder to correct the violation within 48 hours of receiving the ticket, and to submit evidence to the county licensing agency showing the correction.

(e) Allows commissioner to issue a correction order if the violation on the fix-it ticket is not corrected at the time of inspection or within 48 hours, or if the evidence the license holder submits is not sufficient to establish that the violation has been corrected.

(f) Requires commissioner to issue a report by October 1, 2017, identifying violations of statute and rule that are eligible for a fix-it ticket, and to provide the report to county agencies and legislative committees, and post the report online.

Makes the section effective October 1, 2017.

27 **Information for child care license holders.** Proposes coding for § 245A.1434. Adds the commissioner's duty to timely inform family child care and child care center license holders of changes in federal and state statute, rule, regulation, or policy, relating to child care, child care assistance, child care quality rating and improvement, and licensing functions, in order to promote license holder compliance with changes. Allows notice via electronic means, requires the commissioner to make the notice available to the public online.

28 **Report to legislature on the status of child care.** Proposes coding for § 245A.153.

Subd. 1. Reporting requirements. Requires the commissioner of human services to provide a report on the status of child care in Minnesota to the chairs and ranking minority members of committees with jurisdiction over child care, by February 1, 2018, and February 1 thereafter.

Subd. 2. Contents of report. Requires that the child care report include the following:

Section

(1) summary data on trends in child care capacity and availability;

(2) description of any changes to statutes, rules, or policies and procedures;

(3) description of actions DHS has taken to address or implement the recommendations of the Legislative Task Force on Access to Affordable Child Care, including:

(i) encouraging uniformity in implementing and interpreting statutes, rules, policies, and procedures relating to child care licensing;

(ii) improving communication with county licensors and child care providers;

(iii) providing notice to child care providers before issuing correction orders or negative licensing actions relating to recently changed statutes, rules, or policies;

(iv) implementing confidential communication processes for provider questions;

(v) streamlining processes to reduce duplication and training and paperwork requirement overlap; and

(vi) compiling and distributing information detail trends in violations resulting in correction orders and negative licensing actions;

(4) description of DHS efforts to cooperate with counties;

(5) summary data on CCAP, including state funding and number of families served

(6) summary data on family child care correction orders.

Subd. 3. Sunset. Section expires February 2, 2020.

29 **Exemption from positive support strategies requirements.** Proposes coding for § 245A.23. Exempts licensed family day care programs, licensed group family day care facilities, and licensed child care centers from Minnesota Rules, chapter 9544, the positive supports rule. Makes this section effective the day following final enactment.

30 **Credible allegation of fraud.** Amends § 245E.01, by adding subd. 6a. Defines "credible allegation of fraud" in the chapter of statutes governing child care assistance program fraud investigations. Makes this section effective July 1, 2017.

31 **Investigating provider or recipient financial misconduct.** Amends § 245E.02, subd. 1. Adds agents and consultants to the list of persons who may be investigated for provider or recipient financial misconduct. Makes this section effective April 23, 2018.

32 **Determination of investigation.** Amends § 245E.02, subd. 3. Makes technical and conforming changes. Makes this section effective April 23, 2018.

33 **Referrals or administrative actions.** Amends § 245E.02, subd. 4. Modifies the list of actions the Department of Human Services may take after making a determination. Makes technical changes. Makes this section effective April 23, 2018.

34 **Failure to provide access.** Amends § 245E.03, subd. 2. Clarifies the actions that may be taken if a provider fails to provide the department immediate access to records, who must grant access, and when access must be granted. Makes this section effective April 23, 2018.

Section

35 **Continued or repeated failure to provide access.** Amends §245E.03, subd. 4. Modifies the action taken for continued or repeated failure to provide access and makes conforming changes. Specifies the duty to provide access continues after the provider's authorization is denied, revoked, or suspended. Makes this section effective April 23, 2018.

36 **Honest and truthful statements.** Amends § 245E.04. Makes technical changes. Makes this section effective April 23, 2018.

37 **Records required to be retained.** Amends § 245E.05, subd. 1. Adds contractor records identifying persons employed by the provider's child care business to the list of records that must be retained. Makes this section effective April 23, 2018.

38 **Factors regarding imposition of administrative actions.** Amends § 245E.06, subd. 1. Changes terminology from "administrative sanctions" to "administrative actions." Makes this section effective April 23, 2018.

39 **Written notice of department action; action effective date.** Amends § 245E.06, subd. 2. Removes language related to providing notice (this language has been moved, see sections 13 and 16). Lists to whom notice must be sent when the department takes action against a provider. Makes technical and conforming changes. Removes language allowing the department to consider the economic hardship of a person in implementing a proposed sanction. Makes this section effective April 23, 2018.

40 **Appeal of department action.** Amends § 245E.06, subd. 3. Removes language specifying the information that must be included in an appeal, when an appeal must be received, and allowing the department to take adverse actions against a provider before the appeal hearing under certain circumstances (this language has been moved, see section 11). Specifies a provider's rights related to an action taken under this chapter are established in sections 119B.16 and 119B.161. Makes this section effective April 23, 2018.

41 **Grounds for and methods of monetary recovery.** Amends § 245E.07, subd. 1. Allows the department to obtain monetary recovery from a provider who has been improperly paid by the child care assistance program, regardless of whether the error was on the part of the provider, the department, or the county. Makes this section effective April 23, 2018.

42 **Disqualification from program.** Amends § 256.98, subd. 8. Modifies the disqualification period for a child care provider who has been found to have wrongfully obtained child care assistance. Makes this section effective April 23, 2018.

43 **Individual eligibility requirements.** Amends § 256I.04, subd. 1. Modifies GRH individual eligibility requirements by adding individuals who are receiving licensed residential crisis stabilization services and medical assistance. Allows these individuals to receive concurrent GRH payments if receiving licensed residential crisis stabilization services. Makes this section effective October 1, 2017.

44 **Moratorium on development of group residential housing beds.** Amends § 256I.04, subd. 3. Modifies an exception to the moratorium on the development of GRH beds by increasing the number of supportive housing units that are allowed in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or HIV/AIDS.

Section

45 **Supplementary rate; St. Louis County.** Amends § 256I.05, by adding subd. 1p. Requires a county agency to negotiate a supplemental rate, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a GRH provider located in St. Louis County that operates a 35-bed facility that serves women who are chemically dependent, mentally ill, or both, and provides certain support services.

46 **Supplemental rate; Anoka County.** Amends § 256I.05, by adding subd. 1p. Requires a county agency to negotiate a supplemental rate for 42 beds, not to exceed the standard GRH supplemental rate, including any legislatively authorized inflationary adjustments, for a GRH provider located in Anoka County that provides emergency housing on the former Anoka Regional Treatment Center campus. States Anoka County is not responsible for any additional costs associated with this supplemental rate.

47 **Supplemental rate; Olmsted County.** Amends § 256I.05, by adding subd. 1p. Requires a county agency to negotiate a supplemental rate, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a GRH provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

48 **Transfer of emergency shelter funds.** Amends § 256I.05, by adding subd. 11. Requires the commissioner to make a cost-neutral transfer of funding from the GRH fund to county human service agencies for emergency shelter beds removed from the GRH census under a biennial plan submitted by the county and approved by the commissioner. Sets the due date of the biennial plan on August 1, beginning August 1, 2017. Lists the information that must be described in the plan, including: (1) anticipated and actual outcomes for persons experiencing homelessness; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and outcomes. Requires the commissioner to review the county plan to monitor implementation and outcomes. Allows the funding to be used for room and board or supplemental services. Requires funding to be allocated annually. Requires the room and board portion of the allocation to be determined at the time of transfer. Allows the commissioner or county to return beds to the GRH fund with 180 days' notice. Makes this section effective July 1, 2017.

49 **Amount of group residential housing payment.** Amends § 256I.06, subd. 8. Establishes the GRH payment calculation for individuals who receive licensed residential crisis stabilization services. Makes this section effective October 1, 2017.

50 **General information.** Amends § 256J.45, subd. 2. Adds to the list of information that must be presented during the MFIP orientation by including information about certain income exclusions. Makes this section effective July 1, 2018.

51 **Support for adoptive, foster, and kinship families.** Proposes coding for § 256N.261.

Subd. 1. Program established. Instructs the commissioner to design and implement a program to reduce the need for changes in child and youth foster, adoptive, or permanent physical and legal custody kinship placements, improving the stability of these families. Requires the commissioner, to the extent funds are available, to ensure

Section

that placements are trauma-informed and child and family-centered, and to provide services as follows:

(1) Information, referrals, parent-to-parent support, peer support for youth, family activities, respite care, crisis services, educational support, and mental health services to children, youth, and families;

(2) Training for adoptive, foster, and kinship families, and the professionals who serve them, on the effects of trauma, common disabilities of children in placements, and other challenges; and

(3) Periodic evaluation of these services.

Subd. 2. Definitions. Defines "child and family-centered" and "trauma-informed."

52 **Exempted individuals.** Amends § 256P.06, subd. 2. Adds to the list of exempted members of an assistance unit under MFIP and child care assistance program chapters of statute. Makes this section effective July 1, 2018.

53 **Reentering foster care and accessing services after 18 years of age and up to 21 years of age.** Amends § 260C.451, subd. 6. Adds requirement for the responsible social services agency to provide foster care or other services, with a plan specific to the individual's needs, to an individual over 18 years old who was not under the guardianship of the commissioner and who asks to reenter foster care, if the individual left foster care within six months before his or her 18th birthday.

54 **Local welfare agency, Department of Human Services, or Department of Health responsible for assessing or investigating reports of maltreatment.** Amends § 626.556, subd. 3c. Moves responsibility for assessing or investigating allegations of child maltreatment in children's residential facilities licensed by the Department of Corrections from the county local welfare agency to the Department of Human Services.

55 **Mobile Food Shelf Grants.**

Subd. 1. Grant amount. Requires Hunger Solutions to award grants on a priority basis. Limits grant amounts for sustaining existing mobile programs and creating new mobile programs.

Subd. 2. Application contents. Lists the information that grant applicants must provide to Hunger Solutions.

Subd. 3. Awarding grants. Requires Hunger Solutions to give priority to certain applicants when evaluating applications and awarding grants.

56 **Minnesota Pathways to Prosperity Dakota and Olmsted Counties' Pilot Project.**

Subd. 1. Authorization. Requires the commissioners of human services, health, education, Minnesota Housing Finance Agency, and management and budget to work together with Dakota and Olmsted Counties, and other interested stakeholders, to

Section

consider the design of a pilot that will test an alternative financing model for the distribution of publicly funded benefits in Dakota and Olmsted Counties.

Subd. 2. Pilot project design and goals. Describes the goals of the pilot project.

Subd. 3. Executive team work. Requires the executive team to consider certain characteristics of pilot project participants when planning the potential pilot project.

57 **Child care correction order posting guidelines.** Requires commissioner to develop guidelines, consulting with stakeholders, for posting public licensing data for licensed child care providers, by November 1, 2017.

58 **Direction to commissioner; GRH study.** Requires the commissioner, within available appropriations, to study the GRH supplementary service rates and makes recommendations on the rate structure to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2018.

59 **Repealer**. Paragraph (a) repeals §§ 179A.50; 179A.51; 179A.52; 179A.53.

Paragraph (b) repeals Minnesota Statutes, sections 119B.16, subd. 2 (informal conference); 245E.03, subd. 3 (notice of denial or termination); and 245E.06, subd. 4 and 5 (consolidated hearings with licensing sanction; effect of department's administrative determination or sanction), and Minnesota Rules, part 3400.0185, subp. 5 (notice to providers of actions adverse to the provider), effective April 23, 2018.

Article 5: Health Occupations

Overview

This article makes changes to licensing provisions for advance practice registered nurses (APRNs), psychology, and dental professionals. The article also clarifies what constitutes the practice of telemedicine, makes certain restrictive covenants void, and repeals the expiration of the medical faculty licensure section.

1 **Practice of telemedicine.** Proposes coding for § 147.033. Defines "telemedicine;" specifies that a physician-patient relationship may be established via telemedicine; specifies that the same standards of practice and conduct apply to physicians providing services via telemedicine as would apply to in-person services.

2 **Encumbered**. Amends § 148.171, subd. 7b. Adds definition of "encumbered" to mean:

(1) a nursing license that is revoked, suspended, or limited by a state licensing board; or

(2) a license that is voluntarily surrendered.

Makes section effective the day following final enactment

3 **Intervention.** Amends § 148.171 to add subd. 7c. Moves definition of "intervention" previously in subdivision 7b.

Makes section effective the day following final enactment.

Section

4 **Advanced practice registered nurse licensure.** Amends § 148.211, subd. 1a. Removes January 1, 2015, effective date.

(3)(i) Modifies requirements for APRN programs sufficient for licensure, completed on or after January 1, 2016, to include at least one graduate-level course in each of the following subjects: advanced physiology and pathophysiology, advanced health assessment, and pharmacokinetics and pharmacotherapeutics.

(ii) Requires APRN license applicant to, in lieu of educational requirements listed in (3)(i), demonstrate compliance with APRN education requirements in effect at the time the applicant completed an APRN program.

Makes section effective the day following final enactment.

5 **Postgraduate practice.** Amends § 148.211, subd. 1c. Allows for a collaborative agreement to include physicians licensed in another U.S. state or territory. A collaborative agreement allows a nurse practitioner or clinical nurse specialist who qualifies for APRN licensure to complete postgraduate practice hour requirements within a hospital or integrated clinical setting.

Makes section effective the day following final enactment.

6 **Licensure by endorsement.** Amends § 148.211, subd. 2. Removes additional requirements for APRN licensure by endorsement that were effective January 1, 2015, to allow for licensure without examination for an applicant licensed or registered as a nurse in another state, territory, or country with equivalent qualifications as are required in Minnesota.

Makes section effective the day following final enactment.

7 **Declaration of policy.** Amends § 148.881. Specifies that the Board of Psychology regulates the practice of psychology through licensure and regulation to promote access to quality, ethical psychological services. Designates sections 148.88 to 148.98 as the Minnesota Psychology Practice Act.

8 **Definitions.** Amends § 148.89.

Subd. 2a. Modifies "client" definition.

Subd. 2c. Modifies "designated supervisor" definition.

Subd. 2d. Adds definition of "direct services," to mean the delivery of preventive, diagnostic assessment, or therapeutic intervention services to benefit a direct recipient client.

Subd 2e. Adds definition of "full-time employment," to mean a minimum of 35 hours per week.

Subd. 3a. Adds definition of "jurisdiction," to mean United States, United States territories, or Canadian provinces or territories.

Subd. 4. Modifies "licensee" definition.

Subd. 4a. Modifies "provider or provider of services" definition.

Subd 4b. Modifies "primary supervisor" definition.

Section

Subd 5. Modifies "practice of psychology" definition to include prediction of human behavior, evaluating, assessing, or predicting behavior, and applying psychological principles in legal settings.

Modifies the activities that constitute the practice of psychology.

Subd. 6. Adds definition of "telesupervision" to mean clinical supervision of psychological services through an audio/video format where the supervisor and supervisee are not in the same physical location.

9 **Board of Psychology.** Amends § 148.90, subd. 1. Modifies the composition of the Board of Psychology. Adds one member who is a licensed psychologist with a doctoral degree; requires both psychologists, not necessarily licensed, to have doctoral degrees representing different training programs in psychology; removes individually licensed or qualified to be a licensed psychologist.

10 **Members.** Amends § 148.90, subd. 2. Specifies that a public board member shall not be licensed by another health-related licensing board, the commissioner of health, or licensed in another jurisdiction.

11 **General.** Amends § 148.905, subd. 1. Removes "psychological practitioners" from those licensed. Adds requirements for the board to consider before adopting or implementing a new national licensing examination.

12 **Effective date.** Amends § 148.907, subd. 1. Removes August 1, 1991 date, adds exemption.

13 **Requirements for licensure as a licensed psychologist.** Amends § 148.907, subd. 2. Specifies that postdoctoral supervised employment must be completed between 12 and 60 months. Allows the board to grant a variance.

14 **Exemptions to license requirement.** Proposes coding for § 148.9075.

Subd. 1. General. Prohibits licensed health professionals or mental health practitioners from holding themselves out as licensed to practice psychology; specifies that they may perform the functions of their occupations.

Subd. 2. Business or industrial organization. Specifies that a business, organization, or agency may use psychological techniques for personnel or evaluation purposes. Prohibits these entities from selling, offering, or providing psychological services unless performed or supervised by a person licensed by the board.

Subd. 3. School psychologist. Permits the practice of school psychology within the scope of employment, with a license or certificate from the State Board of Teaching.

Subd. 4. Clergy or religious officials. Permits recognized religious officials to conduct counseling activities within the scope of their regular duties, if the official does not use the title of psychologist.

Subd. 5. Teaching and research. Permits an educator in an accredited institution to teach and conduct research in psychology if the institution provides oversight and the educator is not providing direct clinical services.

Subd. 6. Psychologist in disaster or emergency relief. Permits a psychologist sent to Minnesota to respond to a disaster or emergency relief effort to practice in the state

Section

for less than 30 days, and the sponsoring organization can certify the psychologist's assignment. Permits the board to grant an extension.

Subd. 7. Psychological consultant. Specifies that a license from the board is not required for a licensed, certified, or registered nonresident serving as an expert witness, consultant, presenter, or educator on a limited basis.

Subd. 8. Students. Permits the practice of psychology for practicums, internships, and postdoctoral supervised employment. Requires student trainees and interns to use specified titles.

Subd. 9. Other professions. Clarifies that a person licensed under sections 148.88 to 148.98 may not engage in any other regulated profession, unless licensed or registered in that profession.

15 **Relicensure.** Proposes coding for § 148.9077. Permits a former licensee to reapply to the board for licensure under the laws and rules in effect on the date of initial licensure.

16 **Application.** Amends § 148.9105, subd. 1. Removes psychological practitioner emeritus registration; changes fee for retired providers.

17 **Documentation of status.** Amends § 148.9105, subd. 4. Removes psychological practitioner.

18 **Representation to the public.** Amends § 148.9105, subd. 5. Removes psychological practitioner emeritus.

19 **Generally.** Amends § 148.916, subd. 1. (a) Extends the amount of time an applicant for guest licensure must intend to practice in Minnesota, from seven days to 30 days.

(b) Establishes eligibility requirements for guest licensure:

(1) psychology license/registration/certification in another jurisdiction;

(2) doctoral degree in psychology from accredited institution;

(3) good moral character;

(4) no pending complaints or disciplinary actions;

(5) passage of professional responsibility exam; and

(6) payment of fee.

20 **Applicants for licensure.** Amends § 148.916, subd. 1a, guest licensure technical changes.

21 **Supervision.** Amends § 148.924.

Subd. 1. Supervision. Modifies definition of "supervision;" specifies that supervision may include telesupervision.

Subd. 2. Postdegree supervised psychological employment. Specifies "psychological."

Subd. 3. Individuals qualified to provider supervision. Removes master's-level licensure supervision provisions, allowing for only doctoral applicants for licensure.

Section

Subd. 4. Repeals subdivision 4.

Subd. 6. Supervisee duties. Technical changes to duties for applicants preparing for licensure during postdegree supervised psychological employment.

Subd. 7. Repeals subdivision 7.

22 **Requirements for representations to public.** Amends § 148.96, subd. 3. Adds "psychology fellow" to permitted designations. Removes reference to the practice of school psychology.

23 **General requirements.** § 148B.53, subd. 1. Removes exception for licensed psychologists to be licensed as professional counselors.

24 **Waiver of examination.** Amends § 150A.06, subd. 3. Adds dental therapists and dental assistants to the list of professionals for whom examination requirements may be waived, under certain circumstances and at the discretion of the board.

25 **Licensure by credentials.** Amends § 150A.06, subd. 8. Requires dental assistants to have graduated from an accredited dental assisting program and be certified by the Dental Assisting National Board.

26 **Restorative procedures.** Amends § 150A.10, subd. 4. Allows dental assistants and dental hygienists trained and board certified in certain restorative dental functions to place restorative material on primary and permanent teeth, after a dentist or dental therapist has prepared the tooth structure.

27 **Health care practitioner restrictive covenants void.** Proposes coding for § 181.987. Defines "health care practitioner." Makes any contract restricting a health care practitioner from engaging in a lawful profession void and unenforceable in Wabasha County. Makes this section effective the day following final enactment, applying to a contract on or entered into on or after that date.

28 **Revisor's instruction.** Instructs the revisor to change the headnote of § 147.0375, to read "LICENSURE OF EMINENT PHYSICIANS."

29 **Repealer.** Repeals §§ 147.0375, subd. 7; 148.211, subd. 1b; 148.243, subd. 15; 148.906; 148.907, subd. 5; 148.908; 148.909, subd. 7; and 148.96, subds. 4, 5. Makes section effective the day following final enactment

Section

Article 6: Chemical and Mental Health

Overview

This article makes several reforms to the state's substance use disorder treatment services, expanding the providers included as eligible vendors for comprehensive assessment services, care coordination, and peer recovery support services. The article also increases rates for chemical dependency services and certain mental health services, provides for targeted case management through interactive video, and establishes a mental health innovation grant program.

1 **Diagnostic assessment.** Amends § 245.462, subd. 9. Modifies definition of "diagnostic assessment," in the Adult Mental Health Act, adding cross-reference to Minnesota Rules, parts 9505.0370 and 9505.0372; describes what a brief diagnostic assessment must include; and creates exceptions to items in Minnesota Rules, part 9505.0371.

2 **Diagnostic assessment.** Amends § 245.4871, adding subd. 11a. Adds definition of "diagnostic assessment" to Children's Mental Health Act.

3 **Diagnostic assessment.** Amends § 245.4876, subd. 2. Removes "outpatient" from children's mental health services for which a diagnostic assessment must be completed.

4 **Exclusion from licensure.** Amends § 245A.03, subd. 2. Expands DHS licensing exemption for chemical dependency or substance abuse treatment activities of licensed professionals in private practice; exempts counties and recovery community organizations that are eligible vendors under § 254B.05 for care coordination, comprehensive assessment, or peer recovery support services.

5 **Provider eligibility for payments from the chemical dependency consolidated treatment fund.** Amends § 245A.191. Corrects cross-reference.

6 **Rules for chemical dependency care.** Amends § 254A.03, subd. 3. Paragraph (b) allows eligible vendors to provide substance use disorder comprehensive assessment services for public assistance recipients, upon federal approval. Instructs commissioner to develop and implement a utilization review process for publicly funded treatment placements.

Paragraph (c) clarifies that an individual's choice to access a vendor for comprehensive assessment will not affect an individual's eligibility for the consolidated chemical dependency treatment fund or a subsidized health plan.

7 **Program requirements.** Amends § 254A.08, subd. 2. Adds cross-reference to rules for detoxification program licensing.

8 **Recovery community organization.** Amends § 254B.01, adding subd. 8. Defines "recovery community organization."

9 **Chemical dependency fund payment.** Amends § 254B.03, subd. 2. Adds cross-reference to rules for detoxification services licensing.

Section

10 **Licensure required.** Amends § 254B.05, subd. 1. Specifies that the following are eligible vendors, upon federal approval:

(b) Licensed professionals in private practice, for comprehensive assessment and individual substance use disorder treatment services.

(c) Counties, for comprehensive assessment services provided by licensed professionals in private practice, and for care coordination services when provided by an individual who meets certification requirements.

(d) Recovery community organizations, for one-to-one peer support services provided by an individual in recovery.

(e) Specifies that a licensed detoxification program is not an eligible vendor, and that a program not licensed as a chemical dependency residential or nonresidential treatment or withdrawal management program is not an eligible vendor.

11 **Rate requirements.** Amends § 254B.05, subd. 5. Instructs commissioner to establish rates for comprehensive assessment services, care coordination services, peer recovery support services, and withdrawal management services provided under chapter 245F.

12 **Chemical dependency provider rate increase.** Amends § 254B.12 by adding subd. 3.

Provides for a 3 percent rate increase for chemical dependency services listed in section 254B.05, subdivision 5 provided on or after July 1, 2017.

13 **Payment rates.** Amends § 256B.0621, subd. 10. Adds that in assisting a client who is moving from an institutional setting to the community, a case manager may bill medical assistance for relocation targeted case management services conducted by interactive video as provided in section 256B.0924, subdivision 4a.

14 **Mental health case management.** Amends § 256B.0625, subd. 20. Provides that medical assistance and MinnesotaCare will pay for mental health case management services provided by interactive video if the interactive video contact meets the requirements of subdivision 20b.

15 **Mental health targeted case management through interactive video.** Amends § 256B.0625, by adding subd. 20b. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.

Paragraph (b) allows the person receiving services the right to consent to use of interactive video and to refuse the use of interactive video at any time.

Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.

Section

Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video.

16 **Targeted case management through interactive video.** Amends § 256B.0924, by adding subd. 4a. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.

Paragraph (b) allows the person receiving services the right to consent to use of interactive active and to refuse the use of interactive video at any time.

Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.

Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video.

17 **Critical access mental health rate increase.** Amends § 256B.763. Requires the medical assistance payment rate to mental health clinics and centers that are not designated as essential community providers under section 62Q.19 to be the same as the payment rate for those facilities that are designated as essential community providers under section 62Q.19, for the following services:

(1) Group skills training as a component of mental health services.

(2) Medication education services provided by adult rehabilitative mental health services providers.

(3) Mental health behavioral aide services provided by children's therapeutic services and support providers.

(4) Individual and family skills training provided by children's therapeutic services and support providers.

Requires a provider to demonstrate a commitment to serve low-income and underserved populations, in order to receive increased payments by:

(1) charging for services on a sliding fee schedule based on poverty guidelines; and

(2) not restricting access or services because of financial limitations.

Section

18 **Grant program; mental health innovation.**

Subd. 1. Definitions. Defines the following terms: community partnership, eligible applicant, intensive residential treatment services, and metropolitan area.

"Eligible applicant" includes a county, Indian tribe, mental health center, hospital, and community partnership.

Subd. 2. Grants authorized. Authorizes the commissioner to award grants to eligible applicants to plan, establish, or operate programs to improve community-based outpatient mental health services. Specifies that half of grant funds will be awarded to applicants in the metropolitan area, and half outside the area. Specifies that the funding is a one-time appropriation, available until June 30, 2021.

Subd. 3. Allocation of grants. Specifies application deadlines and what applications must contain. Lists guidelines for the commissioner to establish criteria, and relevant factors for the commissioner to consider. Lists grant award purposes: intensive residential treatment services, mental health urgent care centers, crisis residential services, new or expanded community mental health services, supportive housing, and other innovative projects.

Subd. 4. Report to legislature. Requires the commissioner to provide a report to the legislature by December 1, 2019, on program outcomes. Requires grantees to provide information to commissioner for the report.

19 **Residential treatment and payment rate reform.** Requires the commissioner to contract with an outside expert to develop a substance use disorder residential treatment program model that is not subject to the federal IMD exclusion, and that is financially sustainable and improves treatment outcomes. Requires analysis to include recommendations and a timeline for providers to transition to the new models of care. Requires report to legislative committees by December 15, 2018.

20 **Commissioner duty to seek federal approval.** Instructs the commissioner to seek federal approval necessary to implement the provisions related to interactive video case management.

21 **Repealer.** Repeals § 256B.7631.

Article 7: Opiate Abuse Prevention

Overview

This article establishes requirements for opiate prescriptions, limits the use of patient pain assessments, establishes pilot and demonstration projects, requires a report on the use of opioid grant funding, and establishes a provider grant program related to injectable or implantable medications.

1 **Limit on quantity of opiates prescribed for acute dental and ophthalmic pain.** Amends § 152.11, by adding subd. 4. (a) Limits prescriptions for opiate or narcotic pain relievers listed in Schedules II to IV to a four-day supply, when used for treatment of acute dental pain, or

Section

acute pain associated with refractive surgery. Requires the quantity prescribed to be consistent with the dosage listed in the professional labeling for the drug.

(b) Defines "acute pain."

(c) Allows a practitioner to prescribe more than a four-day supply, based on the practitioner's professional judgement.

2 **Required disclosures for prescription opioids.** Adds § 152.121.

Subd. 1. Required information. (a) Requires a dispenser, when dispensing a prescription opioid, to provide a patient, or the patient's agent or caregiver, clear and conspicuous written information, in plain language, about:

(1) the addictive nature of opioids and risks of opioid abuse; and

(2) safe disposal of unused prescription opioids, that is consistent with the requirements of section 152.105.

(b) Provides a definition of "dispenser."

Subd. 2. Board of Pharmacy development of materials. Requires the board to develop the text that a dispenser may use to comply with subdivision 1, and to make this available to dispensers by posting it on the board's Web site, in a format that allows downloading and printing.

Provides a January 1, 2018, effective date.

3 **Performance reporting and quality improvement system.** Amends § 256B.072. Prohibits the assessment of patient satisfaction with pain management to be used in determining compensation or quality incentive payments under MA and MinnesotaCare. Directs the commissioner to require managed care and county-based purchasing plans, and integrated health partnerships, to comply with this prohibition as a condition of contract. States that the prohibition does not apply to: (1) assessing patient satisfaction with pain management for the purpose of quality improvement; and (2) pain management as part of a palliative care plan to treats patient with cancer or receiving hospice care.

A new subdivision 2 requires the commissioner, by January 1, 2019, to consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socio-economically complex populations and request to be scored on these additional measures. Specifies that this requirement applies to all MA and MinnesotaCare programs and enrollees.

4 **Opioid abuse prevention.** (a) Requires the commissioner of health to establish opioid abuse prevention pilot projects in geographic areas throughout the state, to reduce opioid abuse through the use of controlled substance care teams and community-wide coordination of abuse-prevention initiatives. Allows the commissioner to award grants to health care providers, health plan companies, local units of government, or other entities.

(b) Provides that each pilot project must:

(1) be designed to reduce emergency room use and health care provider visits resulting from opioid use or abuse, and reduce rates of opioid addiction;

(2) establish multidisciplinary controlled substance care teams;

Section

(3) deliver health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids and rates of opioid addiction;

(4) address unmet social service needs that create barriers to managing pain and obtaining optimal health outcomes;

(5) provide prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

(6) promote best practices for opioid disposal and reducing illegal access to opioids; and

(7) engage partners outside of the health care system, to address root causes of opioid abuse and addiction at the community level.

(c) Requires the commissioner to contract with an accountable community for health that operates an opioid abuse prevention project and can document reductions in opioid use through the use of controlled substance care teams, to assist the commissioner in administering this section and to provide technical assistance to the commissioner and entities selected to operate a pilot project.

(d) Requires the accountable community for health under contract to evaluate the extent to which pilot projects were successful in reducing the inappropriate use of opioids. Specifies requirements for the evaluation and requires results to be reported to the chair and ranking minority members of specified legislative committees by December 15, 2019.

5 **Report on opioid crisis grant; use of grant funds.** (a) Requires the commissioner of human services, by October 1, 2017, to report to legislative committees on: (1) funds received as part of federal State Targeted Response to the Opioid Crisis Grants; and (2) uses of the funds received.

(b) Requires the commissioner to use remaining grant funds, and any additional funds received from other sources, to provide grants to counties for opioid abuse prevention, increase public awareness of opioid abuse, and prevent opioid use through the use of data analytics.

6 **Chronic pain rehabilitation therapy demonstration project.**

Subd. 1. Establishment. Directs the commissioner to develop and authorize a two-year demonstration project with a rehabilitation institute meeting specified criteria for a bundled payment arrangement for chronic pain rehabilitation therapy for MA enrollees. Specifies components of the demonstration project.

Subd. 2. Performance and cost savings indicators. Requires the commissioner, in developing the demonstration project, to identify cost savings and performance indicators.

Subd. 3. Eligibility. To be eligible, requires individuals to: (1) be 18 or older; (2) be eligible for MA as an individual who is elderly, blind, or has disabilities, is an adult without children, a child age 19 to 20, or an adult formerly in foster care; (3) have moderate to severe pain lasting longer than four months; (4) have an impairment in daily functioning; (5) have a referral from a medical professional indicating that all

Section

reasonable medical and surgical options have been exhausted; and (6) be willing to engage in chronic pain rehabilitation therapies.

Subd. 4. Integrated health partnerships. States that the demonstration project and participating individuals may be incorporated into the demonstration site's health care delivery system demonstration.

Subd. 5. Report. Requires the institute to annually report to the commissioner on cost and savings indicators. Requires the commissioner, three months after completion of the demonstration project, to report to legislative committees on the successes and limitations of the demonstration project and recommendations to increase access to chronic pain rehabilitation therapy.

7 **Substance use disorder provider capacity grant program.** Requires the commissioner of human services to design and implement a grant program to assist providers to purchase the first dose of a nonnarcotic injectable or implantable medication to treat substance abuse disorder for MA enrollees. Requires grants to be distributed between July 1, 2017, and June 30, 2019. Requires the commissioner to conduct provider outreach, ensure a simplified grant application process, and provide technical assistance to providers. Also requires the commissioner, in collaboration with stakeholders, to analyze the impact of the program and barriers to provider access to, and reimbursement for, the medications, and to develop recommendations to address these barriers. Requires the commissioner to report to specified legislative committees by September 1, 2019.

Article 8: Miscellaneous

Overview

This article makes changes to various health and human services statutes, including:

- allowing mental health practitioners to provide telemedicine services
- expanding state law on drug substitution to apply to biological products
- defining "controlling individual" and "owner" in the Human Services Licensing Act;
- requiring legislative notice and approval for certain federal waivers and approvals; and
- requiring the commissioner of commerce to plan for Minnesota to convert from MNsure to the federally facilitated marketplace.

1 **Licensed health care provider.** Amends § 62A.671, subd. 6. Includes mental health practitioners in the definition of licensed health care providers who may be reimbursed by health carriers for services provided by telemedicine. Provides a January 1, 2018, effective date.

2 **Drug.** Amends § 151.01, subd. 5. Modifies the reference to biological products, in a definition of "drug," and excludes blood and blood components.

Section

3 **Biological product.** Amends § 151.01, by adding subd. 40. States that "biological product" has the meaning provided in United States Code, title 42, section 262 (federal law regulating biological products). This section defines biological product as including a virus, therapeutic serum, toxin, antitoxin, vaccine, allergenic product, protein, and other specified products.

4 **Interchangeable biological product.** Amends § 151.01, by adding subd. 41. Defines "interchangeable biological product" as a biological product that the U.S. Food and Drug Administration (FDA) has: (1) licensed, and determined to meet federal standards for interchangeability; or (2) determined to be therapeutically equivalent.

5 **Substitution.** Amends § 156.21. The amendment to subdivision 3 requires a pharmacist, when a biological product is prescribed, to dispense a less expensive interchangeable biological product after disclosing the substitution to the purchaser, unless the purchaser objects or the prescriber has required that the prescription be dispensed as written. Prohibits the pharmacist from substituting a biological product, unless the FDA has determined the substitute is interchangeable with the prescribed biological product.

The amendment to subdivision 4 clarifies that a pharmacist is to substitute the least expensive safely interchangeable drug, and removes reference to brand name or generic drug. (This has the effect of allowing interchangeable biological products to be substituted.) Also strikes obsolete language.

A new subdivision 10 requires a dispensing pharmacist or the pharmacist's designee, within five business days of dispensing a biological product, to communicate to the prescriber the name and manufacturer of the biological product dispensed. Specifies requirements for this communication. Also provides that communication of this information is not required if: (1) there is no FDA approved interchangeable biological product for the product prescribed; or (2) the biological product is a refill and is the same product dispensed on the prior filling.

This section also makes changes in terminology and conforming changes throughout. These change include use of the term "prescription drug order," and adding references to biological products.

6 **Controlling individual.** Amends § 245A.02, subd. 5a. Clarifies the definition of "controlling individual" in the Human Services Licensing Act to mean the owner of a licensed program, each officer of the organization, each authorized agent, each compliance officer, and each managerial official with decision-making authority for operation of the program. Clarifies that an employee stock ownership plan trust or a participant or board member of an employee stock ownership plan is not a controlling individual, unless the participant or board member is otherwise a controlling individual as specified in this subdivision.

7 **Owner.** Adds subd. 10b to § 245A.02. Defines "owner" in the Human Services Licensing Act to mean an individual or organization that has a direct or indirect ownership interest of 5 percent or more in a licensed program. Also defines related terms.

8 **Legislative notice and approval required for certain federal waivers or approvals.** Adds § 256.999. Before submitting an application for a section 1332 waiver, for a section 1115 waiver, or for a state Medicaid plan amendment, requires the commissioner or board seeking the waiver or amendment to provide notice and a copy of the application to the legislative

Section

committees with jurisdiction over health and human services policy and finance and commerce.

If a 1332 waiver, 1115 waiver, or state Medicaid plan amendment is approved during the legislative session, requires approval of the waiver or amendment by a law enacted after the waiver or approval is granted, in order for the waiver or amendment to be implemented.

If a 1332 waiver, 1115 waiver, or state Medicaid plan amendment is approved when the legislature is not in session, requires a positive recommendation from the Legislative Advisory Commission (LAC) in order for the waiver or amendment to be implemented. If the LAC makes no recommendation, a negative recommendation, or a recommendation for further review, prohibits implementation of the waiver or amendment.

9 Establishment of federally facilitated marketplace.

Subd. 1. Establishment. Paragraph (a) directs the commissioner of commerce to establish a federally facilitated marketplace for Minnesota to replace MNsure, for coverage beginning January 1, 2019. Directs the commissioner to incorporate elements of the Minnesota eligibility system, where appropriate and cost-effective; consult with stakeholders; and seek federal funds for planning and development costs.

Paragraph (b) provides that health plans that are offered through the federally facilitated marketplace, when implemented, and that use provider networks must at least satisfy state distance or travel times for geographic accessibility and state network adequacy requirements.

Subd. 2. Implementation plan; draft legislation. Directs the commissioner of commerce to consult with others and develop and present to the 2018 Legislature an implementation plan and draft legislation for conversion to a federally facilitated marketplace. Lists items that the implementation plan must address.

Subd. 3. Vendor contract. Requires the commissioner to contract with a vendor for technical assistance in developing the plan to convert to a federally facilitated marketplace.

10 Repealer. Repeals statutes in the MNsure chapter, effective January 1, 2019.

Article 9: Nursing Facility Technical Corrections

Overview

This article removes and corrects obsolete nursing facility cross-references throughout Minnesota Statutes.

The 2016 Legislature enacted a bill to recodify the nursing facility payment statutes (see Laws 2016, ch. 99). Given the complexity of the nursing facility payment and rates language, the recodification was accomplished by moving most of the nursing facility language out of Minnesota Statutes, chapter 256B, and into a new chapter 256R. In addition, the nursing facility payment and rates language was reorganized

Section

for clarity and ease of use, obsolete language was removed, consistent terminology was used, and language was redrafted for clarity and consistency. This article corrects obsolete cross-references that were created by the recodification and removes obsolete language.

Article 10: Human Services Forecast Adjustments

Overview

Adjusts appropriations for fiscal year 2017 for forecasted programs administered by the Department of Human Services.

Article 11: Appropriations

Overview

Appropriates money or adjusts appropriations for fiscal years 2018 and 2019 for the Department of Human Services, Department of Health, health-related licensing boards, Council on Disability, Ombudsman for Mental Health and Developmental Disabilities, Ombudsperson for Families, and Department of Commerce.