HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. 25 **DATE:** July 28, 2011
Version: As introduced

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Subject: Health and Human Services Omnibus Bill

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Article 1: Children and Family Services

Overview

Article 1 makes changes to children and family services programs including child care assistance, general assistance, group residential housing, MFIP, EBT cards, and CCSA grants.

1 **Assistance.** Amends § 119B.035, subd. 4. Reduces the maximum rate of assistance that can be paid for the at-home infant child care program from 90 percent to 68 percent of the rate that is paid for licensed family child care assistance. Makes this section effective October 31, 2011.

2 **Child care centers; assistance.** Amends § 119B.09, by adding subd. 9a. Paragraph (a) defines "qualifying child."

Paragraph (b) prohibits child care assistance funds from being used for child care services provided for a child by a provider who employs either the parent of the child or a person who resides with the child, unless at least 50 percent of the children being cared for by the provider meet the definition of qualifying child under paragraph (a).

Paragraph (c) specifies requirements providers must meet if at least 50 percent of the children in their care are not qualifying children in order to continue to receive payment under the child care assistance program.

Makes this section effective January 1, 2013.

3 **Payment of funds.** Amends § 119B.09, subd. 10. Prohibits child care assistance funds from being used for child care services provided by a provider who resides in the same household or occupies the same residence as the child for whom care is provided. Makes this section effective March 5, 2012.

4 **Child care in the child's home.** Amends § 119B.09, by adding subd. 13. Specifies conditions that must be met in order for child care in the child's home to be authorized under the child care assistance program. Makes this section effective March 5, 2012.

5 **Training required.** Amends § 119B.125, by adding subd. 1b. Effective November 1, 2011, requires legal nonlicensed family child care providers to complete first aid and CPR training and provide verification of the training to the county. Specifies requirements for providers authorized before November 1, 2011, and specifies requirements for each reauthorization.

6 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Reduces the maximum rate paid for child care assistance by 2.5 percent, beginning October 1, 2011. Specifies that the maximum payment to a provider must not exceed the maximum daily or weekly rate. Prohibits child care providers from being paid activity fees or an additional rate above the maximum rates for care provided during nonstandard hours under the child care assistance program. Makes paragraph (d) effective April 16, 2012, and paragraph (e) effective September 3, 2012.

7 **Legal nonlicensed family child care provider rates.** Amends § 119B.13, subd. 1a. Reduces legal nonlicensed family child care provider rates from 80 percent to 68 percent of the rate paid for licensed family child care. Clarifies maximum daily and weekly rate calculations. Makes this section effective April 16, 2012, except the rate reduction is effective October 31, 2011.

8 **Absent days.** Amends § 119B.13, subd. 7. Modifies the absent day payment policy under the child care assistance programs. Limits absent day payments to ten full-day absent days per child, excluding holidays, in a fiscal year. Removes language related to documented medical conditions. Prohibits legal nonlicensed family child care providers from being paid for absent days. Removes exemptions

from the absent day limits for families that meet certain criteria. Removes language allowing counties to pay for additional absent days if that is the current market practice in the county. Makes this section effective January 1, 2013.

9 **Electronic Benefit Transfer (EBT) debit card.** Creates § 256.987.

Subd. 1. EBT debit card. Requires cash benefits for the GA, MSA, and MFIP programs to be issued on a separate EBT card with the head of household's name printed on the card. Requires the card to state that it is unlawful to purchase tobacco products or alcoholic beverages with the card. Requires the card to be issued within 30 days of an eligibility determination. Allows recipients to have benefits issued on a card without a name printed on the card during the initial 30 days of eligibility. Specifies that the temporary card does not need to meet the requirements of this section.

Subd. 2. Prohibited purchases. Prohibits EBT cardholders in programs listed under subdivision 1 from using their EBT card to purchase tobacco products and alcoholic beverages. Makes it unlawful for an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic beverages with an EBT card.

Makes subdivision 1 effective June 1, 2012.

10 **Eligibility.** Amends § 256D.05, subd. 1. Modifies eligibility for the general assistance program. Makes this section effective May 1, 2012.

11 **Emergency need.** Amends § 256D.06, subd. 2. Modifies general assistance emergency need by requiring applicants to be ineligible for MFIP assistance, have annual net income no greater than 200 percent of the federal poverty guidelines for the previous calendar year, and limiting recipients to one emergency general assistance grant in any 12-month period. Establishes a floor of $1,000 per fiscal year for county emergency general assistance allocations. Makes this section effective November 1, 2011.

12 **Eligibility.** Amends § 256D.46, subd. 1. Allows applicants for or recipients of SSI or MSA who have emergency need to apply for emergency general assistance. Makes this section effective November 1, 2011.

13 **Household eligibility; participation.** Amends § 256E.35, subdivision 5. Strike references to funding for the family assets for independence program.

14 **Withdrawal; matching; permissible uses.** Amends § 256E.35, subdivision 6. Strike references to funding for the family assets for independence program.

15 **Supplementary services.** Amends § 256I.03 by adding subd. 8. Defines "supplementary services."

16 **Supplementary service rates.** Amends § 256I.05, subd. 1a. Prohibits counties from negotiating supplementary services rates with providers that do not enforce a policy of sobriety. Makes this section effective May 1, 2012.

17 **Other property limitations.** Amends § 256J.20, subd. 3. Reduces the MFIP vehicle asset limit from $15,000 to $10,000.

18 **Work activity.** Amends § 256J.49, subd. 13. Specifies that activities done for political purposes are not included as work activities.

19 **Citation.** Amends § 256M.01. Changes the title of the act from the Children and Community Services Act to the Vulnerable Children and Adults Act. Removes language related to the service plan outcomes and review.

20 **Vulnerable children and adults services.** Amends § 256M.10, subd. 2. Modifies terminology to conform to the change in the title of the Act. Limits services provided under the Act. Defines "vulnerable children."

21 **General supervision.** Amends § 256M.20, subd. 1. Makes conforming changes related to whom services may be provided.

22 **Additional duties.** Amends § 256M.20, subd. 2. Makes conforming changes to the commissioner's duties.

23 **Sanctions.** Amends § 256M.20, subd. 3. Makes a technical change.

24 **Service plan.** Amends § 256M.30.

Subd. 1. Service plan submitted to commissioner. Modifies the timeline in which counties must have their service plan approved by the commissioner.

Subd. 2. Contents. Modifies terminology to conform to the change in the title of the Act. Removes obsolete language. Removes a requirement that counties spend a certain portion of funds on children in low-income families. Makes other technical and conforming changes.

Subd. 3. Continuity of services. Repeals this subdivision.

Subd. 4. Information. Makes conforming changes related to whom services may be provided.

Subd. 5. Timelines. Requires services plans to be submitted to the commissioner by October 15, 2011.

Subd. 6. Public comment. No changes to this subdivision.

Subd. 7. Commissioner's responsibilities. Removes a requirement that the commissioner inform counties if their service plan has been approved within 60 days of receiving the plan.

25 **Grant allocation.** Amends § 256M.40.

Subd. 1. Formula. Removes obsolete language. Specifies how the commissioner must allocate funds to each county for calendar years 2011 through 2016.

Subd. 3. Payments. No changes to this subdivision.

26 **Federal grant allocation.** Amends § 256M.50. Removes obsolete language and prohibits Title XX funds from being used for any expenditures prohibited by section 2005 of the Social Security Act and requires all federal certification requirements to be met by counties receiving Title XX funds.

27 **Responsibilities.** Amends § 256M.60, subd. 1. Makes conforming changes and removes language related to certain county board requirements.

28 **Identification of services to be provided.** Amends § 256M.70, subd. 2. Modifies which services must receive the highest funding priority. Limits the criteria counties must follow in making funding decisions under this chapter.

29 **Program evaluation.** Amends § 256M.80.

Subd. 1. County evaluation. Removes obsolete language.

Subd. 2. Statewide evaluation. Makes conforming changes. Removes a requirement that the commissioner prepare an annual report and disseminate it throughout the state.

30 **Expedited issuance of food stamps.** Amends § 393.07, subd. 10a. Modifies the time in which counties have to issue food support for applicants who meet the federal criteria for expedited issuance of food support.

31 **Fees for IV-D services.** Amends § 518A.51. Increases the cost recovery fee from one percent to two percent of the monthly court-ordered child support and maintenance obligation. Modifies how the nonfederal share of certain fees are distributed and limits how counties may use the funds. Makes this section effective January 1, 2012.

32 **Requirement for liquor stores, tobacco stores, gambling establishments, and tattoo parlors.** Requires liquor stores, tobacco stores, gambling establishments, and tattoo parlors to negotiate with their third party processors to block EBT cash transactions at their places of business and withdrawals of cash at ATMs located in their places of business.

33 **Minnesota EBT Business Task Force.**

Subd. 1. Members. Establishes the membership of the Minnesota EBT Business Task Force.

Subd. 2. Duties. Establishes the duties of the task force.

Subd. 3. Report. Requires the task force to report to the legislative committees with jurisdiction over health and human services policy and finance by April 1, 2012, with recommendations related to the duties in subdivision 2.

Subd. 4. Expiration. Makes the task force expire on June 30, 2012.

34 **Repealer.** Paragraph (a) repeals §§ 256.979, subds. 5, 6, 7, 10 (county child support incentive grants); and 256.9791 (county medical support bonus incentive grants), effective July 1, 2011.

Paragraph (b) repeals §§ 256M.10, subd. 5 (former children's services and community services grants); 256M.60, subd. 2 (DT&H services; alternative habilitation services); and 256M.70, subd. 1(demonstration of reasonable effort).

Paragraph (c) repeals Minnesota Rules, part 3400.0130, subp. 8 (child care assistance payment of activity fees), effective September 3, 2012.

Paragraph (d) repeals Minnesota Rules, part 9500.1261, subp. 3, items D and E, 4, and 5 (emergency assistance eligible persons, payment provisions, and assistance for transportation) effective November 1, 2011.

Article 2: Department of Health

1 **Cost containment duties.** Amends § 62J.04, subd. 3. Makes conforming change by removing references to statutory sections repealed in this article.

2 **Expenditure reporting.** Amends § 62J.17, subd. 4a. Removes certain annual reporting requirements for physician clinics related to major spending commitments.

3 **Medical education.** Amends § 62J.692. Provides that training sites with a grant level less than $1,000 are ineligible for funds. Removes direct payments of MERC funds.

4 **Alzheimer's disease; prevalence and screening measures.** Adds § 62U.15.

Subd. 1. Data from providers. (a) Requires the commissioner of health, beginning July 1, 2012, to review quality measure and make recommendations for future measurements for

improving assessment and care related to Alzheimer's and other dementia diagnoses, including cognitive screening, diagnoses and treatment plans.

(b) Permits the commissioner to contact with a private entity to collect the data under this section and permits the commissioner to use an existing contract to do so.

Subd. 2. Learning collaborative. Requires the commissioner to develop, by July 1, 2012, a health care home learning collaborative curriculum for identification and management of Alzheimer's disease and other dementia patients.

Subd. 3. Comparison data. Requires the commissioners of health and human services, the Minnesota Board of Aging, and other appropriate state offices to conduct a literature review in order to estimate current outcomes and costs compared with improved practices related to Alzheimer's disease and other dementias.

Subd. 4. Reporting. Requires the commissioner to provide a progress report to the legislature by January 15, 2013.

5 **Fees for variances.** Amends § 103I.101, subd. 6. Increases a well application fee.

6 **Well notification fee.** Amends § 103I.101, subd. 6. Increase certain well notification fees paid by the property owner.

7 **Permit fee.** Amends § 103I.208, subd. 2. Increases certain fees related to well permits.

8 **Disclosure of wells to buyer.** Amends § 103. 235, subd. 1. Increases fees related to well disclosure certificates.

9 **Certification fee.** Amends § 103I.525. subd. 2. Adds a renewal fee for certification of well contractors.

10 **Certification fee.** Amends § 103I. 531, subd. 2. Adds a renewal fee for certification of limited well/boring contractors.

11 **Certification fee.** Amends § 103I.535, subd. 2. Adds a renewal fee for certification of elevator boring contractors.

12 **Certification fee.** Amends § 103I. 541, subd. 2c. Adds a renewal fee for certification of monitoring well contractors.

13 **Summer internships.** Amends § 144.1464, subd. 1. Requires the commissioner to award summer internship grants within available appropriations.

14 **Definitions.** Amends § 144.1501, subd. 1. Modifies the definition of "designated rural area" for purposes of the health professionals loan forgiveness program, to include small rural and isolated rural areas as described by the Rural Urban Commuting Area system.

15 **Standards.** Amends § 144.98, subd. 2a. Makes a conforming change related to environmental lab accreditation.

16 **Initial accreditation and annual accreditation renewal.** Amends § 144.98, subd. 7. Makes a conforming change related to environmental lab accreditation.

17 **Exemption from national standards for quality control and personnel requirements.** Amends § 144.98 by adding subd. 8. Permits certain environmental labs to request an exemption from personnel requirements and specified quality control provisions, as of January 1, 2012. Permits the commissioner of health to grant exemptions provided the lab complies with methodology and quality

control requirements.

18 **Exemption from national standards for proficiency testing frequency.** Amends § 144.98, by adding subd. 9. Requires labs requesting accreditations under the exemption in section 144.98, subdivision 8, to obtain acceptable proficiency test results and sets out requirements related to subsequent analysis of proficiency testing samples.

19 **Waiver from federal rules and regulations; penalties.** Amends § 144A.102. Requires the commissioner of health to work with certain long-term care providers to examine state and federal rules and regulations. Requires the commissioner to report to the legislature by January 31, 2012, as to the implementation of this paragraph.

20 **Electronic transmission.** Amends § 144A.61 by adding subd. 9. Requires the commissioner of health to accept electronic transmission of applications for the nursing assistant registry.

21 **Prehospital care data.** Amends § 144E.123. Removes the penalty for failing to report. Requires the EMS regulatory board to convene a working group, by October 1, 2011, to redesign policies related to data collection. Requires the working group to report its findings by July 1, 2012.

22 **Requirements for programs; process.** Amends § 145A.17, subd. 3. Requires local public health family home visiting programs to obtain permission from the family to share data with other family service providers to select a lead agency and coordinate available resources.

23 **Limited food establishment.** Amends § 157.15 by adding subd. 7a. Creates a "limited food establishment" as a type of food and beverage establishment. Requires them to use equipment that is nontoxic and durable, and permits them to request a plumbing variance.

24 **Variance requests.** Amends § 157.20, by adding subd. 5. Clarifies that a variance may be requested from all parts of Minnesota Rules, chapter 4626, unless specified in rule or this section.

25 **Tax and use tax on cigarettes.** Amends § 297F.10, subd. 1. Reduces the amount of a transfer of cigarette tax funding that is credited to the MERC program.

26 **Evaluation of health and human services regulatory responsibilities.** Requires the commissioners of health and human services to evaluate and recommend options for reorganizing a variety of regulatory responsibilities. Requires that recommendations be submitted to the legislature by February 15, 2012.

27 **Minnesota task force on prematurity.** Establishes a Minnesota Task Force of Prematurity to evaluate and make recommendations on methods to reduce prematurity and improve premature infant health care. Specifies membership of the task force and requires the commissioner of health to convene the first meeting by July 31, 2011. Requires a report on the current state of prematurity by November 30, 2011, and a final report by January 15, 2013.

28 **Nursing home regulatory efficiency.** Requires the commissioner of health to work with stakeholders to review, implement, and make recommendations related to efficiency for nursing home licensure.

29 Repealer. (a) Repeals § 62J.321, subd. 5a (prescription drug price disclosure data); 62J.381 (prescription drug price disclosure); 62J.41, subds. 1 and 2 (cost containment reporting; and 144.1499 (promotion of health care and long-term care careers).
(b) Repeals certain provisions of Minnesota Rules, chapter 4651 related to health care provider reporting.

30 Effective date. Provides an immediate effective date for sections in this article.

Article 3: Miscellaneous

1 **Special family day care homes.** Amends § 245A.14, subd. 4. Permits a family day care or group family day care provider to locate the program in a commercial space, rather than a residence, if the license holder is the primary provider of care and complies with specific zoning and fire code requirements. Requires the license holder to display the license issued by the commissioner which will contain the statement, "This special family day care provider is not licensed as a child care center."

2 **Children's therapeutic services and supports providers.** Amends § 245C.03, by adding subd. 7. Requires the commissioner to conduct background studies for CTSS providers.

3 **Children's therapeutic services and supports providers.** Amends § 245C.10, by adding subd. 8. Allows the commissioner to recover the cost of performing background studies for CTSS providers. Limits the charge to no more than $20 per study.

4 **Background studies.** Amends §256B.0943, by adding subdivision 5a. Allows a CTSS agency to access the commissioner's NETStudy system for purposes of complying with the background study requirements.

5 **Spousal contribution.** Amends § 256B.14, by adding subdivision 3a.

Paragraph (a) provides definitions of commissioner, community spouse, cost of care, department, disabled child, income, and long-term care spouse.

Paragraph (b) requires the spouse of the long-term care spouse who receives medical assistance for long-term care services or alternative care services to contribute to the cost of care unless the community spouse is caring for a minor or disabled child in the home.

Paragraphs (c) to (f) provide the formula for computing the contribution amount.

Paragraph (g) requires the commissioner at the time of application for services to provide the spouse and community spouse a written explanation of the spousal contribution requirement, how to request a variance for undue hardship, review and redetermination of the contribution, and consequences for noncompliance.

Paragraph (h) provides that the contribution is to be assessed for each month the long term care spouse has a community spouse and is eligible for medical assistance or alternative care.

Paragraph (i) requires a review of the spousal contribution a minimum of once every 12 months and when there is a loss or gain of income in excess of 10 percent. Sets out the requirements for requesting a review and the commissioner's responsibilities in scheduling a redetermination.

Paragraph (j) provides that the contribution cannot exceed the amount of medical assistance expended or the cost of alternative care services provided. Sets out the method of reimbursement if the community spouse has contributed an amount in excess of costs.

Paragraph (k) allows a community spouse who has personal medical needs to request a variance for undue hardship if the spouse needs to retain the contribution amount to pay for these medical needs. Sets out the method for requesting the variance.

Paragraph (l) sets out the appeal rights.

Paragraph (m) sets out the method to enforce payments.

Provides an effective date of July 1, 2012.

6 **Nonemergency medical transportation single administrative structure proposal.**

Paragraph (a) requires the commissioner to develop a proposal to create a single administrative structure to provide nonemergency medical transportation services to fee-for-service medical assistance recipients.

Paragraph (b) lists the required components of the proposal.

Paragraph (c) requires the commissioner to consult with the advisory council established in paragraph (d) when developing the proposal.

Paragraph (d) lists the entities to be represented on the council.

Paragraph (e) requires the commissioner to submit the proposal and legislation needed for implementation to the chairs and ranking minority members of the house and senate committees with jurisdiction over health care policy by January 15, 2012.

Article 4: Department of Human Services Licensing

1 **Application or license fee required, programs exempt from fee.** Amends § 245A.10, subd. 1. Strikes state-operated programs from the list of programs exempt from a licensing fee.

2 **Application fee for initial license or certification.** Amends § 245A.10, subd. 3. Allows a private agency to submit a single application for a license to provide statewide foster care or adoption services.

3 **License or certification fee for certain programs.** Amends § 245A.10, subd. 4. Modifies and establishes licensing fees for child care centers, day training and habilitation programs, supported employment programs for persons with developmental disabilities, crisis respite services programs for persons with developmental disabilities, semi-independent living programs to persons with developmental disabilities, residential habilitation services programs, residential programs certified by the Department of Health as ICF/DD and a noncertified residential program to provide health or rehabilitative services for persons with developmental disabilities, chemical dependency treatment programs, children's residential programs (except child foster care), residential facilities for persons with mental illness, residential facilities for persons with physical disabilities, independent living programs for youth, private agencies providing foster care and adoption services, adult day care centers, treatment programs for persons with sexual psychopathic personalities or sexually dangerous persons, and certain mental health centers and clinics.

4 **Human services licensing fees to recover expenditures.** Amends § 245A.10, by adding subd. 7. Requires the commissioner to plan to fully recover direct expenditures for licensing activities under this chapter over a five-year period. Allows the commissioner to use surplus revenues from a previous biennium to cover expenditures.

5 **Deposit of license fees.** Amends § 245A.10, by adding subd. 8. Creates a human services licensing account in the state government special revenue account. Requires licensing fees to be deposited in this account. Makes an annual appropriation from this account to the commissioner for licensing activities under this chapter.

6 **Adult foster care; family adult day services.** Amends § 245A.11, subd. 2b. Allows an adult foster care provider to provide family adult day care for adults 18 and older. Current law allows the provision of adult day care to adults 55 and older. Strikes language that prohibits dual provision of services if any participant has a serious and persistent mental illness or a developmental disability.

Provides that a separate license to provide family adult day services is not required in a licensed adult foster home.

7 **Scope.** Amends § 245A.143, subd. 1. Makes conforming changes to the family adult day services statute to allow adults 18 and older to receive family adult day services. Adds that an adult foster care license holder does not need a separate license to provide adult day services.

8 **Human services licensed programs.** Amends § 245C.10, by creating subd. 8. Requires the commissioner to recover the cost of background studies for all licensed programs, except child foster care and family child care, through a fee of no more than $20 charged to the license holder.

9 **Medical assistance reimbursement.** Amends § 256B.49, subd. 16a. Instructs the commissioner to seek a federal waiver for medical assistance reimbursement of family adult day services. Requires the commissioner, after the waiver is granted, to include family adult day services in the common services menu.

Provides an immediate effective date.

10 **Repealer.** Repeals § 245A.10, subd. 5 (current licensing fees).

Article 5: Health Related Licensing

1 **Renewal fees.** Amends § 148.07 subd. 1. Makes technical change to require the Board of Chiropractic Examiners to set fees in statute rather than by rule.

2 **Animal chiropractic.** Amends § 148.108 by adding subd. 4. Sets registration fees for animal chiropractors.

3 **Powers.** Amends § 148.191, subd. 2. Removes language related to adopting rules. Permits the Board of Nursing to accept and expend grants and gifts for purposes consistent with the board's authority. Permits the board to accept registration fees for certain meetings and conferences.

4 **Issuance.** Amends § 148.212 subd. 1. Modifies the requirements for a temporary permit to practice by the Board of Nursing.

5 **Registration; failure to register; reregistration; verification.** Amends § 148.231. Makes technical changes.

6 **Fees.** Adds § 148.242. Requires fees set in statute to be deposited in the state government special revenue fund.

7 **Fee amounts.** Adds § 148.243. Sets out the fee schedule in statute for the Board of Nursing.

8 **Fees.** Amends § 148B.17. Makes technical changes and sets out the fee schedule in statute for the Board of Marriage and Family.

9 **Fee.** Amends § 148B.33, subd. 2. Make a conforming change.

10 **Duties of the board.** Amends § 148B.52. Makes a technical change to require fees to be established in statute.

11 **Application fees.** Amends § 150A.091, subd. 2. Adds a fee for advanced dental therapist certification and for full faculty dentist.

12 **Initial license or permit fees.** Amends § 150A.091, subd. 3. Makes a conforming change.

13 **Annual license fees.** Amends § 150A.091, subd. 4. Clarifies annual license fee.

14 **Biennial license or permit fees.** Amends § 150A.091, subd. 5. Makes a conforming change.

15 **Duplicate license or certification fee.** Amends § 150A.091, subd. 8. Makes a conforming change.

16 **Failure of professional development portfolio audit.** Amends § 150A.091 by adding subd. 16. Provides a fee to be collected by the Board of Dentistry for a licensee who fails two consecutive professional development audits.

17 **Fee amounts.** Adds § 151.065. Sets out a fee schedule in statute for the Board of Pharmacy.

18 **Meetings; examination fee.** Amends § 151.07. Makes a conforming change.

19 **Internship.** Amends § 151.101. Makes a conforming change and modifies a reference from licensure of interns to registration of interns.

20 **Registration fee.** Amends § 151.102 by adding subd. 3. Requires a fee for pharmacy technicians to be registered by the Board of Pharmacy.

21 **Reciprocity; licensure.** Amends § 151.12. Makes a conforming change.

22 **Renewal fee.** Amends § 151.13, subd. 1. Makes conforming changes and modifies references to fee changes by cross-referencing Minnesota Statutes, section 151.065.

23 **Registration; fees.** Amends § 151.19. Makes conforming changes and modifies references to fee changes by cross-referencing Minnesota Statutes, section 151.065.

24 **Registration of manufacturers; fee; prohibitions.** Amends § 151.25. Makes a conforming change.

25 **Requirements.** Amends § 151.47, subd. 1. Makes a conforming change.

26 **Out-of-state wholesale drug distributor licensing.** Amends § 151.48. Makes a conforming change.

27 **Research project use of controlled substances.** Amends § 152.12, subd. 3. Adds a cross-reference to fees set out in Minnesota Statutes, section 151.065.

28 **Health-related licensing boards administrative services unit.** Adds § 214.107. Establishes administrative services for health-related licensing boards to perform administrative, financial, and management functions common to all the boards in a manner that streamlines services and reduces expenditures. The administrative services shall act as an agent of the boards. The funding for the services comes from an amount apportioned to each board.

29 **Registration and license renewals; health-related licensing boards.** Prohibits health-related licensing boards from assessing late fees or initiating disciplinary actions for failure to timely renew a license or registration for licenses and registrations due during the State shutdown, if the renewal application is submitted by July 31, 2011.

30 **Effective date.** Provides an immediate effective date for sections in this article.

Article 6: Health Care

1 **Managed care plans.** Amends § 13.461, subd. 24a. Updates a cross-reference to reflect a new provision added in section 63 and the repeal of section 256B.69, subdivision 9b in section 97.

2 **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** Amends § 62E.14, by adding subd. 4f. Allows individuals to enroll in an MCHA plan with a waiver of the preexisting condition limitation, if they are eligible for the healthy Minnesota contribution program and have been denied private sector coverage. Provides an effective date of July 1, 2012.

3 **Growth limits; federal programs.** Amends § 62J.04, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

4 **Authority to administer Minnesota electronic health record incentive program.** Amends § 62J.495, by adding subd. 7. Directs the commissioner of human services to administer an electronic health record incentives program according to the American Recovery and Reinvestment Act and federal regulations.

5 **Definitions.** Amends § 62J.495, by adding subd. 8. Defines terms related to the electronic health record incentives program.

6 **Registration, application, and payment processing.** Amends § 62J.495, by adding subd. 9. Specifies requirements for the electronic health record incentives program.

7 **Audits.** Amends § 62J.495, by adding subd. 10. Authorizes the commissioner to audit eligible providers or hospitals that apply for incentive payments through the electronic health record incentives program, and authorizes the commissioner to use state and federal laws, regulations, and circulars to develop audit criteria.

8 **Provider appeals.** Amends § 62J.495, by adding subd. 11. Allows eligible providers and hospitals that have received notice of adverse action related to the electronic health record incentives program to appeal the action.

9 **MEIP appeals.** Amends § 62J.495, by adding subd. 12. Allows eligible providers and hospitals that have received notice of an appealable issue related to the electronic health record incentives program to appeal the action.

10 **Definitions.** Amends § 62J.495, by adding subd. 13. Defines terms related to appeals under the electronic health record incentives program.

11 **Filing an appeal.** Amends § 62J.495, by adding subd. 14. Specifies provider appeal procedures and lists requirements for the notice of appeal. Requires appeals to be postmarked or received by the commissioner within 30 days of the date of issuance specified in the notice of action.

12 **Appeals review process.** Amends § 62J.495, by adding subd. 15. Specifies the procedures to be used by the commissioner in reviewing appeals. Allows providers to request a contested case hearing if the provider disagrees with the appeal determination.

13 **Review of eligible providers.** Amends § 62J.692, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

14 **Local ombudsperson.** Amends § 62Q.32. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

15 **Provider peer grouping.** Amends § 62U.04, subd. 3. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

16 **Uses of information.** Amends § 62U.04, subd. 9. Requires information on provider cost and quality to be used by government and the private sector for product renewals or new products, after 12 months have elapsed from publication by the commissioner of this information.

17 **Legislative oversight.** Amends § 62U.06, subd. 2. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.

18 **Contingency contract fees.** Amends § 256.01, by adding subd. 33. When the commissioner enters into a contingency-based contract for the purpose of recovering MA or MinnesotaCare funds, allows the commissioner to retain that portion of recovered funds equal to the amount of the contingency fee. Appropriates recoveries to the commissioner to the extent they fulfill contract terms, and recoveries to be deposited into an account other than the general fund. Provides a retroactive effective date of July 1, 2011.

19 **Diagnostic categories.** Amends § 256.969, subd. 2. Requires the commissioner to recategorize hospital diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013. Requires recategorizations to occur January 1, 2013, and every two years thereafter. When hospital rates are not rebased, allows the commissioner to establish relative values and case mix indices based on charge data and to update the base year.

20 **Operating payment rates.** Amends § 256.969, subd. 2b. Eliminates hospital rebasing beginning January 1, 2011 (current law would have delayed rebasing for 24 months beginning January 1, 2011, and implemented rebasing January 1, 2013.)

21 **Rateable reduction and readmissions reduction.** Amends § 256.969, by adding subd. 3c. (a) Reduces fee-for-service payments to hospitals for inpatient services by 10 percent, for admissions occurring on or after September 1, 2011, through June 30, 2015. Excludes Indian health service facilities, long-term hospitals, children's hospitals, and payments under managed care from this reduction.

(b) Requires the commissioner to calculate a regional readmissions rate for admissions to all hospitals occurring within 30 days of a previous discharge, for admissions occurring during CY 2010 and each year thereafter.

(c) For the period July 1, 2013, through June 30, 2015, reduces the payment reduction under paragraph (a) by one percentage point, for every percentage point reduction in the overall readmissions rate between the two previous calendar years, up to a maximum reduction of five percentage points.

22 **Termination; terminate.** Amends § 256B.02, by adding subd. 16. Defines "termination" and "terminate" for purposes of the MA program.

23 **Prohibition on payments to providers outside of the United States.** Amends § 256B.03, by adding subd. 4. Prohibits MA payments for services delivered or items supplied outside of the U.S., or to providers, financial institutions, or entities located outside of the U.S.

24 **Ordering or referring providers.** Amends § 256B.03, by adding subd. 5. Requires claims for payments for supplies or services that are based on an order or referral of a provider to include that provider's national provider identifier (NPI). Prohibits coverage of claims or services ordered or referred by a provider not enrolled in MA.

25 **Applications for medical assistance.** Amends § 256B.04, subd. 18. Requires the commissioner to

modify the Minnesota health care programs application form to add a question asking applicants if they ever served in the U.S. military.

26 **Provider enrollment.** Amends § 256B.04, by adding subd. 21. (a) Allows the commissioner to withhold payment upon initial enrollment for a 90-day period, for providers within categories designated "high-risk" by the commissioner or CMS.

(b) Allows the commissioner to require providers within a particular industry sector or category to establish, as a condition of MA enrollment, a compliance program that contains the core elements established by CMS.

(c) Allows the commissioner to revoke the enrollment of an ordering or rendering provider for up to one year, if the provider fails to maintain and provide access to documentation related to orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services, when the commissioner has identified a pattern of a lack of documentation.

(d) Requires the commissioner to terminate or deny the enrollment in MA of any individual or entity, if the individual or entity has been terminated from participation in Medicare, or under the Medicaid or Children's Health Insurance Program of another state.

(e) Directs the commissioner to require that providers designated moderate or high-risk by CMS or DHS, as a condition of MA enrollment, permit CMS and the state agency, and agents or contractors, to conduct unannounced on-site inspections.

(f) Directs the commissioner to require, as a condition of MA enrollment, that high-risk providers, or persons with a direct or indirect ownership interest in the provider of 5 percent or higher, consent to criminal background checks including fingerprinting, when required under state law or by a determination of the commissioner or CMS that the provider is designated high-risk for fraud, waste, or abuse.

27 **Citizenship requirements.** Amends § 256B.06, subd. 4. Clarifies services covered under emergency MA, by specifying that various services, including those related to chronic conditions, are not covered. Eliminates state-only funded medical assistance coverage for certain legal noncitizens. Provides a January 1, 2012 effective date.

28 **Evidence-based childbirth program.** Amends § 256B.0625, by adding subd. 3g. Requires the commissioner to implement a program to reduce the number of elective inductions of labor prior to 39 weeks gestation. For births covered by MA or MinnesotaCare on or after January 1, 2012, prohibits payments for professional services associated with a delivery unless certain information is submitted to the commissioner. Exempts from this requirement deliveries performed at hospitals that have policies and processes in place to prohibit elective inductions prior to 39 weeks gestation, that have been approved by the commissioner. Allows the commissioner to not implement or discontinue any or all aspects of the program, if the commissioner determines that at least 90 percent of MA and MinnesotaCare births occur at hospitals that have approved policies. Provides a January 1, 2012 effective date.

29 **Physical therapy.** Amends § 256B.0625, subd. 8. Effective January 1, 2012, limits specialized maintenance therapy provided as a physical therapy service to recipients age 20 and under. Eliminates the exemption from prior authorization for service levels below specified thresholds, effective March 1, 2012.

30 **Occupational therapy.** Amends § 256B.0625, subd. 8a. Effective January 1, 2012, limits specialized maintenance therapy provided as an occupational therapy service to recipients age 20 and under. Eliminates the exemption from prior authorization for service levels below specified thresholds,

effective March 1, 2012.

31 **Speech-language pathology and audiology services.** Amends § 256B.0625, subd. 8b. Effective January 1, 2012, limits specialized maintenance therapy provided as a speech-language pathology service to recipients age 20 and under. Eliminates the exemption from prior authorization for service levels below specified thresholds, effective March 1, 2012.

32 **Care management; rehabilitation services.** Amends § 256B.0625, subd. 8c. Requires a care management approach for authorization of physical therapy, occupational therapy, and speech-language pathology and audiology services to be instituted. Also makes conforming changes. Provides a March 1, 2012 effective date.

33 **Chiropractic services.** Amends § 256B.0625, subd. 8e. Increases from 12 to 24 the number of chiropractic visits allowed before prior authorization is required. Provides a January 1, 2012 effective date.

34 **Acupuncture services.** Amends § 256B.0625, by adding subd. 8f. Provides that MA covers acupuncture, only when provided by a licensed acupuncturist, or by a practitioner for whom acupuncture is within scope of practice and who has specific acupuncture training or credentialing. Provides a January 1, 2012 effective date.

35 **Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) converts MA payment for drug ingredient costs from a formula based on average wholesale price (AWP) to one based on wholesale acquisition cost (WAC). Sets payments at WAC plus 4 percent for independently owned pharmacies located in a designated rural area within Minnesota, and at WAC plus two percent for all other pharmacies. Also strikes payment language related to antihemophilic factor drugs.

The amendment to paragraph (c) sets payment for multisource drugs at the lower of the usual and customary price or the maximum allowable cost, unless other conditions are met. (Current law sets the payment at the maximum allowable cost.)

The amendment to paragraph (d) sets payment rates for drugs administered in an outpatient setting at the lower of the usual and customary cost or 106 percent of the average sales price. Payment under current law is at the lower of the usual and customary cost or the amount established by Medicare.

The amendment to paragraph (e) includes antihemophilic factor products in the list of specialty pharmacy products for which the commissioner may negotiate lower reimbursement rates and require enrollees to obtain from providers that have agreed to the lower rates.

Provides an effective date of September 1, 2011, or upon federal approval.

36 **Medication therapy management services.** Amends § 256B.0625, subd. 13h. Makes the following changes related to coverage of medication therapy management services:

- allows persons taking three or more prescriptions with one or more chronic conditions to be eligible (current law requires four or more prescriptions with two or more chronic conditions)
- allows coverage of persons with a drug therapy problem that is identified by a pharmacist and approved by the commissioner
- allows provision of the service in home settings, without an order from the provider-directed care coordination team, and also expands the definition of home settings to include long-term care settings, group homes, and assisted living facilities, but excluding skilled nursing facilities.

Provides an effective date of September 1, 2011, or upon federal approval.

37 **Transportation costs.** Amends § 256B.0625, subd. 17. Effective September 1, 2011, reduces nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.

38 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective September 1, 2011, reduces ambulance service rates by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.

39 **Bus or taxicab transportation.** Amends § 256B.0625, subd. 18. Removes language providing that MA covers the "costs" of the most appropriate and cost-effective form of transportation.

40 **Prior authorization required.** Amends § 256B.0625, subd. 25. Requires the commissioner to implement a modernized electronic system for providers to request prior authorization. Lists criteria for the system. Requires the system to be completed by March 1, 2012. Requires all authorization requests to be submitted electronically by providers, except for requests for outpatient pharmacy drugs, services provided outside of the state and surrounding local trade area, and services included on a service agreement.

41 **Authorization with third-party liability.** Amends § 256B.0625, by adding subd. 25b. (a) Prohibits the commissioner from considering a request for authorization of a service when the recipient has third-party coverage, unless the provider has made a good faith effort to obtain payment or authorization from the third-party.

(b) States that a provider is not required to bill Medicare before requesting authorization from the commissioner, if the provider has reason to believe the service is not eligible for Medicare payment.

(c) Provides that authorization is not required if a third-party has made payment equal to or greater than 60 percent of the maximum payment allowed under MA.

Provides a September 1, 2011 effective date.

42 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. A new paragraph (b) requires vendors of durable medical equipment, prosthetics, orthotics, or medical supplies to enroll as a Medicare vendor.

A new paragraph (c) allows the commissioner to exempt a vendor from the Medicare enrollment requirement if specified conditions are met.

A new paragraph (d) defines durable medical equipment.

43 **Augmentative and alternative communication systems.** Amends § 256B.0625, subd. 31a. Requires augmentative and alternative communication systems to be paid at the lower of: (1) the submitted charge; or (2) the manufacturer's suggested retail price minus 20 percent for providers that are manufacturers, or the manufacturer's invoice charge plus 20 percent for providers that are not manufacturers. (Under current law, payment is at the manufacturer's suggested retail price.) Provides a September 1, 2011 effective date.

44 **Payment for noncovered services.** Amends § 256B.0625, by adding subd. 55. Specifies the conditions under which a provider can seek payment from a recipient for services not eligible for payment under MA. Provides a September 1, 2011 effective date.

45 **Medical service coordination.** Amends § 256B.0625, by adding subd. 56. (a) Provides MA coverage for in-reach community-based service coordination that is performed in a hospital emergency department as an eligible procedure under a state health care program or private insurance for a

frequent user. Defines "frequent user."

(b) Requires reimbursement to be made in 15-minute increments under Medicaid mental health social work reimbursement methodology and allowed for up to 60 days following discharge. Provides that frequent users participating in care coordination within a health care home framework are not eligible for reimbursement. Sets requirements for in-reach service coordinators. Requires the commissioner to request any waivers necessary to implement this subdivision.

(c) Defines "in-reach community-based service coordination" as the practice of a community-based worker meeting specified criteria working with an organization's staff to transition an individual back into the individual's living environment. Provides that this coordination includes working with an individual during discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

Provides a January 1, 2011 effective date.

46 **Payment for Part B Medicare crossover claims.** Amends § 256B.0625, by adding subd. 57. Effective for services provided on or after January 1, 2012, limits MA payment for an enrollee's Medicare Part B cost-sharing to an amount up to the MA total allowed, when the MA rate exceeds the amount paid by Medicare. Excludes specified services from this limit.

47 **Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, by adding subd. 58. Limits MA payment amounts for EPSDT screening to the payment rate established in rule (75th percentile of charges) and in effect on October 1, 2010 (this has the effect of eliminating annual adjustments to the rate).

48 **Services provided by advanced dental therapists and dental therapists.** Amends § 256B.0625, by adding subd. 59. Provides MA coverage for services provided by advanced dental therapists and dental therapists, when provided within their scope of practice. Provides a September 1, 2011 effective date.

49 **Cost-sharing.** Amends § 256B.0631, subd. 1. Makes the following changes related to MA cost-sharing:

- reinstates certain co-payments effective September 1, 2011 (these had been reduced or eliminated by the legislature)
- increases the copayment for nonemergency visits to an emergency room to $20 upon federal approval
- requires a family deductible effective January 1, 2012

50 **Exceptions.** Amends § 256B.0631, subd. 2. Makes a conforming change related to cost-sharing changes.

51 **Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to cost-sharing changes.

52 **Imposition of monetary recovery and sanctions.** Amends § 256B.064, subd. 2. Modifies the criteria and procedures used by the commissioner to seek monetary recoveries from and sanction vendors of medical care.

53 **Recovery procedures; sources.** Amends § 256B.0641, subd. 1. Allows the commissioner, in order to collect past due obligations, to adjust payments to a provider or vendor that has the same tax I.D. number as the provider or vendor with the past due obligation.

54 **Alternative models and waivers of requirements.** Amends § 256B.0751, subd. 4. A new paragraph (b) allows the commissioner of health to waive health care home certification requirements if the applicant demonstrates that compliance will create a major financial hardship or is not feasible, and establishes an alternative method of meeting the objectives of the certification requirement. Provides a September 1, 2011 effective date.

55 **Coordination with local services.** Amends § 256B.0751, by adding subd. 8. Requires health care homes and counties to coordinate care and services for health care home enrollees with complex medical needs or a disability, who need or are eligible for waivered services, mental health services, or other local services. Provides a September 1, 2011 effective date.

56 **Commissioner's duties.** Amends § 256B.196, subd. 2. Expands an existing intergovernmental transfer to include other billing professionals affiliated with Hennepin County Medical Center and Regions Hospital and makes related changes.

57 **Intergovernmental transfers.** Amends § 256B.196, subd. 3. Expands an existing intergovernmental transfer to include other billing professionals affiliated with Hennepin County Medical Center and Regions Hospital and makes related changes.

58 **Recession period.** Amends § 256B.196, subd. 5. Extends from December 31, 2010, to June 30, 2013, the date through which the Hennepin and Ramsey County intergovernmental transfer is voluntary.

59 **Payments for nonhospital-based governmental health centers.** Adds § 256B.198. (a) Allows the commissioner to make payments to nonhospital-based health centers operated by a governmental entity for the difference between MA expenditures incurred for MA enrollees and permitted MA payments to the health center.

(b) Requires the nonfederal share of payments under paragraph (a) to be provided through certified public expenditures.

(c) Allows Hennepin County to receive federal matching funds for certified public expenditures under paragraph (a), if the county participates in a total cost of care demonstration project and exceeds the minimum performance threshold set by the commissioner.

(d) Allows any additional available federal matching funds for certified public expenditures to be allocated to Hennepin County if savings in one year exceed savings from the previous year.

(e) States that this subdivision does not preclude Hennepin County from receiving an additional gain-sharing payment or from paying a downside risk-sharing payment under the health care delivery systems demonstration project.

60 **Payments reported by governmental entities.** Amends § 256B.199. Requires the commissioner to apply for additional federal matching funds available as disproportionate share hospital payments under MinnesotaCare, for services provided on or after September 1, 2011.

61 **Managed care contracts.** Amends § 256B.69, subd. 5a. The amendment to paragraph (g) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's emergency department utilization rate for MA and MinnesotaCare enrollees. Requires a reduction of no less than 10 percent from the previous calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's emergency department utilization rate is reduced by 25 percent.

A new paragraph (h) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's hospital admission rate for MA and MinnesotaCare enrollees. Requires a reduction of no less than 5 percent from the previous

calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's admission rate is reduced by 25 percent.

A new paragraph (i) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's rate subsequent hospitalizations within 30 days of a previous hospitalization. Requires a reduction of no less than 5 percent from the previous calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.

62 **Medical education and research fund.** Amends § 256B.69, subd. 5c. Provides an additional transfer from capitation rates to the medical education and research fund, of $23,936,000 for FYs 2012 and 2013 and $36,744,000 in FY 2014 and thereafter.

63 **Managed care financial reporting.** Amends § 256B.69, by adding subd. 9c. (a) Requires the commissioner to collect detailed data on financials, provider payments, provider rate methodologies, and other data. Requires the commissioner, in consultation with the commissioners of health and commerce, and with managed care and county-based purchasing plans, to set uniform criteria, definitions, and standards for the data submitted, and require managed care and county-based purchasing plans to comply with these requirements.

(b) Requires each plan to annually provide to the commissioner the following information on state public programs: (1) administrative expenses by category and subcategory, by program; (2) revenues by program, including investment income; (3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program; (4) data on the amount of reinsurance or transfer of risk by program; and (5) contribution to reserve, by program.

(c) Requires plans to have 30 days to review reports.

64 **Medicare special needs plans; medical assistance basic health care.** Amends § 256B.69, subd. 28. Requires the commissioner to enroll MA enrollees with disabilities in managed care plans, unless the individual chooses to opt-out of enrollment. Also limits the number of sets of marketing materials that the commissioner must mail to potential enrollees on behalf of health plans, to two sets of materials per contract year.

65 **Payment reduction.** Amends § 256B.69, by adding subd. 30. (a) Beginning September 1, 2011, requires the commissioner to reduce payments and limit future rate increases for managed care and county-based purchasing plans. Specifies that the limits in this section are to be achieved on a statewide aggregate basis by program. Allows the commissioner to use competitive bidding, payment reductions, or other reductions to meet the limits.

(b) Requires the commissioner, beginning September 1, 2011, to reduce payments to managed care and county-based purchasing plans by between 2.0 and 10.1 percent depending upon the enrollee group.

(c) Applies the percentage reductions in paragraph (b) to CY 2012.

(d) Requires the commissioner to limit maximum annual trend increases for managed care and county-based purchasing plans for CY 2013 to between 2.0 to 7.5 percent, depending upon the enrollee group.

(e) Limits maximum annual trend increases for CYs 2014 to 2015 to between 2.0 and 7.5 percent, depending upon the enrollee group. States that the commissioner may limit trend increases to less than the maximum.

66 **Physician reimbursement.** Amends § 256B.76, subd. 1. Reduces payment rates for physician and professional services by 3 percent, for services provided September 1, 2011, through June 30, 2011.

Exempts physical therapy, occupational therapy, and speech pathology and related services from this reduction.

67 **Dental reimbursement.** Amends § 256B.76, subd. 2. Reduces payment rates for dental services by 3 percent, for services provided September 1, 2011, through June 30, 2011. Exempts state-operated dental clinics from this reduction.

68 **Critical access dental providers.** Amends § 256B.76, subd. 4. Eliminates critical access dental provider eligibility for a dental clinic "associated with an oral health or dental education program" operated by the University of Minnesota or MNSCU, and requires a dental clinic to be owned and operated by these entities in order to qualify as a critical access dental provider. Provides a September 1, 2011 effective date.

69 **Reimbursement for basic care services.** Amends § 256B.766. A new paragraph (c) reduces total payments for outpatient hospital facility fees by 5 percent, for services provided September 1, 2011, through June 30, 2013.

A new paragraph (d) reduces total payments by 3 percent for the following services, for services provided September 1, 2011, through June 30, 2013: ambulatory surgical center facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, anesthesia services, and hospice services.

70 **Complementary and alternative medicine demonstration project.** Adds § 256B.771. Requires the commissioner of human services to contract with a Minnesota-based academic or clinical research institution or institutions specializing in complementary and alternative medicine education and clinical services to implement a demonstration project to improve the care provided to MA enrollees with neck and back problems. The project must be conducted with FQHCs and FQHC look-alikes. Requires the project to be implemented beginning January 1, 2012, or upon federal approval, whichever is later.

71 **Financial management.** Amends § 256L.02, subd. 3. Eliminates a reference to the legislative commission on health care access, which is repealed later in the article.

72 **Cost-sharing.** Amends § 256L.03, subd. 5. Requires MinnesotaCare enrollees to pay a family deductible. Provides a January 1, 2012 effective date.

73 **Healthy Minnesota contribution program.** Adds § 256L.031.

Subd. 1. Defined contribution to enrollees. (a) Requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are adults without children, with gross family income equal to or greater than 200 percent of FPG, with a monthly defined contribution to purchase a health plan.

(b) Exempts these enrollees from MinnesotaCare premiums, and required enrollment in a managed care or county-based purchasing plan.

(c) Provides that the provisions related to MinnesotaCare covered services and cost-sharing (§ 256L.03), the effective date of coverage (§ 256L.05, subd. 3), and provider payment rates (§ 256L.11) do not apply to these enrollees. Covered services, cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage are as provided by the terms of the health plan purchased by the enrollee.

(d) States that all MinnesotaCare requirements related to eligibility, income and asset

methodology, income reporting, and program administration continue to apply, unless otherwise provided in this section.

Subd. 2. Use of defined contribution; health plan requirements. (a) Allows enrollees to use up to the monthly defined contribution to pay premiums for coverage under a health plan.

(b) Requires an enrollee to choose a health plan within three calendar months of eligibility approval.

(c) Requires health plans purchased with a defined contribution to: (1) provide coverage for mental health and chemical dependency services; and (2) comply with the limitations on abortion coverage that apply under the MinnesotaCare program.

Subd. 3. Determination of defined contribution amount. (a) Requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per-person defined contribution is a function of age and income. Specifies the monthly per-person base contribution for age groups, ranging from $125 for persons age 19 to 29 to $360 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 93 to 80 percent, to obtain the monthly per-person defined contribution amount.

(b) Requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through the Minnesota Comprehensive Health Association (MCHA).

Subd. 4. Administration by commissioner. (a) Requires the commissioner to administer the defined contributions, by calculating and processing defined contributions for enrollees and paying the defined contribution to health plan companies or MCHA, as applicable.

(b) Provides that nonpayment of premium results in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Prohibits persons disenrolled for nonpayment or who voluntarily terminate coverage from reenrolling until four calendar months have elapsed.

Subd. 5. Assistance to enrollees. Requires the commissioner of human services, in consultation with the commissioner of commerce, to develop an efficient and cost-effective method to refer applicants to professional insurance agent associations.

Subd. 6. MCHA. Beginning July 1, 2012, makes MinnesotaCare enrollees who are denied coverage under an individual health plan eligible for coverage under MCHA. Requires incremental costs to MCHA resulting from implementation of this section to be paid from the health care access fund.

Subd. 7. Federal approval. Requires the commissioner to seek federal financial participation for adult enrollees eligible under this section.

74 **Families with children.** Amends § 256L.04, subd. 1. Eliminates an exemption from the program income limit for certain children who transition from MA to MinnesotaCare (other provisions related to this transition group are repealed in this article; federal approval for this transition has not yet been obtained). Also eliminates a contingent effective date related to federal approval for a provision increasing the program income limit for parents to $57,500.

75 **Citizenship requirements.** Amends § 256L.04, subd. 10. Makes a change in statutory citation, to reflect the elimination of state-only funded MA coverage for certain legal noncitizens in section 27, and to maintain MinnesotaCare coverage these legal noncitizens. Provides a January 1, 2012 effective date.

76 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Specifies that for MinnesotaCare enrollees who are children who formerly resided in foster care or a juvenile residential correctional facility, the first period of renewal begins the month the enrollee turns age 21. (This section reinstates some of the language repealed in section 97.)

77 **Referral of veterans.** Amends § 256L.05, by adding subd. 6. Requires the commissioner to ensure that all MinnesotaCare applicants who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the U.S. Department of Veterans Affairs for any VA benefits for which they are eligible.

78 **Residency requirement.** Amends § 256L.09, subd. 2. Eliminates the requirement that adults without children be permanent residents of Minnesota in order to qualify for MinnesotaCare. States that this provision is effective the day following final enactment or upon federal approval of federal financial participation for adults without children, whichever is later.

79 **Enrollees 18 or older.** Amends § 256L.11, subd. 6. Provides that hospital admissions for MinnesotaCare adults without children paid directly by the commissioner do not include chemical dependency hospital-based and residential treatment.

80 **Critical access dental providers.** Amends § 256L.11, subd. 7. Reduces MinnesotaCare payments to critical access dental providers from 50 percent to 30 percent above the regular payment rate, effective for services provided on or after September 1, 2011.

81 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. The amendment to paragraph (d) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's emergency department utilization rate for MA and MinnesotaCare enrollees. Requires a reduction of no less than 10 percent from the previous calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's emergency department utilization rate is reduced by 25 percent.

A new paragraph (e) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's hospital admission rate for MA and MinnesotaCare enrollees. Requires a reduction of no less than 5 percent from the previous calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's admission rate is reduced by 25 percent.

A new paragraph (f) requires the commissioner, effective for services provided on or after January 1, 2012, to include as a performance target a reduction in a health plan's rate subsequent hospitalizations within 30 days of a previous hospitalization. Requires a reduction of no less than five percent from the previous calendar year, in order for the withhold to be returned. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.

82 **Premium determination.** Amends § 256L.15, subd. 1. Eliminates the expiration date for a provision under which DHS pays MinnesotaCare premiums for members of the military and their families for 12 months.

83 **Current reduction in tax rate.** Amends § 295.52, by adding subd. 8. (a) Requires the commissioner of management and budget, by December 1 of each year beginning in 2011, to determine the projected balance in the health care access fund for the biennium.

(b) If the commissioner of management and budget determines that the projected balance in the fund reflects a ratio of revenues to expenditures and transfers that is greater than 125 percent and the cash balance in the fund is adequate, requires that commissioner, in consultation with the commissioner of revenue, to reduce MinnesotaCare provider tax rates for the subsequent calendar year to the extent that the 125 percent ratio is not exceeded. States that any rate reduction expires at the end of each

calendar year and is subject to annual redetermination.

(c) Requires the commissioner of management and budget to include projected revenues in conducting the analysis under paragraph (b), notwithstanding the January 1, 2020, repeal of the tax.

84 **Effective date.** Delays the effective date of a provision modifying the treatment of bank accounts as assets under MA, until October 1, 2019, or the date it is no longer subject to the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

85 **Effective date.** Delays the effective date of a provision modifying procedures for the reduction of excess assets under MA, until January 1, 2014, or the date it is no longer subject to the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

86 **Effective date.** Delays the effective date of a provision modifying procedures for the determination of periods of ineligibility for MA, until January 1, 2014, or the date it is no longer subject to the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

87 **Effective date.** Delays the effective date of a provision setting nursing facility level of care criteria, until January 1, 2014, or the date it is no longer subject to the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

88 **Effective date.** Delays the effective date of a provision related to the treatment of pooled trusts under MA, until January 1, 2014, or the date it is no longer subject to the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act.

89 **Plan to coordinate care for children with high-cost mental health conditions.** Requires the commissioner of human services to develop and submit to the legislature, by January 15, 2011, a plan to provide care coordination to MA and MinnesotaCare enrollees who are children with high-cost mental conditions.

90 **Regulatory simplification and reduction of provider reporting and data submittal requirements.**

Subd. 1. Regulatory simplification and report reduction work group. Requires the commissioner of management and budget to convene a regulatory simplification and report reduction work group to eliminate redundant, unnecessary, and obsolete state reporting or data submittal requirements for health care providers and group purchasers.

Subd. 2. Plan development and other duties. Requires the commissioner, in consultation with the work group, to develop a plan for regulatory simplification and report reduction activities of the commissioners of health, human services, and commerce, that focuses on specified types of data and reporting. Requires the commissioners, following consultation with the work group, to present proposals to implement their recommendations by February 15, 2012.

Subd. 3. New reporting and other duties. Requires the commissioner of management and budget, in consultation with the work group and the commissioners of health, human services, and commerce, to develop criteria to be used by the commissioners in determining whether to establish new reporting and data submittal requirements. Specifies parameters for the criteria. Allows the commissioners to propose to the legislature new reporting and data submittal requirements to take effect on or after July 1, 2012. Requires the proposals to include an analysis of the extent to which the requirements meet the criteria developed.

91 **Specialized maintenance therapy.** Requires the commissioner of human services to evaluate whether providing MA coverage for specialized maintenance therapy will reduce rates of hospitalization for enrollees with serious and persistent mental illness. Requires a report to the

legislature by December 15, 2011.

92 **Reducing hospitalization rates.** Requires the commissioner of human services, by January 15, 2012, to present recommendations to the legislature to reduce hospitalization rates for state health care program enrollees who are children with high-cost medical conditions.

93 **Medicaid fraud prevention and detection.**

Subd. 1. Request for proposals. Requires the commissioner of human services, by December 31, 2011, to issue an RFP to prevent and detect Medicaid fraud and mispayment. Specifies criteria for the RFP.

Subd. 2. Proof of concept phase. Requires the vendor to implement its recommendations on a subset of data to demonstrate the direct recoveries of the solution.

Subd. 3. Data confidentiality. Requires vendors to maintain the confidentiality of information provided.

Subd. 4. Full implementation phase. Requires the commissioner to implement the vendor recommendations if recoveries are demonstrated under subdivision 2. Requires the vendor to be paid following full implementation from recoveries obtained through the vendor's work.

Subd. 5. Selection of vendor. Requires the commissioner to select a vendor by January 31, 2012.

Subd. 6. Progress report. Requires the commissioner to provide progress report to the governor and specified legislative chairs and ranking minority members, by June 15, 2012.

94 **Capitation payment delay.** Requires the commissioner to delay $135 million of the MA and MinnesotaCare capitation payment to managed care and county-based purchasing plans due in May 2013 and the payment due in April 2013 for special needs basic care plans, until July 2013.

Requires the commissioner to delay $135 million of the MA and MinnesotaCare capitation payment to managed care and county-based purchasing plans due in the second quarter of CY 2015 and the payment due in April 2015 for special needs basic care plans, until July 2015.

95 **Minnesota autism spectrum disorder task force.**

Subd. 1. Members. (a) Specifies the membership of the Autism Spectrum Disorder Task Force.

(b) Requires that appointments be made by September 1, 2011, and that the first meeting be convened by the majority leader of the senate by October 1, 2011. Directs the task force to elect a chair at its first meeting and to meet at least six times per year.

Subd. 2. Duties. (a) Requires the task force to develop a statewide strategic plan for autism spectrum disorder (ASD) to improve awareness, early diagnosis and intervention, and to ensure delivery of treatment and services to persons diagnosed with ASD.

(b) Requires the task force to coordinate existing efforts relating to ASD at certain state agencies, and other organizations,

Subd. 3. Report. Requires the task force to submit its strategic plan to the legislature by January 15, 2013, provide assistance with the implementation of the plan as approved by the legislature, and submit annual progress reports by January 15, 2014, and 2015.

Subd. 4. Expiration. States that this task force expires June 30, 2015, unless extended by law.

96 **Competitive bidding pilot.** For managed care contracts effective January 1, 2012, requires the commissioner of human services to establish a competitive bidding pilot for nonelderly, nondisabled adults and children in MA and MinnesotaCare in the seven-county metro area. Requires a minimum of two managed care organizations to serve the metro area. Provides that the pilot expires after two full calendar years, on December 31, 2013. Requires the commissioner to evaluate the cost-effectiveness of the pilot and its impact on provider access.

97 **Repealer.**

Subd. 1. Legislative oversight commission. Repeals § 62J.07, subds. 1, 2, and 3 (Legislative Commission on Health Care Access).

Subd. 2. Children formally under medical assistance. Repeals § 256L.07, subd. 7 (exemption of certain children transitioned from MA from MinnesotaCare insurance barriers) retroactively from October 1, 2008 (this provision has not yet been approved by the federal government).

Subd. 3. Extending medical assistance. Repeals § 256B.057, subdivision 2c (extended MA coverage for certain children; this provision has not yet been approved by the federal government).

Subd. 4. Repeals § 256B.69, subd. 9b (reporting of provider payment rates).

Subd. 5. Repeals provisions in Laws 2008, chapter 358, article 3, sections 8 and 9, providing MinnesotaCare enrollees with a renewal rolling month and a premium grace month (these provisions have not yet been approved by the federal government).

Subd. 6. MinnesotaCare provider taxes. Repeals § 13.4967, subd. 3 (data classification for provider tax data) and sections in chapter 295 (MinnesotaCare provider taxes), effective for gross revenues received after December 31, 2019.

Subd. 7. Renewal of medical assistance eligibility. Repeals Laws 2009, chapter 79, article 5, section 62, retroactively from July 1, 2009 (provides continued eligibility under MinnesotaCare for children who fail to submit renewal information in a timely manner; a provision related to children who formerly resided in foster care or juvenile residential correctional facilities is repealed but reinstated in this article in section 76).

Article 7: Continuing Care

Overview

This article makes changes to long-term care consultation services, MA-EPD, assessments, home and community-based waiver services, alternative care, nursing facilities, and ICF/DD facilities.

1 **Licensing moratorium.** Amends § 245A.03, subd. 7, as amended by Laws 2011, ch. 86, § 4. Requires the county to immediately inform DHS when a foster care recipient moves out of a foster care home that is not the primary residence of the license holder. Requires DHS to immediately decrease the licensed capacity for the home. Makes decreased licensed capacity according to this paragraph not subject to appeal.

2 **Disability linkage line.** Amends § 256.01, subd. 24. Specifies duties of the disability linkage line.

3 **State medical review team.** Amends § 256.01, subd. 29. Removes a cross-reference.

4 **Money Follows the Person Rebalancing demonstration project.** Amends § 256B.04, by adding subd. 20. Requires amounts equal to the value of enhanced federal funding resulting from the operation of the demonstration project grant to be transferred from the medical assistance account in the general fund to an account in the special revenue fund. Funds in the special revenue fund account do not cancel and are appropriated to the commissioner to carry out the goals of the Money Follows the Person Rebalancing demonstration project as required under the approved federal plan for the use of the funds, and may be transferred to the medical assistance account if applicable.

5 **Obligation of local agency to process MA applications within established timelines.** Amends § 256B.05, by adding subd. 5. Requires local agencies to act on MA applications within ten working days of receipt of all necessary information, but no later than 45 days.

6 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Removes obsolete language and makes this section effective January 1, 2014.

7 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Makes technical changes reorganizing the language in this subdivision. Removes obsolete language. Excludes spousal assets for purposes of determining eligibility for MA-EPD. Increases the MA-EPD premium and increases the amount of unearned income that must be paid in addition to the premium. Requires the commissioner to reimburse enrollees with incomes below 200 percent of the federal poverty guidelines for Medicare Part B premiums. Makes this section effective January 1, 2014, for adults age 21 or older, and October 1, 2019, for children age 16 to before the child's 21st birthday.

8 **Personal care assistance services.** Amends § 256B.0625, subd. 19a. Removes a change in PCA eligibility related to the number of ADLs required.

9 **Authorization; personal care assistance and qualified professional.** Amends § 256B.0652, subd. 6. Limits home care rating determination to recipients with dependencies in two or more ADLs. Limits the amount of PCA service recipients with a dependency in only one ADL or Level I behavior may receive.

10 **Personal care assistant; requirements.** Amends § 256B.0659, subd. 11. Limits payment to PCAs who are providing services to a relative. Defines "relative" for purposes of this section. Makes this section effective October 1, 2011.

11 **PCA provider agency; required documentation.** Amends § 256B.0659, subd. 28. Expands documentation requirements for PCA provider agencies and allows the commissioner to fine agencies that do not comply with documentation requirements.

12 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services" to conform to nursing facility level of care.

13 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Requires the person to be provided with alternatives to residential settings, including, but not limited to, foster care settings that are not the primary residence of the license holder.

14 **Consultation for housing with services.** Amends § 256B.0911, subd. 3c. Requires long-term care consultation for housing with services. Specifies how the long-term care consultation services are delivered. Specifies how the point of entry service must be provided. Specifies requirements for housing with services establishments. Makes this section effective October 1, 2011.

15 **Preadmission screening activities related to nursing facility admissions.** Amends § 256B.0911, subd. 4a. Makes conforming changes related to MA maintenance of effort and nursing facility level of care.

16 **Eligibility for funding for services for nonmedical assistance recipients.** Amends § 256B.13, subd. 4. Modifies eligibility criteria for alternative care to conform to federal maintenance of effort requirements. Makes eligibility changes for individuals assigned a case mix classification A and reduces the monthly budget cap for these individuals.

17 **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Removes an automatic annual adjustment to EW monthly case mix caps related to nursing facility payment rates. Makes eligibility changes for individuals assigned a case mix classification A and reduces the monthly budget cap for these individuals.

18 **Cost limits for elderly waiver applicants who reside in a nursing facility.** Amends § 256B.0915, subd. 3b. Removes an automatic annual adjustment to EW monthly case mix caps related to nursing facility payment rates. Modifies the monthly conversion budget limit calculation.

19 **Customized living service rate.** Amends § 256B.0915, subd. 3e. Reduces the individualized monthly payment for customized living for low-needs individuals. Requires the new rate limit to be applied to all new applicants enrolled in the program on or after July 1, 2011, and to all other participants at reassessment. Requires licensed home care providersthat do not participate in or accept Medicare assignment to refer and document the referral of dual-eligible recipients to Medicare providers when Medicare is determined to be the appropriate payer for services and supplies and equipment. Prohibits providers from billing or otherwise charging an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits, nor for additional units of any allowable component services beyond those approved in the service plan by the lead agency.

20 **Service rate limits; 24-hour customized living services.** Amends § 256B.0915, subd. 3h. Increases the criteria for 24-hour customized living. Prohibits providers from billing or otherwise charging an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits, nor for additional units of any allowable component services beyond those approved in the service plan by the lead agency.

21 **Assessment and reassessments for waiver clients.** Amends § 256B.0915, subd. 5. Makes conforming changes related to MA maintenance of effort and nursing facility level of care.

22 **Waiver payment rates; managed care organizations.** Amends § 256B.0915, subd. 10. Removes obsolete language. Prohibits MA rates paid to customized living providers by managed care organizations from exceeding the maximum component rates.

23 **State quality assurance, quality improvement, and licensing system.** Creates § 256B.0961.

Subd. 1. Scope. Specifies that the system is a partnership between the Department of Human Services and the State Quality Council established in subdivision 3. Lists the services eligible under this section. Defines "commissioner," "council," "Quality Assurance Commission," and "system."

Subd. 2. Duties of the commissioner of human services. Requires the commissioner to establish the State Quality Council. Requires the commissioner to delegate authority to perform certain licensing functions to a host county in Region 10. Allows the commissioner to conduct random licensing inspections based on outcomes at facilities, programs, and services eligible under this section. Requires the commissioner to ensure that federal home- and community-based waiver requirements are met. Requires the commissioner to seek a federal waiver by July 1, 2012, to allow ICFs/DD to participate in this system.

Subd. 3. State Quality Council. Creates a State Quality Council, lists members of the council, allows certain council members to receive per diem payment when performing council duties,

and lists the duties of the council.

Subd. 4. Regional quality councils. Requires the commissioner to establish regional quality councils, lists the members of the councils, and lists the duties of the councils.

Subd. 5. Annual survey of service recipients. Requires the commissioner to conduct an annual independent survey of service recipients. Specifies requirements the survey must meet.

Subd. 6. Mandated reporters. Makes members of the State Quality Council, regional quality councils, and quality assurance teams mandated reporters under the Maltreatment of Minors and Vulnerable Adults Acts.

Makes subdivisions 1 to 6 effective July 1, 2011. Requires the jurisdictions of the regional quality councils to be defined by July 1, 2012. Requires the Quality Assurance Commission to continue to implement the alternative licensure system during the 2012-2013 biennium.

24 **Additional local share of certain nursing facility costs.** Amends § 256B.19, subd. 1e. Clarifies the start date of the inter-governmental transfer program and allows the commissioner to revoke participation rather than withhold funds in the event that an owner fails to make a timely payment of the nonfederal share.

25 **Payment restrictions on leave days.** Amends § 256B.431, subd. 2r. Limits payments for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident and allows this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent.

26 **Payment limitation.** Amends § 256B.431, subd. 2t. Beginning January 1, 2012, updates resident reimbursement classifications from RUG-III to RUG-IV case-mix.

27 **Payment during first 30 days.** Amends § 256B.431, subdivision 32. Renames the subdivision and makes the necessary language changes to reflect the current first 30-day incentive program for new nursing facility residents.

28 **Alternate rates for nursing facilities.** Amends § 256B.434, subd. 4. Suspends automatic property rate adjustments for the rate years beginning on October 1, 2011, and October 1, 2012.

29 **Planned closure rate adjustment.** Amends § 256B.437, subd. 6. Prohibits the commissioner from accepting applications for planned closure rate adjustments as of July 16, 2011.

30 **Scope.** Amends § 256B.438, subd. 1. Updates cross-references and updates resident reimbursement classifications from RUG-III to RUG-IV effective January 1, 2012.

31 **Case mix indices.** Amends § 256B.438, subd. 3. Requires the commissioner to assign a case mix index to each resident class based on the CMS staff time measurement study upon implementation of the 48-group RUG-IV resident classification system. Requires the case mix indices assigned to each resident class to be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

32 **Resident assessment schedule.** Amends § 256B.438, subd. 4. Effective January 1, 2012, requires the commissioner to determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner.

33 **Rate determination upon transition to RUG-IV payment rates.** Amends § 256B.438, by adding subd. 8. Requires the commissioner to determine payment rates at the time of transition to the RUG-IV-based payment model. Requires nursing facilities to report certain information related to MA resident days to the commissioner for the six-month reporting period ending June 30, 2011. Specifies

how the commissioner shall determine the case mix adjusted component for the January 1, 2012, rate. Specifies that noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

34 **Determination of proximity adjustments.** Amends § 256B.441, subdivision 50a. Modifies certain nursing facility operating payment rates proximity adjustments.

35 **Alternative to phase-in for publicly owned nursing facilities.** Amends § 256B.441, subd. 55a. Clarifies the start date of the inter-governmental transfer program, provides for the continuation of the program when the phase-in of rebasing is complete and specifies a replacement limit to go into effect at that time, allows annual application to participate, and permits the owner to revoke an application.

36 **Rate increase for low-rate facilities.** Amends § 256B.441, by adding subd. 61. Increases certain low-rate nursing facility reimbursement rates by up to 2.45 percent effective October 1, 2011.

37 **Repeal of rebased operating payment rates.** Amends § 256B.441, by adding subd. 62. Prohibits any further steps toward phase-in of nursing facility rebased operating payment rates from being taken.

38 **Informed choice.** Amends § 256B.49, subd. 12. Makes conforming changes related to MA maintenance of effort and nursing facility level of care.

39 **Assessment and reassessment.** Amends § 256B.49, subd. 14. Adds a cross-reference to assessments under long-term care consultation services. Requires the commissioner to develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Requires individuals who meet the commissioner's criteria to have a comprehensive transitional service plan developed. Makes counties, case managers, and service providers responsible for conducting these reassessments and for completing them within existing funds. Makes paragraph (f) effective July 1, 2013.

40 **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Paragraphs (b), (c), and (d) specify timelines and requirements in developing and implementing comprehensive transitional service plans and maintenance service plans.

Paragraph (f) specifies requirements at the time of reassessment that local agency case managers must meet related to CADI and TBI recipients who reside in a licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver. Requires this reassessment process to be completed by June 30, 2012.

Makes paragraphs (b), (c), and (d) effective July 1, 2013.

41 **Community-living settings.** Amends § 256B.49, by adding subd. 23. Defines "community-living settings."

42 **ICF/DD rate increase.** Amends § 256B.5012, by adding subd. 9. Requires the commissioner to increase the daily rate to $138.23 at a specified ICF/DD in Clearwater County.

43 **ICF/DD rate adjustment.** Amends § 256B.5012, by adding subd. 10. Requires the commissioner to decrease operating payment rates for all facilities, with one exception, equal to 0.095 percent of the operating payment rates in effect on June 30, 2011. Specifies how the rate reduction must be applied to each facility by the commissioner.

44 **ICF/DD rate decrease effective July 1, 2011.** Amends § 256B.5012, by adding subd. 11. Decreases operating payment rates equal to 1.5 percent of the operating payment rates in effect on June 30,

2011. Specifies how the commissioner shall apply the rate reduction.

45 **ICF/DD rate increase effective July 1, 2013.** Amends § 256B.5012, by adding subd. 12. Increases operating payment rates equal to 0.5 percent of the operating payment rates in effect on June 30, 2013. Specifies how the commissioner shall apply the rate increase.

46 **ICF/DD rate decrease effective July 1, 2012.** Amends § 256B.5012, by adding subd. 13. Decreases operating payment rates equal to 1.67 percent of the operating payment rates in effect on June 30, 2012. Specifies how the commissioner shall apply the rate reduction. Makes this section effective only if the federal approval required under section 52 has not been received by June 30, 2012.

47 **Effective date.** Amends Laws 2009, ch. 79, art. 8, § 4, the effective date, as amended by Laws 2010, First Special Session ch. 1, art. 24, § 12. Makes conforming changes related to MA maintenance of effort and nursing facility level of care.

48 **Effective date.** Amends Laws 2009, ch. 79, art. 8, § 51, the effective date, as amended by Laws 2010, First Special Session ch. 1, art. 17, § 14. Makes conforming changes related to MA maintenance of effort and nursing facility level of care.

49 **Continuing care grants.** Amends Laws 2009, ch. 79, art. 13, § 3, subd. 8, as amended by Laws 2009, ch. 173, art. 2, § 1, subd. 8, and Laws 2010, First Special Session, ch. 1, art. 15, § 5, and art. 25, § 16. Removes a provision related to alternatives to PCA services.

50 **Nursing facility pilot project.** Creates a nursing facility pilot project to develop a new approach to caring for certain individuals. A report is due to the legislature on November 15, 2011.

51 **Provider rate and grant reductions.** Requires the commissioner of human services to decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.5 percent effective July 1, 2011, through June 30, 2013, for services rendered during those dates. Beginning July 1, 2013, requires the commissioner of human services to decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.0 percent for services rendered on or after those dates. Specifies the long-term care home and community-based programs these rate changes affect. Specifies how these rate reductions must be applied to managed care organizations and county or tribal contracts for services.

52 **Implement nursing home level of care criteria.** Requires the commissioner to seek any necessary federal approval in order to implement the changes to level of care criteria on July 1, 2012.

53 **Medical Assistance Reform Waiver.**

Subd. 1. Intent. Specifies the intent of the legislature to reform components of the MA program for seniors and people with disabilities and other complex needs, and MA enrollees in general, in order to achieve better outcomes.

Subd. 2. Proposal. Requires the commissioner of human services to develop a proposal to the U.S. Department of Health and Human Services for projects specified in subdivision 4. Requires the commissioner to ensure that all projects are budget neutral or result in savings to the state budget, considering cost changes across all divisions and other agencies that are affected.

Subd. 3. Legislative proposals; rules. Requires the commissioner to report to the members of the legislative committees with jurisdiction over human services issues by January 15, 2012, regarding the progress of this waiver, and to make recommendations regarding any legislative changes necessary to accomplish the projects in subdivision 4.

Subd. 4. Projects. Requires the commissioner to request permission and funding to further

several initiatives, including (1) health care delivery demonstration projects; (2) promoting personal responsibility and rewarding healthy outcomes; (3) encouraging utilization of high quality, cost-effective care; (4) limiting assets for certain adults without children; (5) empowering and encouraging work, housing and independence; (6) redesigning home and community-based services; (7) coordinating and streamlining services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions; (8) implementing nursing home level of care criteria; (9) improving integration of Medicare and Medicaid; (10) providing intensive residential treatment services; (11) seeking federal Medicaid matching funds for Anoka Metro Regional Treatment Center; and (12) seeking waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities.

Subd. 5. Federal funds. Authorizes the commissioner to accept and expend federal funds that support the purposes of this section.

54 **Contingency provider rate and grant reductions.** Requires the commissioner of human services to decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2012, for services rendered during those dates. Specifies the long-term care home and community-based programs these rate changes affect. Specifies how these rate reductions must be applied to managed care organizations and county or tribal contracts for services. Makes these payment rate reductions, allocation rates, and rate limits expire for services rendered on December 31, 2013. Makes this section effective only if the federal approval required under section 52 has not been received by June 30, 2012.

Article 8: Chemical and Mental Health

1 **Liability of county; reimbursement.** Amends § 246B.10. Increases the county share for persons civilly committed to the Minnesota sex offender program from 10 percent to 25 percent.

Provides this section is effective for individuals who are civilly committed to the sex offender program on or after August 1, 2011.

2 **Commitment; Red Lake Band of Chippewa Indians; White Earth Band of Ojibwe.** Amends § 253B.212. Makes technical changes. Adds subdivision 1a. Allows the White Earth Band to enter into the same agreements as the Red Lake Band with the Indian Health Service for care and treatment of tribal members committed for care and treatment due to mental illness, developmental disability, or chemical dependency. Adds that White Earth can also contract with the commissioner of human services for treatment of tribal members who have been committed by the tribal court. Requires tribal court commitment procedures to comply with the provisions of section 253B.05 to 253B.10.

3 **Division of costs.** Amends § 254B.03, subd. 4. Increases the county share under the consolidated chemical dependency treatment fund from 16.14 percent to 22.95 percent.

Provides that this increase is effective for claims processed beginning July 1, 2011.

4 **Eligibility for treatment in residential settings.** Amends § 254B.04, by adding subd. 2a. Increases the assessment level score for an individual to be approved for residential chemical dependency treatment.

5 **Allocation of collections.** Amends § 254B.06, subd. 2. Increases the county share under the consolidated chemical dependency treatment fund from 16.14 percent to 22.95 percent.

Provides that this increase is effective for claims processed beginning July 1, 2011.

6 **Residential services for children with severe emotional disturbance.** Amends § 256B.0625, subd. 41. Adds that medical assistance covers services provided by a tribe for children who have a severe emotional disturbance and require residential care.

Provides that this section is effective October 1, 2011.

7 **Payment rates.** Amends § 256B.0945, subd. 4. Adds paragraph (c) which states that payment for mental health rehabilitative services provided by tribal organizations must be made according to section 256B.0625, subd. 34, (Indian health services facilities) or other federally approved methodology.

Provides that this section is effective October 1, 2011.

8 **Community mental health services; use of behavioral health hospitals.** Instructs the commissioner to issue a report to the legislature on how the community behavioral health hospitals will be utilized to meet the mental health needs of the regions in which they are located. Requires the report to address future use of the hospitals that are not certified as Medicaid eligible or have less than 65 percent licensed bed occupancy. Requires the commissioner to consult with the regional mental health authorities.

9 **Integrated dual diagnosis treatment.** Requires the commissioner to implement integrated dual diagnosis treatment for individuals with co-occurring substance abuse and mental health disorders. Requires the commissioner to seek federal waivers as necessary.

10 **Regional treatment centers; employees; report.** Provides that no layoffs shall occur as a result of restructuring services at the Anoka-Metro Regional Treatment Center. Requires the commissioner to issue a report which provides the number of employees in management positions at Anoka and the Minnesota Security Hospital and the ratio of management to direct care staff for each facility.

Article 9: Redesigning Service Delivery

1 **American Indian child welfare projects.** Amends § 256.01, subd. 14b, by adding paragraph (i). Instructs the commissioner to develop a plan to transfer local responsibility for providing child welfare services for White Earth member children who reside in Hennepin County to the White Earth Band.

2 **Provision of required materials in alternative formats.** Amends § 256B.69, by adding subd. 30. Paragraph (a) defines the terms "alternative format," and "prepaid health plan."

Paragraph (b) allows prepaid health plans to provide in an alternative format a provider directory and certificate of coverage and other specified materials if certain conditions are met.

Paragraph (c) allows prepaid health plans to provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. Requires the commissioner or local agency to inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. Requires prepaid health plans to provide sufficient paper versions of the primary care network list to the commissioner and to local agencies to accommodate potential enrollee requests for paper versions of the primary care network list.

Paragraph (d) allows prepaid health plans to provide in an alternative format certain materials to specified persons as long as certain specified conditions are met.

Paragraph (e) requires the commissioner to seek any federal Medicaid waivers within 90 days after the effective date of this subdivision that are necessary to provide alternative formats of required

materials to enrollees of prepaid health plans as authorized under this section.

Paragraph (f) requires the commissioner to consult with specified parties to determine how materials required to be made available to enrollees of prepaid health plans may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. Requires the commissioner to consult with specified parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

3 **Recovery of overpayments.** Amends § 256D.09, subd. 6. Exempts certain GA recipients from recovery of overpayments. Limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

4 **Overpayment of monthly grants and recovery of ATM errors.** Amends § 256D.49, subd. 3. For the MSA program, limits establishment of an overpayment to 12 months from the date of discovery due to agency error and six years due to client error. Specifies that no limit applies to the establishment period if the overpayment is due to an intentional program violation or if the client wrongfully obtained assistance.

5 **Scope of overpayment.** Amends § 256J.38, subd. 1. For the MFIP program, limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

6 **Food stamp program; Maternal and Child Nutrition Act.** Amends § 393.07, subd. 10. Limits establishment of an overpayment to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation.

7 **Essential human services or essential services.** Amends § 402A.10, subd. 4. Adds tribal services to the definition of essential human services or essential services.

8 **Service delivery authority.** Amends § 402A.10, subd. 5. Adds that the commissioner has the authority to assign a county to be a member of a service delivery authority. Adds that a tribe or group of tribes to the definition of service delivery authority.

9 **Steering committee on performance and outcome reforms.** Amends § 402A.15.

Subd. 1. Duties. Removes the requirement for the steering committee to include recommendations on resources and funding needed to achieve performance measures. Eliminates certain considerations such as geography, populations served, and administrative demands when determining performance measures and goals. Requires the steering committee to incorporate federal performance measures when federal funding is contingent on meeting these performance measures.

Subd. 2. Composition. Removes the requirement for two members of the steering committee to also serve as representatives to the redesign council.

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

Subd. 1. Underperforming county; specific service. Grants the commissioner authority to adjust state and federal funds for an underperforming county.

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

Subd. 2a. Financial responsibility of underperforming county. Requires an underperforming county to provide the nonfederal and nonstate funding needed to remedy

performance deficiencies to the entity assuming administration of the essential service.

Subd. 3. Conditions prior to imposing remedies. Makes a technical change.

11 **Council.** Amends § 402A.20.

Subd. 1. Council. Clarifies that recommendations must be approved by a majority of the voting council members. There are nonvoting members of the council.

Subd. 2. Council duties. Clarifies the duties of the council. Among the duties:

- Review the service redesign process, including proposed memoranda of understanding;
- Review and make recommendations on requests for waivers of statutory or rule program requirements;
- Establish a process for public input on the scope of essential services administered by a service delivery authority;
- Serve as a forum to resolve conflicts;
- Engage in the program improvement process; and
- Identify and recommend incentives for counties to participate in service delivery authorities.

Subd. 3. Program evaluation. Requires the council to request that the legislative auditor perform a reevaluation of human service administration that was initially reported in 2007.

12 **Designation of service delivery authority.** Creates § 402A.35.

Subd. 1. Requirements for establishing a service delivery authority. Paragraph (a) sets out the population and geographic requirements for establishing a service delivery authority.

Paragraph (b) lists the requirements for a human service authority: compliance with state and federal laws; defining the scope of essential services; designating a single administrative structure; identifying needed waivers from statutory or rule program requirements; establishing a targeted reduction of administrative expenses; establishing terms for a county to withdraw from participation.

Paragraph (c) prohibits a county or tribe that is a member of a service delivery authority from participating in another service delivery authority.

Paragraph (d) provides that nothing in this chapter limits or prohibits local governments or tribes from combining services or county boards or tribes from entering into contracts for services that are not under the jurisdiction of the service delivery authority.

Subd. 2. Relief from statutory mandates. Lists the statutory mandates. Allows the service delivery authorities to request additional waivers from other statutory and rule mandates in order to allow greater flexibility and control.

Subd. 3. Duties. Lists the duties of the service delivery authority.

Subd. 4. Process for establishing a service delivery authority. Paragraph (a) provides that a county or consortium of counties seeking to establish a service delivery authority must present a proposed memorandum of understanding, and a resolution from the board of county commissioners of each participating county. Provides that a tribe must have a resolution from tribal government stating the tribe's intent to participate.

Paragraph (b) allows the commissioner to finalize and execute the memorandum of understanding upon the recommendation of the council.

Subd. 5. Commissioner authority to seek waivers. Gives the commissioner authority to grant waivers, but they must be approved by the council.

13 **Transition to new bargaining unit structure.** Creates § 402A.40.

Subd. 1. Application of section. Provides that this section governs the initial certification and decertification of exclusive representatives for service delivery authorities. Defines service delivery authorities as public employers.

Subd. 2. Existing majority. Establishes the method for an existing employee organization to be certified as exclusive representative.

Subd. 3. No existing majority. Establishes the method for an employee organization to be certified as exclusive representative when there is no existing majority.

Subd. 4. Decertification. Provides that the commissioner of the Minnesota Bureau of Mediation Services cannot consider a petition for decertification of an exclusive representative for one year after certification.

Subd. 5. Continuing contract. Provides that collective bargaining agreements remain in effect until successor agreements become effective. Provides that employees' accrued leave and benefits continue to apply in the newly created service delivery authority. Establishes the protocol for layoffs.

Subd. 6. Contract and representation responsibilities. Requires exclusive representatives to remain responsible for administration of their contracts until a contract is agreed upon with the service delivery authority. Provides that the exclusive representative certified after the creation of the service delivery authority is responsible for administration of contracts, including administering unresolved grievances.

14 **County electronic verification procedures.** Requires the commissioner to define which public assistance program eligibility requirements may be electronically verified. Instructs the commissioner to submit draft legislation, if needed, by January 15, 2012.

15 **Alignment of verification and redetermination policies.** Requires the commissioner, in consultation with counties and stakeholders, to develop recommendations to simplify and streamline program eligibility and access. Requires the commissioner to report back to the chairs of the legislative committees with jurisdiction over these issues by January 15, 2013, with recommendations and draft legislation to implement the recommendations.

16 **Alternative strategies for certain redeterminations.** Requires the commissioner to develop and implement by January 15, 2012, a simplified process to redetermine eligibility for recipients in the MA, MSA, food support, and GRH programs who are eligible based on disability or age, and who are expected to experience minimal change in income or assets from month to month. Requires the commissioner to apply for any federal waivers needed to implement this section.

17 **Simplification of eligibility and enrollment process.** Paragraph (a) requires the commissioner to issue a request for information for an integrated service delivery system for health care, food support, cash assistance, and child care programs. Lists requirements for the system.

Paragraph (b) requires the commissioner to issue a final report and implementation plan to the legislature no later than January 31, 2012.

Paragraph (c) lists the agencies and entities the commissioner must consult to develop this system.

Paragraph (d) requires an annual report to the legislature beginning May 15, 2012.

Paragraph (e) instructs the commissioner to work with the Minnesota Association of County Social Service Administrators and the Office of Enterprise Technology to develop task forces to support implementation of specified components of the service delivery framework.

Paragraph (f) requires the commissioner to issue an RFP subject to a legislative appropriation.

Provides that this section is effective the day following final enactment.

18 **White Earth Band of Ojibwe human services project.** Paragraph (a) requires the commissioner, in consultation with the White Earth Band of Ojibwe, to transfer legal responsibility for providing human services for tribal members and their families who reside on or off reservation in Mahnomen County to the White Earth Band.

Paragraph (b) provides that determinations as to which programs will be transferred will be made by a consensus decision of the tribal governing body and the commissioner. Allows the commissioner to waive existing rules and seek federal approvals and waivers.

Paragraph (c) relieves Mahnomen County of responsibility for providing human services to tribal members while the tribal project is in effect and funded, unless a family member who is not a member of the tribe chooses to receive services from the county.

Paragraph (d) instructs the commissioner and the tribe to develop a plan to transfer legal responsibility for providing human services for tribal members in Clearwater and Becker counties to the White Earth Band.

Paragraph (e) requires the commissioner to submit a progress report to the legislature no later than January 15, 2012, along with any proposed legislation necessary to effectuate the transfer.

19 **Repealer.** Paragraph (a) repeals §§ 402A.30 and 402A.45 (service delivery authority).

Paragraph (b) repeals Minnesota Rules part 9500.1243, subp. 3 (recovery of overpayments).

Article 10: Health and Human Services Appropriations

See Spreadsheet.

Article 11: Effective Date

1 **Effective date; relationship to other appropriations.** Makes this act effective retroactive to July 1, 2011, unless another effective date is specified.